lebanon field office

reform of unrwa health programme
a three- year journey
2010-2012

Embassy of Italy

Italian Ministry of Foreign Affairs

www.unrwa.org

unrwa
الاونروا

reform of unrwa health programme
a three- year journey
2010-2012

lebanon field office

Table of Contents

foreword of the chief field health programme in lebanon

Palestine refugees in Lebanon live in harsh conditions and poor socio-economic status. Amongst other pressing needs, they are in dire need of comprehensive health care services. While high quality services are available in Lebanon, they are not readily accessible to the majority of Palestine refugees. UNRWA, a firm believer that health is a basic human right, is their main provider of health care services.

Towards the end of 2009, UNRWA has taken a proactive step towards improving the provision of health services to Palestine refugees in Lebanon. With the generous support from the international community, UNRWA was able to launch an ambitious reform of its Health Programme, aiming at improving the accessibility of Palestine refugees in Lebanon to quality health care services while at the same time working on improving the efficiency and effectiveness of these services.

It is with great pleasure that we present to you this report that describes the different components of the reform of the Health Programme at the Lebanon Field Office (LFO). This reform is the result of collective efforts of colleagues in Health Department at LFO, the Front Office, and the Health Department at Headquarter. Our partners including the international community, the Lebanese Government, the Palestine Red Crescent Society, international and local Non-Governmental Organisations, the private sector as well as the community contributed significantly to this reform.

The reform addressed the different components of a health system namely governance, workforce, delivery of services, health information system, communication and partnerships. Several activities were introduced in this respect such as improving coverage and accessibility to hospitalisation services; developing a monitoring and evaluation system of these services; improving the infrastructure of the health centers; building the capacity of the health staff; and raising health awareness of the community. Moreover, two innovative interventions were introduced as part of the reform. The first is the CARE programme, a joint collaboration between UNRWA and the private sector with the support of the international community, which aims at providing additional support for Palestine refugees with catastrophic health conditions. The second is the Family Health Team (FHT) approach, introduced by the Health Department at Headquarter, which aims to deliver comprehensive, continuous and quality primary care services to the individuals within the context of their family and community.

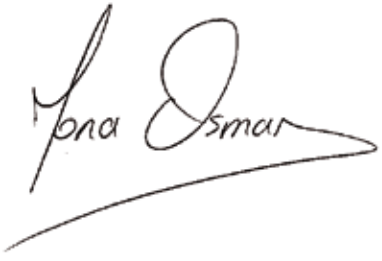
Several positive developments, highlighted in this report, were realized during the last three years at the different levels of care delivery: primary, secondary and tertiary. More efforts still need to be exerted regarding improving the quality of primary health care services and improving the tertiary care coverage.

It is crucial also to be able to address the different challenges facing the progress of the reform: limited financial resources of the Agency; continuously evolving needs of the Palestine refugees with more prevalence of chronic non-communicable diseases necessitating a long-term sophisticated and expensive care; increasing health care costs in Lebanon and the increasing numbers of Palestine refugees displaced from Syria.

Our main aim remains to ensure a universal access to health for all Palestine refugees in Lebanon. It is true that this is a long and challenging process but we, in UNRWA, firmly believe that with the collaboration of all relevant partners, we will be able to protect, preserve and promote the health of Palestine refugees so they may live a long and healthy life.

Mona Osman MD, MPH, MBA

Chief Field Health Programme



message of the director of unrwa affairs in lebanon

Palestine refugees in Lebanon are a marginalized and disadvantaged group. They suffer from high poverty and unemployment rates and a significantly precarious socio-economic situation. 95% of Palestine refugees in Lebanon have no health insurance. Health services are very expensive in Lebanon and thus with no access to public health care. Palestine refugees are heavily dependent on UNRWA's health services and coverage of health costs.

This report illustrates the health care service reforms implemented by UNRWA in the Lebanon Field. These include Primary health care reforms introduced in the 28 UNRWA health clinics across the country and improvements made to the coverage for secondary health care, where additional contracted hospitals have improved patient services. In tertiary care - the most complicated and expensive form of health services - UNRWA has increased its coverage from 30% in 2010 to 40% in 2011 and then to 50% as of May 2012. Through the CARE programme, set up in 2011 in partnership with the private sector, UNRWA has sought to cover a number of catastrophic cases which otherwise would not have received assistance.

While many improvements have been made and much progress continues to be made, Palestine refugees in Lebanon are still not covered for numerous types of highly expensive treatments. Medical conditions therefore can go untreated if costs cannot be met.

The challenge remains for UNRWA to address these cases whilst maintaining the improvements made in the field of primary health care and hospitalisation. In addition, The Agency is dealing with the escalating and profound humanitarian crisis resulting from the situation in Syria. Tens of thousands of Palestinians have already fled Syria to Lebanon and continue to do so in large numbers.

The challenges UNRWA face are mounting and pressing but with the continued support of our existing donors - and hopefully attracting new ones - we will be able to continue to provide the much needed humanitarian assistance.

Ann Dismorr

Director of UNRWA Affairs in Lebanon

executive summary

Palestine refugees in Lebanon live under dire conditions. Two thirds of them are poor, and 56% of those of working age are jobless. The Palestine refugees' population is a young one with half of the population being under the age of 25 years. Palestine refugees face double burden of disease; on one hand, health problems related to infectious diseases such as acute respiratory and gastrointestinal infections are still present; on the other hand, non-communicable diseases such as hypertension, diabetes mellitus and mental health problems are becoming more prevalent.

Palestine refugees in Lebanon do not benefit from any form of social or public health insurance and therefore rely heavily on UNRWA. In this respect, UNRWA in Lebanon, similar to other fields, provides free comprehensive primary health care services for Palestine refugees in its 28 health centers located inside and outside the camps. In addition, UNRWA contracts locally operational hospitals for the provision of secondary and tertiary care. Although secondary care hospitalisation is almost fully covered by UNRWA, tertiary care remains the main burden to the refugees because of the partial coverage offered by the Agency and the escalating prices of the health care system in Lebanon.

In an attempt to improve its services, UNRWA conducted several assessments of its health programme both internally and by external consultants. The assessments highlighted several areas that need improvement in the provision of health services, which ultimately affects the quality of the services (such as crowdedness in health centers, short consultation time, high load per medical officer per day) and accessibility to care (such as limited availability of hospital care and unclear rights for the beneficiaries).

The reform of the UNRWA Health Programme was launched at the end of 2009 in Lebanon Field Office and is still ongoing. The objectives of the reform are to increase the access of Palestine refugees to quality healthcare, to enhance equity and to improve efficiency and effectiveness in the delivery of services, while at the same time ensuring the sustainability of these services.

This reform was supported initially and is still supported by the Italian Government and the Italian Development Cooperation Office. Other donors contributed later to the different activities of the reform namely the Australian Government, the German Government, the Monaco Government, European Union, the European Community Humanitarian Office (ECHO), the Government of United States of America, Medical Aid for Palestinians (MAP) and the Qatar Red Crescent (QRC).

