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

The enjoyment of health care is a fundamental human right and an instrumental element of human development. UNRWA, with the effective and strong support of the World Health Organisation (WHO), contributes towards realizing this right for Palestine refugees and, for the seventh decade, its Health Programme has been delivering comprehensive primary health care services through a network of 143 health facilities in Gaza, the West Bank, Jordan, Lebanon and Syria. In addition, the Agency supports Palestine refugees' access to secondary and tertiary health care services.

UNRWA provides these health care services amidst conditions of intense conflict, economic crisis and growing poverty. The 560,000 Palestine refugees registered with UNRWA in Syria are among those worst affected. Hundreds of thousands have been subjected to continued and repeated displacement and thousands remain trapped in areas of active conflict, in conditions of unimaginable suffering. Those able to flee to Jordan and Lebanon face an extremely fragile and precarious existence. 2015 was the eighth year of the blockade in Gaza leading to health, food, electricity and fuel crises. In the West Bank, the recurrent violence and occupation continue to deeply affect the delivery of health services. Faced with these challenges, UNRWA provides a critical lifeline and fulfils a key development role for an increasingly vulnerable population of Palestine refugees.

Despite these conditions, UNRWA has made significant progress in the delivery of health care to Palestine refugees. The Agency's Health Programme goal for the period 2010-2015 was to enable "Palestine refugees enjoy long and healthy lives". For the next six years, the emphasis will be to ensure that the "refugees' health is protected and the disease burden is reduced". This is consistent with the Global Sustainable Development Goals (SDGs) 2015-2030, specifically, Goal 3: Ensure healthy lives and promote well-being for all at all ages.

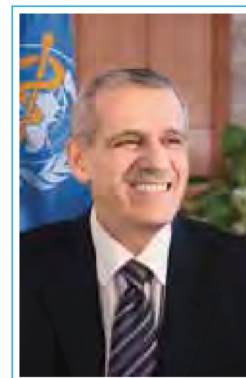
UNWA is committed to further enhancing and improving its health care services. In 2011, UNRWA began a reform process based on a Family Health Team approach and the development of electronic medical records (e-Health). The aim was to modernize the Agency's primary health care services, making them more person-centered and more efficient. By the end of 2015, significant progress was made, as all health centres in Jordan, Lebanon, West bank and Gaza, except two under construction, implemented successfully the Family Health Team approach. In Syria, four health centres implemented the Family Health Team approach by the end of 2015.

Many health-related indicators compare favourably to regional averages, a result that can be attributed in large part to the strength of UNRWA's programmes. However, an ageing refugee population will lead to an intensification of existing health trends and the epidemiological transition with increasing numbers of refugees suffering from non-communicable diseases. At present, it is estimated that about 70 to 80% of refugee deaths are caused by non-communicable diseases. In its hospitalization sub-programme, UNRWA will accord the highest priority to those refugees with life-threatening illnesses requiring life-saving/life-supporting medical care, but who lack the necessary financial assets or insurance coverage to attain such treatment.

UNRWA's infrastructure and assets, the remarkable dedication of its staff, the generosity of donors, host governments and the support of key partners, such as the WHO, enable the Agency to respond rapidly and effectively to ever mounting needs. To cope with the numerous challenges, and facilitate access to health care services, UNRWA will continue to actively cooperate with its longstanding local, national and international partners.
UNRWA remains committed to provide critically needed services, such as health care, until a just and durable solution to the Palestinian refugee question is addressed.

Pierre Krähenbühl

UNRWA Commissioner General



Dr. Ala Alwan

Regional Director, WHO/EMRO

Foreword of the Director of Health

2015 continued to be a difficult year. The instability and conflicts in the region, in addition to UNRWA's budget constraints, have affected UNRWA's work in all the Fields. During the past five years of conflict in Syria, UNRWA Health Department strived to make sure that Palestine refugees are offered quality health services. In addition, many years of blockade, isolation and repeated intense conflicts in the Gaza Strip, had evident worsening impact on the health of refugees living there. The protection challenges in West Bank, as a result of the occupation, including conflict-related violence, and restrictions on movements and access to health resources, had affected the health and wellbeing of the refugees. In Jordan and Lebanon, although the situation is somewhat stable, the rush of refugees from Syria, including Palestine refugees, and the support that UNRWA health centres offered to them, had exerted pressures on the provision of these services.

UNRWA continued its struggle and was able to make significant progress. Efforts to expand and institutionalize the reform process continued. By the end of, the Family Health Team (FHT) approach was operational in 119 health centres serving 90% of the Agency served population, and the e-health system was functional at 97 health centres. To improve NCD management and control, the Department of Health worked on introducing a life-saving medicine for diabetic and hypertensive patients, called statin, and on introducing two important lab tests; HbA1c and microalbuminuria. With the increasing demand on hospitalization across all fields of UNRWA operations, and to be able to offer this service to Palestine refugees who need it, UNRWA, in 2015, to addressed this issue through conducting a hospitalization survey, and reviewing its hospitalization policy, especially for Lebanon and Qalqilia hospital in West Bank. For more comprehensive services, UNRWA Health Department is working on integrating Mental Health and Psychosocial Support (MHPSS) to its primary health care system through the FHT model.

The Health Department continued to generate evidence on its activities through conducting research and publishing the findings. The assessments conducted have shown very positive responses to the FHT approach from both staff and patients. The latest published research was on Neonatal Mortality among Palestine refugees in the Gaza Strip, and on the outcomes of the diabetes campaign that UNRWA implemented during 2013.

Still, our challenges remain significant to protect Palestine refugees' health and to reduce the burden of disease. We will continue to address the effects of all the determinants of health including the social, economic, and particularly, the political ones, all of which negatively affect the health of Palestine refugees.

UNRWA will continue to collaborate with longstanding historical partners, including host countries' concerned authorities, the World Health Organization (WHO) and other United Nations organisations, in addition to local and international organisations. The Palestine refugee communities and other UNRWA programmes will remain, as have been always, very important partners in achieving our goals. As we move into 2016, let us all hope that the objectives of our strategic outcome for the years 2016-2021; "refugees' health is protected and the disease burden is reduced" would be fully achieved. I am confident that this will happen, because I trust that a highly dedicated and extremely committed staff working for the health of Palestine refugees in all fields of UNRWA operations, whom I have the privilege of working alongside, would never accept less than that.

Dr. A. Seita

WHO Special Representative
Director of the UNRWA
Health Programme

Executive Summary

For the seventh decade, UNRWA Health programme continues to deliver comprehensive preventive and curative primary health care (PHC) services to Palestine refugees through a network of 143 primary health care facilities, and helps them access secondary and tertiary health care services. The total number of registered Palestine refugees has reached some 5.7 million, out of whom; about 3.5 million are served at our health centres.

During 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. In addition, the blockade in Gaza and the ongoing conflict in Syria, seriously affected the proper delivery of health services to Palestine refugees during 2015.

By the end of its 5th year, the health reform has reached an advanced stage of implementation in the Fields. The Family Health Team (FHT) approach was implemented in 119 health centres, excluding Syria, covering about 90.0% of the served population. In Syria, only 4 health centres rolled out the FHT model. Moreover, the other reform pillar, the e-health system, was introduced to 104 health centres in the five Fields, which implement either the classical or the FHT-e-health versions, fully or partially.

The changing disease burden among Palestine refugees is still challenging. An ageing refugee population will continually lead to an intensification of existing health trends, with increasing numbers of older refugees at risk of non-communicable diseases (NCDs), which cause more than 70 per cent of refugee deaths. The number of patients with 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.

The second diabetes care clinical audit, conducted in 2015, followed the same methodology of the first one conducted in 2012. The second audit showed some improvements and maintenance of good diabetes care at UNRWA health centres. Health education was provided more frequently to patients, and the technical instructions on treatment and monitoring of diabetes patients were regularly followed. The problems identified in the first audit, namely low control rates and poor health lifestyle remained the major problem facing diabetes care in UNRWA. Control rates were only around 25%. Obesity and overweight remained prevalent among 90.9%. In 2015, it was decided to introduce HbA1c testing widely and to update the NCD technical instructions accordingly.

A joint project between UNRWA Health Programme and Microclinic International (MCI) was launched in 2015, with the financial support by World Diabetes Foundation (WDF). The project aims to scale up diabetes prevention at UNRWA health centres, basically through training of all nursing staff and recruiting patients and their social network in health education interactive sessions aiming at helping them to follow a healthy life style.

A follow up survey was conducted on infant and neonatal mortality rates (IMR and NMR consequently) among Palestine refugees in Gaza. The IMR was found to be 22.7 per 1000 live births, while the NMR was 18.3 per 1000 live births. This survey confirmed that for the first time in decades, mortality rates among Palestine refugee new-borns in Gaza seems to increase.

In 2015, the integration of Mental Health and Psychosocial Support services (MHPSS) into primary health care was designated as an Agency-wide priority, and WHO's mental health Global Action Programme (mhGAP) was adopted to use with patients who need additional mental health care for depression, unexplained medical complaints (including anxiety), grief, and epilepsy. On 31 January, 2016 Saftawi Health Centre in North Gaza became the first pilot MHPSS health centre, integrating the full package of services developed in 2015.

A pilot survey was conducted in November 2015 to collect more data on the effectiveness of the current hospitalization strategy. An Agency wide hospitalization policy revision and development of a hospitalisation database are still under development.

In 2015, and in cooperation with the Procurement and Logistics Division at HQA, the Health Department introduced UNRWA Pharmaceutical Quality Assurance policy and Strategic Sourcing for qualified pharmaceutical manufacturers, a sizable procurement efficiency gain was achieved. The unit price difference for some products ranged between 25 – 40%, thereby enabling access to high quality and lower cost medicines.

One milestone that UNRWA has achieved in 2015 was the decision to go 100% smoke free in all UNRWA premises and vehicles, and the launching of a new no-smoking Policy that went into effect on 11 November 2015.

During 2015, UNRWA Health Programme in Gaza, in cooperation with the Health Department at HQA, launched the Family Medicine Diploma Programme (FMDP). This programme aims at developing the competencies of UNRWA doctors in Family Medicine as an essential component of the FHT model.

Based on WHO's Community Based Initiatives, in particular, the Healthy Cities programme, the West Bank Field implemented a Healthy Camp Initiative (HCI) as a pilot in 2015, in both Shu'fat and Aida Camps, and it is anticipated as a model to be expanded to other health centres in the Field and to the other Fields.

In 2015, the prevention and control of communicable diseases did not face big challenges, as 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.

Finally, in this annual report, we have followed a structure that reflects the structure of the new UNRWA Medium Term Strategy for 2016-2021. Therefore, it is organized in the following manner:

Section 1 – Introduction and Progress to Date
This section includes an introduction to UNRWA and to the Department of Health's activities over the past seven decades. It highlights progress in the reform process, particularly the implementation of the FHT approach and the e-health system. In addition, this section examines the demographics of an aging refugee population, and the epidemiological shifts towards NCDs, that evoked the introduction of the reform model. Moreover, this section presents the way forward regarding the implementation of the MHPSS model, improved hospitalization support, and a new innovative approach to medicine and medical supplies procurement. Lastly, it introduces some of the innovations implemented during 2015 by the health programmes both at HQ and Fields' levels.

Section 2 – Strategic Outcome 2:
Refugees' health is protected and the disease burden is reduced
Under this section, there are two outputs: Under the first output, "people centred primary health care system using FHT model," the activities and achievements of all sub-programmes are presented. They include outpatient care, non-communicable diseases (NCDs), communicable diseases, maternal health services, child health services, school health, oral health, community mental health, physical rehabilitation and radiology services, disability care and pharmaceutical services. Under the second output, "efficient hospital support services," information and data about in-patient care, outsourced hospital services, and crosscutting issues are presented. Crosscutting issues include nutrition, laboratory services, health communication, human resources and gender mainstreaming.
Section 3 – Data
Under this section, data major indicators are presented in four parts followed by annexes.

Part 1: Agency-wide trends for selected indicators, presented in graphical form. The 24 selected indicators show the overall health programme performance Agency-wide from 2008 to 2015.

Part 2: Trends in selected 27 indicators under strategic objectives 1-3, for the years 2010-2015, per Field and Agency-wide, in table format.

Part 3: 2015 data tables by Field and Agency-wide presenting details on all relevant information and indicators per Field and Agency-wide.

Part 4: Includes selected survey indicators.

Annexes: Include Annex 1 that represents Health Department research activities published papers, oral presentations and poster presentations during 2015, Annex 2 that includes the Health Department Field Implementation Plan for 2014/2015, Annex 3 that presents updated health maps, Annex 4 which presents names and contact info of senior staff at both HQ and Fields, and lastly, Annex 5 includes a list of abbreviations used in this document.

Section 1 – Introduction and progress to date

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 5.7 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 (FOs).

UNRWA's health system has three tiers:

(1) 1 Headquarters: handles policy and strategy development
(2) 5 Field Departments of Health: concerned with operational management
(3) 143 Health Centres: provide health services to Palestine refugees

The Department of Health employs over 3,000 staff throughout the three tiers, including 500 doctors. About 3.5 million Palestine refugees; the served population or beneficiaries, out of the some 5.7 million registered, utilize UNRWA health services free of charge. UNRWA does not operate its own hospitals (except for one, Qalqilia hospital, in the West Bank), but instead operates a reimbursement scheme for its beneficiaries, which varies by Field.

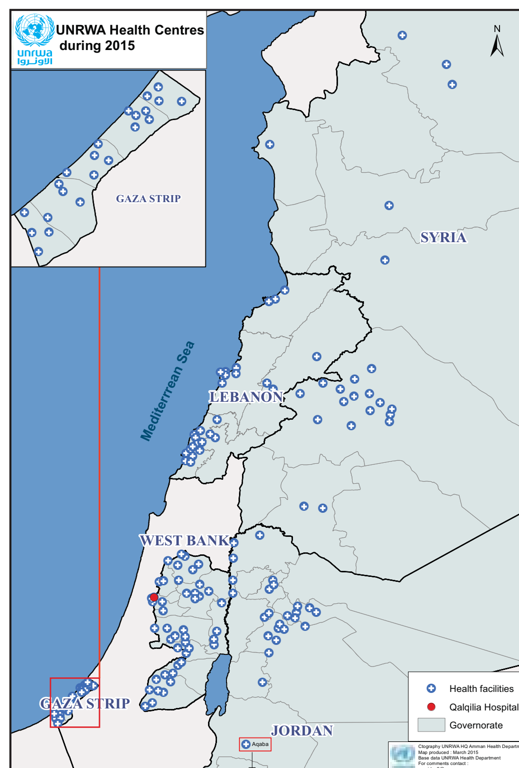


Figure 1- UNRWA health facilities distribution in the five Fields, 2015

Health Profile

UNRWA has contributed to sizeable health gains for Palestine refugees since the beginning of its operations in 1950. More than 5.7 million Palestine refugees are registered with UNRWA. The population is ageing, but it is still predominantly young, with enduringly high fertility rates and increasing life expectancies. Across UNRWA's areas of operation, 31.5% of refugees are children below 18 years of age. A high dependency ratio of 57.1% suggests a particularly great economic burden on families living in a context of high unemployment rates and worsening poverty levels.

Approximately 29% of registered refugees live in 58, densely populated, official UNRWA camps. The remaining refugees live in unofficial camps, towns and villages, side by side with host country populations.

The infant mortality rate (IMR) declined from 160 per 1000 live births in the 1960s to less than 25 in the 2000s. Nevertheless, an ongoing study by UNRWA has revealed that the IMR rate among Palestine refugees may not have decreased in the Gaza Strip. In 2015 UNRWA services cared for 409,772 infants and children 0-5 years.

There has been a sharp reduction in maternal mortality and morbidity over the past 40 years. Principal features of UNRWA healthcare for Palestine refugee women of reproductive age are: universal access to antenatal care; safer delivery care, with referrals to and subsidies for hospital delivery; and the availability of modern contraceptive methods. There has been a reduction in the overall fertility rate, which has stabilized over time. Despite this, fertility and maternal mortality rates remain relatively high. Unless additional resources are secured, further reductions will be a challenge. In 2015, UNRWA services cared for 153,030 family planning users and 91,245 pregnant women.

Communicable diseases are largely under control, thanks to high vaccination coverage and the early detection and control of outbreaks. Diseases related to personal hygiene and poor environmental sanitation are under control, though refugees continue to suffer from food insecurity and the burden of micronutrient deficiencies.

The reduction in communicable disease incidence, combined with a longer life expectancy and lifestyle modifications, have led to a change in refugees' morbidity profile. Non-communicable diseases (NCDs), such as cardiovascular diseases, chronic respiratory diseases, diabetes mellitus, hypertension and cancer, are emerging as today's leading health concerns. These diseases are costly to treat and are often the result of sedentary lifestyles, obesity, unhealthy diets and smoking. UNRWA treats patients with diabetes and hypertension. In 2015, UNRWA health centres cared for more than 245,682 registered Palestine refugee patients with diabetes and hypertension.

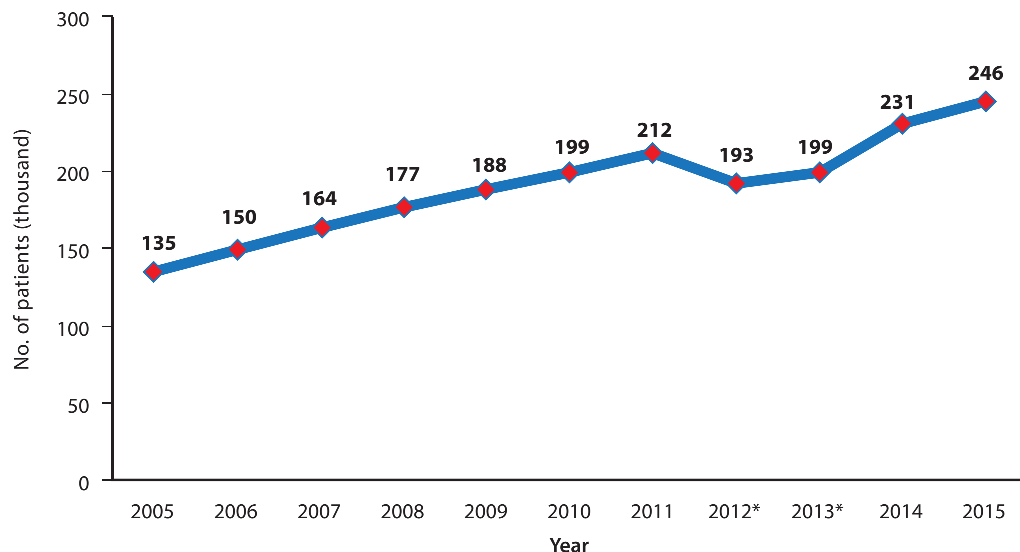


Figure 2- Patients with diabetes mellitus and/or hypertension under care Agency wide, 2005-2015 (*data not available from Syria)

UNRWA will continue working hand in hand with the Palestine refugee communities, host countries and other stakeholders, to implement control measures for these diseases, applying a multidimensional strategy that focuses on three dimensions: disease surveillance to collect, analyse and interpret health-related data on NCDs and their determinants; health promotion and prevention interventions to combat the major risk factors and their environmental, economic, social and behavioural determinants among Palestine refugees across the life-cycle; and the provision of cost-effective interventions for the management of established NCDs.

The ongoing protracted and acute conflicts, occupation, and the lack of a just and durable solution for Palestine refugees, continue to affect the population's physical, social and mental health. There is scientific evidence of a high prevalence of mental distress among Palestine refugees. Mental health and psychosocial-related disorders are major issues to address when working to ensure that refugees enjoy the highest attainable level of health.

The crisis in Syria has entered its sixth year, with no lasting, peaceful solution in the horizon. Over 280,000 Palestine refugees from Syria (PRS) have been internally displaced, and more than 80,000 have fled to neighboring countries, including Jordan and Lebanon, where PRS have been accessing UNRWA services for years. This has placed additional pressures on camps, schools and health centres with scarce resources. The blockade and recurrent emergencies in Gaza, and the occupation the West Bank, remain major obstacles to socioeconomic development of Palestine refugee communities, and on the health-care provision.

To respond to these challenges, UNRWA's strategy is to focus on: improving the quality of healthcare delivered through a Family Health Team (FHT) model; improving the quality of medical consultations and care for NCDs; providing staff with training in family health; integrating Mental Health and Psychosocial Support (MHPSS) and protection into the day-to-day activities of health centres; engaging the community in health prevention and promotion activities; and improving hospitalization support to ensure financial protection for the most vulnerable. UNRWA will continue to roll out the health information system, the e-health system, and strengthen the FHT primary health-care model, the new norm at all s in the four Fields, and expanding it to new health centres in the fifth Field, namely Syria.

UNRWA Response: Health Reform

Family Health Team (FHT) Approach

Late in 2011, and in response to the changing health needs of the Palestine refugee population, UNRWA launched a health reform package based on the Family Health Team (FHT) approach. This model offers a comprehensive and holistic primary healthcare package for the entire family, emphasizing long-term provider-patient and provider-family relationships, and aiming to improve the quality, efficiency and effectiveness of health services, particularly for NCDs.

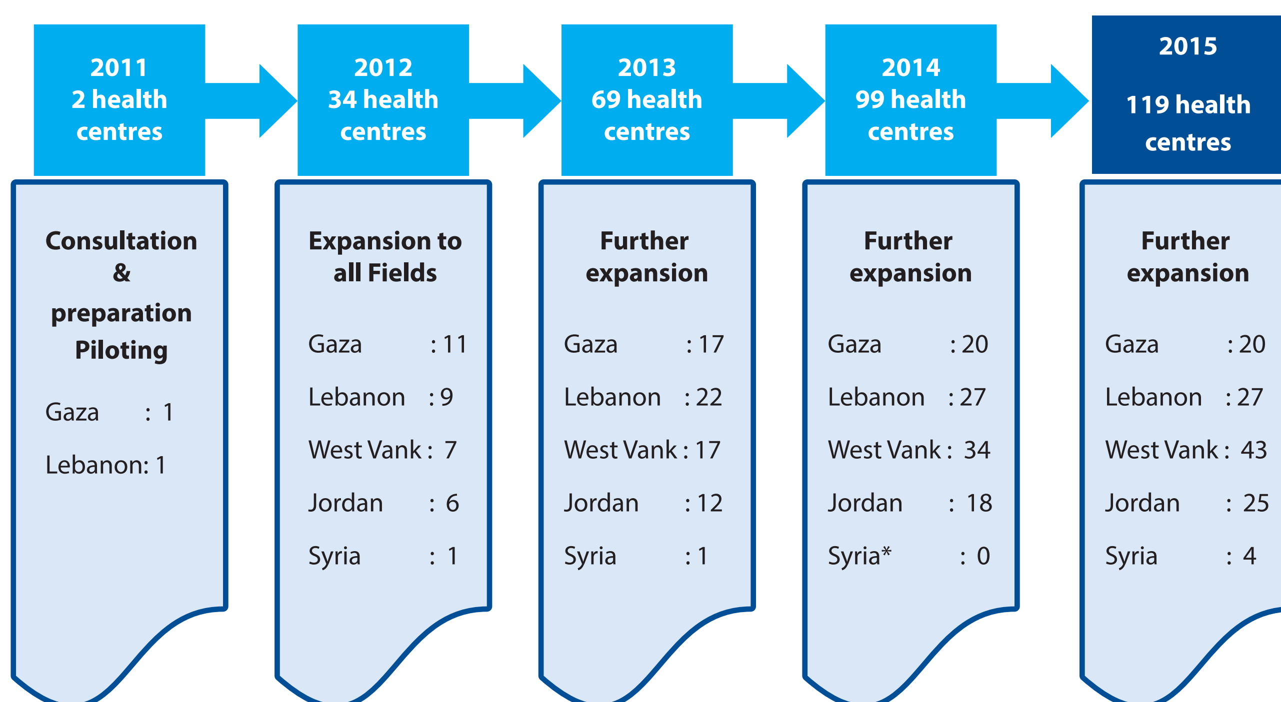
Under the FHT model, when families register at a health centre, they are assigned to a team of health professionals, consisting of a doctor, nurse and midwife. The team is responsible for the entire family's health needs, through all stages of the lifecycle.

The FHT Health Reform is supported by the concurrent introduction of electronic medical records (e-health), and the necessary health centre infrastructure upgrades.

Before the end of 2015, the FHT approach was operational in 119 health centres serving 90.0% of the Agency served population. It was expanded to all health centres in Lebanon, West Bank and Jordan. In Gaza, only two out of 22 health centres are still implementing the old vertical model, as they were under construction, and the Field will achieve full expansion of FHT to all its health centres during 2016. In Syria, exceptional efforts were made by the Field to roll out FHT at 4 health centres in 2015.

The goal for 2016 is to launch FHT in a total of six health centres in Syria, as the security situation and the suitability of the infrastructure allow.

Since 2012, several assessments have been conducted at health centres that have been implementing the FHT approach. Different methods for the assessment were used including: focus group discussions, client flow analysis exercises and patient and staff satisfaction surveys. These assessments have shown very positive responses to the FHT approach from both staff and patients.