The reform was channeled through six main pillars: governance, health workforce, service delivery, health information system, communication and partnerships. The health department at the Lebanon Field Office (LFO) was restructured as to decrease the bureaucracy of work and enhance decentralization to the five areas of operation in the country. Investment in the health workforce was and still is a main priority of the

programme: a revision of job descriptions, upgrading of some health posts as well as capacity building programs were the main activities conducted in this respect.

Several interventions were implemented to improve the delivery of services at multiple levels. These include but are not limited to the following: introduction of the Family Health Team (FHT) approach, piloting of the appointment system, introducing new services that aim at improving quality of care (Echocardiography, specialist in diabetes care, and preventive oral health namely fluoride application) as well as the rehabilitation of some health centers in order to improve the safety of the working environment.

At the level of secondary and tertiary care, a new hospitalisation strategy was introduced early 2010. An increased number of hospitals was contracted and the previous bed-ceiling applied to each hospital per month for Palestine patients was discontinued. This strategy introduced also a thorough monitoring and evaluation system with periodic measurement of quality indicators. Secondary care continues to be almost fully covered by the Agency with better access for patients to quality hospitalisation, while the coverage of tertiary care has increased during the last years from an average of 30% to around 50% of the bill. More patients were found to have access to hospitalisation care (an increase of 41% in 2012 as compared to 2009) with more than 80% satisfaction for the quality of services received. In order to improve the access of patients in need of tertiary services to the care needed, a new programme entitled CARE programme was launched April 2011. This programme succeeded in extending support to 425 patients by the end of December 2012. Patients with multiple sclerosis, thalassemia and sickle cell anemia have now access to medications at discounted rates, an unattainable privilege before the CARE programme started.

UNRWA has committed to improve access, quality and quantity of the health services it provides and has been undergoing substantial reforms to appropriately meet the needs of the Palestine refugees in Lebanon. While some targets are being achieved, there are still significant gaps that require action. This is even more relevant if it is taken into consideration that the conditions of Palestine refugees in Lebanon are worse than in other fields where UNRWA operates, that needs are growing with time and health costs in the country are on the rise. Other challenges worth mentioning here, though they are not part of the reform and will not be covered in this report are the relief special programme for the Internally Displaced Population from Naher El-Bared Camp (ongoing since 2007) and the relief programme for the newly displaced Palestine Refugees from Syria. These two have an impact on the delivery of services as well as the resources of the health programme at Lebanon Field Office.

Securing sustainable sources of funding remains a major challenge in improving and expanding UNRWA's health services. Nevertheless, the Agency will continue its reform process in the coming years for these services to become even more efficient and effective. UNRWA will continuously advocate for more funding and support from the international community and the host Government of Lebanon. Moreover, various partners need to join efforts in order to achieve the reform targets. In this respect, the Palestinian Liberation Organisation (PLO) can still play an important role in improving the delivery of health services to Palestine refugees in Lebanon, despite its limited budget for health and medical care. International non-governmental organisations as well as the local non-governmental organisations can substantially contribute, in partnership with other parties, to complement the services provided by UNRWA, as well as continue to raise health awareness and knowledge among refugees. The Lebanese Ministry of Public Health has been so far supportive in facilitating provision of services. UNRWA will continue working with the Lebanese Government in order to improve the provision of health services for Palestine refugees, a basic right that everyone should be entitled to. Finally, the role of the community is and remains crucial in determining and shaping the health services that are provided to its members.

1 overview & context

1.1 Conditions of Palestine Refugees in Lebanon

UNRWA's Relief and Social Services records indicate that 474,053 Palestine refugees were registered with the Agency in Lebanon as of December 2012. A survey conducted in August 2010 by a multi-disciplinary team of experts from the American University of Beirut (AUB)[1], in collaboration with UNRWA, revealed that between 260,000 to 280,000 Palestine refugees currently reside in Lebanon while 469,901 were registered with the Agency during that year.

According to this survey, around 62% of the refugees live in 12 official refugee camps. The remainder live in 27 gatherings intermixed with Lebanese and other communities, usually located in the vicinity of the camps. The Palestine refugee population is young. The average age is 30 years and half of the population is under 25 years old, as opposed to 11.5% that are aged 60 years and above. The average household size is reported to be 4.5 persons.

Table 1- List of official Palestinian camps in Lebanon

List of Official Camps by Area	
North	Naher El-Bared, Beddawi
Central Lebanon Area	Dbayeh, Mar Elias, Shatila, Burj Barajneh
Bekaa	Wavel
Saida	Mia Mia, Ein El-Hillweh
Tyre	Rashidieh, El Buss, Burj Shamali

Palestine refugees living in Lebanon are vulnerable. Approximately 66.4% of the refugees are poor (not able to meet basic food and non-food needs) and 6.6% suffer from extreme poverty (not able to meet essential food requirements). With this poverty level, 28% of Palestine refugees in Lebanon are moderately food insecure, while 15% of them report severe food insecurity. According to the AUB-UNRWA survey, 56% of the Palestine refugees in Lebanon of working age are jobless. Lebanese laws contribute to this phenomenon by imposing a number of restrictions on Palestine refugees such as the disbarment from formal employment in various fields, where only 37% of the working age population is actually employed. It is worth noting that only half of the young individuals of secondary school age (16-18 years old) are enrolled in schools or vocational training centers.

Household conditions in camps are worse than in surrounding areas, as an ever increasing number of refugees share a finite space. In fact, the AUB-UNRWA survey showed that in 66% of the houses, dampness and leakage can be encountered, resulting in psychological and chronic illnesses, and 8% of households surveyed suffer from overcrowded conditions (more than 3 people in 1 room).

Due to poor housing conditions, overcrowding, and lack of proper sanitation and infrastructure in the camps, acute infectious illnesses are common among the refugee population. The incidence of vehicle-borne and vector-borne diseases such as diarrhea, hepatitis A, and typhoid fever are high. The AUB-UNRWA survey showed that approximately 24% of the refugees suffered from acute illnesses during the six months period prior to data collection in August 2010, with respiratory and gastrointestinal illnesses accounting for 55% of total acute illnesses. An acute illness was found to push the family more into poverty, turning Palestine refugees in Lebanon in a vicious circle of poverty and sickness.

The prevalence of non-communicable diseases such as diabetes mellitus, cardiovascular diseases and mental health disorders, is increasing among Palestine refugees. The AUB-UNRWA survey revealed that the prevalence of chronic illnesses is of 31%, with the most common cited conditions: hypertension 32%, asthma 9% and diabetes

1 Chabaan, J., Ghattas, H., Habib, R., Hanafi, S., Sahyoun, N., Salti, N., Seyfert, K., Naamani, N. (2010), "Socio-Economic Survey of Palestinian Refugees in Lebanon", Report published by the American University of Beirut (AUB) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

mellitus 8%. In addition, 21% of the population reported that they had a mental health illness within the last 12 months prior to data collection in August 2010, namely anxiety or depression. Finally, 4% of the population was found to suffer from functional disabilities mainly paralysis and disability of extremities (excluding paralysis and amputation).