"Syria Field started the implementation of the FHT in Khan El-Sheih health centre in April 2014. This health centre was heavily affected by the conflict and it is not functioning

Figure 3- Progress in the implementation of the Family Health Team approach at health centres in the Fields.

A more equitable workload distribution – a likely consequence of the new team structure and the switch from specialized services to comprehensive primary healthcare services – was cited by staff as one of the key positive outcomes of the health reform. Staff also expressed their improved professional satisfaction following implementation of FHT, and having the opportunity to build relationships with patients over time. Patients appreciated having a doctor who knows the health profile of the whole family, and they reported that health centres became more organized and less congested since the transition to FHT.

Other improvements in the quality of services were observed, including a decrease in the average number of daily medical consultations per doctor, an increase in consultation time per patient, and a decrease in antibiotics prescription rate. Maternal and child health indicators show that vaccination coverage, early registration to preventive care and percentage of pregnant women attending at least four antenatal care visits, remain high.

As part of the FHT implementation process, a friendship committee was established by each health centre, and has worked on fostering community participation aiming at making the FHT practice more responsive to community needs.

The FHT approach will continue to work as platform to coordinate all crosscutting issues within the Agency as well as with all other stakeholders like: protection, school health, mental health and psychosocial support, hospitalization services and operational research, among others.

An important component of the FHT reform is developing the capabilities of health professionals. Most of the physicians working in UNRWA are general practitioners without further specialist training after graduating from medical schools. In 2015, jointly with local and international partners (Al- Azhar University, Rila Institute of Health Sciences and Imperial College London and Middlesex University in the UK), UNRWA launched the an on-the-job training for 15 doctors in Gaza working to achieve a one-year postgraduate diploma in Family Medicine.

E-Health (Electronic Medical Records)

In 2009, UNRWA began developing and piloting the use of electronic medical records (EMRs), named as the classical e-health system, in its health centres, transitioning away from a time consuming, costly and labor-intensive unprecise paper-based system.

Developed in-house, the e-health system included originally four principal modules: NCD, outpatient, child health, and maternal health, and the support modules such as pharmacy, laboratory, dental, and specialist care. Following the implementation of the FHT approach in 2012, a major reform to healthcare delivery, 'classical' e-health was redesigned into a new FHT-based e-health system. The new package is more comprehensive, and it incorporates a synergised interface that accommodates the information technology and management needs for the FHT.
On the ground, the use of e-health system has facilitated and streamlined the daily operation of health centres. It has led to better documentation and follow-up of referrals, more efficient use of space, rational use of stationary and printed forms and streamlined patient movement. It has eased the burden of paperwork on staff, reduced patient waiting times, and increased provider-patient contact time; thereby increased opportunities for the delivery of health education messages.

At the administrative level, e-health has facilitated the de-centralization of health centres, and strengthened the continuous process of quality improvement, which in turn enhanced staff managerial and administrative capacity. The system enables the automatic generation of health reports, the compilation of health data, and the production of data on all health indicators. The improved accuracy and reliability of statistical information, enables the development of evidence-based policies in the future that are essential to sustain and improve the outcomes of the health reforms.

Table 1- Number of health centres using classical and FHT e-health versions by the end of 2015.

e-health version	Jordan	Lebanon	Gaza	West Bank	Agency
Classical Version	11	12	15	0	38
FHT version	5	14	3	31	53
In progress FHT version	2	1	1	9	13
Total	18	27	19	40	104

To further enhance UNRWA's capacity for monitoring the health of patients, an innovative e-health monitoring system, cohort analysis, was developed in 2012. This cohort analysis allows the comprehensive monitoring of NCD care: incidence, prevalence, treatment compliance and outcomes, and non-attendance follow-up. This monitoring system has led to the publication of research in international peer-reviewed journals such as the Lancet.

At the end of 2015 at least one e-health module was implemented in 91 health centres and 13 health centres are in progress to implement FHT version.

UNRWA aims at implementing its FHT e-health system across all Fields by mid-2017, including Syria if the situation on the ground allows. In Syria Field, the installation of e-health infrastructure and training of staff started in 2015, however, the challenge of securing sufficient resources is ongoing.

E-health system was developed in collaboration with other UNRWA departments, in particular the Information Systems Division (ISD) at UNRWA Headquarters and in all Fields.

The United States of America has been the main supporter for the e-health program, in addition to the contributions by the governments of Denmark, Japan and Switzerland.

Clinical Audit of Diabetes among Palestine Refugees, 2015

UNRWA conducted the first clinical audit for diabetes care in 2012, which aimed to acquire evidence- based information on the quality of UNRWA diabetes care. The second audit, conducted in 2015, followed the same methodology of the first one. The sample size was a total of 1,600 diabetic patients randomly selected from 32 of the largest UNRWA health centres (8 health centres in each Field, except Syria, with 50 patients from each health centre). The second audit showed, in general, some improvements and maintenance of good diabetes care at UNRWA health centres. Health education was provided more frequently to patients, and the technical instructions on treatment and monitoring of diabetes patients were regularly followed. As indicated in the first audit, the availability of competent health care providers and updated sound protocols (technical instructions) are the main strengths of the diabetes care in UNRWA health system. Medical officers have appropriate knowledge about diabetes care and are able to provide suitable treatments.

At the same time, the problems identified in the first audit, namely low control rates and poor health lifestyle remained the major problem facing diabetes care in UNRWA. Control rates were only around 25%, similar to the first audit. Obesity and overweight, a major risk factor in diabetes, remained prevalent: 90.9% of patients were either obese or overweight. Addressing such fundamental issues is critical for the future success of diabetes care in UNRWA and for the health of Palestine refugees. Along with UNRWA's health reform based on the person-centred family health team model, such issues need to be addressed comprehensively and continuously.

Moreover, the second clinical audit showed that the study population included elder patients, with longer duration of diabetes care, more patients with both diabetes and hypertension, and more prevalence of late complications.

This population, as expected, have more frequent visits to the health centres based on UNRWA technical instructions, which states that patients with poor control should visit the health centre monthly, while those with good control are required to conduct quarterly visits. This may be the reason why patients with poor control had higher probability of being selected in this study, and hence the lower control rate and higher rates of late complications found in the second audit compared to the first audit results. In addition, the second clinical audit results indicated two urgent strategic points to address. One is an urgent need to introduce HbA1c testing widely and to update the technical instructions accordingly, since the use of the traditional 2-h PPG tests were found not as effective. The second issue is the need to have a comprehensive, long-term intervention for healthy lifestyle promotion among Palestine refugees. For example, the high prevalence of obesity might justify the continuous rise of diabetes prevalence among Palestine refugees.

Infant and Neonatal Mortality among Palestine refugees in Gaza – a follow up study

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 maternal and infant health.

In 2015, the Health Department conducted a follow up survey on infant and neonatal mortality among Palestine refugees in Gaza to monitor any changes over time, as well as to define the main risk factors and causes of infant death. In accordance with the previous studies, the preceding-birth technique survey methodology was used. In this method, mothers, with more than one child who came to health centres to register their last-born child for immunization, were asked if their preceding child was alive or dead.

Table 2- Infant and neonatal mortality rates in Gaza, 2015

Infant & child mortality rate	2008	2013	2015
Early neonatal (<=7 days)	No data	10.3	11.7
Late neonatal(8to<=28 days)	No data	10.0	6.5
Neonatal (<=28 days)	12.1	20.3	18.3
Post-neonatal (>28 days to 1 year)	8.2	2.1	4.5
Infant mortality (< one year)	20.2	22.4	22.7

The IMR was found to be 22.7 per 1000 live births, while the NMR was 18.3 per 1000 live births. Of the 66 infant deaths, 51.5% died in early-neonatal period, 28.8% in late-neonatal period and 19.7% in post-neonatal period. This survey confirmed that for the first time in decades, mortality rates among Palestine refugee new-borns seems to increase. There was a slight increase of IMR (from 20.2 in 2008 to 22.7 in 2015) and significant increase in NMR from 12.1 in 2008 to 18.3 in 2015.

The main causes of infant deaths were congenital malformations or metabolic disorders (41%), prematurity (25%) and infection (16%)

Table 3- Causes of infant death in Gaza, 2015

Cause of death	2008	2013	2015
Preterm birth	25	39	24
Birth complication	3	3	0
Congenital malformation/metabolic disorder	30	29	40
Infections	20	19	15
Accidents/injuries	0	0	2
Other	22	11	16

Way Forward

Integrating Mental Health and Psychosocial Support (MHPSS) into UNRWA's Primary Health Care (PHC) Family Health Team Model

In 2015, the integration of mental health and psychosocial support services (MHPSS) into primary health care was designated as an Agency-wide priority. Globally, one third of persons visiting PHC facilities have issues related to mental health and psychosocial problems. WHO recommends that 70% of those cases can be managed at this level. In the Middle East – and the Palestine Refugee community, in particular – the impact of socio-economic stressors, abuse, poverty, protracted displacement and on-going violent crises likely increase the risk of mental health and psychosocial problems.

During 2015, the Department of Health consulted with key local, regional and global experts to develop a package of services that addresses the major issues borne by visitors to UNRWA health centres. Additionally, the West Bank health team, who have been providing comprehensive services for years, served as key advisors throughout the process. The final conclusions of the whole process included the need for a strong focus on the integration of psychosocial support for refugees to be delivered largely through nurses and midwives. In Gaza and the West Bank, psychosocial counsellors constituted another source of support for patients. Trainings to be offered for staff will enable them to focus on each patient as a whole person, to understand the social and political determinants of their health, and to work with the patients to help them cope with their daily stressors in a more positive way.

The Department of Health has also adapted a portion of the WHO's mental health Global Action Programme (mhGAP) to use with those patients who need additional mental health care for depression, unexplained medical complaints (including anxiety), grief, and epilepsy. Doctors will be equipped with skills and tools needed to recognize, diagnose and manage the care of these patients, identify those who need help beyond UNRWA's capacity, and refer them to local external partners. Collaboration with other Agency programmes and departments is essential to the success of this integration, and to ensure strong referral pathways and feedback mechanisms.

On 31 January, 2016 Saftawi Health Centre in North Gaza became the first pilot MHPSS health centre, integrating the full package of services developed in 2015. Initial feedback from patients and staff is positive and encouraging.

Improving Hospital Support

In addition to services provided at PHC level, UNRWA provides assistances towards essential and affordable hospital services by contracting beds with non-governmental and private hospitals, or by partially reimbursing costs for the hospitalisation of patients. The level of support for Palestine refugees varies across the Fields according to the rights granted to the Palestine refugees in each host country.

UNRWA hospitalization services are managed by the Health Department (HD) at UNRWA Headquarters (HQ) and Field Offices (FOs) in line with the Agency's decentralization policies to provide equitable, affordable and sustainable hospital services to the eligible Palestine refugees. Each Field manages its own resources for hospitalization services and establishes its coverage limits and reimbursement policies.

Financial support to hospitalization services is the second highest health-related expenditure after personnel. It has been always essential to ensure effectiveness and efficiency despite the tight UNRWA financial situation.

A policy adjustment in Lebanon Field was developed mid-2015 to be implemented at the beginning of 2016. The policy adjustment focused on improving financial protection for Palestine refugees, and on aligning the support offered to eligible refugees in Lebanon with that in the other Fields, and with that the Lebanese Ministry of Health offers to Lebanese citizens. Patient contributions were introduced for secondary care at different rates for the type of hospital attended – a 5% patient contribution at Palestinian Red Crescent Society (PRCS) hospitals, 15% at Governmental Hospitals and 20% at Private Hospitals. An increased reimbursement for tertiary care cases from 50% to 60% – where services are more expensive and catastrophic health expenditure is more likely – was also introduced. Hospital contracts were renegotiated and strengthened with quality indicators. A mechanism to provide additional support for the most vulnerable patients was flagged as a possibility in the adjusted policy.

A review of UNRWA hospitalization programme in Lebanon, Gaza and Jordan and the West Bank was carried out in 2013/2014. This review highlighted the very limited knowledge about the financial protection conferred by the Agency, and the coping mechanisms used by Palestine refugees to minimize the risk of catastrophic expenditure.

A pilot survey was conducted in November 2015 to collect more data on the effectiveness of the current hospitalization strategy. Of particular concern was assessing the financial services available to the most vulnerable Palestine refugees, for whom hospitalization could be major financial burden and path to catastrophic health expenditures. In this pilot survey, targeting ex-Gazans in Jordan, a total of 42 families were randomly selected, and information was collected by trained social workers using a standardized questionnaire. The pilot survey indicated that hospitalization is a major financial burden for ex-Gazans. Of the sample studied, 48.5% could not get hospitalization due to financial reasons. Even among those hospitalized, 62.5% were in need of financial support from others.

An Agency wide hospitalization database is still under development. The 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.

An Innovative Approach to Medicine and Medical Supplies Procurement

Background

In 2011, a study was commissioned to analyse UNRWA's medicine procurement prices and processes. The study highlighted several areas for improvements, to ensure procuring high quality drugs with low prices. The study report is available at:

http://goo.gl/GBQaLP

Based on the outcomes of the report and to ensure access to affordable high quality products, UNRWA entered into a Time-Bound Long Term Agreement (LTA) with Empower School of Health (ESH), aiming at implementing the Health Procurement Strengthening Project. The three main terms of reference, under this project were to:

- Harmonize and simplify quality assurance standards and procedures
- Harmonize and simplify tendering procedures
- Strengthen the capacity for purchasing pharmaceutical and medical commodities

In accordance with the LTA, a three phase work plan was developed at the beginning of the assignment.

The objective of Phase One was to establish Quality Assurance standards for pharmaceuticals and medical devices for UNRWA in accordance with WHO and other Stringent Drug Regulatory Authorities (SRA). UNRWA carried out a comprehensive review of the current pharmaceutical list in order to ensure adherence to the treatment guidelines. Some alternatives sources were also suggested for the current list of 134 drugs and 49 non-drugs. Furthermore, UNRWA's special conditions for purchasing pharmaceuticals and medical commodities was thoroughly reviewed followed by discussions on ways for improvement. Several changes were made to the document accordingly for the purpose of implementation in the coming tenders, for the upcoming procurement cycle. UNRWA also developed several new guidelines and Standard Operating Procedures for Quality Standards and procurement actions based on the UN Inter-Agency guidelines with the support of ESH.

In Phase Two, the main objective was to improve the internal procurement procedures and deficiencies, through mapping of all procurement and supply chain management processes. To achieve that, this phase dealt with quantification of products, reviewing and editing/ developing vendor registration forms for pharmaceutical and medical commodities, pre-qualification of products and suppliers and reviewing and strengthening of tender documents to incorporate quality assurance standards.

The main objective of Phase Three, which is still running, is to develop new procurement strategy which will include (but not limited to) rationalizing the product list for procurement purposes. ESH has carefully scrutinized and reviewed the list of suppliers of current pharmaceutical supplies/ commodities, and has helped in identifying new quality assured sources. The new list will aim at facilitating UNRWA's Expression of Interest and Technical Pre-Qualification of suppliers in order to assist the tendering process and to establish new Long Term Agreements for the year 2016 – 2017, and potentially for 2018. To further ensure compliance with UNRWA's quality assurance standards, Good Manufacturing Practices (GMP) Inspections will be conducted for manufacturing sites based on WHO cGMP guidelines.

Major Achievements in 2015

Two workshops were conducted in February and May 2015 for UNRWA's Headquarters and Field Offices staff from Health Department and Procurement and Logistics Division by ESH. The objective was to train the staff on Quality Assurance standards and procedures, Health Financial Forecasting/ Budgeting Methodology as well as Health Quantification Re-validation.

The tender exercise for the Top 36 medicines (this category accounts for almost 80% of the budget) has been completed. With the introduction of UNRWA Pharmaceutical Quality Assurance policy and Strategic Sourcing for qualified pharmaceutical manufacturers, a sizable procurement efficiency gain was achieved. The unit price difference for some products ranged between 25 – 40%, thereby enabling access to hvigh quality and lower cost medicines. The efficiency gain was estimated to be around US$ 1.4 m to 2 m annually which will ultimately help the Agency to build sufficient buffer stock and introduce statins as the treatment of choice for lowering cholesterol, in addition to the introduction of HbA1c test as the standard test for diabetes control in UNRWA's Health Programmes, and the introduction of the microalbuminuria test to help in detecting and preventing late complications concerning kidney function.

Innovations

During 2015, UNRWA Health Programmes at HQ and the Fields introduced a number of innovations that aimed at strengthening and complementing the successes achieved by implementing the FHT approach and e-health. Through these innovations, creative and innovative ways to improve the quality and efficiency of UNRWA's health services were implemented.

UNRWA Health Department at HQ, Amman

UNRWA 100% Smoke-free Policy

Active smoking is harmful to smokers' health. In addition, breathing other people's tobacco smoke, commonly known as passive smoking, is harmful to the health of non-smokers. Exposure to second-hand smoke increases the risk of lung and other cancers, heart disease, asthma, stroke and many other serious illnesses. Ventilation or separating smokers and non-smokers within the same airspace does not completely stop potentially dangerous exposure.

Therefore, and based on many facts that are evidence based, and to protect the health and wellbeing of its employees, their families, and Palestine refugee beneficiaries, UNRWA has decided to go 100% smoke free in all its premises, and issued a Policy to go into effect on 11 November 2015.

Based on this Policy, the Agency has decided to implement a complete ban on smoking and the use of any Tobacco Products on all UNRWA Premises, indoor and outdoor. This decision protects personnel, Palestine refugees visiting UNRWA premises and other visitors from exposure to secondhand smoke.

A complete ban on smoking and the use of tobacco products contributes to the right to health in the workplace, while still maintaining an individual's choice to smoke or use tobacco products when not on UNRWA premises or in UNRWA vehicles. Smoking, based on this Policy, is prohibited in the following places:

1. UNRWA Premises
2. UNRWA Vehicles
3. Private vehicles on UNRWA Premises
4. Places outside UNRWA Premises, where the Agency conducts activities or organizes events. This shall be done by, for example, clearly visible signage.

The compliance with this Policy is being monitored by managers at all UNRWA installations. Fields' Directors, for the Fields, and the Director of Human Resources, for HQ, are responsible for regular reporting to the Chief of Staff on the status of implementation of the Policy as per their areas of responsibility.

The Gaza Field

Family Medicine Diploma Programme (FMDP)

Postgraduate medical training is not only important for the professional development of doctors, but also for patient safety and health services' efficient and effective delivery. This is why UNRWA Health Programme in Gaza, in cooperation with the Health Department at HQA, launched the Family Medicine Diploma Programme (FMDP). The main goal of the FMDP is to offer clinicians in the Field a model of in-service training that will build on their existing knowledge, skills and experience and to improve their mastery of the clinical management of the patient and raise the standards of clinical care.

With the generous donation of Al-Waleed Ben Talal Foundation, in July 2015, Gaza Field implemented the FMDP. The course runs over a period of 12 months. It integrates and blends several components of learning; face to face workshops combining lectures and hands-on sessions, directed learning resources available online, regular assessments to monitor acquisition of knowledge and skills, regular mini tests to assess understanding and test competency of a section of the programme, and interactive webinars to develop the skills of in depth knowledge, analysis, communication and inter-professional discourse. Hospital training is done in UNRWA contracted hospitals directly supervised by the assigned tutors. The design of the course enables the participating doctors to continue in their usual work.

Selection criteria for the participation in the programme set by the Health Programme was used to select 15 candidates to join the programme. The basic requirements include that the candidate be a permanent or fixed-term staff who is less than 55 years of age by the end of the programme. In addition to fulfilling the required criteria, those 15 candidates were selected based on a written test prepared by Rila institute. AL-Azhar University selected tutors, who have specialty in family medicine with educational experience in the Field to facilitate the implementation of this programme. The Diploma is validated by the University of Westminster in UK. Two Area Health Officers (AHOs) and 3 Senior Medical Officers (SMOs) were assigned to supervise and support the candidates.

The course includes 61 reading topics, available on-line and composed of three modules:

Module 1: Core generic topics in medical practice
Module 2: Advances in Family Medicine
Module 3: Clinical Practice in Family Medicine (practical skills required for the family medicine specialty)

Upon successful completion of all parts of the program, and passing a final summative examination, the participating doctors will receive a Postgraduate Qualification offered to them jointly by University of Westminster in UK University, Rila Institute of Health Sciences and Al- Azhar University.

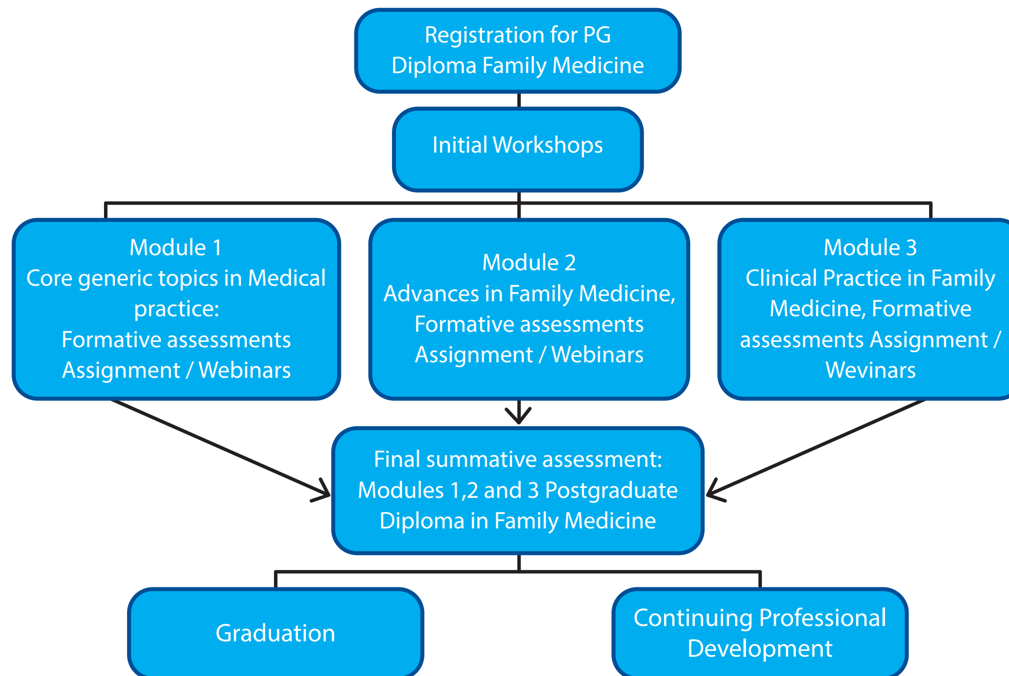


Figure 4- Modules of Family Medicine Diploma Programme (FMDP)

The feedback received from the participants was positive. They highlighted the impact of the training they receive on the quality and the comprehensiveness of the health care they offer, more sharing of knowledge and experience, more focus on prevention and on the psychosocial-physical model, in addition to the rational use of resources. They reported acquiring new skills, such as better ability to identify timely, and to correct their mistakes, practical implementation of what they learned, and improved communication with the patients. They also expanded the scope of cases managed at primary health care level to include new cases.

The West Bank Field

The Healthy Camp Initiative (HCI) in Shu'fat and Aida Camps

The Healthy Camp Initiative (HCI) is a new project based on WHO's Community Based Initiatives, in particular, the Healthy Cities programme. The project is being implemented in both; Shu'fat and Aida Camps. The aim of HCI is to create opportunities for Palestine refugees living in the camps, to improve their health and wellbeing through a participatory process where community members come together to identify community needs, generate solutions to common problems based on their priority, and to take collective and well planned actions. The initiative is also aimed at building capacity within the camp community in order to address urgent issues, and to take advantage of opportunities, to unify the goals and balance competing interests amongst stakeholders within these communities. The ultimate goal of the initiative is to improve the overall quality of life for all Palestine refugees living in the camps. Practically, the stakeholders contributing to the HCI, worked on mobilizing and engaging the communities, as well as building institutional and individual capacities. They were able to create enabling conditions to ensure sustainability of the developmental process in both camps. The participatory nature of the initiative, with the individual and institutional capacity building embedded in the approach, ensures ownership and sustainability of the process. The project includes three components including

1. Capacity building and institutional development of Community Based Organizations (CBOs), which will be strengthened and enabled to plan, manage and execute their own projects.
2. Improvement of Environmental Health in both camps which includes: (i) improvement of solid waste management in Shu'fat camp, and (ii) rehabilitation of sewer storm water drainage in both Shu'fat and Aida camps.
3. Implementation of Family and Child Protection and Gender Based Violence (GBV) strategies at Shu'fat and Aida camps. Examples include the introduction of "Youth Friendly Health Centers" and "Summer Camps for children."

Family and Child Protection Programme Addresses Youth Needs

The demographic transition in West Bank Palestinian population, whereby the youth segment is constantly increasing reaching to 29% of the total population, calls for special attention to the youth and their growing needs. In line with the strategic vision of the West Bank Health Programme, which aims at creating "Youth Friendly Health Centres", the Family and Child Protection Programme has been concentrating its efforts to empower youth to increase their participation and engagement in their communities, improve their resilience to help them cope with the everyday challenges in the West Bank context and create positive leadership among this important segment of the population.

Through a thoroughly planned and well organized programme in a Central Camp (CC), a core group of 60 youth from 14 refugee camps in West Bank were gathered and trained on several topics including: leadership, volunteerism, conflict resolution, human and child rights, life-skills and youth civic engagement. The participating youth were mostly vulnerable youth who have been subjected to political violence. Building on the achievements attained through the CC, 17 summer camps were organized in additional 14 West Bank camps, in addition to three Bedouin communities. The summer camps were led by the 60 trained youth from the CC and supervised by Community Mental Health counsellors. Each of the summer camps targeted around 100 children aged 10-14 years, who were selected from the peer to peer groups previously organized and supported by the programme, in addition to other active children with vulnerable backgrounds. The core activities concentrated on children's rights. The summer camps took place in UNRWA schools and a total of 1,552 children benefited from their activities.

The Syria Field

Health Education Campaign in Summer 2015

The Health Programme (HP) in Syria, in cooperation with other UNRWA Programmes, put into implementation a plan during Summer 2015 (mid-June through August) aimed at raising awareness between Palestine refugees about the most important issues related to public health. These issues were listed and prioritized by a group of doctors at the Field. This was followed by in-depth interviews with senior medical officers and the directors of the main departments in UNRWA (education and RSS). The final outcome was a plan prepared for a Health Education campaign. The HP prepared, designed and produced relevant health education materials that were used during the health education sessions, which took place in all health centres, schools, teaching and health points, in addition to Women Programme Centres and the shelters of the Internally Displaced Persons' (IDPs) shelters. All concerned UNRWA Programmes participated in delivering the sessions.

The health issues discussed during the health education sessions included the following:

- Personal hygiene, especially proper hand washing.
- Prevention and treatment of diarrhoeas
- Risks of random use of drugs and antibiotics
- Risks of tobacco use
- Food safety
- Prevention and treatment of insect borne diseases
- Psychosocial support
- Lice and scabies (prevention and treatment)
- Hepatitis A (prevention and treatment)
- The importance of vaccination
- Physical activity
- The importance of breastfeeding

The average number of Palestine refugee beneficiaries who benefited from these sessions was around 10,000.

The Lebanon Field

Nutrition service

Unhealthy diet is known to have negative impact on health. A survey conducted by the American University of Beirut (AUB) revealed that around 57% of the Palestine refugees in Lebanon eat sweets frequently, and that 58% consume sweetened drinks. According to the results of the first and the UNRWA second clinical audits conducted in 2012 and in 2015 consequently, it was found that around 90.0% of the patients registered in the non-communicable diseases (NCD) programme, were either obese (around 64.0%) or overweight (around 26.0%). In dealing with this problem of bad dieting, Lebanon Field introduced, during 2015, a new post, and recruited a full time clinical dietician under Monaco Project, to assist in developing and implementing integrated actions to address obesity and overweight and the rise in non-communicable diseases among Palestine refugees attending the health centres and at their communities. Guidelines, materials and tools were developed to help NCD patients, mainly diabetic patients, as well as those at risk of developing diabetes, to improve their eating habits. Regular visits were conducted to the health centres to offer the support to health staff concerning the management and control of patients' conditions using life-style modifications, especially the encouragement of healthy eating habits.

Immunization Programme

During 2015, UNRWA immunization schedule was reviewed by WHO, UNICEF and UNRWA at both Lebanon and HQ levels. The purpose of this revision was to update the immunization schedule to coincide with the standards adopted by the health authorities in the host country, and to be consistent with the overall policies and strategies of the WHO. The new and updated immunization schedule includes the introduction of IPV vaccine and two doses of MMR.

The Jordan Field

Inaugurating a new health centre

In December 2015, UNRWA FO in Jordan inaugurated a newly established, FHT implementing health centre in Al-Dulail, Zarqa Area. Following the merger of the two health centres at Irbid Camp in 2014, the Agency was able to redeploy the necessary health posts to establish a health team for running the newly established health centre at Al-Dulail quarter so as to serve the poor pockets of refugees in that remote area. The new health centre will serve more than 14,000 Palestine refugees living in this area, some of whom cannot afford transport expenses every time they are in need of the Agency health services in Zarqa city.

Al-Dulail and the surrounding quarters have a high rate of poverty. UNRWA's Social Safety Net (SSN) supports about 7.0% of the population living there; these Palestine refugee beneficiaries are "abject poor" and cannot meet their basic food needs. The health centre was established as a result of strong collaboration between the Municipality, which offered the plot of land, the local donor, who covered the construction expenses and the Agency that staffed, equipped and furnished the health centre. By the end of 2015, establishing Al-Dulail health centre made the total number of PHC facilities in Jordan to be 25, serving about 1,108,065 Palestine refugees.

Section 2: Strategic Outcome 2 : Refugees' health is protected and the disease burden is reduced

Output 2.1: People-centred primary health care system using FHT model

Services under output 2.1 include outpatient health care, non-communicable diseases (NCDs), communicable diseases, maternal health services child health services, school health, oral health, community mental health, physical rehabilitation and radiology services, disability care and pharmaceutical services.

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 postnatal care, infant and child care, NCD management, basic laboratory testing and medicine distribution.

Utilization

UNRWA currently provides comprehensive PHC through a network of 143 health centres, of which 69 (48.3%) are located inside Palestine 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 outpatient services Agency-wide decreased by 2.8 % in 2015 compared to 2014, with a total of approximately 9.2 million medical consultations. Of these consultations, 141,904 were specialist consultations. This decrease in utilization was found in all Fields except West Bank and Syria.

Table 4- No. of medical consultations, Agency-wide in 2014 and 2015

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2014	1,721,440	1,276,153*	983,635	4,181,967	1,293,960	9,457,155
2015	1,598,989	1,218,279*	1,051,195	4,010,882	1,312,576	9,191,921

*Data include medical consultations provided to Palestine Refugees from Syria (PRS)

- In Syria, the utilization of outpatient services was still affected by the closure of health centres, and the limited access to health services due to the prevailing security constraints. However, during 2015, medical consultations increased by 6.9% compared to 2014.

- In Jordan, Lebanon and Gaza, the utilization of outpatient services decreased. This decrease could be attributed to implementing the appointment system, e-health system and the FHT approach in some health centres.

In the UNRWA health system, out-patient medical consultations are classified into two groups: first visits 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 increased from 2.9 in 2014 to 3.3 in 2015, with wide variation, both among Fields, and between health centres in the same Field. The highest ratio (4.2) was found in Lebanon, while the lowest (2.2) 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 day decreased from 95 in 2014 to 86 in 2015. The highest workload was 98 as reported by Lebanon Field, and the lowest was 81 in Jordan. Despite the variation throughout the Fields, the Agency-wide average number of consultations per day has declined by 9.5%; from 95 in 2014 to 86 in 2015 as mentioned before, which is slightly above the 2015 target of 83.

The introduction of the FHT approach has begun to help reduce the workload, mainly through the shifting of some 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 have helped to reduce irrational health care seeking behaviour.

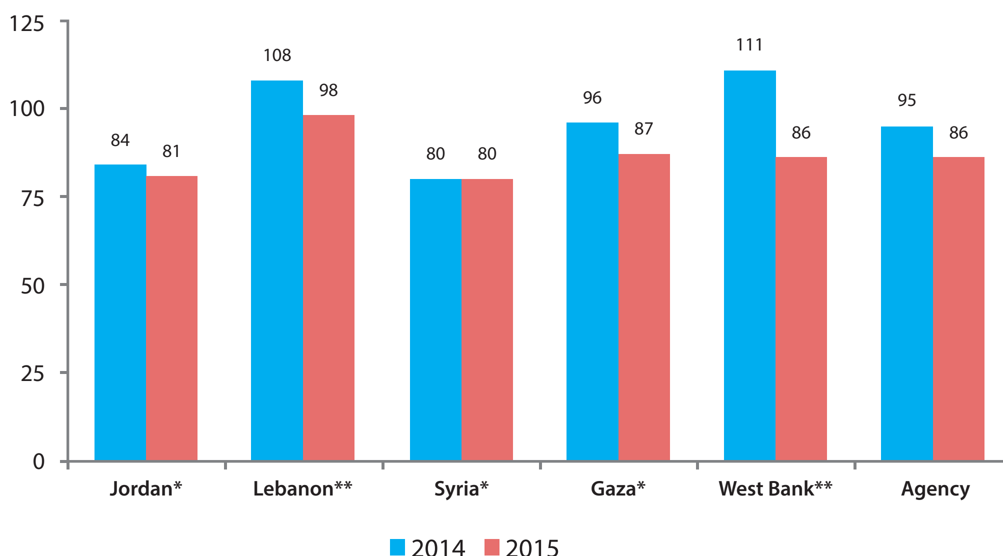


Figure 5- Average daily medical consultations per doctor, in 2014 and 2015 (*HCs open six days/week, **HCs open 5 days/week)

Non Communicable Diseases (NCDs)

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 92.0% of all patients under UNRWA NCD care in 2015, which is consistent with that in 2014. The percentage of male patients diagnosed with NCDs has been increasing steadily, from 25.0% in 2012, to 38.0% in 2013, to 39.0% in 2014 and to 40% in 2015. Distribution by morbidity showed that 39.0% of patients have both hypertension and diabetes mellitus; 16.3% had diabetes mellitus only, and 44.7% had hypertension only. The number of patients with type I diabetes mellitus Agency-wide was 3,708 by the end of 2015, representing 1.5% of all NCD patients, and 2.7% of all patients with diabetes mellitus.

The total expenditure on medicines in 2015 was US$ 17.7 million. Analysis for drugs expenditure revealed 46.0% was spent on medicines for the treatment of NCDs[1] . By the end of 2015, a total of 245,682 patients, including Palestine refugees from Syria (PRS), with diabetes mellitus and/or hypertension were registered for UNRWA NCD services across the five Fields of UNRWA operations. In addition, the Agency-wide prevalence rates of diabetes mellitus and hypertension were 11.4% and 17.5% respectively for patients who were 40 years and older. These prevalence rates are also consistent with 2014's prevalence rates.

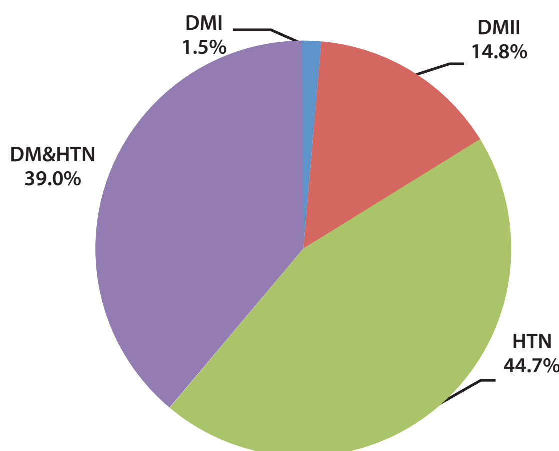


Figure 6- Percentage of NCD by morbidity

Table 5- Patients with diabetes mellitus and/or hypertension by Field and by type of morbidity (*PRS data included)

Morbidity type	Jordan	Lebanon*	Syria	Gaza	West Bank	Agency
Type I diabetes mellitus	1,199	288	410	1,143	668	3,708
Type II diabetes mellitus	11,181	3,213	3,318	12,414	6,237	36,363
Hypertension	29,943	14,851	14,420	35,270	15,357	109,841
Diabetes mellitus & hypertension	31,308	10,468	9,819	26,450	17,725	95,770
Total	73,631	28,820	27,967	75,277	39,987	245,682

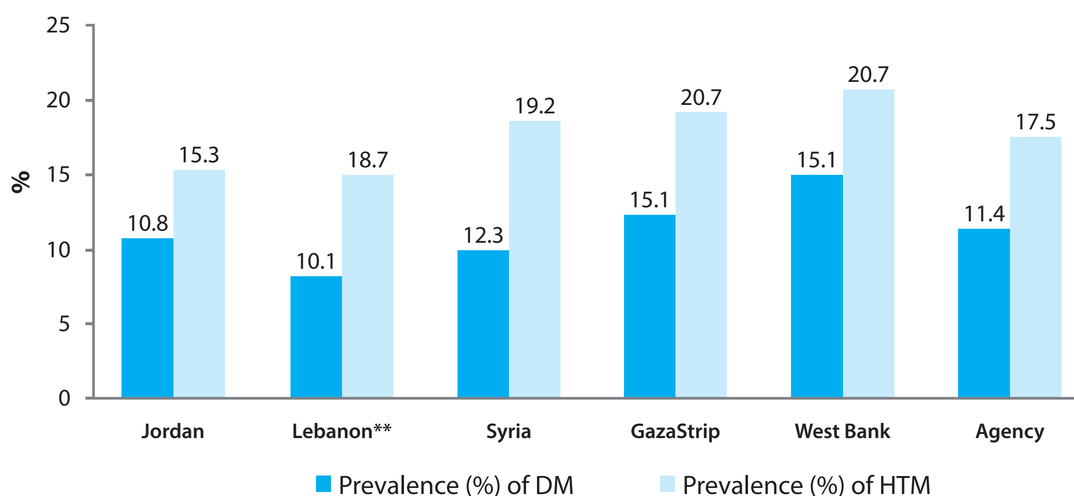


Figure 7- Prevalence (%) of patients diagnosed with type I and II diabetes mellitus and hypertension among served population ≥40 years of age, 2015 (**PRS data included)

1. Medicines & Medical Supplies section for drug cost calculations

Risk scoring

A risk assessment system is used to assess the risk status of NCD patients. This system assesses the presence of modifiable risk factors such as smoking, hyperlipidaemia, physical inactivity, blood pressure, blood sugar and non-modifiable risk factors such as age and family history of the disease. The system helps health staff to manage patients according to their risk score and to refer them for specialist care when necessary. During 2015, all patients registered with the NCD programme at an UNRWA health centre were assessed using the risk scoring assessment system. The risk scoring assessment revealed that an average of 24.9% of all NCD patients was considered to be at high risk.

Treatment

Although doctors at the health centres in all Fields are required to implement the same guidelines for NCD case management, there were significant variations among them in relation to the management of patients with type II diabetes mellitus and hypertension, which can be attributed to the variation in individual and personal judgement, in addition to differences in case management actions made. Additionally, technical instructions - under revision during 2015 – will be updated to meet the most recent directions in management of hypertension, mainly the priority for using antihypertensive drugs, namely statins.

Health care providers at UNRWA health centres counsel the NCD patients on the use of healthy life style practices. For example, the use of non-pharmacological disease management among hypertensive patients was 7.1% in Lebanon, 5.3% in Gaza, 4.0% in West Bank, 1.8% in Jordan, and 0.7% in Syria. 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, with an average of 30.2% Agency-wide. As per Field, this proportion ranged from 19.0% in Syria, to 21.8% in Lebanon, followed by 30.9% in West Bank, and 32.0% in Gaza, and the highest range was 34.3% in Jordan.

The control status based on 2-hours post prandial plasma glucose (2-hrPPG) levels was at 50.7% among patients with type II diabetes mellitus and 47.5% 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 68.7% 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 provides 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 test is planned to be used at health centres Agency-wide in 2016, in addition to microalbuminuria test. As mentioned earlier, and following the diabetes mellitus care clinical audit during 2012,[2] UNRWA's Department of Health, in cooperation with World Diabetes Foundation (WDF), carried out a variety of interventions. Later, diabetes care was re-assessed through the second round clinical audit in 2015 at 32 health centres in Gaza, Jordan, Lebanon and West Bank. Main findings can be found in section I.

Table 6- No. of patients with DMI & II only, controlled disease condition using lifestyle or insulin, 2015 (** PRS data included)

	Jordan	Lebanon**	Syria	Gaza Strip	West Bank	Agency
Lifestyle Control Only No. (%)	169 (1.4%)	238 (6.8%)	45 (1.2%)	595 (4.4%)	157 (2.3%)	1,204 (3.0%)
Insulin Only No. (%)	2,056 (16.6%)	595 (17%)	637 (17.1%)	2,090 (15.4%)	1,145 (16.6%)	6,523 (16.3%)

Table 7- No. of patients with hypertension only, controlled disease condition using lifestyle or antihypertensive agents, 2015 (** PRS data included)

	Jordan	Lebanon**	Syria	Gaza Strip	West Bank	Agency
Lifestyle Control Only No. (%)	538 (1.8%)	1,058 (7.1%)	108 (0.7%)	1,875 (5.3%)	609 (4.0%)	4,188 (3.8%)
Antihypertensive Agents Only (%)	29,405 (98.2%)	13,792 (92.9%)	14,312 (99.3%)	33,395 (94.7%)	14,748 (96.0%)	105,652 (96.2%)

2. 2012/2015 clinical audit of diabetes care among Palestine refugees

Late complications

Late complications of NCDs include, but are not limited to: cardiovascular diseases (myocardial infarction and/or congestive heart failure), cerebrovascular disease (stroke), end-stage renal failure (ESRF), above-ankle amputation and blindness. During 2015, 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 10.5% of the NCD patients Agency-wide, while it was 9.1% in 2014. Patients with both diabetes mellitus and hypertension had the highest incidence of late complications of 15.3%, followed by patients with hypertension only at 8.1%, and patients with diabetes mellitus type 2 only at 6.8%. 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 variations in treatment offered by different doctors as 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 health centre). To reach patients who miss follow-up appointments, health staffs use all means possible, including home visits, telephone calls and notifications via family members. The Agency-wide rate of defaulter NCD patients was 5.9% (13,698 patients) in 2015, which is close to the 6.0% recorded in 2014. The Field-specific defaulter rate ranged from as low as 3.6% in Gaza to as high as 8.9% in Jordan. Lebanon's defaulter rate was 5.5%, while in the West Bank it was 4.4%. Defaulters in Syria Field were 6.9%, the continued conflict and displacement of patients has likely led to an increased defaulter rate.

Case fatality

A total of 3,516 (1.5%) of UNRWA's NCD patients were reported to have died during 2015; however, deaths may, be under-reported. Patients with co-morbidities (hypertension and diabetes mellitus) comprised 55.0% of all deaths, while patients with only hypertension represented 33.6% and those with only diabetes mellitus represented 11.4% 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 on risk factors among Palestine refugees on diabetes mellitus and 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-reviewed journal,[3,4] and also by the Lancet.[5] This cohort monitoring system is now integrated in monitoring system for NCD care, and currently as part of the FHT approach, at health centres that implement e-health.

UNRWA will continue to explore options to introduce life-saving lipid-lowering agents into the UNRWA essential drugs list. In 2016, statins and the Primary Essential Package (PEN) scoring system will be introduced for high risk NCD patients according to WHO experts' recommendations.

3. 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)
4. 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.
5. Cohort reporting improves hypertension care for refugees. Mullins J. Lancet. 2012 Aug 11; 380(9841):552

The PEN scoring system will allow the Department of Health to follow 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 campaigns into daily health centre activities, specifically:

(1) Encouraging behaviour change of both patients and staff through:
   a. Conducting health awareness sessions in the waiting areas in the health centres 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 those with late complications) through special group sessions held during the slower afternoon hours
   c. Training of nurses on proper diabetes care through the Microclinic-UNRWA project

(2) 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 between UNRWA Health Programme and Microclinic International (MCI) was launched, with the financial support by World Diabetes Foundation (WDF). The project aims to scale up UNRWA and the Microclinic's model for diabetes prevention and management within the Palestine refugee population, basically through training of nursing staff at all UNRWA health centres.

While smoking within health centres has been prohibited for years, UNRWA, in 2015, implemented its new 100% smoke-free policy at all its premises. This means that smoking is prohibited inside and outside the buildings, and in UNRWA vehicles.

Communicable Diseases

In 2015, the prevention and control of communicable diseases did not face big challenges, as 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 at UNRWA facilities.

Zika Virus Disease

An outbreak of Zika Virus Disease occurred during 2015 in some countries in South America particularly in Brazil, where an increased number of infants were born with microcephaly. Microcephaly is a rare neurological condition, in which an infant's head is significantly smaller than the heads of children of the same age and sex, and it usually results from abnormal brain development in the womb or not growing as it should after birth. Evidence about the link between Zika virus and microcephaly is increasing.

Although no cases were reported in this region, UNRWA, as a part of the regional and global efforts to control, and in coordination with WHO and other UN Agencies, issued general-staff circulars and distributed WHO posters on how to prevent transmission, and to recognize symptoms. The posters were circulated to UNRWA installations in all Fields. Medical officers were given updated information on the disease and its complications.

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). In all Fields, immunisation coverage, for both 12 month old and 18 month old children registered with UNRWA, continued to be above WHO target of 95.0%. 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 2015.

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 36.8 per 100,000 population in 2014, to 53.5 per 100,000 population in 2015. The highest increase during 2015 was reported by Syria at 309 per 100,000 population; this increase is attributable to poor quality of water and hygienic conditions in addition to very difficult environmental conditions caused by on-going armed conflict and displacement of refugees. Gaza's incidence was 49.4 per 100,000 population, while Lebanon's was 21.7 per 100,000 population, which can be attributed to the low quality of water and poor hygienic conditions. 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 5.4 per 100,000 population in 2014, to 9.7 cases per 100,000 in 2015. No cases were confirmed. The highest and main incidence was observed in Syria (76.4 per 100,000 population) which is also explained by poor quality of water and hygienic conditions, in addition to very difficult environmental factors caused by the on-going armed conflict and displacement of refugees. Jordan and West Bank Fields reported no cases as in 2015.

Tuberculosis

Cases of tuberculosis reported in 2015 were 24 cases compared to 47 in 2014. Syria Field reported 16 cases, Lebanon reported 7 cases, Gaza reported one case and no cases were reported in Jordan or West Bank. Of the 24 reported cases, 6 cases were smear-positive, 3 were smear-negative and 15 were extra pulmonary. Syria reported one confirmed case, Lebanon reported 4 and Gaza reported one. With the exception of Syria, detection rates in all Fields remained below the WHO target of 70.0% of the expected number of cases for the country.[6] Patients diagnosed with tuberculosis are managed through national tuberculosis programmes using the directly observed treatment, short course (DOTS) strategy.

Brucellosis

During 2015, out of 256 total cases, 251 were reported from Syria, 3 from West Bank, and 2 cases from Lebanon. Gaza and Jordan had no reported cases.

Maternal 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 always available to all women accessing UNRWA health centres. Services are 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. The FHT approach offers a good opportunity to enhance male participation in family planning services.

During 2015, a total of 24,023 new family planning users were enrolled in the Family Planning Programme.

6. Bulletin of the World Health Organization 2009; 87:296-304

The total number of continuing users of modern contraceptive methods Agency-wide increased from 146,469 in 2014 to 153,030 in 2015 with an annual increase of 4.3%.

Table 8- Utilization of UNRWA family planning services, 2015

Indicator	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
New users	6,539	1,858	2,801	10198	2,627	24,023
Total continuing users at year end	38,387	14,229	9,083	66,567	24,764	153,030
Discontinuation rate (%)*	6.5	6.0	2.8	5.3	3.6	4.8

*(No. of discontinuers / total no. of remaining FP users)X100

The distribution of family planning users according to contraceptive method remained stable. The intra-uterine device continued to be the most popular method (49.1% of the users) followed by oral contraceptive pills (26.9%), condoms (21.4%), injectables (2.6%), and spermicide suppositories (0.1%).

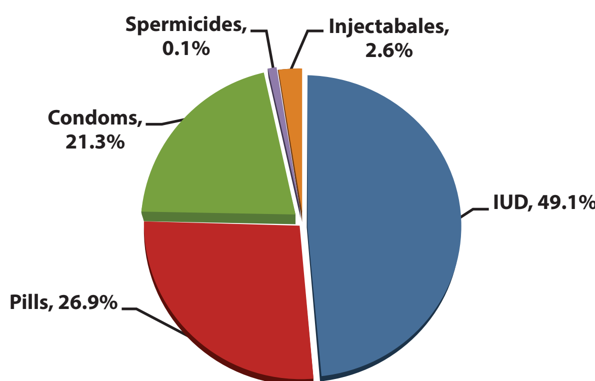


Figure 8- Contraceptive method mix, agency-wide, 2015

Couple-Years of Protection (CYP) is an output indicator used to estimate the number of clients (or couples) that were protected from pregnancy in a year. The contraceptives dispensed during 2015 through the Agency's family planning services provided 136,268 (CYP) with variations between the Fields.

Preconception care

To achieve further reduction in infant and maternal mortality, UNRWA introduced a Preconception Care Programme (PCP) in 2011 as an important component of the maternal health care, and it was fully integrated within its FHT-PHC model. The aim of preconception care is to prepare women of reproductive age to enter pregnancy in an optimal health status. 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.

During 2015, a total of 19,264 women had been enrolled in UNRWA's PCP representing an increase of 23.0% compared with 2014 (15,670). This increase can be attributed to the 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 on good relationship with a patient and her family.