1.2 Financing of Health Care Services for Palestine Refugees

Palestine refugees in Lebanon, unlike other fields, cannot benefit from any form of social or public health insurance due to restrictions imposed by Lebanese regulations. Around 95% of the refugees do not have health insurance and rely predominantly on UNRWA for their health services. These restrictions added to the unfavourable socio-economic conditions of the Palestine refugees in Lebanon have reduced affordable alternatives for health care. They also mean that UNRWA must provide a higher level of healthcare to Palestine refugees in Lebanon than in UNRWA's other fields of operations.

While Palestine refugees benefit from free primary health care services in UNRWA's health centers and an almost full coverage for secondary hospitalisation services, they must pay the largest share of their most expensive health bills often accrued at the tertiary health care level. According to the AUB-UNRWA survey, over a six month period, households with a hospitalised family member spent on average US$ 614, while households with a member with disabilities spent US$ 262 on doctor visits and medicines. Households with an acutely ill family member not requiring hospitalisation spent US$ 164 and households with a chronic illness case spent US$ 137. The data clearly indicates that the refugee family's financial burden grow considerably when a member faces a more serious medical problem. This is reflected similarly in the AUB-UNRWA survey where it was found that the household expenditures on health jump from 3% to 13% of total household expenditures when a family member is chronically ill or disabled.

Therefore, despite UNRWA's support, patients need to find additional funding sources to pay their health bills, particularly for those hospitalised or suffering from functional disability. Adding to the burden, health services are very expensive in Lebanon where the annual total expenditures on health per capita are estimated to be $651, as compared to $357 in Jordan and $96 in Syria (World Health Organisation, 2010).

2 unrwa's health programme

UNRWA's health programme seeks to protect, preserve and promote the health of Palestine refugees for them to live a long and healthy life. In 2009 and in all its fields, UNRWA adopted the Life Cycle Approach, which puts the refugee at the center of all health activities carried out by the health programme from preconception care to active ageing, and focuses on delivering comprehensive primary health care.

In Lebanon, as in the other fields of UNRWA's operations, the Agency provides free-of-charge Primary Health Care (PHC) to Palestine refugees through a network of 28 health centers, with 14 of them located inside the camps. Health centers range from small community health centers operating on a part-time basis, to large polyclinics providing more comprehensive services. All health centers offer a basic package of services composed of general medical consultations, Mother & Child Health (MCH) services, Non-Communicable Disease (NCD) services, and supply of essential medicines at an internal pharmacy.

Specialists' consultations including gynaecology, cardiology, ophthalmology, and oral health services are also provided in some health centers. Basic laboratory services are available on-site in 17 facilities, which receive laboratory specimens collected in the remaining facilities, and four centers provide basic radiology tests. Additionally, during the last few years, UNRWA health programme introduced new services such as endocrinology service (focusing on Diabetes care) in order to improve the quality and widen the spectrum of care provided to patients.

The health programme also offers health services to UNRWA schools consisting of general physical exams for first graders and new students, as well as vision, hearing and dental screening for students in grades four and seven. It also provides Vitamin A, immunisation and de-worming treatment (anti-helminthic medications). It is worth noting that vaccines and Vitamin A are generously provided by UNICEF. Moreover, school educational activities and assessment of the school environment are conducted periodically.

Table 2 - School Health Services provided during scholastic year 2011-2012

School Health Services
• A total of 2,772 new students underwent a general medical examination. Dental caries continue to be the highest medical condition encountered with 62% suffering from dental caries. Around 8% of examined students were found to have visual problems (impairment or squint), 2% were found to suffer from bronchial asthma and around 1% were found to suffer from hearing impairment.
• 3,442 students from fourth grade as well as 3,228 first preparatory students were screened for visual and hearing impairment. 11% of fourth graders and 14% of first preparatory graders were found to have visual impairment. Around 1% of both groups were found to have hearing impairment. 69% of fourth graders and 67% of first preparatory were found also to have dental caries.
• 5,293 students received Tetanus-Diphtheria (Td) vaccine.
• 9,044 students received de-worming treatment.
• 19,496 students received Vitamin A (two doses).

For hospitalisation, UNRWA provides these services to Palestine refugees through contracting local hospitals in Lebanon. Hospitalisation services are divided into two main categories: secondary and tertiary services, the latter necessitating specialised consultative care and more advanced technology.
Secondary health care services are almost fully covered by the Agency with minimal co-sharing by patients in the cost of prosthesis and non-essential sophisticated medications, whereas tertiary services are covered only partially by the Agency.

Last but not least, UNRWA provides partial coverage of out-patient tests performed in contracted health facilities (50% of the cost) as well as cancer medications for patients suffering from cancer (50% of the bill up to a ceiling of $8000 per patient per year).

Table 3- List of UNRWA health centers by area with target and served population in 2012

Area	Health Center	Target Population	Served Population
Central Lebanon Area	Beirut Polyclinic	35,321	23,927
	Burj Barajneh	21,710	12,904
	Shatila	8,371	6,404
	Mar Elias	5,153	2,922
	Burj Hammoud	3,506	1,656
	Dbayeh	2,046	1,306
Bekaa	Saadnayel	5,782	4,821
	Bar Elias	5,476	5,371
	Wavel	5,932	4,599
North	Naher El-Bared 1	17,515	17,440
	Naher El-Bared 2	6,118	6,118
	Beddawi (with Nahr el-Bared population displaced to Beddawi)	34,220	30,283
	Mina	9,965	7,790
Saida	Saida Polyclinic	41,115	33,471
	Ein El Hillweh 1	29,066	25,826
	Ein El Hillweh 2	26,081	18,060
	Nabatieh	5,216	1,550
	Mieh Mieh	5,058	4,563
	Ansarieh	3,125	1,144
	Ghazieh	1,976	1,526
	Iqlim Kharoub	14,024	6,847
Tyre	El Buss	24,541	18,975
	Burj Shemali	17,069	14,520
	Rashidieh	16,332	15,481
	Qasmieh	3,194	2,305
	Shabriha	2,903	2,087
	Maashouk	2,830	979
	Kfarbada	2,805	865
Total		**356,450**	**273,740**

3 assessment of unrwa health programme

An assessment of the UNRWA Health Programme in Lebanon Field Office was conducted both internally and by external consultants during 2009 and 2010 covering both the primary health care services and the hospitalisation services.

The assessments revealed positive characteristics of the primary health services such as the fact that UNRWA's health centers are located in a way that caters to the neediest population and that available services are comprehensive and free. Yet, the assessments showed that the delivery of some services within the health centers needed revamping especially related to the centralised management of health centers affecting operational efficiency; over-consumption of health services in the centers (repeat visits, over-prescription of medications, and excessive overload); over-crowding and long waiting times; short doctor-patient consultation time; and under-utilisation of screening services mainly for non-communicable diseases.