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 healthy lifestyle and early detection and management of risk factors and complications. Pregnant wom en 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.

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

Antenatal care coverage

During 2015, UNRWA primary health care facilities cared for 91,245 pregnant women, representing a coverage rate of 83.4% of all expected pregnancies among the served refugee population. The antenatal care coverage was calculated based on the expected number of pregnancies in the served refugee population.
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.

Table 9- UNRWA antenatal care (ANC) coverage, 2015

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served population	1,108,065	327,516	377,071	1,280,850	463,433	3,556,934
Expected No. of pregnancies*	31,026	6,550	10,558	47,263	13,949	109,347
Newly registered pregnancies	25,981	4,814	5,096	41,924	13,430	91,245
ANC Coverage (%)	83.7	73.5	48.3	88.7	96.3	83.4

* Expected No. of pregnancies = Total No. of served population (from UNRWA registration system) X crude birth rate published by host authorities; 2.8% in Jordan, 2.0% in Lebanon, 2.8% in Syria, 3.69% in Gaza, 3.01% in West Bank

Registration for antenatal care in the 1st trimester

Early registration for neonatal care facilitates timely detection and management of risk factors and complications, thus improving the likelihood of positive outcomes for the mother and the baby. In 2015, the proportion of pregnant women who registered during the 1st trimester of pregnancy was 78.9%, for those registered during the 2nd trimester it was 18.2%, and for the women registered during the 3rd trimester it was 2.9%. There was an increase in the proportion of registration in the 1st trimester in all Fields except Syria. This could be attributed to the expansion of preconception care services and the introduction of the FHT approach in the other Fields.

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. In 2015, the average number of antenatal visits per client ranged from 4.3 in Syria to 7.0 visits in Gaza giving an Agency-wide average of 5.7 antenatal visits.

Analysis of the 2015 data reveals that the Agency-wide percentage of pregnant women who paid ≥ 4 antenatal visits was 90.2%. The highest was in Gaza at 93.8%, and the lowest was in Syria at 59.9%. The decrease in utilization in Syria is mainly due to accessibility problems caused by the prevailing security constraints.

Table 10- Number of antenatal care visits during 2015

Indicator	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
% of pregnant women with four antenatal visits or more	86.6	93.1	59.9	93.8	91.5	90.2
Average number of antenatal visits per pregnant women	5.1	6.6	4.3	7.0	5.4	5.7

Tetanus Immunisation Coverage

Results of the annual rapid assessment survey of antenatal records for 2015 showed that 99.2% 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. UNRWA currently uses a risk scoring classification based on three risk categories (high, alert, low). During 2015, and Agency-wide, 13.4% of women were classified as high risk, while 27.7% were considered alert risk. Pregnant women categorized as high & alert receive more intensive follow-up than low risk and are referred to specialists as needed.

Diabetes mellitus and hypertension during pregnancy

Pregnant women are screened regularly for diabetes mellitus and hypertension all through pregnancy. Agency-wide, in 2015, the prevalence of diabetes mellitus during pregnancy (pre-existing and gestational) was 4.2% compared to 3.6% in 2014, with wide variation between Fields. The lowest rate was 1.8% in Syria and the highest rate was 7.5% 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.[7] 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 7.2% Agency-wide in 2015, the lowest rate was 4.2% in Syria and the highest rate was 8.6% in Gaza.

Delivery Care

Place of delivery

UNRWA subsidizes hospital delivery for pregnant women classified as high-risk. During 2015, a total of 83,726 (99.9% of the total reported) deliveries took place in hospital, while only 111 (0.1%) deliveries took place at home.

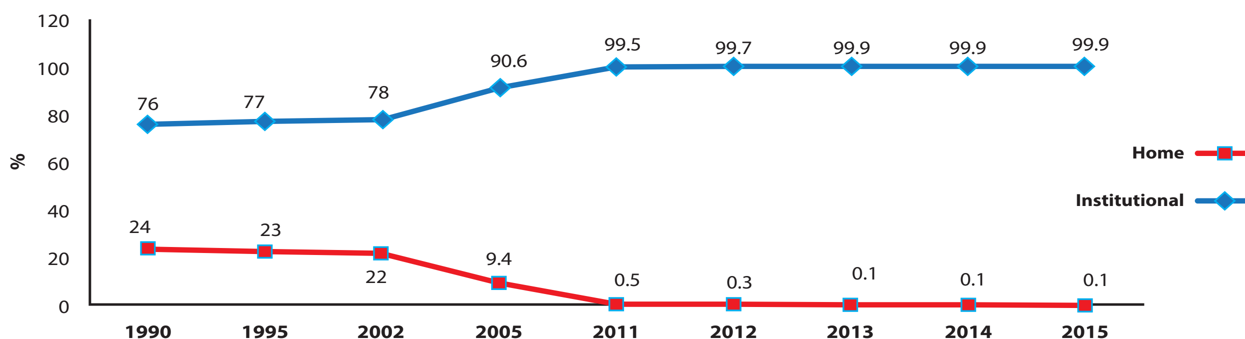


Figure 9- Trends (%) of home versus institutional deliveries, 1990 -2015

7. 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.

Caesarean sections

The proportion of deliveries by caesarean section among Palestine refugees served by UNRWA was 23.1% during 2015, compared to 22.4% during 2014. 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% [8].

Table 11- Caesarean section rates among UNRWA reported deliveries, 2014-2015

Field	No. of total deliveries in 2015	Caesarean section rate (%)	
		2014	2015
Jordan	24,280	24.7	25.2
Lebanon	4,445	44.6	44.6
Syria	4,752	34.0	21.0
Gaza Strip	37,270	17.4	18.4
West Bank	12,700	22.5	26.1
Agency	83,447	22.4	23.1

Monitoring the outcome of pregnancy

In 2002, UNRWA established a registration system (based on the expected date of delivery) to track the outcome of the pregnancy for each pregnant woman attending every health facility. During 2015, the total number of pregnant women who were expected to deliver was 89,470. Of these, 83,079 delivered successfully, while 6,109 resulted in miscarriages or abortions (6.8%) and the outcome of only 282 pregnant women (0.3%) remained unknown. The percentage of unknown outcomes dropped from 2.8% in 2002 to 0.2% in 2007, and had since that time remained approximately constant. The highest proportion of unknown outcomes was reported from Syria (4.1%). This could be attributed to the prevailing conditions, where 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 2015, a total of 21 maternal deaths were reported in all Fields. This is equivalent to an overall, Agency-wide, maternal death ratio of 25.0 per 100,000 live births among women registered with UNRWA antenatal services. UNRWA health staff conduct a thorough assessment following each reported maternal death using a standardized verbal autopsy questionnaire. Five women died during pregnancy, 16 deaths occurred in the post-natal period. Eighteen women died in hospitals while 3 died at home. The main reported cause of death was pulmonary embolism in 10 cases (47.6%), heart disease in 4 cases (19.0%), haemorrhage in 4 cases (19.0%), bacterial encephalitis in one case (4.8%), sickle cell anaemia in one case (4.8%), and lymphoma in one case (4.8%). 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.

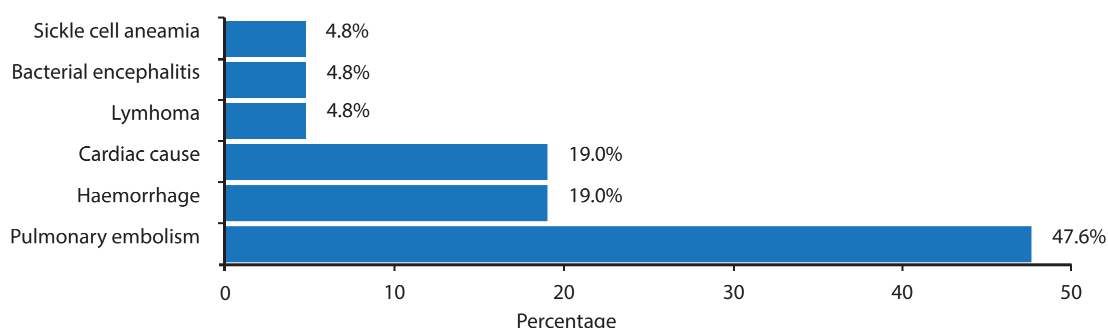


Figure 10- Underlying causes of maternal deaths, 2015

8. 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.

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 new-born care. Of the 83,079 pregnant women who delivered live births during 2015, a total of 78,444 women received post-natal care within six weeks of delivery, representing a coverage rate of 94.4%.The highest rate was 98.9% in Gaza and lowest rate was 85.9% in Syria.

Child Health Services

UNRWA provides care for children across the phases of the lifecycle, with specific interventions to meet the health needs of new-borns, 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 a registration system for children up to five years (60 months) of age has been maintained. This system enables the follow-up of children who have missed important appointments for services such as immunisation, growth monitoring, and screening.

Child care coverage

During 2015, UNRWA primary health care facilities cared for 341,956 children and children below one year, a coverage rate of 79.8% of all expected number of children. Service coverage rates were estimated based on the number of infants below 12 months of age who have been registered for care and the expected number of surviving infants, which is calculated by multiplying the crude birth rates (as published by the Host Authorities) by the number of registered refugees in each country.

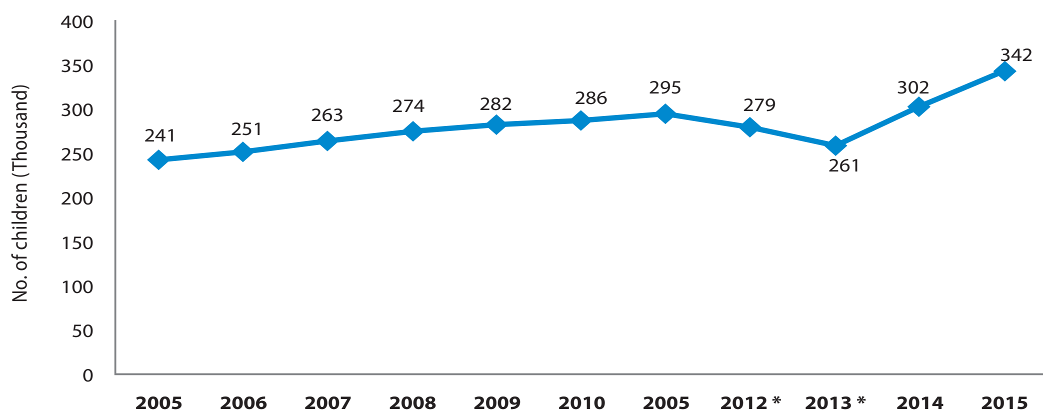


Figure 11- Children 0-5 years registered at UNRWA health centres, 2005 – 2015 (*Data not available for Syria)

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 rapid assessment technique). 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 99.9% and 99.3%, respectively. Coverage has been close to 100% for more than a decade. This extraordinary achievement has led to a substantial decrease in the incidence, morbidity and mortality due to communicable diseases.

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. At the end of 2015, the Agency-wide prevalence rate for under-weight was 2.9%, for stunting was 4.1%, for wasting was 1.9% and for the overweight /obesity was 2.7%. There was no disparity between girls and boys.

Surveillance of Infant and Child Mortality

Infant mortality

During 2015, a total of 597 cases of death among infants below one year were reported from all Fields. The main causes of death reported by Fields were: prematurity (29.5%), congenital malformations or metabolic disorders (24.1%), respiratory infections and other respiratory conditions (17.9%), septicemia (3.4%), and gastroenteritis (1.3%).

Child mortality

In addition, during 2015, a total of 163 cases of death among children 1-5 years were reported. The main causes of child death are congenital malformations (25.8%), followed by respiratory tract infections and other respiratory conditions (11.6%). In terms of the distribution of deaths by sex, child mortality was higher among males than females at 56.2 % and 43.8% respectively, however there is no direct correlation between the sex of the child and the cause of death. Almost (16.7%) of the children who died during 2015 died at home and were not hospitalized.

School Health

School Health Programme

UNRWA's existing School Health Programme (SHP) consists of a number of health services provided in cooperation between the Health and Education Departments. The health services provided include: new school-entrants medical examination, immunizations, hearing and vision screening, dental screening, de-worming and vitamin A supplementation. Additionally, the SHP follows up children with special health needs and conducts school environment and canteen inspection. These health services are provided to UNRWA schools, via health centres and School Health Teams (SHTs) that include a medical officer and nurses. SHTs follow agreed on visit schedules to cover all schools in their areas during a scholastic year.

During the school year 2014/2015, a total of 507,175 students 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.

As a result of the SHP activities during 2015, a total of 6,913 students were referred to UNRWA health facilities for further care, and additional 7,222 students were referred for specialist assessment. Furthermore, 13,631 students were assisted on the cost of eyeglasses, and 160 received assistance on the cost of hearing aids.

New school entrants medical examination

In the school year 2014/2015, UNRWA schools registered 56,747 new entrants at first grade. All of them received a thorough medical examination, immunization and follow-up. The major morbidity conditions detected among new students included: dental caries (43.2%), vision defects (6.5%), 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 1.8% and scabies in 0.5% 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 2014/2015 targeted pupils in the 4th and 7th grades in all Fields, and involved assessment for vision and hearing impairments and assessment for oral health problems.

Among 4th grade students, 56,723 were screened, achieving 92.5% coverage rate. The main morbidity conditions detected were vision defects (11.5%) and hearing impairment (0.3%). Among students in the 7th grade, 48,461 were screened, with 94.3% coverage rate. The main morbidities were again vision defects (15.2%) and hearing impairment (0.4%).

Oral health screening

Oral health screening was conducted for 1st, 4th and 7th grade students in all Fields, and for 3rd grade students in the West Bank. A total of 84,288 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 grades, fluoride mouth rinsing, and teeth brushing campaigns. Pit and fissure sealant application achieved 39.3% 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 2014/2015, a total of 3,339 school children were identified with special health needs. Of these, 923 students had bronchial asthma, 171 students were affected by type 1 diabetes mellitus, 363 had heart disease, 454 showed behavioural problems, and 345 were living with epilepsy. These children received special medical attention from teaching staff and the school health team, and their school records are maintained separately to facilitate follow-up.

Immunisation

UNRWA Immunisation programme for school children is streamlined with each host country requirements. During the school year 2014/2015, new entrants in all Fields received a booster dose of tetanus-diphtheria (DT/Td). The Agency-wide coverage was 99.2%. Coverage of oral polio vaccine (OPV) for new entrants was 99.9%, and coverage of Td vaccination among 9th grade students in the five Fields was 98.0%.

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 grades. During the 2014/2015 school year, the Agency-wide coverage was 99.4%. In addition, health awareness campaigns were carried out to emphasize the importance of personal hygiene in preventing transmission of infections at all schools.

Vitamin A supplementation

During the 2014/2015 school year, children from grades one to six at all UNRWA schools received two doses of Vitamin A 200,000 International Units (IU), taken at six-month intervals.

Oral Health

During 2015, oral health services were provided through 101 fixed and 9 mobile dental clinics. The total number of curative oral health consultations decreased by 6.0% in 2015 compared to 2014; reaching a total of 604,743. This decrease in utilization was observed in all Fields except West Bank and Syria. The decrease observed could be explained by the change in UNRWA strategy to focus on oral health preventive interventions.

Oral health screening activities reached a total of 259,748 in 2015, showing a decrease by 8.0% compared to 2014,. These activates reached pre-school children, school children, women at the first preconception care visit, pregnant women and patients with non-communicable diseases.

During 2015, UNRWA continued to reinforce the preventive component of oral health. Oral health education was introduced as part of routine mother and child health care, where dental screening was done for women at the first preconception care visit and for all pregnant women.

Comprehensive oral health assessment and the application of sealant were conducted for all children at the age of one and two years. A total of 53,077 assessments were conducted for pre-school children. Regular dental screening for new school entrants and for 7th and 9th grades students, along with oral hygiene education, continued in all Fields except Gaza, where they targeted only first graders with comprehensive dental care.

Table 12- Utilization of dental services in 2014 and 2015

Year	Indicator	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
2014	No. of curative interventions	160,170	64,567	47,946	309,465	61,001	643,149
	No. of preventive interventions	82,963	38,976	24,528	137,079	33,059	283,183
	% of preventive services	34.1	37.6	33.8	30.7	35.1	33.0
2015	No. of curative interventions	147,217	55,523	48,114	292,863	61,026	604,743
	No. of preventive interventions	82,192	38,148	23,172	155,808	29,435	328,755
	% of preventive services	35.8	40.7	32.5	34.7	32.5	35.2

Assessment of the 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. The average workload decreased from 44.2 in 2014 to 40.4 per Dental surgeon [9].

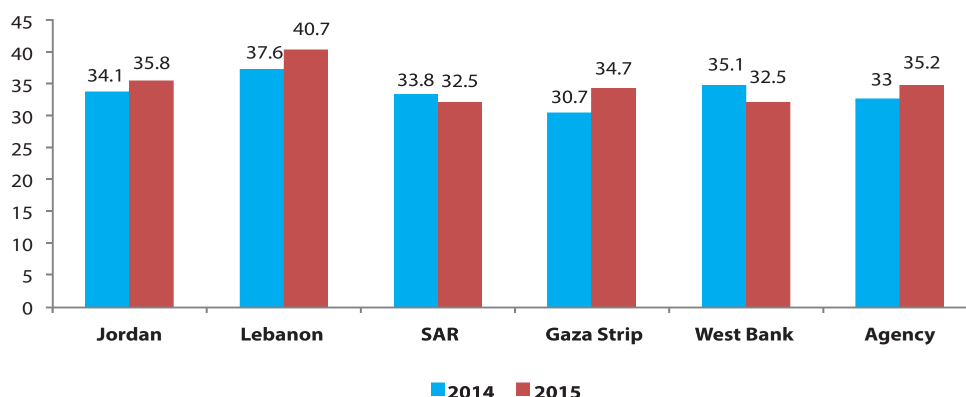


Figure 12- Average daily dental consultations (per dental surgeon) in 2014 and 2015.

9. The 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. Each procedure has a unit value (UV). The workload for each procedure obtained by multiplying the count of each procedure by its unit value and expressed in minutes. All workload units are finally added together to express the total workload. The productivity is expressed in the ratio of output (total workload units) to input (total available person-hours). In Jordan, for example, a total of 66,587 workload units (WLUs) per dentist were used for 8,650 different procedures during 216 working days (6.25 hours/day).Productivity/dentist./hour = 66,587/ (216*6.25) = 49.3 WLUs/h, which is within the WHO-recommended limits (average productivity in WLU/hr per dentist (target 50 WLUs/hr).

Community Mental Health

Community Mental Health Programme (CMHP)

Mental Health, and related issues, is a major public health priority. Hundreds of millions of people worldwide are affected by psychosocial problems, signs of psychological distress and mental health disorders. Mental health and psychosocial wellbeing have a direct effect on the physical health and well-being of individuals and their families.

For decades, Palestine refugees have suffered the trauma of forced displacement, coupled with human rights violations, poverty, poor living conditions, and recurring episodes of conflict and violence. In 2002, as a response to a 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 aims to protect and improve the mental health status and well-being of Palestine refugees through an integrated, community-based psychosocial and mental health services.

Mental Health and Psychosocial Support (MHPSS) and the FHT Approach

The FHT approach, which is a person-centred, family-based, holistic and multi-sectorial model, puts UNRWA's healthcare providers in an ideal position to address the full spectrum of mental health and psychosocial support and protection issues in a systematic comprehensive and effective way.

Using the FHT approach, health teams currently provide basic counselling and education to promote healthy living and well-being among clients.

Integrating MHPSS within UNRWA's FHT-PHC services is central to the values and principles of the FHT approach, and is the optimal solution for preventing and managing both: ill-physical health and ill-mental health. It is the most appropriate response to the mental health and psychosocial needs of Palestine refugees.

Community Mental Health Programme (CMHP) - West Bank

In the West Bank, CMHP targets those at risk, and the most vulnerable among the refugee and other encampment populations. It provides psychological support, life skills and defense mechanisms, to enhance resilience to adverse influences and life pressures. This is achieved through: individual counselling, family counselling, group counselling, home visits, open days, summer and winter camps, referral of cases, and coordination and collaboration with other services providers.

Furthermore, in response to increasing levels of domestic violence and abuse, the UNRWA Health Programme established the Family and Child Protection Programme (FCPP) in 2009, which aims to protect the rights of vulnerable groups (children, young adults, women, the elderly, and people with special needs) from all forms of violence, abuse, neglect, and discrimination.

To meet needs, and to keep pace with the continuous development of the programme, the Health Programme works for staff development and capacity-building. In 2015, a total of 20 training sessions were conducted, for 347 staff members, on separate but related topics.

In 2015, a total of 10,040 persons received individual, family, or group psychosocial counselling through CMHP and FCPP support services. In addition, 429 victims of gender-based violence (GBV) and abuse were identified. Furthermore, 364 cases of neglect among the elderly were reported through home visits. There were 41 critical cases referred to services outside UNRWA. More than 26,028 individuals and families were reached through public awareness and education activities through 1,085 sessions. Topics included GBV, mental health and nutrition, sexual and reproductive health and rights, sexual abuse, and other family and child protection matters. A total of 704 supportive counselling group sessions were conducted for 2,033 individuals including mothers, NCD patients, pregnant women, newly married couples, environmental health workers and medical staff.

In 2015, 1,488 persons were referred internally to other UNRWA programmes, while 274 beneficiaries were referred externally, to specialized NGOs.

The Emergency Community Mental Health Project (ECMHP) aims to increase the resilience, coping capacities, and mental health and psychosocial wellbeing of 49 vulnerable Bedouin and herding communities at risk of acute crises, violations of human rights and are having difficulties accessing psychosocial and mental health services.

Within these 49 targeted communities, 10,834 individuals benefited from 713 psychosocial group activities, and 1,640 participants benefited from individual, group or family counselling. In addition, 20 individuals were referred to other UNRWA programmes, while 21 individuals were referred to other service providers. As supporting bodies, 14 Community Committees were established and continue to act as psychosocial support networks. Training on prevention, responses to crises and psychosocial first aid was offered to 340 community members.

Table 13- Beneficiaries of the Emergency Community Mental Health Project (ECMHP) to Bedouins' communities during 2015

Service	Total Number of Beneficiaries		
	Male	Female	Total
Individual, group and family counselling	531	1,109	1,640
Group psychosocial activities	4,690	6,144	10,834
Internal Referral	9	11	20
External Referral	7	14	21

In 2015, a total of 834 cases of neglect, violence and abuse were detected. Of these, 429 were cases of GBV and abuse, 364 cases of neglected elderly people, and 41 cases were referred externally to specialized NGOs.
The CMHP in West Bank works in close coordination with national governmental and non-governmental stakeholders, UN agencies, and international organizations. Key national partners include the Ministry of Health, Ministry of Social Affairs, Women's Centre for Legal Aid and Counselling (WCLAC), Juzoor for Health and Social Development, Palestinian Counselling Centre (PCC), and the Women's Studies Centre. The Programme also enjoys productive relationships with Save the Children, UNICEF, UNFPA, and the YMCA.

Community Mental Health Programme- Gaza

The CMHP in Gaza delivers Mental Health and Psychosocial Support Services (MHPSS) to Palestine Refugees through the main core programmes of UNRWA, with 204 school counsellors, 25 health centre counsellors and 26 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.

In 2015, 13,581 beneficiaries accessed individual counselling either at schools or health centres, while 9,463 accessed group counselling services. In addition, community education and public awareness campaigns served approximately 90,396 individuals. The capacity-building component was another major element of activities. In 2015, 10,055 staff members have benefited from training programmes, including teachers, school principals, Area Education Officers (AEOs), doctors, and nurses,.

Health centre-based activities: there were 25 counsellors, in 22 UNRWA primary care health centres, who provided mental health and psychosocial support services to Palestine refugees attending these health centres. In addition, 5 legal advisers deliver legal consultations to women regarding marital conflict, child custody and other gender-sensitive legal issues.

In 2015, the health centres have conducted 14,546 individual counselling sessions. Of these, 3437 sessions were conducted with men, and 11,109 sessions with women, reaching a total of 4,212 clients. Complaints related to: stress (29.4%), behavioural problems (29.3%), family problems (19.3%), emotional problems (9.0%), other psychiatric disorders (6.7%), somatoform problems (3.0%) and psychosomatic disorders (1.6%).

Table 14- Activities of the Community Mental Health Programme (CMHP) at health centres in Gaza

	Individual counselling			Group counselling			GBV sessions		
	male	Female	total	male	Female	total	male	Female	total
Sessions	3,437	11,109	14,546	40	814	890*	244	4,227	4,471
Beneficiaries	983	3,229	4,212	70	1,278	1,348	92	1,199	1,291

*19 sessions for both men and women

Counsellors and health staff conducted 1,395 public awareness meetings across health centres, reaching 26,120 beneficiaries (3,220 men and 22,900 women). Health teams also conducted 151 home visits to 374 beneficiaries (89 men and 285 women).

Gender Based Violence (GBV): Since 2009, UNRWA has made a concerted effort to tackle GBV. Counsellors at health centres act as case managers for these cases. The counsellors work hand-in-hand with health professionals, social workers, and legal counsellors to provide comprehensive integrated services to survivors. CMHP also delivered GBV training to a number of UNRWA staff working within the referral system, and conducted awareness-raising sessions within the refugee communities.

Throughout 2015, 1,291 GBV cases have been detected throughout UNRWA primary health care centres. The well-being of each individual was assessed, and appropriate services were provided, including referral to a legal counsellor for advice and, in 71.4% of cases, at least one follow-up visit was conducted.

A total of 4,471 therapeutic interventions, including community-based psycho-educational intervention sessions, were provided to beneficiaries who were being seen for GBV-related issues, while a total of 5,580 refugees attended awareness-raising sessions.

Training and capacity building: In 2015, the CMHP developed various training programmes on GBV and life skills education, with the aim of building new capacities. A training course was delivered for 43 health staff on the integration of MHPSS into primary health care. Training on the Mental Health Global Action Programme (mhGAP) was delivered to 15 health staff, including doctors, nurses and midwives. Separately, 60 frontline UNRWA staff working at health centres, and 168 Relief and Social Services Programme (RSSP) social workers, received training on GBV.

Physical Rehabilitation and Radiology Services

Physiotherapy services

Physiotherapy services were provided to 3,487 patients through six physiotherapy units in the West Bank, to 13,003 patients through 11 units in Gaza Strip and to 397 patients through one unit in Jordan. The patients received 32,188 sessions through 11 physiotherapists in the West Bank, 181,739 physiotherapy treatment sessions through 34 physiotherapists in Gaza Strip and 3,711 sessions through one physiotherapist in Jordan.

These units provided a wide range of physiotherapy and rehabilitation services including: manual treatment, heat therapy, electrotherapy, and gymnastic therapy. In addition, an outreach programme, using advanced equipment which exceeded 50, facilitated the provision of therapeutic exercise, manipulation massage, functional training, hydrotherapy, electrotherapy and self-training.

The outcome of the physiotherapy treatment sessions provided at UNRWA physiotherapy units in Gaza Field was the discharge of 80% of treated patients without any disability (full recovery) and 17.0% with mild disability. Only 3.0% remained disabled due to the nature of injury or disorder. The outcome of the treatment sessions provided at UNRWA physiotherapy units and through home visits in West Bank Field was the discharge of 86.7% of treated patients without any disability (full recovery) and 11.1% with mild disability, only 2.2% 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, this will enable the health professional staff to devote more time for other patients.

Radiology services

UNRWA operates 19 radiology units (seven units in Gaza, seven units in 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, are provided through different contractual agreements with hospitals and private radiology centres to patients, to newly recruited UNRWA staff, to UNRWA local staff during periodic medical examinations, and as part of medical board examinations.
During 2015, radiology services included: 104,885 X-rays for 91,498 patients. Out of these, 90,383 were plain X-rays for 77,470 patients conducted through UNRWA X-ray facilities and 14,502 X-rays for 14,028 patients conducted at contracted X-ray facilities.

Disability Care

Disability is a crosscutting issue relevant to the work of all UNRWA Programmes. UNRWA adopts the definition of disability as 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 2015, disability awareness was addressed among staff through a variety of activities aiming at 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 provision of quality family planning services, antenatal, intra-natal, postnatal care, growth monitoring, immunization, disease prevention and control, screening activities to early detect and correct disability for new born infants and school children.

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 such as hearing aids, eye glasses, artificial limbs, wheel chairs and other aids. During 2015, more than 13,000 students were assisted with the cost of eyeglasses, and 160 students received assistance to cover the cost of hearing aids.

While Physiotherapy Centres (operating in Jordan, Gaza and West Bank) are not targeted specifically by persons with disabilities, it is recognized that a significant proportion of beneficiaries from there services are likely to be considered as 'persons with disabilities' under the definition contained in the UNRWA Disability Policy. Currently, data collection regarding physiotherapy services does not differentiate between beneficiaries with disabilities and others.

Pharmaceutical Services

Total expenditure

In 2015, the total value of medical supplies and equipment from all funds (General Fund, in-kind contributions and emergency appeals) was approximately US$ 21.99 million, representing a slight decrease compared with 2014 (US$ 23.09 million).

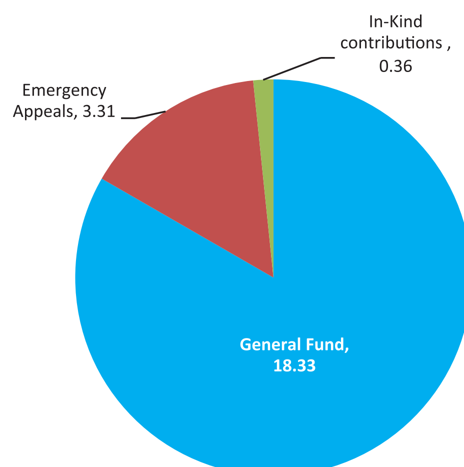


Figure 13- Total value of medical supplies and equipment from different resources, 2015

Expenditure on medical supplies

In 2015, the average expenditure Agency-wide on medical supplies per outpatient medical consultation was US$ 2.40 representing a slight decrease as compared to 2014 (US$ 2.44). The average annual expenditure on medical supplies per served refugee was US$ 6.25 Agency-wide, compared with US$ 6.28 in 2014. The comparatively high cost per served refugee in Gaza, Syria (US$ 8.44, 7.95 respectively) is due to the necessity of procuring larger quantities compared to the other Fields, including buffer stock, to avoid any shortages during emergencies.

Table 15- Average medical products expenditure (USD) for medical supplies per outpatient medical consultation and per served refugee, 2015

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Expenditure (US$) for medical supplies per medical consultations	2.1	1.5	2.9	2.7	2.4	2.4
Expenditure (US$) for medical supplies per served refugee	3.05	5.62	7.95	8.44	6.85	6.28

During 2015, medical equipment and related supplies accounted for 19.5% (US$ 4.29 million) of the total expenditure for medical supplies (US$ 21.99 million).

Expenditure on medicines

The total expenditure on medicines in 2015 was US$ 17.7 million. Analysis for drugs expenditure revealed that 46.0% was spent on medicines for the treatment of NCDs and that 17.0% on antibiotics.

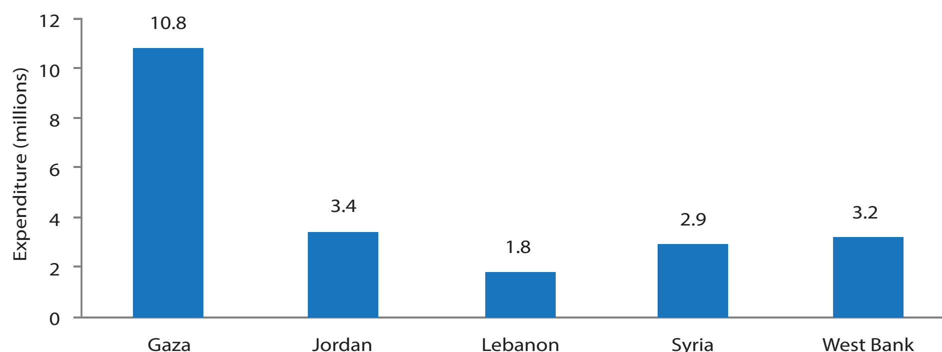


Figure 14- Expenditure on medicines by, Field 2015

Further analysis of expenditure on NCD drugs shows that 47.0% of that expenditure was on antihypertensive medications, followed by 43.0% on antidiabetics, 6.0% on cardiovascular drugs and 4.0% on lipid lowering agents.

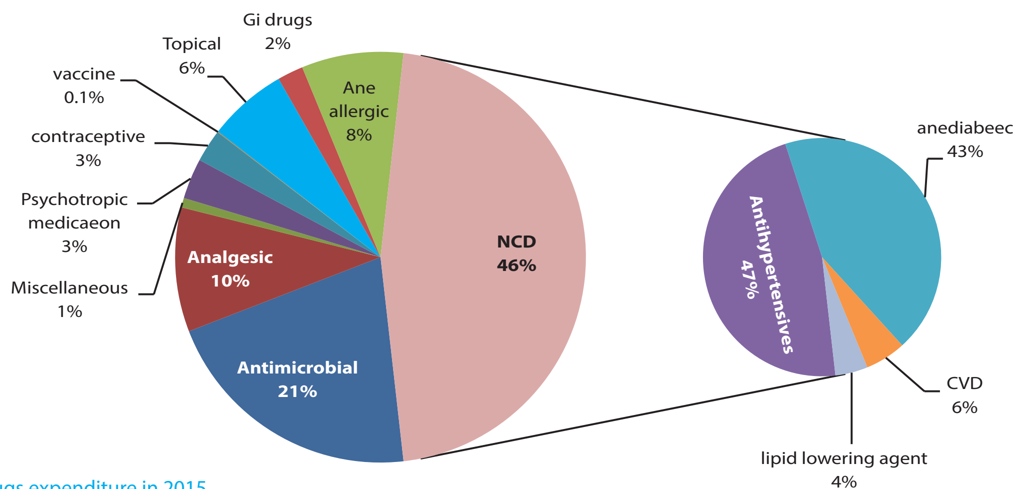


Figure 15- Drugs expenditure in 2015

Antibiotic prescription rate

UNRWA aims for an antibiotic prescription rate below 25.0% in line with WHO recommendations. Antibiotic prescription rates ranged from 20.0% in Jordan to 38.8% in Syria in 2015. It is worth mentioning that in Syria Field the rate decreased slightly in 2015 compared to 2014 (43.0%), as a lot of efforts were done to rationalize antibiotic prescription. However, the rate is still higher than all the other Fields due to the ongoing conflict and where the need for antibiotics increased to manage the increasing numbers of cases with infections.

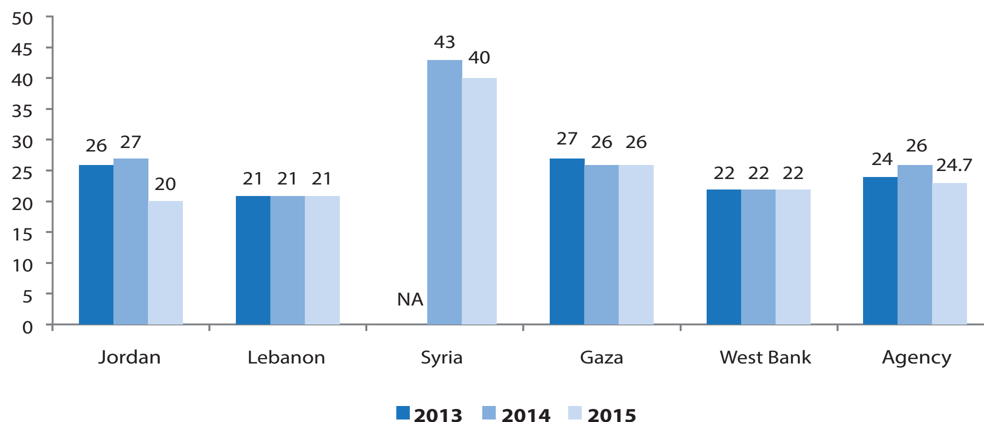


Figure 16- Antibiotics prescription rate (%) by Field, 2013-2015

Donations of medical supplies

In 2015, UNRWA received in-kind donations of medical supplies (medicines, medical equipment and others) equivalent to US$ 3.57 million. Gaza received 73.0% of these donations, followed by Lebanon (13.0%), West Bank (10.0%), Syria (2.0%), and Jordan (2.0%).

The following medicines and consumables were received during 2015:

- 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 & Health Care Society, an NGO, 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.

Please refer to the subsection on: An Innovative Approach to Medicine and Medical Supplies Procurement

Output 2.2: Efficient hospital support services

In-patient 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 2015, a total of 102,464 Palestine refugees benefited from assistance for hospital services. The average length of stay was 1.8 days across UNRWA's five Fields of operations.

Table 16- Patients who received assistance for outsourced hospital services during 2014 and 2015

	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2014	21,902	29,269	7,130	9,615	20,719	88,635*
2015	14,652	33,086	19,346	12,653	22,727	102,464

*Numbers exclude Qalqilia Hospital

Of all the patients hospitalized, 47.8% were between 15 and 44 years old, while 29.1 % were children below the age of 15. Almost 64.8% 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 differences, 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.

Please refer to the subsection on: Improving Hospital Support

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, and 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 5,624 patients were admitted to the hospital in 2015 compared to 5,175 in 2014. The average bed occupancy in Qalqilia Hospital was 57.6% in 2015, compared with 47.5% the previous year. The average length of stay in 2015 was 2.4 days.

Table 17- In-patient care at the UNRWA hospital (Qalqilia, West Bank) in 2014 and 2015

Indicators	2014	2015
Number of beds	63	63
Persons admitted	5,175	5,624
Bed days utilized	10,914	13,247
Bed occupancy rate (%)	47.5	57.6
Average stay in days	2.1	2.4

Crosscutting Services

Nutrition

During 2015, the first phase of the UNRWA-Microclinic international (MCI) project activities started; one of this project's millstones was to conduct training of the trainers' workshop for 32 senior nurses from all Field offices, except Syria. Healthy nutrition and good food choices for patients with diabetes were covered during the training. Educational materials on healthy lifestyle practices were also developed and distributed to the Fields.

In Lebanon, nutritional awareness group sessions were conducted by the newly appointed dietitian under the Monaco project. In collaboration with HQ Health Department leaflets, brochures and posters on healthy lifestyle practices especially for diabetic patients were produced.

In order to raise awareness of Palestine refugees and UNRWA staff about the implementation phase for the new e-voucher approach, and in collaboration with HQ health and others departments, UNRWA front office have launched a healthy lifestyle campaign to advocate on the benefits of the new e-voucher concerning the purchase of healthy food items by the beneficiaries. The Health Department has contributed in developing the UNRWA campaign action plan and educational materials.

In 2015, a paper titled "Evaluation of the diabetes campaign for Palestine refugees with diabetes mellitus attending UNRWA health centres" was published in the international Journal of Food Science, Nutrition and Dietetics. This paper presented the results of the first diabetes campaign, which was held during 2013. For the second DM campaign, data collection, data entry and data analysis, were finalized and will be published soon. Out of 1600 patients who were enrolled in the second campaign, 1599 (1187 female, 412 male) have completed the campaign. The average age of the participants was 52.9 ±10.8. There were 576 patients with diabetes type 2, 960 with diabetes and hypertension and 62 with diabetes type 1. Improvements in body measurements and blood tests were observed. The participants' knowledge about diabetes management, control and healthy lifestyle practices have been improved based on the analysis of the results of pre- and post-campaign questionnaires.

Table 18- Changes of body measurements and blood tests from baseline to the end of the campaign

Anthropometric / biomarkers	Categories	%	Before	After
			Mean + SD	Mean + SD
Waist circumference (cm) - Male	<94	14%	87.1 +7.0	85.1 +6.5
	94-102	23%	98.9 +2.5	96.2 +4.1
	>102	64%	114.8 +13.6	110.2 +12.5
Waist circumference (cm) - Female	<80	2%	66.1 +9.7	66.1 +10.9
	80-88	3%	84.1 +2.7	82.7 +2.7
	>88	95%	111 +11.1	106.9 +10.9
PPGT (mg/dl)	≤180	40%	141.1 +27.3	148.1 +45
	>180	60%	258.6 +69.1	187.5 +57.9
Cholesterol (mg/dl)	<200	64%	161.5 +25.4	163.6 +31.6
	≥200	36%	234.6 +37.2	202.8 +46.1

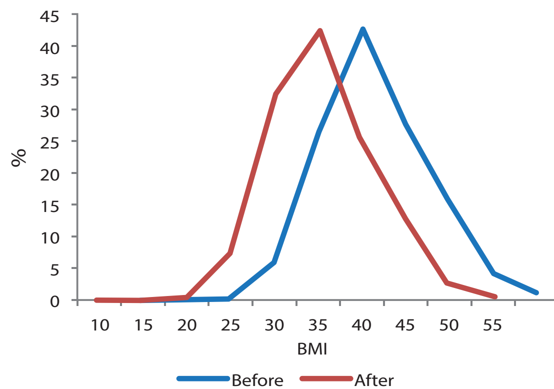


Figure 17- % of BMI values before & after the campaign, males

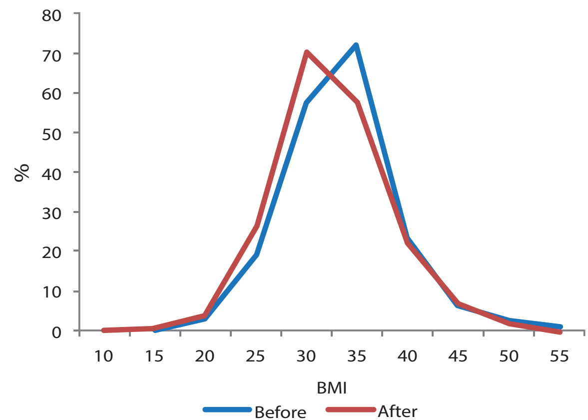


Figure 18- % of BMI values before & after the campaign, females

Laboratory services

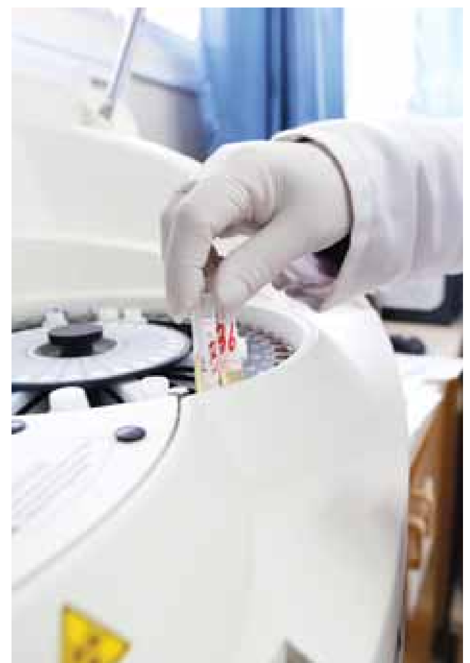
Comprehensive laboratory services were provided through 125 out of 143 health facilities. Out of the remaining 18 facilities, 10 facilities continued to provide basic laboratory support (blood glucose, blood haemoglobin and urine tests by dipstick) through competent nursing staff using basic laboratory equipment, and the remaining 8 facilities are in Syria Field and are not functioning.

Utilization trend

The Agency-wide number of tests performed in 2015 decreased by 5.3 % compared to 2014 (from 4.84 to 4.59 million). The Fields varied; while rates of decrease were observed in Gaza (11.5%), in Jordan (7.5%) and in Lebanon (8.5%), rates of increase were observed in Syria (19.1%) and in West Bank (5.1%). The remarkable increase in Syria is due establishing new health points that provided laboratory services in DTC, Jdaidah, Rukn Addin and Qudsaia areas, while the decrease of in Gaza and in Jordan was mainly due to massive stock rupture in laboratory supplies. The decrease in Lebanon was mainly due to underutilization of laboratory services by NCD patients.

Periodic self-evaluation

The annual comparative study of workloads and efficiency of the laboratory services was carried out based on 2015 data as part of UNRWA's periodic self-evaluation of the programmes using the WHO approach for workload measurement. The productivity target ranged from 45 to 55 Workload Units (WLUs)/hour. The productivity was 46.8 in Jordan, 41.9 in Lebanon, 55.8 in Gaza, 61.5 in the West Bank and 33.6 in Syria. The average Agency-wide productivity was 50 WLUs/hour.



Laboratory costs

The overall cost of laboratory services provided by UNRWA was US$ 7.4 million, out of which US$ 6.67 million (90.1%) were secured through Programme budget; US$ 0.27 million (3.7%) through in-kind donations, projects or emergency funds and the remaining US$ 0.46 million (6.2%) was due to equipment depreciation cost. The cost of laboratory services continued to be far below the rates of the host countries for equivalent services (estimated at US$ 18.0 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 19- Expenditure on laboratory services.

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Programme Budget	1,864,863	1,020,820	1,037,291	1,256,257	1,485,992	6,665,223
Non-Programme Budget	0	23,043	33,334	204,096	11,929	272,402
Equipment Depreciation	80,962	95,672	66,748	84,441	130,586	458,409
Total	1,945,824	1,139,534	1,137,373	1,544,794	1,628,507	7,396,035

Table 20- Comparative analysis on annual cost of laboratory services performed at UNRWA facilities and cost of the same services if outsourced to host authorities (USD), 2015

Cost	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Host authorities	3,137,682	1,506,094	884,008	8,035,164	4,446,524	18,009,472
UNRWA	1,945,825	1,139,535	1,137,374	1,544,794	1,628,508	7,396,035

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.
- Implementing an internal quality control system at all UNRWA laboratories and for all tests.
- Implementing an External Quality Assurance System (EQAS) at all UNRWA laboratories in all Fields.
- 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 check-up of the quality of laboratory supplies in coordination with relevant staff at the procurement division.
- Making arrangements with the public health laboratories of the host countries concerning the referral of patients or samples for surveillance of diseases of public health importance.

Health Communication

Health communication is defined as "the study and use of communication strategies to inform and influence individual decisions that enhance health "[10], and it is also defined as" the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues "[11].

As is the case for other contexts, for UNRWA Health Department, the scope of health communication covers all the programmes, sub-programmes and activities that it implements. These include, but are not limited to, disease prevention and control, health promotion, health care policy, as well as enhancement of the quality of life and health of individuals within the Palestine refugee communities. UNRWA's health communication uses a variety of channels to deliver its messages to specific segments among varied audiences, including individuals, communities, UNRWA health professionals, and policy makers.

10. http://www.thecommunityguide.org/healthcommunication/index.html
11. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448586/

Research evidence indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. This is why several training workshops on communication skills were conducted for health staff in some Fields.

In addition, health communication campaigns are the most utilized and effective method for spreading public health messages, especially in endorsing disease prevention, and in general health promotion and wellness. Therefore, and as NCDs constitute a deep concern for the UNRWA Health Programme, health communication campaigns on NCDS, especially diabetes, were implemented during 2015. For these campaigns, more innovative tools, ideas and activities were introduced to be used at the Fields to help them communicate relevant issues with NCD patients. In addition, an innovative tool (magnetic educational tool) about Iron Deficiency Anemia (IDA) was produced and distributed to the Fields to use them in educating mothers on the prevention of IDA for their children.

A proposal seeking support from donors was prepared aiming at the extension of diabetes care activities for all patients; including the production and distribution of an NCD booklet, flip charts on diabetes care, and several other tools. As a means to disseminate the results of the DM campaign, reports were prepared and published.

During 2015, a new programme on diabetes care was introduced to all Fields except Syria. This programme is based on a partnership between UNRWA Health Programme and Microclinic International, via a grant from the World Diabetes Foundation, to support the implementation of MCI model for raising the awareness of diabetic patients and their social networks. Fields nursing officers and staff nurses from the four Fields received ToT on the programme. By the end of 2015, all nurses in the four Fields were trained on the programme and started recruiting patients to UNRWA-MCI groups.

Health communication is also about health policies that should reflect positively on the health and wellbeing of people. A new UNRWA no-smoking policy (100% smoke-free UNRWA) was implemented and went into effect on 1 November 2015 at all UNRWA work places. In addition, all relevant materials needed for the successful implementation were produced and shared with the five Fields. Before that, UNRWA health communication was supported by having a presence at the 2015 Global Tobacco Control Leadership Programme at Johns Hopkins School of Public Health, Baltimore, MA, USA.

In addition, all relevant materials needed for the successful implementation were produced and shared with the five Fields. Before that, UNRWA health communication was supported by having a presence at the 2015 Global Tobacco Control Leadership Programme at Johns Hopkins School of Public Health, Baltimore, MA, USA.

The most important health-related world days were observed during 2015 at both HQ and Fields' levels. The three main days observed during 2015 included: the World Health Day, the World No-tobacco Day, and the World Diabetes Day. Relevant communication plans and materials were prepared and shared, and many activities were conducted at different levels in cooperation with the UNRWA's External Relations and Communication Department (ERCD).

Several health awareness materials were produced using different channels for communication. In addition to printed materials, videos were produced for two Palestine refugees telling their stories, and several shots on the progress and benefits of the implementation of FHT approach at one health centre in Jordan and with the Director of Health.

Human Resources

In 2011, UNRWA Health Department started a comprehensive reform of the health services based on the Family Health Team (FHT) model which was implemented in parallel with electronic medical record system (e-health) and the introduction of appointment systems.

Successful health reform could not have been achieved without the exemplary dedication and commitment of health staff, who crafted creative models, created the atmosphere of team spirit, developed their technical capacity, strengthened community engagement, and expanded collaboration with new partners. Their efforts were acknowledged and highly praised by the refugees, other UNRWA programmes, WHO, host countries, and donors.