Regarding hospitalisation and at the level of secondary health care, the assessment revealed high rate of self-referrals of simple medical cases that could have been treated in emergency rooms without hospital admission (percentage reaching 20-25% in secondary care hospitals). The limited availability of hospital care and the resulting excessive bed occupancy were found to be compounded by extremely short stays (Average Length of Stay -ALOS- in secondary care hospitals of 1.9 days in 2008).

An important issue confirmed by the assessment was the lack of clarity regarding Palestine refugees' rights and entitlements over access, financial protection, and choice of providers for hospitalisation. Additionally, it was confirmed that unregulated out-of-pocket payment were made by admitted patients to secondary care hospitals.

The main findings regarding tertiary hospitalisation included the uneven distribution of hospitals over different areas; the lengthy and bureaucratic referral process; and the unclear rights for the beneficiaries. The escalating prices of the tertiary care services coupled with the absence of financial protection for Palestine refugees, left the patient responsible to pay the larger share. In turn, Palestine refugees become unattractive to providers who fear that they will not cover their bills and are at high risk of incurring debts. The assessment also showed that there was little coordination among UNRWA, other organisations and individuals that might financially support Palestine refugees in tertiary care hospitalisation and treatment bills.

Table 4 – Findings of the different assessments of UNRWA health programme - Lebanon Field Office conducted during 2009 & 2010.

Findings of Health Programme - Lebanon Field Office Assessment

Main findings of the assessment of primary health care services (2009, 2010):
• The management of the health centers is centralised thus impacting operational efficiency.
• Over-consumption of health services in the centers is manifested through:
  o High frequency of repeat visits with an average of six visits per person per year to the general clinic in 2009 (ranging from 4 to 11 visits);
  o Over-prescription of medication;
  o Excessive workload for the health staff with an average of 107 daily medical consultations per doctor in 2009.
• Challenges in the management of patients' flow in health centers resulting in:
  o Over-crowding, especially between 8:00 am and 11:30 am;
  o Long waiting times;
  o Short doctor-patient consultation time ranging between 2.5 and 6 minutes.
• Uncoordinated use of the specialised services available in the health centers
• Low utilisation rate of screening services mainly for non-communicable diseases

Main findings of the assessment of secondary health care services (2009): • Limited availability of hospital care and excessive bed occupancy are compounded by extremely short stays (Average Length of Stay -ALOS- in secondary care hospitals was 1.9 days in 2008). • Uneven availability of hospitalisation beds between areas, which are not based on need criteria, thus reducing ready access. • Unclear Palestine refugee rights and entitlements over access, financial protection, and choice of providers. • High rate of self-referrals of simple medical cases that can be treated in emergency rooms and do not require hospital admission (percentage reaching 20-25% in secondary care hospitals). • The discount provided to UNRWA's patients by the healthcare provider incentivises low-cost procedures. Coupled with the limited bed number per hospital per month, this resulted in the inability to admit serious emergency cases towards the end of each calendar month. • The escalating costs of health care in Lebanon combined with UNRWA's limited rate per hospitalisation day, which does not cover the costs incurred by hospitals, resulted in unregulated out-of-pocket payment by admitted patients to secondary care hospitals. • Having one delegated medical officer (DMO) who partially follows up on hospitalisation admissions in each area has prevented having a strong grasp over mechanisms and admissions bearing in mind that DMO also provides daily consultations in the health centers.
Main findings of the assessment of tertiary health care services (2009): • Unclear rights for the beneficiaries • Little coordination among UNRWA, other organisations and individuals that might financially support Palestine refugees in tertiary care • Palestine refugees are unattractive to providers who fear that they will not cover their cost and are at high risk of incurring debts.

4 reform of unrwa health programme

Based on the assessments' results, a reform of the UNRWA Health Programme was launched in Lebanon at the end of 2009 thanks to a generous donation from the Italian government & Italian Development Cooperation Office.
The reform was launched gradually starting with a focus on improving the access of Palestine refugees to hospitalisation services, a recognised urgent priority. Parallel to this, an in-depth analysis of the primary care services was conducted in order to identify all the specificities related to this sector.

From 2010 to 2012, several donors continued to support the reform of the health programme. These include: the Italian Government & Italian Development Cooperation Office, the Australian Government, the Monaco Government, the German Government, the European Union, the European Community Humanitarian Office (ECHO) and the Government of the United States of America, Medical Aid for Palestinians (MAP), and the Qatar Red Crescent. The specific role of each donation will be highlighted later in this report.

Without these generous funds, it would have been impossible to introduce improvements and effective changes into UNRWA health programme in Lebanon at its different levels of service provision.

4.1. Objectives of the Reform

The main objectives of the reform of the UNRWA Health Programme in Lebanon are: to improve access of Palestine refugees to quality health care; to enhance equity and to improve efficiency and effectiveness in the delivery of health services, while also ensuring the sustainability of these services.

4.2. Strategy of the reform

The reform started incrementally using a participatory approach involving concerned staff in UNRWA, as well as other stakeholders and partners. Several meetings were conducted with community members and UNRWA's staff to discuss the results of the different baseline assessments, as well as to explore the way forward. Specifically a workshop was conducted within UNRWA during June 2010 in order to discuss the results of the primary health care assessment with health staff and agree on the main priorities for the reform. Another workshop was conducted in June 2011, involving relevant stakeholders whereby the general condition of health services for Palestine refugees in Lebanon was discussed both from an academic and operational perspective (Health services for Palestine refugees in Lebanon : past, present and future , June 2011)

Table 5 – Recommendations of the workshop on UNRWA Health Services, June 2011

- Family Health Team: Introducing family health concept within the services of the agency will ensure the provision of continuous holistic comprehensive services with emphasis on prevention and promotion of health.
- Life-cycle Approach: an approach that puts the refugee at the center of all health activities carried out by UNRWA's health programme from preconception care to active aging, and focuses on delivering comprehensive primary health care.
- Balance between illness and wellness approaches: focus on both preventive services and curative services.
- Evidence-based: link the package of health services provided to Palestine refugees to evidence about burden of disease and distribution of different diseases.
- Social Determinants of Health: join efforts to address other different determinants affecting health such as education, housing, job status, etc. instead of focusing only on curing direct health problems.
- Information System (Family-based): Development and rolling-out of the integrated e-health module will restructure information of patients and their medical data in an easily accessible way, linking their file across different departments and specialties.
- Private Insurance: the suggestion of establishing a private health insurance scheme to cover Palestine refugees was discussed during the workshop. It is true that this insurance would help solving the financing gaps for health services of Palestine refugees; however, its cost is estimated to be at least $40M yearly, thus far from being affordable or sustainable.