Historically, UNRWA used to receive hundreds of applications for each vacant post, allowing it to pick from the best pool of applicants. However, in recent years, the competition for a qualified health force in the local and global market has created challenges for the recruitment and retention of health staff. UNRWA is no longer an attractive employer to new graduates – particularly doctors and nurses – and those who do join the team often leave shortly. Reasons include non-competitive compensation packages, lack of training opportunities and career trajectories.

The current grading system for health posts is inadequate to respond to the faced staffing challenges in the Fields to retain competent staff, to keep staff motivated and to ensure the recruitment of qualified professionals.

To respond to these challenges, the Health Department, in collaboration with Human Resources Department, has proposed a new health staffing structure which comprehensively addresses all these concerns and ensures recruiting competent and motivated staff through fair and costumed compensation package (internal and external), clear career progression, competitive with comparator and achieves internal equity. It will align health staff functions with the health reform objectives, and ensure consistency and fairness to staff functioning with similar qualification requirements.

Gender Mainstreaming

In accordance with the UNRWA Gender Policy adopted in 2007 and the Gender Mainstreaming Strategy (GMS) adopted in 2008, the Health Programme has continued to work in 2015 on providing support to Field offices in the implementation of their areas of priority focusing on reducing gender gaps among UNRWA health staff, addressing gender-based violence (GBV) among Palestine refugees attending the health centres and improving men's participation in pre-conception care and family planning.

Addressing the gender gap in the workforce

To address the gender balance among health staff, UNRWA's Health Department 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 32.0% in Jordan to 63.0% in Gaza.

However, the staffing structure in UNRWA health centres, similar to what is observed in host countries' health systems, reflects persistence in stereotypes regarding positions occupied by women and men, and there is a continued need to follow-up on women's access to senior positions. Nurses are primarily females and medical officers are mostly males. To tackle these challenges, UNRWA is working to ensure that recruitment procedures are gender-bias free. 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.

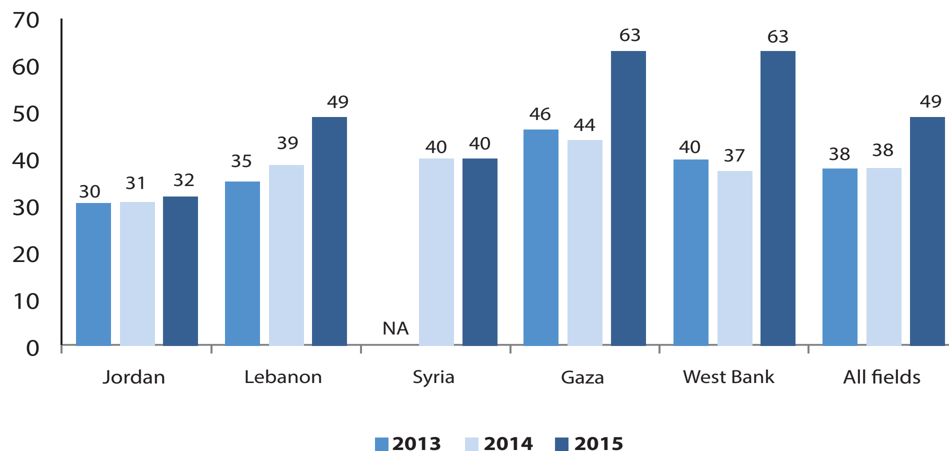


Figure 19- Percentage of female staff at UNRWA health centres

Gender Based Violence (GBV)

In line with Agency-wide efforts to address GBV since 2009, the Health Programme has sought to embed the identification and referral of GBV survivors to needed services. One of the major challenges reported is the limited or lack of private spaces at health centres, which does not allow for the safe and confidential identification and addressing on GBV. This issue is also a challenge in the context of Syria crisis, where health points in the collective centres have absolutely no room for confidential spaces. This is complicated by increased needs and vulnerabilities for the refugee community displaced in these collective centres.

To support this effort, in 2014, the Department of Health developed protocols and technical guidelines on GBV to be implemented within the Agency to better systemize the identification 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 psychosocial support. In addition, they are sought to better sensitize healthcare providers and policy makers in UNRWA on GBV, and improve their capacity to address it.

Including men in family planning and preconception care

As part of UNRWA's commitment towards improving coverage and quality of maternal and child health care services, the engagement of men in preconception care (PCC) and family planning (FP) continued to be a priority in the 2015 Gender Action Plan (GAP) for some of the Field offices. In addition, the Health Programme continued its efforts to ensure the inclusion of men in preconception care and family planning by working at both: the community level, through awareness raising specifically targeting men, and on the staff level through the GBV basic trainings organized by the Fields. Furthermore, in some Fields, such as Syria, the Health Programme records the percentage of PCC or FP with both spouses present, and during the first half of 2015, it was reported that 18.0% of women newly enrolled in preconception care were counselled with husbands. In Jordan, 5.6% of pre-conception counselling sessions were attended by both spouses. Despite these observations, staff continued to report cultural obstacles as a major challenge to the involvement of men.

Section 3 –Data

Part 1 - Agency-wide Trends for Selected Indicators

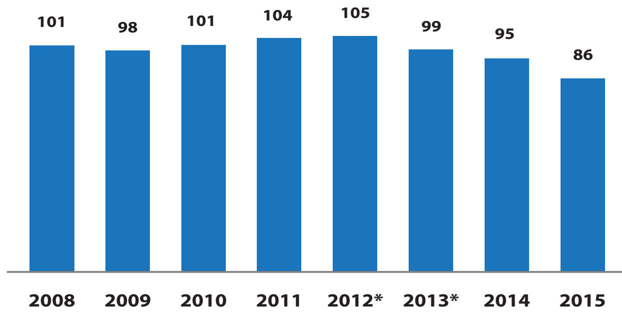


Figure 19- Average daily medical consultations per doctor

*Data from Syria is not included

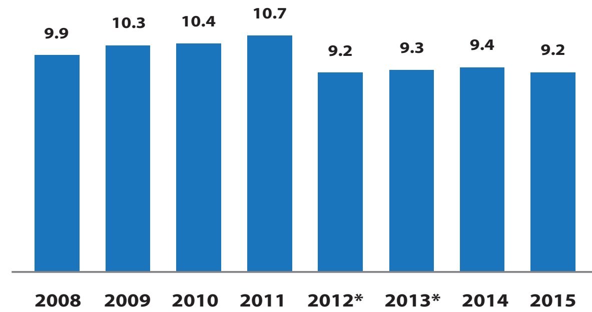


Figure 20- No. of outpatient consultations (million)

*Data from Syria is not included

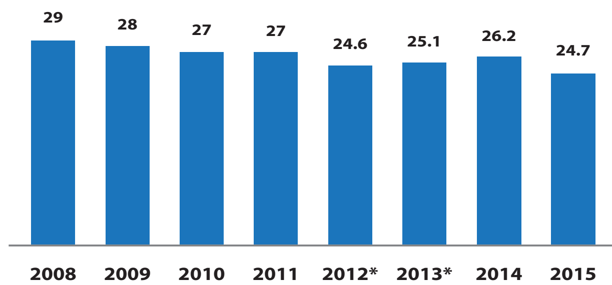


Figure 21- Antibiotics prescription rate

*Data from Syria is not included

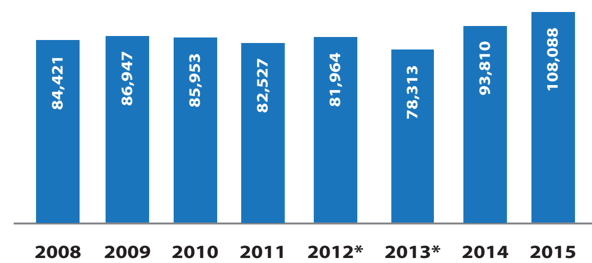


Figure 22- No. of hospitalizations (including Qalqilia hospital)

*Data from Syria is not included

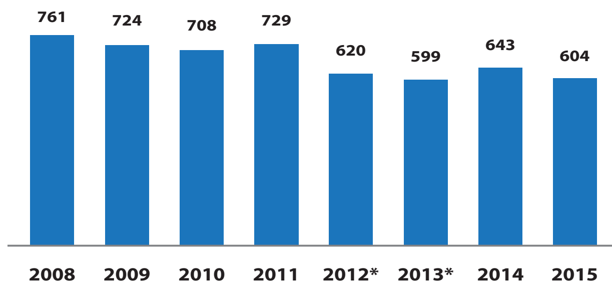


Figure 23- No. of dental consultations (thousand)

*Data from Syria is not included

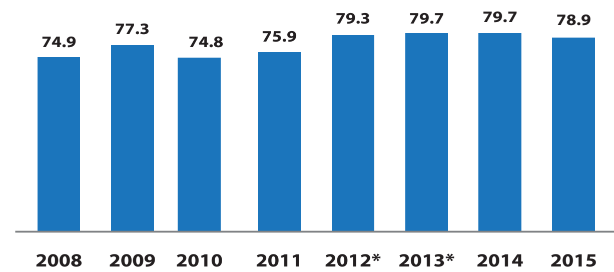


Figure 24- % of pregnant women registered during the 1st trimester

*Data from Syria is not included

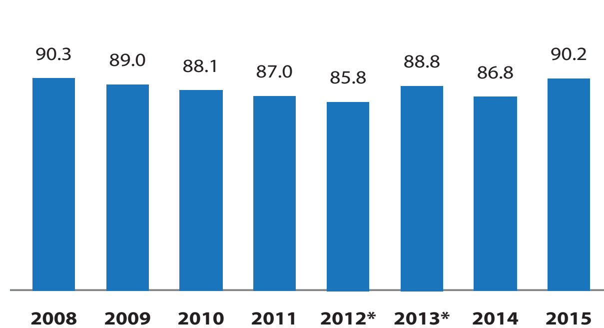


Figure 25- % of pregnant women attending at least 4 ANC visit

*Data from Syria is not included

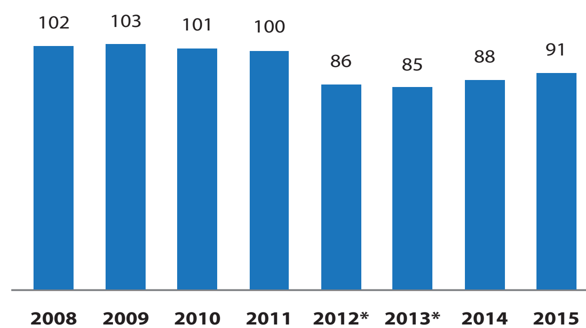


Figure 26- No. of newly registered pregnant women (thousand)

*Data from Syria is not included

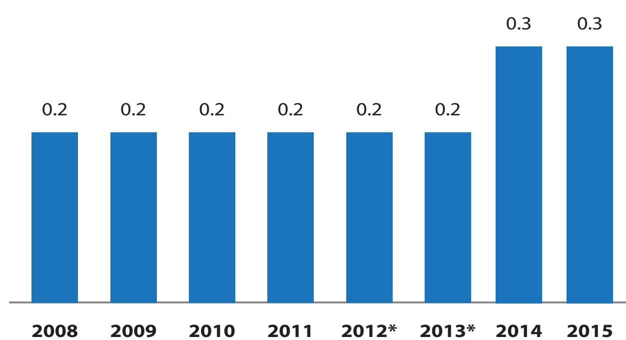


Figure 27- % of delivers with unknown outcome

*Data from Syria is not included

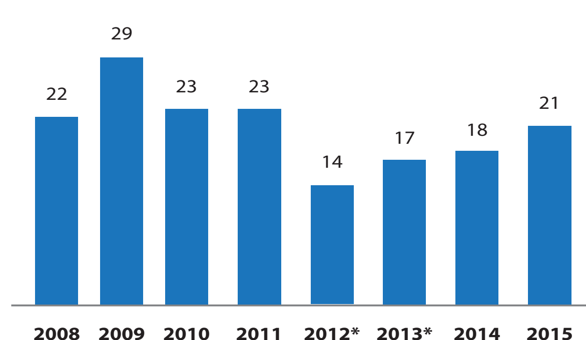


Figure 28- No. of maternal deaths

*Data from Syria is not included

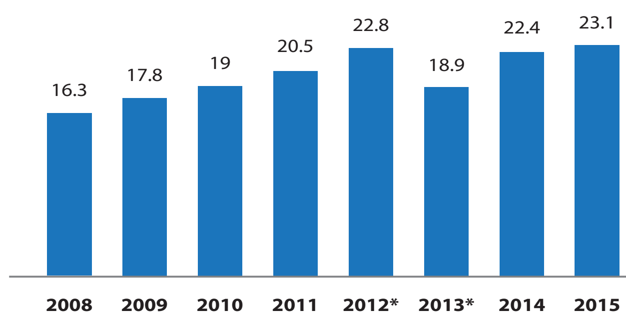


Figure 29- % of caesarean section deliveries

*Data from Syria is not included

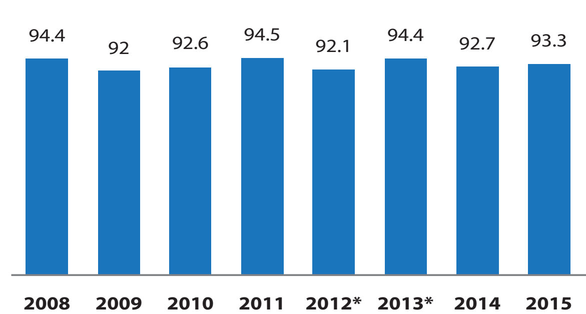


Figure 30- % of women attending PNC within 6 weeks of delivery

*Data from Syria is not included

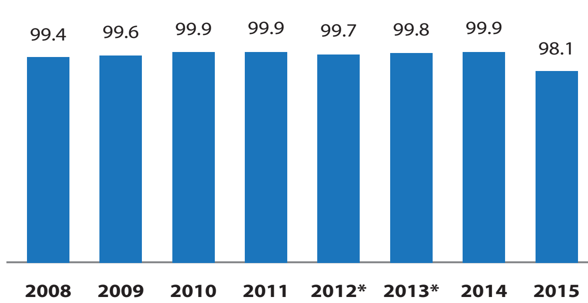


Figure 31- % of pregnant women protected against tetanus

*Data from Syria is not included

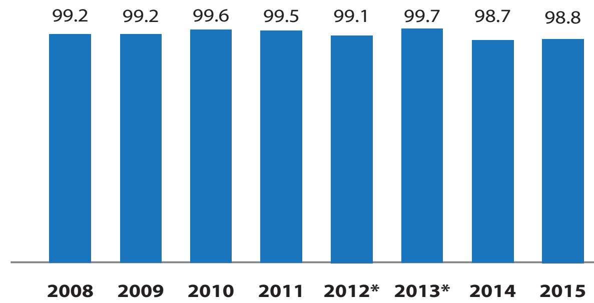


Figure 32- % of deliveries in health institutions

*Data from Syria is not included

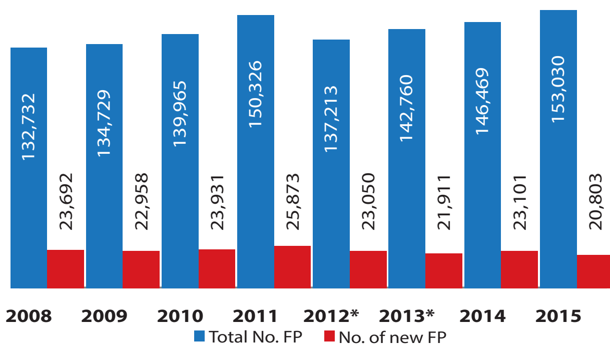


Figure 33- New & total no. of family planning acceptors

*Data from Syria is not included

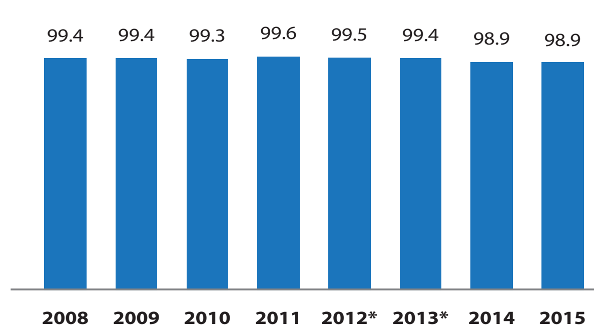


Figure 34- % of children 18 months old received all EPI booster

*Data from Syria is not included

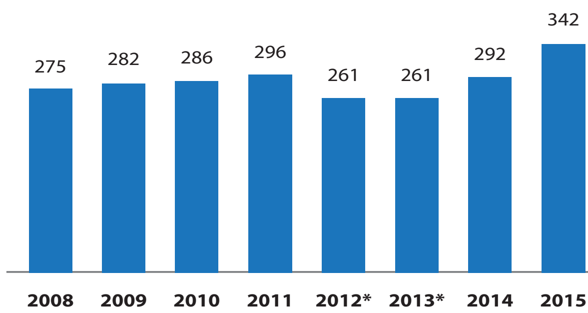


Figure 35-No. of children 0-5 years registered (thousand)

*Data from Syria is not included

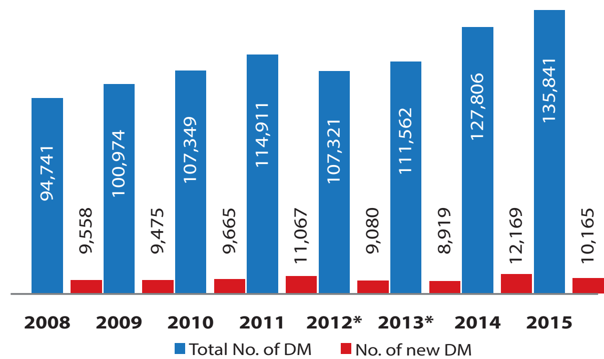


Figure 36- New & total no. of patients with diabetes

*Data from Syria is not included

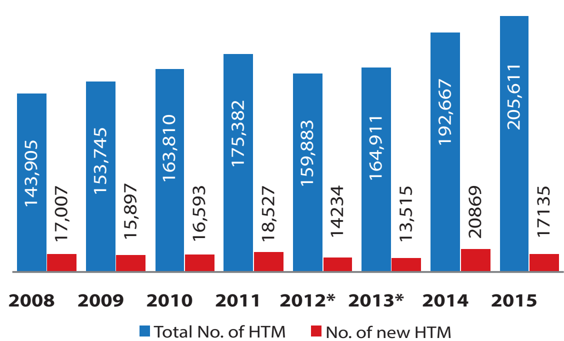


Figure 37- New & total no. of patients with hypertension

*Data from Syria is not included

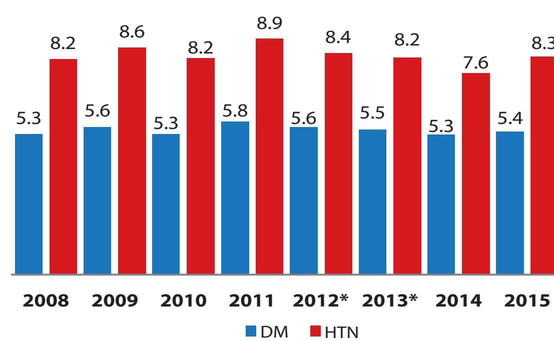


Figure 38- Prevalence of diabetes among population served 20+ years

*Data from Syria is not included

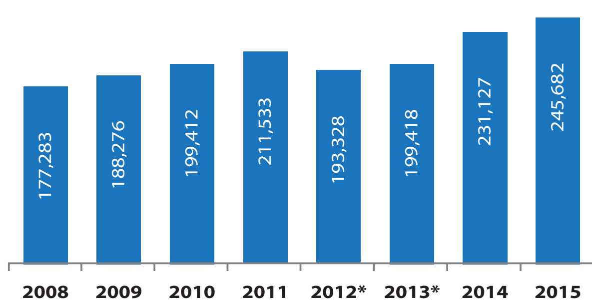


Figure 39- Total No. of all patients with diabetes and/ or hypertension

*Data from Syria is not included

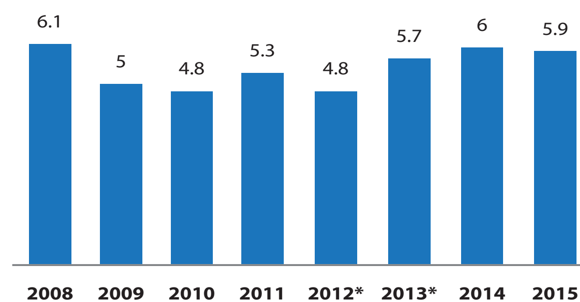


Figure 40- % of NCD patients defaulters

*Data from Syria is not included

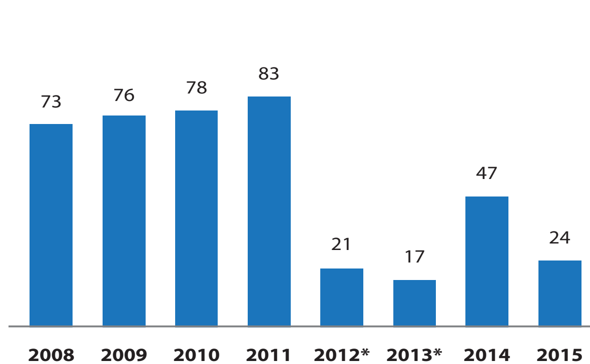


Figure 41- No. of new reported TB cases

*Data from Syria is not included

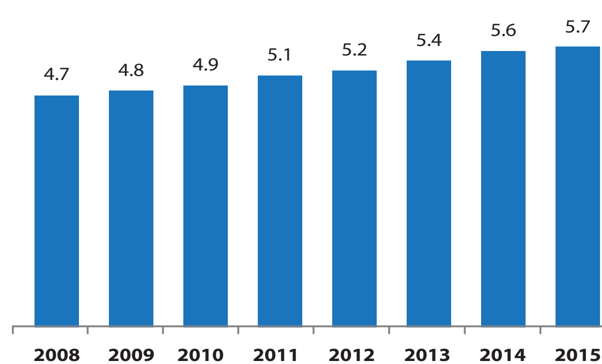


Figure 42- No. of registered populations (millions)

PART 2- Field Implementation Plans 2014/2015 – Indicators Trends

Table 21- Field Implementation Plan 2014/2015 - Indicators Trends: Jordan Field

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	101.0	96.2	87	81	84	81
	Antibiotics prescription rate (%)	29	26	26	26.4	26.5	19.8
	% Preventive dental consultations of total dental consultations	25.5	30.3	31.4	30.4	34.1	35.8
	% 4th grade school children identified with vision defect - male	11.2	13.6	11.9	13	10.4	12.1
	% 4th grade school children identified with vision defect - female	16.7	19.4	19.3	17.9	15.3	14.7
	No. of hospitalizations	19,859	16,069	14,481	12,908	21,902	14,652
	% Health centres implementing at least one E-health module	4.8	12.5	54.2	58	70	72
	% Health centres with no stock rupture of 15 tracer items (1)	-	-	93	100	100	96.8
	% Health centres with emergency preparedness plans in place (1)	-	-	-	100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	85.2	86.2	82.2	83.4	84.1	86.6
	% 18 month old children that received 2 doses of Vitamin A	98.6	98.9	99.0	98.8	98.2	98.1
	No. of women newly enrolled in preconception care programme (3)	-	3332	3267	3371	3,757	3,431
	% Women attending postnatal care within 6 weeks of delivery	87.5	88.0	83.5	87.8	86.3	87.9
	No. of continuing family planning acceptors	37,307	38,640	39,612	40,934	39,747	38,387
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (1)	-	-	37.5	62.5	-	88
	Diphtheria and tetanus coverage among targeted students	99.6	97.8	98.1	95.3	100	98.4
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)	-	-	8.6	9.4	8	8.2
	% Patients with diabetes under control according to defined criteria (2)	-	-	27	52.8	45	23.3
	No. of new patients with diabetes mellitus (only)	2,047	2,218	1,901	1,898	1,939	1,859
	Total no. of patients with diabetes mellitus (only)	11,159	11,829	11,786	12,072	12,492	12,380
	No. of new patients with hypertension (only)	3,942	4,625	3,576	3,339	3,736	3,651
	Total no. of patients with hypertension (only)	27,487	29,010	29,020	29,266	30,169	29,943
	No. of new patients with diabetes & hypertension (only)	1,591	1,919	1,506	1,466	1,435	1,456
	Total no. of patients with diabetes & hypertension (only)	25,307	27,470	28,920	29,884	30,896	31,308
	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	98.9	99.0	98.8	98.2	98.2
	No. of new TB cases detected	5	5	0	1	0	0

(1) New indicators starting 2012

(2) (2) According to (HbA1c clinical audit conducted in 2012 &2015)

(3) (3) PCC programme established in 2011

Table 22-Field Implementation Plan 2014/2015 - Indicator Trends: Lebanon Field

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	104.0	117.3	103	92	108*	98*
	Antibiotics prescription rate (%)	20	20	20	20.8	20.9	20.9
	% Preventive dental consultations of total dental consultations	27.4	35	32	34.6	37.6	40.7
	% 4th grade school children identified with vision defect – male	12	12.6	9.9	10.4	13.3	12.5
	% 4th grade school children identified with vision defect female	12.3	9.9	13.2	10.3	13.1	12
	No. of hospitalizations	25,763	26,030	29,767	30,832	29,269	33,086
	% 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	100
	% Health centres with emergency preparedness plans in place (1)	-	-	100	100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	92.3	90.9	86.2	90.7	89.4	93.1
	% 18 month old children that received 2 doses of Vitamin A	99	100	99.2	99.5	99.5	99.2
	No. of women newly enrolled in preconception care programme (3)	-	1,680	1,432	1,239	1,442	2,071
	% Women attending postnatal care within 6 weeks of delivery	95.1	97.0	97.5	98.3	97.6	97.1
	No. of continuing family planning acceptors	13,269	13,597	14,057	14,055	14,243	14,229
	% of health centres with at least one staff member trained on detection and referral of GBV cases (1)	-	-	25	100	100	100
	Diphtheria and tetanus coverage among targeted students	100	100	100	100	97.6	99.4
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)	-	-	9.8	8.6	13.3	11.9
	% Patients with diabetes under control according to defined criteria (2)	-	-	33.8	65	51.6	26.3
	No. of new patients with diabetes mellitus (only)	397	386	355	362	584*	485*
	Total no. of patients with diabetes mellitus (only)	2,476	2,528	2,616	2,654	3,343*	3,501*
	No. of new patients with hypertension (only)	1,305	1,452	1,152	1,072	1,645*	1,361*
	Total no. of patients with hypertension (only)	11,887	12,276	12,488	12,435	14,480*	14,851*
	No. of new patients with diabetes & hypertension (only)	338	343	214	283	524*	311*
	Total no. of patients with diabetes & hypertension (only)	7,594	8,437	8,602	6,601	10,235*	10,468*
	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	100	99.2	99.5	99.5	99.2
	No. of new TB cases detected	13	19	11	11	18	7

(1) New indicators starting 2012

(2) According to (HbA1c clinical audit conducted in 2012 &2015)

(3) PCC programme established in 2011

(*) PRS data is included

Table 23-Field Implementation Plan 2014/2015 - Indicator Trends: Syria Field

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	97.0	94.9	NA	NA	80	80
	Antibiotics prescription rate (%)	30	31	33	NA	42.5	38.8
	% Preventive dental consultations of total dental consultations	41.3	40.9	NA	NA	33.8	32.5
	% 4th grade school children identified with vision defect – male	2.7	2.9	9.2	NA	4.1	5.4
	% 4th grade school children identified with vision defect female	2.6	2.5	11.9	NA	4.4	6.5
	No. of hospitalizations	8,543	6,926	4,580	NA	7,130	19,346
	% Health centres implementing at least one E-health module	0	0	0	NA	NA	0
	% Health centres with no stock rupture of 15 tracer items [1]	-	-	NA	NA	NA	83.7
	% Health centres with emergency preparedness plans in place [1]	-	-	NA	NA	NA	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	79.5	78.5	76.6	NA	59.7	59.9
	% 18 month old children that received 2 doses of Vitamin A	99.4	99.9	NA	NA	NA	99
	No. of women newly enrolled in preconception care programme [3]	-	638	302	NA	150	365
	% Women attending postnatal care within 6 weeks of delivery	95.6	96.0	NA	NA	92.3	85.9
	No. of continuing family planning acceptors	18,778	19,313	8,436	NA	6,210	9,083
	No. of health centres with at least one staff member trained on detection and referral of GBV cases [1]	-	-	NA	NA	NA	96.15
	Diphtheria and tetanus coverage among targeted students	97.9	99.2	86.7	NA	78.4	97.6
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus [1]	-	-	NA	NA	3	9.6
	% Patients with diabetes under control according to defined criteria [2]	-	-	NA	NA	48.1	40.1
	No. of new patients with diabetes mellitus (only)	544	581	NA	NA	1,076	442
	Total no. of patients with diabetes mellitus (only)	3,838	3,762	NA	NA	2,930	3,728
	No. of new patients with hypertension (only)	1,537	1,614	NA	NA	3,506	1,846
	Total no. of patients with hypertension (only)	12,265	12,753	NA	NA	10,004	14,420
	No. of new patients with diabetes & hypertension (only)	440	452	NA	NA	2,264	503
	Total no. of patients with diabetes & hypertension (only)	8,780	9,598	NA	NA	7,276	9,819
	No. of vaccine preventable disease outbreaks	0	0	NA	NA	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.4	99.9	NA	NA	94	99.6
	No. of new TB cases detected	50	52	54	6	25	16

(1) New indicators starting 2012

(2) According to (PPG test due to clinical audit not conducted in Syria Field)

(3) PCC programme established in 2011

Table 24-Field Implementation Plan 2014/2015 - Indicator Trends: Gaza Field

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	98.1	102.7	113	109	96	87
	Antibiotics prescription rate (%)	26	25.2	26.0	26.9	25.9	25.5
	% Preventive dental consultations of total dental consultations	26.8	26.3	26.3	28.4	30.7	34.7
	% 4th grade school children identified with vision defect – male	12.9	12.1	12.6	7.7	7.7	8.7
	% 4th grade school children identified with vision defect female	18.2	17.8	16.4	13.1	13.1	11.2
	No. of hospitalizations	4,575	4,810	8,719	8,444	9,615	12,653
	% Health centres implementing at least one E-health module	0	0	32	52	71	90.4
	% Health centres with no stock rupture of 15 tracer items (1)	-	-	98.8	100	92	76.6
	% Health centres with emergency preparedness plans in place (1)	-	-	100	100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	93.7	92.5	93.5	93	91.7	93.8
	% 18 month old children that received 2 doses of Vitamin A	99.8	100.0	100	100	100	99.9
	No. of women newly enrolled in preconception care programme (3)	-	6,213	6,773	7,114	8,240	11,227
	% Women attending postnatal care within 6 weeks of delivery	98.7	99.2	99.3	99	99.1	98.9
	No. of continuing family planning acceptors	49,797	54,698	59,001	62,648	61,674	66,567
	%. of health centres with at least one staff member trained on detection and referral of GBV cases (1)	-	-	100	100	100	100
	Diphtheria and tetanus coverage among targeted students	99.8	100	100	100	100	99.5
Strategic Objective 3	% Target population ≥ 40 years screened for diabetes mellitus (1)	-	-	17.3	25.5	16.8	21.1
	% Patients with diabetes under control according to defined criteria (2)	-	-	29.5	42.5	46	25.5
	No. of new patients with diabetes mellitus (only)	1,658	2,066	1,793	2,150	1,647	1,840
	Total no. of patients with diabetes mellitus (only)	11,831	11,880	12,415	12,874	13,096	13,557
	No. of new patients with hypertension (only)	4,156	4,274	4,132	3,801	4,169	3,887
	Total no. of patients with hypertension (only)	27,507	29,093	30,786	31,938	33,945	35,270
	No. of new patients with diabetes & hypertension (only)	1,304	1,496	1,514	1,196	970	1,318
	Total no. of patients with diabetes & hypertension (only)	17,482	19,458	21,699	23,176	24,392	26,450
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.8	100.0	99.8	99.9	99.5	99.8
	No. of new TB cases detected	9	7	9	4	2	1

(1) New indicators starting 2012

(2) According to (HbA1c clinical audit conducted in 2012 &2015)

(3) PCC programme established in 2011

Table 25- Field Implementation Plan 2014/2015 - Indicator Trends: West Bank

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	105.5	103.6	107	116	111	86
	Antibiotics prescription rate (%)	30	30	26.0	22.4	21.7	22.2
	% Preventive dental consultations of total dental consultations	19.5	21	27.3	27.2	35.1	32.5
	% 4th grade school children identified with vision defect – male	10.7	7.6	8.7	13.4	22.9	17.1
	% 4th grade school children identified with vision defect female	10.7	10.7	10.8	16.9	19.4	19.1
	No. of hospitalizations[1]	27,213	28,692	28,997	26,129	25,894	28,351
	% Health centres implementing at least one E-health module	0	0	0	7	31	93
	% Health centres with no stock rupture of 15 tracer items [2]	-	-	90.9	100	100	100
	% Health centres with emergency preparedness plans in place [3]	-	-	100	100	100	100
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	83.6	77.2	81.5	83.3	81.5	91.5
	% 18 month old children that received 2 doses of Vitamin A	99.9	99.8	100	100	100	100
	No. of women newly enrolled in preconception care programme [4]	-	1,585	1,653	1,957	2,081	2,170
	% Women attending postnatal care within 6 weeks of delivery	81.9	91.3	84.8	89.8	84.5	88.4
	No. of continuing family planning acceptors	20,814	24,078	24,543	25,123	24,595	24,764
	%. of health centres with at least one staff member trained on detection and referral of GBV cases [2]	-	-	100	100	100	100
Strategic Objective 3	Diphtheria and tetanus coverage among targeted students	97.9	99	99.2	99.89	99.6	99.9
	% Target population ≥ 40 years screened for diabetes mellitus [2]	-	-	21.1	24.6	29.4	40.3
	% Patients with diabetes under control according to defined criteria [3]	-	-	22.8	34.4	37.7	25.5
	No. of new patients with diabetes mellitus (only)	802	973	1,210	979	1,035	1,113
	Total no. of patients with diabetes mellitus (only)	6,298	6,152	6,628	6,907	6,599	6,905
	No. of new patients with hypertension (only)	1,436	1,719	1,553	1,773	1,925	1,964
	Total no. of patients with hypertension (only)	12,918	13,490	13,662	14,217	14,723	15,357
	No. of new patients with diabetes & hypertension (only)	544	633	587	585	695	838
	Total no. of patients with diabetes & hypertension (only)	12,584	13,797	14,706	15,394	16,547	17,725
	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	100	100	100
	No. of new TB cases detected	1	0	1	1	2	0

(1) Includes Qalqilia Hospital & other hospital admissions subsidized by UNRWA

(2) New indicators starting 2012

(3) According to (HbA1c clinical audit conducted in 2012 &2015)

(4) PCC programme established in 2011

Table 26- Field Implementation Plan 2014/2015 - Indicator Trends: Agency

SO	Indicator	2010	2011	2012	2013	2014	2015
Strategic Objective 1	Average daily medical consultations per doctor	101	104	105*	99*	95**	86**
	Antibiotics prescription rate (%)	27	27	26	25.1*	26.2	24.7
	% Preventive dental consultations of total dental consultations	27.3	29.5	28.8*	30.6*	33.0	35.2
	% 4th grade school children identified with vision defect – male	11.2	11.0	11.5	9.7*	9.9	10.3
	% 4th grade school children identified with vision defect female	14.7	14.5	15.5	14.6*	14.1	12.7
	No. of hospitalizations(1)	85,953	82,527	86,544	78,313*	93,810	108,088
	% Health centres implementing at least one E-health module	21	22.5	34.5	40*	63	71.8
	% Health centres with no stock rupture of 15 tracer items (2)	-	-	93*	90.8*	82	92.7
	% Health centres with emergency preparedness plans in place (3)	-	-	75	100*	100	81.7
Strategic Objective 2	% Pregnant women with at least 4 ANC visits	88.1	87.0	86.5	88.8	86.8	90.2
	% 18 month old children that received 2 doses of Vitamin A	99.3	99.6	99.5*	99.5*	99.5	99.2
	No. of women newly enrolled in preconception care programme (4)	-	13,448	13,427	13,681*	15,670	19,264
	% Women attending postnatal care within 6 weeks of delivery	92.6	94.5	92.1*	94.4*	92.7	93.3
	No. of continuing family planning acceptors	139,965	150,325	145,649	142,760*	146,469	153,030
	% of health centres with at least one staff member trained on detection and referral of GBV cases (2)	-	-	65.6*	87.3*	90.1	97.2
Strategic Objective 3	Diphtheria and tetanus coverage among targeted students	98.9	99.3	99.4	98*	98.2	98.7
	% Target population ≥ 40 years screened for diabetes mellitus (2)	-	-	12.7*	15.8	13.1	16.6
	% Patients with diabetes under control according to defined criteria (3)	-	-	28.3*	47.6*	45.6	25.1
	No. of new patients with diabetes mellitus (only)	5,448	6,224	5,259	5,389	6,281**	5,739**
	Total no. of patients with diabetes mellitus (only)	35,602	36,151	33,445	34,507	38,460**	40,071**
	No. of new patients with hypertension (only)	12,376	13,684	10,413	9,985	14,981**	12,709**
	Total no. of patients with hypertension (only)	92,063	96,622	85,956	87,856	103,321**	109,841**
	No. of new patients with diabetes & hypertension (only)	4,217	4,843	3,821	3,530	5,888**	4,426**
	Total no. of patients with diabetes & hypertension (only)	71,747	78,760	73,927	77,055	89,346**	95770**
	No. of vaccine preventable disease outbreaks	0	0	0	0	0	0
	% Children 18 months old that received all booster doses of EPI vaccines	99.3	99.6	99.5*	99.4*	98.9	99.3
	No. of new TB cases detected	78	83	57	23*	47	24

(1) Includes Qalqilia Hospital & other hospital admissions subsidized by UNRWA
(2) New indicators starting 2012
(3) According to (HbA1c clinical audit conducted in 2012 &2015)
(4) PCC programme established in 2011
(*) Syria Field data not available.
(**) PRS data is included.

PART 3 – 2015 Data Tables

Table 27- Aggregated 2015 data tables

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
27.1 – DEMOGRAPHICS						
Population of host countries in 2015[1]	8,117,564	6,184,701	23,266,853	1,869,055	2,785,366	42,223,539
Registered refugees (no.)	2,247,768	504,376	604,689	1,388,668	970,633	5,716,134
Refugees in host countries (%)	27.7%	8.2%	3.4%	74.3%	34.8%	15.5%
Refugees accessing (served population) UNRWA health services (%/no.)	1,108,065 (49.3%)	327,516 (64.9%)	377,071 (62.4%)	1,280,850 (92.2%)	463,433 (47.7%)	3,556,935 (62.2%)
Growth rate of registered refugees (%)	1.6%	2.3%	2.2%	2.9%	3%	2.3%
Children below 18 years (%)	28.5%	23.8%	30.8%	40.7%	29.9%	31.5%
Women of reproductive age: 15-49 years (%)	28.1%	26.6%	27.6%	25%	28.1%	27.1%
Population 40 years and above (%)	33.7%	40.8%	33%	23.2%	33.3%	31.6%
Population living in camps (%)	17.4%	50.6%	30.2%	40.9%	24.3%	28.6%
Average family size	5.5	5.2	4.5	6.3	5.9	5.5
Aging index (%)	48.7%	67.5%	33.2%	19.7%	50.2%	39.1%
Fertility rate	3.5	3.2	2.5	4.3	3.9	3.5
Male/female ratio	1.0	1.02	0.96	1.02	0.99	1.01
Dependency ratio	51.7	48.4	52.9	72.4	57.7	57.1
27.2- HEALTH INFRASTRUCTURE						
Primary health care (PHC) facilities (no.):						
Inside official camps	12	14	12	11	20	69
Outside official camps	13	13	14	11	23	74
Total	25	27	26	22	43	143
Ratio of PHC facilities per 100,000 population	1.1	5.4	4.2	1.6	4.4	2.5
Services within PHC facilities (no.):						
Laboratories	25	17	16	21	42	125
Dental clinics:						
- Stationed units	29	18	12	18	24	101
- 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	18	27	0	18	31	94
STRATEGIC OBJECTIVE 1						
27.3 - OUTPATIENT CARE						
(a) Outpatient consultations medical officer (no.)						
First visits	376,054	219,697	324,641	811,557	356,828	2,088,777

6. Bulletin of the World Health Organization 2009; 87:296-304

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Male	148,684	88,389	150,661	349,701	154,077	891,512
Female	227,370	131,308	173,980	461,856	202,751	1,197,265
Repeat visits	1,186,707	952,362	706,252	3,162,969	945,703	6,953,993
Male	430,703	379,250	305,808	1,257,954	386,640	2,760,355
Female	756,004	573,112	400,444	1,905,015	559,063	4,193,638
Sub-total (a)	1,562,761	1,172,059	1,030,893	3,162,969	1,302,531	9,042,770
Ratio repeat to first visits	3.2	4.3	2.2	3.9	2.7	3.3
(b) Outpatient consultations specialist (no.)						
Gyn.& Obst.	33,029	17,563	18,330	8,302	8,597	85,821
Cardiology	3,199	9,728	1,714	15,316	98	30,055
Others	0	18,929	258	12,738	1,350	33,275
Sub-total (b)	36,228	46,220	20,302	36,356	10,045	149,151
Grand total (a) + (b)	1,598,989	1,218,279*	1,051,195	4,010,882	1,312,576	9,191,921
Average daily medical consultations / doctor[2]	81	98*	80	87	86	86*
27.4 - INPATIENT CARE						
Patients hospitalized -including Qalqilia (no.)	14652	33,086	19,346	12,653	28,351	108,088
Average Length of stay (days)	1.6	2.4	NA	1.7	1.7	1.8
Age distribution of admissions (%):-						
0-4 yrs	0.2	16.4	10.4	-	15.7	11.0
5-14 yrs	2.4	8.6	16.9	1.7	45.2	18.0
15-44 yrs	93.4	35.1	46.9	77.4	26.5	47.8
< 45 yrs	4.0	39.9	25.8	20.9	12.7	23.1
Sex distribution of admissions (%):						
Male	5.7	44.8	42.0	41.1	32.6	35.2
Female	95.5	55.2	58.0	58.9	67.4	64.8
Ward distribution of admissions (%):						
Surgery	2.4	22.4	44.7	50.9	21.8	26.9
Internal Medicine	7.2	62.8	28.2	0.2	42.9	36.5
Ear, nose & throat	1.5	2.9	6.0	0	0	2.2
Ophthalmology	0.4	2.8	0.16	8.1	3.9	2.9
Obstetrics	88.6	9.2	20.9	40.8	31.4	31.6
27.5 - ORAL HEALTH SERVICES						

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Dental curative consultation – Male (no.)	52,449	22,993	20,267	129,678	24,541	249,928
Dental curative consultation – Female (no.)	94,768	32,530	27,847	163,185	36,485	354,815
Total dental curative consultations (no.)	147,217	55,523	48,114	292,863	61,026	604,743
Dental screening consultations – Male (no.)	26,318	15,440	8,921	50,380	9,830	110,889
Dental screening consultations – Females (no)	55,874	22,708	14,251	105,428	19,605	217,866
Total dental screening consultations (no.)	82,192	38,148	23,172	155,808	29,435	328,755
% preventive of total dental consultations	35.8	40.7	32.5	34.7	32.5	35.2
Productivity (workload units /hour)	49.3	42.1	40.3	89.9	41.5	57.2
Average daily dental consultations / dental surgeon	31.2	29.9	23.9	70.3	27.6	40.4
27.6 - PHYSICAL REHABILITATION						
Trauma patients	-	-	-	4,384	517	4,901
Non-Trauma patients	397	-	-	8,619	2,970	11,986
Total	397	-	-	13,003	3,487	16,887
STRATEGIC OBJECTIVE 2						
27.7 - FAMILY PLANNING SERVICES						
New family planning users (no.)	6,539	1,858	2,832	10,198	2,574	23,998
Continuing users at end year (no.)	38,387	14,229	9,083	66,567	24,764	153,030
Family planning discontinuation rate (%)	6.5	6.0	2.8	5.3	3.6	4.8
Family planning users according to method (%):						
IUD	42.2	47	28.9	51.8	61.1	49.1
Pills	32.9	22.4	36.2	25.7	20	26.9
Condoms	22.1	30	31.3	19.1	17.6	21.4
Spermicides	0.2	0	0	0.1	0	0.1
Injectables	2.6	0.6	3.6	3.3	1.3	2.6
27.8 - PRECONCEPTION CARE						
No. of women newly enrolled in preconception care programme	3,431	2,071	365	11,227	2,170	19,264
27.9 - ANTENATAL CARE						
Served refugees (no.)	1,108,065	327,516	377,071	1,280,850	463,433	3,556,935
Expected pregnancies (no.)[3]	31,026	6,550	10,558	47,263	13,949	109,347

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Newly registered pregnancies (no.)	25,981	4,814	5,096	41,924	13,430	91,245
Antenatal care coverage (%)	83.7	73.5	48.3	88.7	96.3	83.4
Trimester registered for antenatal care (%):						
1st trimester	83.2	93.2	57.7	83.1	77.3	78.9
2nd trimester	14.3	5.9	33.6	15.8	21.2	18.2
3rd trimester	2.4	0.9	8.7	1.1	1.5	2.9
Pregnant women with 4 antenatal visits or more (%)	86.6	93.1	59.9	93.8	91.5	90.2
Average no. of antenatal visits	5.1	6.6	4.3	7.0	5.4	5.7
27.10 - TETANUS IMMUNIZATION						
Pregnant women protected against tetanus (%)	100.9	97.9	100.0	96.0	99.9	98.1
27.11 - RISK STATUS ASSESSMENT						
Pregnant women by risk status (%):						
High	17.0	11.6	7.7	15.9	15.0	13.4
Alert	26.7	32.8	33.3	23.6	22.0	27.7
Low	56.2	55.6	59.0	60.5	63.0	58.9
27.12 - DIABETES MELLUTES AND HYPERTENSTION DURING PREGNANCY						
Diabetes during pregnancy (%)	4.4	6.6	1.8	2.9	7.5	4.2
Hypertension during pregnancy (%)	6.7	6.4	4.2	8.6	5.2	7.2
27.13 - DELIVERY CARE						
Expected deliveries (no.)	26,487	4,879	4,961	40,425	12,781	89,533
a - Reported deliveries (no.)	24,591	4,445	4,519	37,476	12,048	83,079
b- Reported abortions (no.)	1,881	434	178	2,940	676	6,109
a+b - Known delivery outcome (no.)	26,472	4,879	4,697	40,416	12,724	89,188
Unknown delivery outcome (no. / %)	0.1	0.00	4.1	0.00	0.4	0.31
Place of delivery (%):						
Home	0.05%	0.0%	2.0%	0.0%	0.0%	0.1%
Hospital	100%	100%	98%	100%	100%	99.9%
Deliveries in health institutions (%)	99.99	100	99.1	100	100	99.8
Deliveries assisted by trained personnel (%)	100	100	95.3	99.1	99.9	98.8
27.14 - MATERNAL DEATHS	Jordan	Lebanon	Syria	Gaza	West Bank	Agency

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Maternal deaths by cause (no.)						
Pulmonary embolism	4	1		5		9
Haemorrhage	2		1	1		4
Cardiac causes	1			3		4
Lymphoma	1					1
Bacterial encephalitis						1
Sickle cell aneamia			1			1
Total maternal deaths	9	1	2	9	0	21
Maternal mortality ratio per 100,000 live births	36.9	22.3	42.5	23.9	0	25
C-Section among reported deliveries (%)	25.2	44.6	21.0	18.4	26.1	23.1
27.15 - POSTNATAL CARE						
Post natal care coverage (%)	87.9	97.1	85.9	98.9	88.4	93.3
27.16 - CARE OF CHILDREN UNDER FIVE YEARS						
Registered refugees (no.)	2,247,768	504,376	604,689	1,388,668	970,633	5,716,134
Estimated surviving infants (no.) [4]	61,527	9,936	16,454	50,094	28,869	166,880
Children < 1 year registered (no.)	25,611	5,026	6,025	38,610	10,150	85,422
Children < 1 year coverage of care (%)	41.6	50.6	36.6	77.1	35.2	51.2
Children 1- < 2 years registered (no.)	24,892	4,855	5,267	39,023	9,661	83,698
Children 2- < 5 years registered (no.)	25,161	4,828	4,619	118,310	19,918	172,836
Total children 0-5 years registered (no.)	75,664	14,709	15,911	195,943	39,729	341,956
27.17 - IMMUNIZATION COVERAGE						
Immunization coverage children 12 months old (%):						
BCG	99.6	100.0	99.3	100.0	100.0	99.9
Poliomyelitis(IPV)	99.6	NA	98.6	99.7	100.0	93.9
Poliomyelitis(OPV)	99.6	99.8	98.6	99.9	100.0	99.8
Triple (DPT)	99.6	99.5	98.6	100.0	100.0	99.8
Hepatitis B	99.6	99.8	98.6	100.0	100.0	99.8
Hib	99.6	99.5	98.6	100.0	0.0	99.8
Measles	99.5	99.5	98.6	NA	0.0	99.4
All vaccines	99.6	99.7	99	99.9	100.0	99.9
Immunization coverage children 18 months old - boosters (%)						
Poliomyelitis(OPV)	98.2	99.2	100.0	99.8	100.0	99.3
Triple (DPT)	98.4	99.2	100.0	99.8	100.0	99.4
MMR	98.1	99.2	98.8	99.8	100.0	99.2
All vaccines	98.2	99.2	99.6	99.8	100.0	99.3
27.18- GROWTH MONITORING AND NUTRIONAL SURVEILLANCE						