Inherent to the reform is the provision of improved access to healthcare; improved quality of services; increased community ownership and trust of the provided services; and enhanced delivery performance through consistent monitoring and responding.

Focusing on these objectives, the reform of UNRWA health services took off end of 2009; channelled through six (6) main pillars: Governance, Health Workforce, Service Delivery, Health Information System,

Communication, and Partnerships.

4.2.1 Governance

With the aim of improving functional efficiency, hence impact delivery performance and the quality of health services provided at the UNRWA health centers, UNRWA Health Department at the LFO underwent a comprehensive restructuring moving towards decentralisation.

Changes were implemented at the central level, area level as well as the health center level. These included:

- At central level in the LFO: the focus of work shifted from day to day operational management to a more strategic and developmental role. In addition, structural changes were made at this level whereby the composition and role of the different units within the department were defined.
- At area level: decentralising the management of operations to the area where Area Health Coordinators supported by Area Nursing Officers currently supervise the delivery of health services in each area.
- At the health center level: placing supervision responsibilities on the manager (Senior Medical Officer or Medical Officer in charge) in each health center.

4.2.2 Health Workforce

The workforce in UNRWA health programme, namely at the level of the health centers, is multidisciplinary including general practitioners, specialists, dental surgeons, nurses (both staff nurses and practical nurses), midwives, laboratory & radiology technicians, as well as administrative personnel.

A total of 358 staff composes the workforce in the health department at the central, area or health centers' level.

Table 6 - Number of staff by category (2012)

Staff	Number
Medical Doctors (General Practitioners & Specialists)	67
Dental Surgeons	17
Nursing staff (nurses & midwives)	117
Paramedical Staff (Pharmacists, Laboratory & Radiology technicians)	63
Admin- Support Staff	63
Others	31
Total	**358**

Human resources are a great asset and investing in them is crucial to a successful health programme reform. Therefore, UNRWA's health programme conducted a revision of the job descriptions and grading of its different health posts, mainly in the health centers and in coordination with UNRWA headquarter. Several posts were upgraded in order to respond to the new needs in the health centers, namely computerisation of data, decentralisation of services, and health education.

These posts include: practical nurses (the existing posts of practical nurse and senior practical nurse were unified under the title of practical nurse, which was upgraded), midwives, pharmacists (upgraded from assistant-pharmacists), clerks, assistant clerks (upgraded from doorkeepers) as well as unification of the grade of medical officers. These changes are currently effective. The upgrading of additional posts such as the laboratory & radiology technicians, area health coordinators, area nursing officers is still pending implementation. Advanced qualifications were added to the new job descriptions. However, whenever already employed staff lacked such qualifications, trainings were provided and attendance of these trainings was considered fundamental prerequisite in order to get the post upgrading.

A capacity building plan was established as part of the continuous professional development programme of UNRWA staff working in health services in Lebanon. The training plan has been set up to build the health staff capacity in accordance with the new responsibilities introduced by the reform activities. Accordingly, the capacity building programme was launched at the end of 2010 and included different trainings that aimed at improving the skills and knowledge of relevant staff from a technical and managerial perspective.
There is a need to conduct additional trainings for certain categories of staff; funds could be secured for some of them (mentioned in table 8); however, no funds could be secured for the following trainings:

- Training of dental surgeons in public oral health, which will improve their skills and knowledge in preventive oral health.
- Training of radiology technicians to enhance their knowledge and skills in this field.
- Training on the "Family Health Team" approach, which is discussed in more details in the next section.

It is worth noting that additional trainings were conducted in collaboration with other partners. These

Table 7- List of trainings conducted during 2010-2012

Type of training	Trainees	Trainers	Donors
Update in primary health care	Medical Officers	American University of Beirut- Medical Center	Italian Government & Italian Development Cooperation Office
Management of primary health centers	Senior medical officers & medical officers in charge of health centers along with few senior staff	American University of Beirut- Faculty of Health Sciences	Italian Government & Italian Development Cooperation Office
Updates in management of Cardiovascular diseases	Medical Officers	American University of Beirut- Medical Center	Monaco Government
Updates in management of Cardiovascular diseases	Nurses	American University of Beirut- Medical Center	Monaco Government
Updates in Midwifery care	Midwives	Lebanese University	MAP
Updates in Nursing Care	Nurses	Balamand University	Italian Government & Italian Development Cooperation Office- MAP
Update in Pharmacy Care	Assistant Pharmacists/ Pharmacists	Beirut Arab University	Italian Government & Italian Development Cooperation Office
Computer skills	Doorkeepers/ Assistant Clerks	Internal	

included mental health training by Medecins Sans Frontieres for a group of medical officers; training on comprehensive elderly care with Caritas, targeting a multidisciplinary staff from UNRWA (including medical officers, nurses and social workers); and finally training on diagnosing orthopaedic problems in children with Movement for Peace (MPDL) addressing a group of medical officers and nurses.

Table 8 – List of trainings to be conducted in 2013.

Training Workshops
• Updates in Cardiology for cardiologists funded by the Monaco Government • Training of Laboratory Technicians funded by the German Government • Training in Health Education funded by the German Government • Training on Mental health funded by the European Union

4.2.3 Service Delivery

Several activities have been introduced as part of the reform at the different levels of health care delivery: primary, secondary and tertiary.

4.2.3.1 Primary Health Care

The reform of the service delivery has mainly targeted the quality of primary health care services provided at UNRWA health centers embodied in a timely, safe and effective care. It focused on providing: more comprehensive care; organising the flow of patients and the work load on health staff; enhancing preventive and control services for non-communicable diseases; and improving the physical structure of the health centers to ensure safe and healthy working environment for both patients and staff. Below are the most important developments in the reform of service delivery:

Introduction of the Family Health Team (FHT) Approach

The Family Health Team approach was the major response to the challenges facing UNRWA's health programme in the five fields: limited non-communicable disease care and preventive services; overcrowded health centers and long waiting times; vertical and fragmented health care as well as fragmented health information system and health data about patients, their families and medical history. This approach, led by Health Department at UNRWA- Headquarter, was launched in the different fields end of 2011.

The implementation of the Family Health Team (FHT) approach in the health centers of UNRWA entails a change in the delivery of the services. The approach offers comprehensive primary health care services based on holistic care of the entire family, emphasising long term provider-patient relationships. In other words, the FHT approach is based on 3 major concepts: 1) Comprehensiveness, where a specific team of health professionals manages all primary health needs of the family; 2) Continuity, where health services are provided to the patient and her/his family by the same team throughout the life cycle; and 3) Patient-centered, where the provision of services is focused mainly on the individual and all her/his primary health needs within the context of her/his family and community. This approach has become the standard in good quality health care and is common in many countries in the region and around the world.

Within this approach, the teams at the health centers will be following up on their patients during all phases of life; they will be better informed about their medical and family histories; and they will be updated with their medical developments in order to better manage their cases.

In September 2011, the Family Health Team approach was introduced for the first time in the UNRWA Lebanon Field as a pilot in Beirut Polyclinic in Central Lebanon

Area (CLA). This pilot was important to ensure that FHT approach was running smoothly and to allow for a learning process and adjustment period before spreading the model to other health centers.

In January 2012, the implementation of the FHT approach started in Rashidieh health center in Tyre Area. This was later followed by 7 additional centers by the beginning of 2013. It is planned that the FHT approach will be implemented fully in all health centers in UNRWA Lebanon Field by the end of 2013. The FHT implementation is based now on a more systematic approach that includes the following: Communicating with the health center staff regarding the FHT approach; conducting an assessment of the physical infrastructure and information technology needs in the center and applying the necessary modifications; discussing the new approach with the community members; defining the health teams; distribution of families among the teams; internal training of staff on existing services and task-shifting so that a comprehensive service is provided by each team as opposite to the fragmented one; organisation of the workflow and filling patients' data electronically.

Table 9 – List of Health Centers currently implementing Family Health Team Approach

Area	Health Center
Central Lebanon Area	Beirut Polyclinic
	Burj Barajneh
	Shatila
	Mar Elias
	Burj Hammoud
	Dbayeh
Tyre	Rashidieh
	El Buss
	Kfarbadda

Each family health team is composed of one Medical Officer and one or two nurses. An additional nurse responsible for the Immunisations & Growth monitoring and the Midwife are common among the different teams as well as other medical, paramedical and administrative staff in the center. It is estimated that each team will be serving 1,500 to 2,000 families.

The FHT approach is being used as a vehicle for change, which will help to achieve the objectives of the primary health care reform, particularly through improving the quality of care (efficiency, effectiveness, equity and safety) and improving competency and motivation of staff. The introduction of the FHT has also been a driving force in the modernisation of health centers, including the introduction of E-Health and the appointment system. These have been generously supported by the Government of the United States of America, thus facilitating the implementation of the FHT in Lebanon Field.

Table 10 – Preliminary achievements of the FHT approach implementation

- Number of consultations per medical officers per day decreased by 30 to 50%. In Rashidieh center, the number of consultations per medical officer decreased from more than 100 per day to an average of 55.
- The doctor-patient contact time increased from 2.5 minutes to 5 minutes (almost doubled). In Beirut Polyclinic, the average duration of the consultation exceeded 6 minutes during some months.
- The percentage of consultations based on already scheduled appointments almost doubled.
- The average waiting time for patients to see doctors decreased to around 30 minutes.
- The distribution of work is more equitable among the different staff members in the same health center.
- Referral to hospitalisation services (excluding cold cases) decreased by 21.3% over three months in 2012 as compared to the same three months in 2011 in Beirut Polyclinic.
- Prescription of pain killers in Beirut Polyclinic decreased in the third quarter 2012 (July through September) by 3% as compared to third quarter in 2011 and by 26% if compared to the same period in 2010.
- Focus groups conducted with staff show that this approach is leading to better distribution of workload among staff, more trustful relationship with the community and better communication with the beneficiaries.

So far the major challenges facing the implementation of the FHT approach in Lebanon were found to lie mainly in the following: lengthy and laborious initial data entry of patient files; some technical problems that might

arise affecting the functioning of the computerised system such as electricity cuts, and problems with the computer hardwares; substituting absent staff in health teams; the lack of suitable infrastructure for the implementation of FHT in some health centers; the resistance of some staff to the changes in the workload; and the resistance of some patients to the implementation of the appointment system.

Another important challenge in the implementation of the FHT resides in the provision of quality healthcare to patients. In fact, an exit survey with 30 patients in Rashidieh center showed that 63% reported that the doctor did not perform a comprehensive physical examination and focused only on the organ related to the complaint, and only 57% reported that they received an advice regarding the management of their condition. Furthermore, trainings of the staff on the concepts of "Family Medicine" are becoming a necessity at this stage, which will strengthen the FHT implementation and ensure the delivery of comprehensive and continuous care of good quality to beneficiaries.

Introduction of New Health Services

In response to the disease shift (epidemiological transition) among the UNRWA beneficiary population, where patients are increasingly suffering from chronic non-communicable diseases, the reform puts its primary emphasis on strengthening the existing Non-Communicable Diseases Programme. This programme, under UNRWA's primary health care services, targets diabetes mellitus, hypertension and cardiovascular diseases with emphasis on prevention and control.

- **Echocardiography Services**

  Towards the end of 2011 and during the first half of 2012, UNRWA health programme introduced Echocardiography services for the first time in its health centers in Lebanon. This was possible thanks to a generous donation from the Government of Monaco for a project aiming at improving cardiovascular services to Palestine refugees. Four Echocardiography Doppler machines are currently available in four areas: Beirut Polyclinic in CLA; Beddawi health center in North Lebanon area; Saida Polyclinic in Saida area; and El Buss health center in Tyre area. The Echocardiography tests are provided for free, hence decreasing the financial burden of the refugees. Furthermore, they have enhanced the diagnostic capacity of UNRWA health programme. At the same time, new Cardiologists joined UNRWA health centers thereby increasing the specialist cardiac care offered to patients.

- **Improving Diabetes Care**

  In April 2012, UNRWA Health Programme enhanced its services for diabetes as a new Endocrinologist specialised in Diabetes care joined the Non-Communicable Diseases Programme, supporting and developing the services offered to patients with Diabetes Mellitus. In 2012, the UNRWA Health Department at Headquarter conducted a clinical audit of diabetes mellitus. This will be followed by an awareness campaign targeting lifestyle factors namely nutrition, exercise and smoking, which will take place throughout 2013.

Upgrading and Rehabilitation of Health Centers

Improving the physical structure of the health centers is an essential part of a successful reform in primary health care services delivery. Modernised health centers ensure safer and healthier working environment for both patients and staff. Upgrading the equipment is also crucial to increase quality of the service delivered and provide services in a timely and effective matter.

Throughout 2011, UNRWA health centers underwent maintenance activities to guarantee well functioning of day to day operations as part of the reform. Additionally, it was also possible to upgrade some of the equipment and furniture available in some of these centers, always thanks to the generous donation of the Italian Government and the Italian Development Cooperation Office. This helped improving quality and safety measures in services' delivery and increasing the satisfaction of both patients and staff.

Dbayeh health center underwent a major rehabilitation intervention where the whole layout of the health center was re-planned to improve patient flow, ease of access to services and safety measures. This intervention was funded by the Italian Government and Italian Development Cooperation office.

Special attention has been directed to health centers preparing for the implementation of the Family Health

Team approach in order to minimise any challenge that may arise because of poor physical structure or infrastructure problems of the health centers. It is worth noting that the Government of the United States of America provided a valuable financial support in this respect.

During 2013 and 2014, six main health centers (El Buss, Ein El Hillweh 1, Mieh Mieh, Beirut Polyclinic, Burj Barajneh and Beddawi health centers) will undergo major rehabilitation of the physical structure as well as procurement of needed equipment & furniture, thanks to the generous donation of the European Union.