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Infants and Children with Growth Problems (0-5) years of age						
% of children aged <5 years underweight	2.6	2.2	2.9	3.5	0.39	2.9
% of children aged <5 years stunting	4.0	1.7	2.7	4.9	0.61	4.1
% of children aged <5 years wasting	1.2	1.4	1.1	2.6	0.29	1.9
% of children aged <5 years overweight/ obesity	2.5	3.3	0.13	3.3	0.63	2.7
27.19 - SCHOOL HEALTH						
4th grade students screened for vision (No.) :						
Boys	6,164	1,908	1,718	14480	2325	26595
Girls	6,069	1,907	1,727	12910	3270	25883
Total	12,233	3,815	3,445	27390	5595	52478
4th grade students with vision impairment (%)						
Boys	12.1%	12.5%	5.4%	8.7%	17.1%	10.3%
Girls	14.7%	12.0%	6.5%	11.2%	19.1%	12.7%
Total	13.4%	12.2%	6.0%	9.9%	18.3%	11.5%
7th grade students screened for vision (No.) :						
Boys	6547	1,604	1,545	10760	2427	22883
Girls	5586	1,784	1,507	10695	3265	22837
Total	12133	3,388	3,052	21455	5692	45720
7th grade students with vision impairment (%)						
Boys	15.7%	10.5%	6.1%	12.6%	16.7%	13.3%
Girls	18.8%	10.7%	6.4%	17.8%	19.4%	17.0%
Total	17.1%	10.6%	6.3%	15.2%	18.3%	15.2%
STRATEGIC OBJECTIVE 3						
27.20 – NON COMMUNICABLE DISEASES (NCD) PATIENTS REGISTERED WITH UNRWA						
Diabetes mellitus type I (no/%)	1,199 (1.6%)	288* (1.0%)	410 (1.5%)	1,143 (1.5%)	668 (1.7%)	3,708 (1.5%)
Diabetes mellitus type II (no/%)	11,181 (15.2%)	3,213* (11.1%)	3,318 (11.9%)	12,414 (16.5%)	6,237 (15.6%)	36,363 (14.8%)
Hypertension (no/%)	29,943 (40.7%)	14,851* (51.5%)	14,420 (51.6%)	35,270 (46.9%)	15,357 (38.4%)	109,841 (44.7%)
Diabetes mellitus & hypertension (no/%)	31,308 (42.5%)	10,468* (36.3%)	9,819 (35.1%)	26,450 (35.1%)	17,725 (44.3%)	95,770 (39.0%)
Total	73,631	28,820*	27,967	75,277	39,987	245,682
27.21 - PREVALENCE OF HYPERTENSION AND DIABETES						

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Served population 40 years with diabetes mellitus (%)	10.8	8.2*	10.1	12.3	15.1	11.4
Served population 40 years with hypertension (%)	15.3	15.1*	18.7	19.2	20.7	17.5
27.22 – MANAGEMENT						
Hypertensive patients on lifestyle management only (%)	1.8%	7.1%*	0.7%	5.3%	4.0%	3.8%
Diabetes patients on insulin (%)	34.3%	21.8%*	19.5%	32%	30.9%	30.2%
27.23 - RISK SCORING						
Risk status - patients with diabetes mellitus type 1 (%):						
Low	65.9%	54.6%*	61.0%	35.9%	64.9%	47.4%
Medium	29.8%	35.8%*	29.3%	37.8%	30.5%	35.0%
High	4.3%	9.6%*	9.8%	26.4%	4.6%	17.7%
Risk status - patients with diabetes mellitus type 2 (%):						
Low	30.2%	29.0%*	26.8%	32.3%	39.5%	33.1%
Medium	51.9%	53.0%*	53.9%	54.6%	48.3%	52.7%
High	17.8%	18.0%*	19.3%	13.1%	12.2%	14.2%
Risk status - patients with hypertension (%):						
Low	21.3%	26.1%*	30.2%	14.8%	34.2%	21.5%
Medium	55.5%	52.1%*	54.1%	48.1%	51.8%	51.2%
High	23.2%	21.8%*	15.7%	37.1%	14.0%	27.3%
Risk status - patients with diabetes & hypertension (%):						
Low	8.6%	18.5%*	15.2%	28.8%	19.1%	20.9%
Medium	47.9%	47.9%*	51.2%	55.7%	50.0%	52.0%
High	43.5%	33.6%*	33.6%	15.5%	30.9%	27.1%
Risk factors among NCD patients (%):						
Smoking	16.5	40.2*	30.5	12.0	19.7	15.7
Physical inactivity	55.1	15.8*	29.2	45.3	37.8	45.6
Obesity	42.8	45.7*	47.9	45.9	45.7	45.1
Raised cholesterol	40.2	48.7*	51.3	42.7	47.3	42.9
27.24 - LATE COMPLICATIONS AMONG NCD PATIENTS (%)						
Diabetes mellitus type I	3.8	0.75*	0.0	1.9	7.0	2.7

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Diabetes mellitus type II	7.0	7.0*	8.5	5.3	12.9	6.8
Hypertension	9.7	7.4*	9.9	7.2	8.8	8.1
Diabetes mellitus & hypertension	15.3	10.4*	14.9	15.7	15.5	15.3
All NCD patients	11.6	8.0*	11.3	9.8	12.3	10.5
27.25 – DEFAULTERS						
NCD patients defaulting during 2015 (no.)	6542	1548*	1401	2541	1666	13698
NCD patients defaulting during 2015/total registered end 2014 (%)	8.9	5.5*	6.9	3.6	4.4	5.9
27.26 - FATALITY						
Reported deaths among registered NCD patients (no/%)	1.2	1.9*	1.7	1.6	1.6	1.5
Reported deaths among registered NCD patients by morbidity (no):						
Diabetes mellitus	103	32*	32	161	71	399
Hypertension	234	210*	129	444	166	1,183
Diabetes mellitus & hypertension	563	284*	174	551	362	1,934
27.27 - COMMUNICABLE DISEASES						
Registered refugees (no.)	2,247,768	504,376	604,689	1,388,668	970,633	5,716,134
Refugee population served (no.)	1,108,065	327,516	377,071	1,280,850	463,433	3,556,934
Reported cases (no.):						
Acute flaccid paralysis[6]	0	2	0	0	0	2
Poliomyelitis	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Diphtheria	0	0	0	0	0	0
Meningococcal meningitis	0	1	0	6	0	7
Meningitis – bacterial	0	1	0	11	3	15
Meningitis – viral	0	2	0	7	9	18
Tetanus neonatorum	0	0	0	0	0	0
Brucellosis	0	2	251	0	3	256
Watery diarrhoea (>5years)	7,159	11,137	5,701	10,486	8,175	42,658
Watery diarrhoea (0-5years)	7,195	9,871	6,383	23,776	9,551	56,776
Bloody diarrhoea	285	20	214	2,072	454	3,045
Viral Hepatitis	22	71	1,165	632	13	1,903
HIV/AIDS	0	0	0	0	0	0

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Leishmania	0	0	62	0	1	63
Malaria*	0	0	0	0	0	0
Measles	0	1	8	1	0	10
Gonorrhoea	0	3	19	0	0	22
Mumps	1	1,266	28	896	26	2,217
Pertussis	0	0	0	0	1	1
Rubella	1	0	2	0	2	5
Tuberculosis, smear positive	0	4	1	1	0	6
Tuberculosis, smear negative	0	1	2	0	0	3
Tuberculosis, extra pulmonary	0	2	13	0	0	15
Typhoid fever	0	7	288	51	0	346
CROSSCUTTING SERVICES						
27.28 - LABORATORY SERVICES						
Laboratory tests (no.)	1,077,025	335,409	356,747	1,868,549	892,135	4,529,865
Productivity (workload units / hour)	46.8	41.9	33.6	55.7	61.5	47.9
27.29 - RADIOLOGY SERVICES						
Plain X-rays inside UNRWA (no.)	2,577	22,548	-	37,927	27,331	90,383
Plain X-rays outside UNRWA (no.)	1,456	4,791	-	-	-	6,247
Other X-rays outside UNRWA (no.)	3	8,252	-	-	-	8,255

HUMAN RESOURCES 27.30-	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
(.Health staff as at end of December 2014 (no							
: Medical care services							
Doctors	2	104	41	61	174	84	466
Specialist	0	6	9	6	5	9	35
Pharmacists	1	2	33	2	3	2	43
Dental Surgeons	0	30	16	19	29	17	111
Nurses	0	268	115	104	331	283	1101
Paramedical	6	131	30	80	218	197	662
Admin./Support Staff	5	84	80	61	106	95	431
Labour category	0	102	32	71	139	105	449
Sub-total	14	727	356	404	1005	792	3298
International Staff	5	0	0	0	0	0	5
Grand total	19	727	356	404	1005	792	3,303

HUMAN RESOURCES 27.30-	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Health personnel per 100,000 registered refugees:							
Doctors	-	4.6	8.1	10.1	12.5	8.7	8.2
Dental surgeons	-	1.3	3.2	3.1	2.1	1.8	1.9
Nurses	-	11.9	22.8	17.2	23.8	29.2	19.3

Part 4 - Selected Survey Indicators

INFANT AND CHILD MORTALITY SURVEY, 2013

Table 28- Infant and child mortality rate per 1000 live births, 2013

Indicators	Jordan	Lebanon	Gaza Strip	West Bank	Agency
Infant &child mortality rate	10.3	10.8	8.3	5.9	9.2
(Early neonatal (<= 7 days	10.0	2.5	2.8	1.8	4.6
(Late neonatal (8 - <=28 days	20.3	13.3	11.1	7.8	13.7
(Neonatal (<= 28 days	2.1	6.7	3.9	4.1	4.3
(Post neonatal (>28 days - 1 year	22.4	20.0	15.0	11.9	18.0
(Infant mortality (< one year	4.8	1.6	2.2	0.5	2.4
(Child mortality (> one year	27.2	21.6	17.2	12.3	20.4
Infant and child mortality	10.3	10.8	8.3	5.9	9.2

DMFS SURVEY, 2010

Table 29 - Descriptive: total DS, FS and DMFS sorted by age group

Age group	DS[7] Mean, SE (95%CI)	FS[8] Mean, SE (95%CI)	DMFS[9] Mean, SE 95%CI)8)
year 11-12	0.34 ,3.27 (3.94 – 2.61)	0.13 ,0.49 (0.74 – 0.24)	0.38 ,3.83 (4.58 – 3.08)
13year	0.08 ,3.20 (3.36 – 3.04)	0.03 ,0.58 (0.63 – 0.52)	0.09 ,3.92 (4.10 – 3.74)
year 13 <	0.49 ,3.09 (4.06 – 2.11)	0.24 ,0.94 (1.42 – 0.46)	0.54 ,4.22 (5.29 – 3.16)

Table 30 - 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 %
year 11-12	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
year 13 <	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 31 - 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 (2.78 – 2.19) 0.15	0.55 (0.64 – 0.45) 0.05	3.23 (3.56 – 2.89) 0.17	76.9	17.0
Lebanon	2.99 (3.41 – 2.57) 0.21	0.77 (0.92 – 0.61) 0.08	3.78 (4.23 – 3.33) 0.23	79.2	20.3
Syria	3.37 (3.72 – 3.02) 0.18	0.7 (0.93 – 0.59) 0.09	4.22 (4.62 – 3.82) 0.20	80.0	18.0
Gaza	2.21 (2.42 – 1.99) 0.11	0.34 (0.42 – 0.25) 0.04	2.66 (2.87 – 2.38) 0.12	82.9	12.7
West Bank	5.02 (5.44 – 4.60) 0.21	0.54 (0.66 – 0.42) 0.06	5.88 (6.34 – 5.42) 0.23	85.4	9.2

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

Table 32 - 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 33 - 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 34 - Selected anaemia survey indicators

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

Annex1 - Health Department Research Activities and Puplished Papers

Table 35-List of publications

S.No	Title of publication	Published in	Present as
1	Increasing Neonatal Mortality among Palestine Refugees in Gaza Strip	PLOS ONE Journal	Scientific paper
2	Infant and Neonatal Mortality among Palestine Refugees in Gaza – a follow-up cross- sectional survey	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Oral presentation
3	Description of Typhoid Fever Cases in Yalda, Syria	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Oral presentation
4	Evaluation of the Diabetes Campaign for Palestine Refugees with Diabetes Mellitus Attending UNRWA Health Centres	International Journal of Food Science, Nutrition and Dietetics	Scientific paper
5	Evaluation of campaigns for Palestine refugees with diabetes mellitus attending UNRWA health centres	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster
6	Prevalence of non-communicable diseases (NCDs) risk factors among Palestine refugees in Lebanon	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster

7	The Impact of a Family Health Team Approach on the Quality of Healthcare for Palestine Refugee Infants in Jordan: a cross-sectional controlled study	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster
8	The impact of continuity of care and socio-behavioural factors on antibiotics prescription for upper respiratory tract infections in Palestine refugee children in UNRWA health centres	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster
9	Evaluation of contraceptive use practices in family planning services for Palestine refugee mothers in Gaza – A cross sectional survey	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster
10	Causes, determinants and trends in maternal mortality among Palestine refugees during 2005-2014	Lancet Palestinian Health Alliance (LPHA) 7th Conference	Poster

Annex 2 - Health Department Field Implementation Plan (FIP) 2014 / 2015

Table 36 - 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 program
				• % 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*

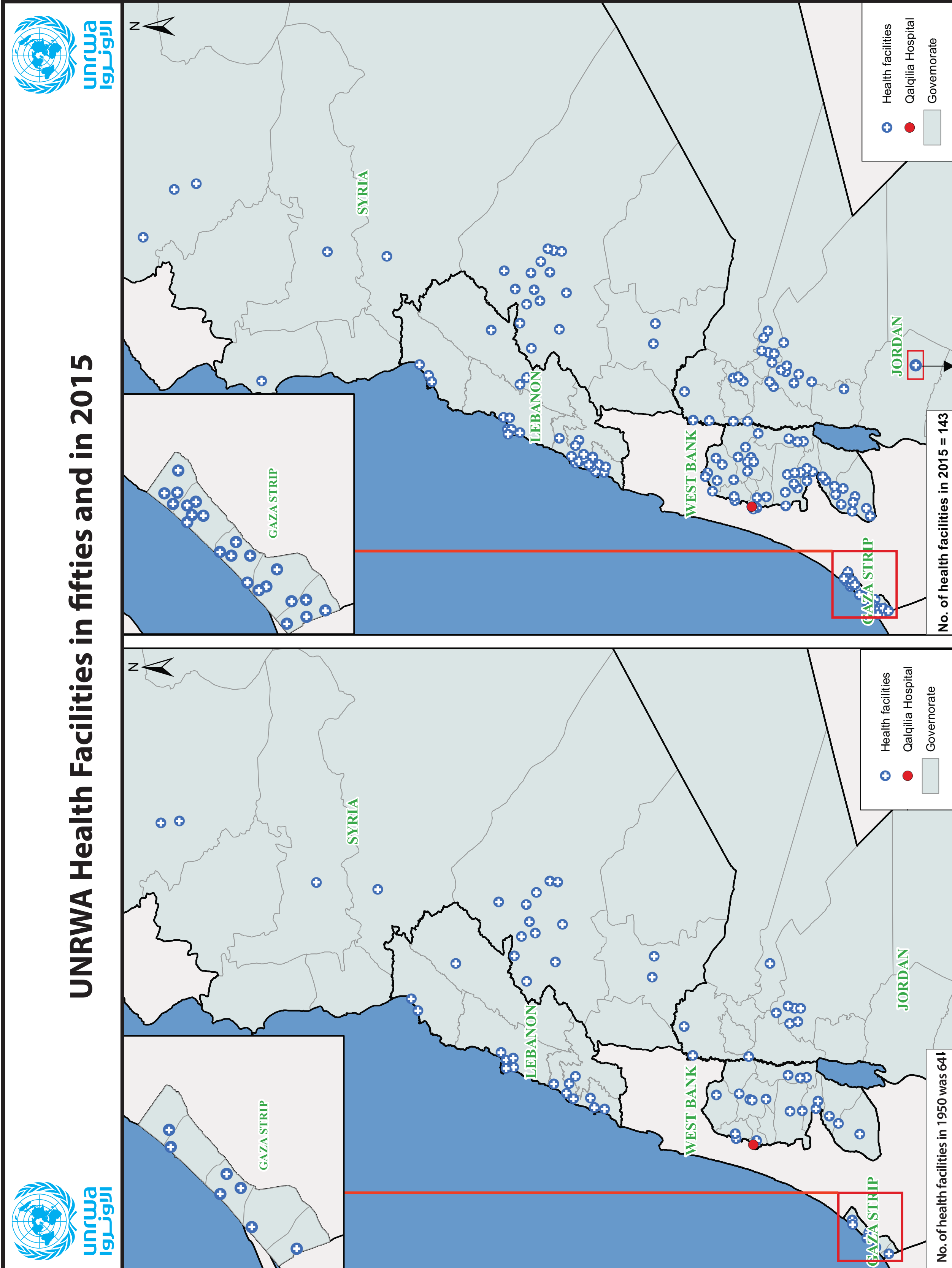
*Monitored by Infrastructure and Camp Improvement Program

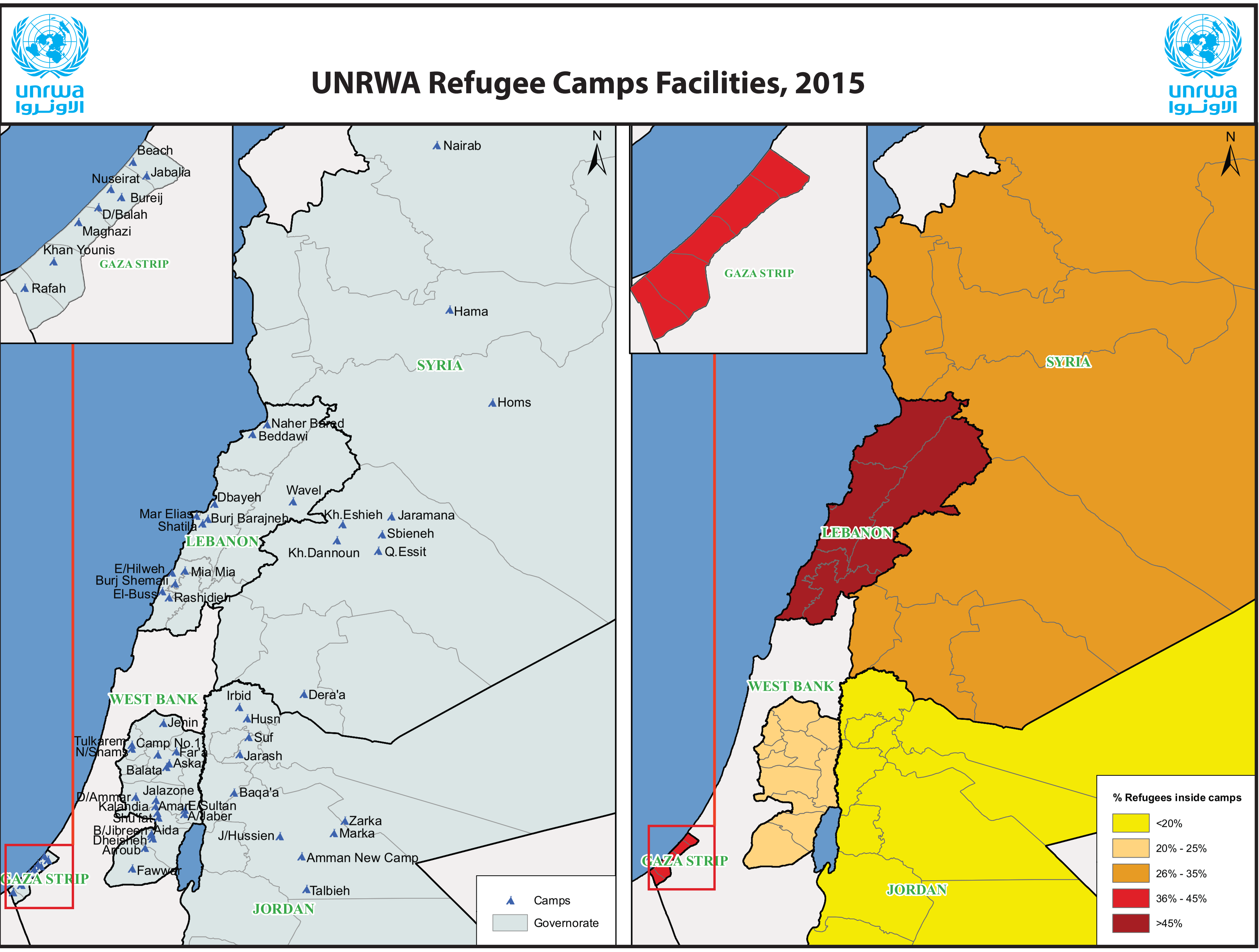
Table 37 - Agency-wide Common Indicators

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 program
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 live births
% 18 months old children that received 2 doses of Vitamin A	No. of children 18 months old that received 2 doses of Vit A x 100 No. of registered children 1 - < 2 years
No. of women newly enrolled in Pre-Conception Care program	No. of women newly enrolled in Pre-Conception Care program
% Women attending PNC within 6 weeks of delivery	No. of women attending postnatal care within 6 wks of delivery x 100 No. of live births
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 program)
% 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
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

Indicator	Calculation
%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 3 - Health Maps. 2015





unrwa
الاونروا
UNRWA Refugee Camps Facilities, 2015
N
Beach
Jabalia
Nuseirat
Bureij
D/Balah
Maghazi
Khan Younis
GAZA STRIP
Rafah
Nairab
Hama
SYRIA
Homs
Naher Bared
Beddawi
Wavel
Dbayeh
Mar Elias
Shatila
Burj Barajneh
Kh.Eshieh
Jaramana
Sbieneh
Kh.Dannoun
Q.Essit
LEBANON
E/Hilweh
Burj Shemali
El-Buss
Mia Mia
Rashidieh
WEST BANK
Irbid
Dera'a
Husn
Jenin
Tulkarem
N/Shams
Camp No.1
Far'a
Suf
Jarash
Aska
Balata
Jalazone
Baqa'a
D/Ammar
Kalandia
Amari
E/Sultan
Shu'fat
A/Jaber
B/Jibreen
Aida
Dheisheh
Arroub
J/Hussien
Zarka
Marka
Amman New Camp
Fawwar
Talbieh
GAZA STRIP
JORDAN
Camps
Governorate
% Refugees inside camps
<20%
20% - 25%
26% - 35%
36% - 45%
>45%

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

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Annex 5 - Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Amman New Camp
AO	Area Office
CBOs	Community Based Organizations
CBR	Crude Birth Rate
CMHP	Community Mental Health programme
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
EMR	Electronic Medical Records
EMRO	Eastern Mediterranean Regional Office
EPI	Expanded Programme of Immunisation
ESRF	End Stage Renal Failure
EOAS	External Quality Assurance System
ERCD	External Relations and Communications Department
FCPP	Family and Child Protection Programme
FHT	Family Health Team
FIP	Field Implementation Plan
FOs	Field Offices
FS	Filling Surface
GAP	Gender Action Plan
GBV	Gender Based Violence
GF	General Fund
GMP	Good Manufacturing Practices
GMS	Gender Mainstreaming Strategy
HD	Health Department
HQ	Headquarters
Hib	Haemophilus Influenza
HIV	Human Immunodeficiency Virus
IDA	Iron Deficiency Anaemia
IDPs	Internally Displaced Persons
IMR	Infant Mortality Rate
IU	International Units
IUD	Intrauterine Device
LPHA	Lancet Palestinian Health Alliance
LTA	Long Term Agreement
MCH	Maternal and Child Health
MCI	Microclinic International
MDG	Millennium Development Goal
mhGAP	mental health Global Action Programme
MHPSS	Mental Health and Psychosocial Support
MMR	Measles, Mumps, and Rubella
MO	Medical Officer
MTS	Medium Term Strategy
NCDs	Non-communicable Diseases
NMR	Neonatal Mortality Rate
NGOs	Non-Governmental Organizations
OPV	Oral Polio Vaccine
PCC	Palestinian Counseling Centre
PCC	Preconception Care
PEN	Primary Essential Package
PHC	Primary Health Care
PPG	Post prandial plasma glucose
PRCS	Palestinian Red Crescent Society
PRS	Palestinian Refugees from Syria
RSS	Relief and Social Services
SMOs	Senior Medical Officers
SSN	Social Safety Net
SRA	Stringent Drug Regulatory Authorities
TB	Tuberculosis
Td	Tetanus/Diphtheria
ToTs	Training of trainers
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief & Works Agency for Palestine Refugees in the Near East

IPV	Inactivated Polio Vaccine
ISD	Information Systems Division
IMR	Infant Mortality Rate
WDF	World Diabetes Foundation
WCLAC	Women's Centre for Legal Aid and Counselling
WHO	World Health Organization

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وكالة الأمم المتحدة لإغاثة وتشغيل
اللاجئين الفلسطينيين في الشرق الأدنى