Organisation of work within UNRWA health centers

- **Refill of medications for controlled patients with chronic diseases**

  In an attempt to organize the work better inside the health centers and decrease the daily load on the medical officers and the nurses, these centers started implementing the medications refill policy for controlled patients suffering from chronic diseases namely hypertension and diabetes mellitus. In this respect, patients pick up their medications directly from the pharmacy for two consecutive months and are evaluated by the medical officer the third month. As a consequence, medical officers should have more time to examine patients presenting for genuine medical problems.

- **Implementation of the Appointment System**

  Findings of the assessments of UNRWA's primary health care services in Lebanon and other fields revealed that health centers were often overcrowded with long waiting times for patients and short doctor-patient consultation times. Staff members were overloaded due to excessive numbers of patients during the peak hours namely 8 to 11 am. With the introduction of the Family Health Team approach to UNRWA's health centers, this created a valuable opportunity to introduce an effective appointment system that was long planned for. Since the FHT approach targets improving the relationship and building the trust between families and the health team, the benefits from implementing an appointment system hand in hand with the FHT are huge. A well functioning appointment system reduces crowdedness, waiting time for the patient and can ensure patients have enough time with health staff to receive appropriate care. The increased consultation time is intended to improve the consultation quality and deliver more comprehensive consultations as much as possible. The system also reduces repeated and unnecessary visits. The staff also benefits from a system that spreads appointments evenly over the working day; decreasing the stress created by crowdedness and overload.

  It is important to mention that emergency cases still receive timely care since a triage system is designed in parallel to the appointment system to keep a smooth running of operations in the health center and cater to the needs of Palestine refugees.

  The experience with the implementation of the appointment system is so far very positive with clear reductions in crowdedness and patient waiting times. Despite some resistance from the community at the beginning, later interviews with regular patients indicated their satisfaction with the appointment system as they realised that they are spending relatively more time with their doctors and they did not have to wait as long as they had to previously before getting treated.

Positive Characteristics of the UNRWA primary health programme

The core activities of the UNRWA Health Programme, which have been running for decades now under the guidance of Health Department at UNRWA Headquarters, continue with the same strength as before. Some of the positive characteristics worth highlighting include the following;

- The Child Health Programme: this programme provides comprehensive care to children from birth until the age of 5 years. This includes the well baby care, provision of immunisations as well as growth monitoring. In 2012, 99.5% of 12 months old children have received all Expanded Programme of Immunization (EPI) vaccinations according to host country requirements. The pentavaccine (DTP, Hepatitis B and HIB) was introduced as of October 2012 in the list of vaccines availble in UNRWA health centers.

- The Maternal Health Programme: this programme provides comprehensive care fo women of reproductive age group including preconception care, antenatal follow up, postpartum follow up and family planning services. In 2012, 89% of pregnant women attended at least 4 antenatal care visits. A Maternal handbook has been developed by UNRWA Headquarter (funded by Japan International Cooperation Agency, JICA) enabling a continuous and comprehensive follow up of pregnant women and their children.
- Non-Communicable Diseases (NCD) programme: this comprehensive programme tailored to the needs of patients suffering from diabetes mellitus and hypertension provides them with clinical continuous consultations, diagnostic and follow up tests as well as medications. It is worth noting that a specific NCD e-health programme sponsored by the Government of Denmark was developed in-house at UNRWA headquarter. This programme is implemented in all the 28 health centers of UNRWA in Lebanon. An analysis of a sample of 6,872 diabetic patients registered and followed up in 21 health centers until 31 December, 2011 was carried out based on the information available in this e-health programme. The results are included in table 11.
- Oral Health Services: that includes both preventive and curative services. Additional services were implemented over the last years namely the application of fluoride varnish to children aged 12 months to 5 years as well as sealant applications to school-aged children. In 2012, fluoride varnish was applied to 14,633 children.

Table 11- Characteristics of a sample of patients diagnosed with diabetes mellitus.

An analysis of a sample of 6,872 patients diagnosed with diabetes mellitus and registered in 21 UNRWA health centers and reveal the following:

- 60% are females.
- Average age is 60 years.
- 97.3% suffer from diabetes mellitus type 2 and 2.6% suffer from diabetes mellitus type 1.
- 71% suffer from obesity, 50% suffer from hyperlipidemia.
- 46.2% had positive family history of diabetes mellitus
- 6% were found to suffer from cardiovascular complications such as myocardial infarction, congestive heart failure and stroke.
- 75.6% of them suffer also from hypertension.
- Late complications are as follows: 0.7% suffers from blindness, 0.6% had amputation of an extremity and 0.5% suffers from end stage renal disease.

Table 12- List of current and upcoming projects during 2013

- **Mental health & psychosocial support for Palestine refugees in Lebanon:** this three-year project is aiming at integrating mental health services within UNRWA primary care centers. This project will be launched in the first half of 2013 thanks to a generous donation from the European Union. It is a multi-component project including building capacity of UNRWA staff (health, education, relief & social services) in identifying and managing children and adults with mental health problems, delivering specialised mental health services, building a referral mechanism both internally and with external stakeholders, and raising the awareness of the community regarding mental health.
- **Prevention of thalassemia and sickle cell anemia among Palestine refugees:** this project funded by the German Government until end of December 2014 was launched in July 2012 and aims at the prevention of thalassemia and sickle cell anemia among Palestine refugees as well as providing children (11 years of age and below) suffering from thalassemia and patients with sickle cell anemia with the required treatment.
- **Improving cardiovascular health of Palestine refugees:** this on-going project is funded by the Monaco Government and is aiming at improving the management of cardiovascular diseases among Palestine refugees through capacity building of health staff, the addition of cardiologists in UNRWA health centers and targeted Echocardiography equipment for these centers. This project was launched in January 2011 and will continue until the end of 2013.

4.2.3.2 Secondary Health Care

With the reform of UNRWA hospitalisation services launched at the end of 2009, a new hospitalisation strategy was introduced in 2010 and is still under implementation. The main objectives of this strategy (outlined in table 13) are to increase Palestine refugees' access to quality hospitalisation services, and to control and monitor those services. The reform of the hospitalisation services was made possible thanks to the generous donation of the Italian Government and the Italian Development Cooperation Office, which supported substantially the development of the strategy and contributed to the coverage of the costs of hospitalisation in both secondary and tertiary care hospitals.

Table 13- Main objectives of the hospitalisation strategy

- **Better Access:** increase the number of contracted hospitals, eliminate the ceiling on number of contracted bed-days per hospital per month (all urgent cases will be admitted), and decentralisation of referrals to area level (decrease of bureaucracy).
- **Better Coverage**: secondary hospitalisation almost fully covered (co-payment by the patient in the cost of prosthesis and non-generic medications only), expand coverage to include Emergency Room services and Intensive Care Services both for neonates and adults.
- **Better Quality:** list of performance indicators agreed upon with all contracted hospitals in addition to list of quality standards based on Lebanese Ministry of public health (MoPH) accreditation standards with Palestine Red Crescent Society (PRCS) hospitals.
- **More control & Monitoring**: development of admission criteria to hospitals; establishment of a hospitalisation unit within the Health Department at UNRWA LFO to manage, monitor and evaluate the hospitalisation programme, monitoring of the hospital admissions by Area Hospitalisation Medical Officers (AHMO) and Area Health Coordinators (AHC), conducting periodic patient satisfaction surveys.
- **Better Coordination:** steering committee with PRCS, coordination among the different areas to ensure available places whenever needed.
- **Better Communication**: production of hospitalisation booklets and community meetings.

Within this new strategy, secondary health care services, which are accounting for around 85% of the hospital admissions, are almost fully covered by the Agency with minimal co-sharing by patients in the cost of prosthesis and non-essential sophisticated medications only. The coverage includes: treatment of medical conditions (Meningitis, Pyelonephritis, and management of Diabetic Ketoacidosis among others); common surgical procedures (appendectomy, cholecystectomy, etc); and delivery for pregnant women classified as high risk.

In addition to the above, UNRWA fully provides Emergency Room Coverage in specified hospitals, as well as Intensive Care Unit (ICU) for the management of conditions that require close observation and intensive care; Coronary Care Unit (CCU) for the management of coronary accidents such as Acute Myocardial Infarction, Unstable Angina, etc; and Intensive Care for the Neonates (ICN) for the treatment of new-borns who are either premature or in specific condition that require close observation and meticulous management.

Main Positive Developments

- In 2010, UNRWA entered in a tripartite agreement with Qatar Red Crescent (QRC) & Palestine Red Crescent Society (PRCS) to fully cover normal deliveries of regular pregnancies in PRCS hospitals. Until end of December 2012, more than 3,600 Palestine refugee pregnant women accessed safe normal delivery in PRCS hospitals covered fully by QRC.
- This partnership with QRC and PRCS has also enabled Palestine refugees to undergo Orthopaedic surgeries as well as specific Eye surgeries. In 2011, 44 children have undergone complicated orthopaedic surgeries followed by post-surgical physiotherapy at no expense for their families. Additionally, several Palestine refugee patients benefited from the support in Laparoscopy or Phacoemulsification (cataract) surgeries in Hamshary Hospital in Saida, with the beneficiaries only participating in the cost of lenses or medications, thereby minimising their financial burden.
- In order to encourage PRCS to improve the quality of services delivered in their hospitals, UNRWA introduced a list of quality standards, extracted from the Lebanese MoPH accreditation standards, as an integral part of the agreement signed with PRCS hospitals, whereby the hospitalisation rates in these hospitals will be increased once the standards are achieved. A survey of these quality standards is conducted yearly by a team from UNRWA & PRCS.
- With the beginning of 2012, UNRWA conducted another survey on the quality standards in PRCS hospitals in order to monitor and follow-up on the quality improvement achieved. In all PRCS hospitals, there was a progress in achieving the agreed-upon quality standards; depending on the hospitals, these standards had improved between 70% and 78%.
- UNRWA strengthened its relationship with the Ministry of Public Health and introduced new unified contracts with 13 governmental hospitals at preferential rates, hence improving the access of Palestine refugees to quality secondary care services.
- The number of contracted hospitals increased from 15 hospitals in 2009 to 37 hospitals in 2012 and 42 hospitals in 2013 (5 PRCS, 13 governmental and the rest private hospitals). The increase in number consequently improved accessibility of Palestine refugees to hospitalisation services.
- Around 25,213 patients were admitted to secondary care hospitals in 2012 as compared to 19,918 in 2009 with an increase of 26.6%. In addition, 8,776 patients benefited from emergency room services in 2012 as compared to zero in 2009. This makes the total of beneficiaries benefiting from secondary care services 33,989 with an increase of 70.6% as compared to those benefiting from secondary care in 2009.
- 2,392 patients were admitted to intensive care services in secondary hospitals, hence almost fully covered.
- The average length of stay increased from 2 days in 2009 to 2.5 days in 2012 with an increase of 20%, indicating that more severe cases are being admitted to hospitals.

4.2.3.3 Tertiary Health Care

Each year in Lebanon around 4,000 Palestine refugees suffer from catastrophic health problems. These encompass a wide variety of medical conditions which require long-term and expensive treatment in tertiary care hospitals, including cancer surgeries and treatment, cardiovascular interventions, neurological diseases, joint and bone surgeries, massive gastrointestinal bleeding, cerebrovascular accidents and/or admission to Intensive Care Units (ICU). UNRWA contributes partially to the financial coverage of these services in contracted tertiary care hospitals, in addition to the partial coverage of cancer medications.

Since May 2012, UNRWA started covering around 50% of the hospitalisation bills up to a ceiling of US $4,200 per admission in hospitals contracted to provide tertiary care. Additionally, UNRWA provides support to patients for 50% of cancer medications up to a ceiling of $8,000 per patient per year. Notwithstanding this extensive support provided, it is apparent that it remains insufficient for many Palestine refugees in Lebanon where the cost of tertiary care vastly exceeds the purchasing power of the average Palestine refugee.

The reform of the hospitalisation programme and the new hospitalisation policy implemented in 2010 has delivered some improvements in tertiary care services provided by UNRWA, and additional improvements are under planning. The reform aims to increase Palestine refugee access to quality tertiary care; to increase coverage for these expensive services; and to

create partnerships and agreements that decrease the remaining costs which patients are left to pay out of pocket.

Main Positive Developments

- Agreements with an increased number of tertiary hospitals were signed with competitive rates (UNRWA has managed to ensure that no cost exceeds the rate offered by the MoPH in any of the tertiary care hospitals and was able to ensure a discount on this rate in the majority of these hospitals). This was done with the hope that it would be reflected in lowering hospitalisation bill, hence decreasing the financial burden on patients by comparison to their admission in non-contracted hospitals by UNRWA.
- By the end of March 2011, a joint programme with the Lebanese MoPH was launched to decrease financial burden of medications for Palestine refugees suffering from cancer and other catastrophic diseases. The agreement provides patients with access to discounts for medication between 15% and 65% of the public price depending on the type of medication and without any financial burden or additional cost on the part of the Lebanese Government.
- UNRWA worked on strengthening the fundraising efforts to increase the coverage of tertiary in-patient costs. On May 1, 2011, thanks to the support of the Australian Government the Agency was able to increase tertiary care coverage from 30% to 40%, thus increasing the ceiling to $3,000 per admission. In 2012 again, and with the continuous support of the Italian Government and the Italian Development Cooperation Office, UNRWA increased its tertiary care coverage to around 50% of the hospitalisation bill up to a ceiling of US $4,200 per admission. The long term goal is to increase the coverage to a rate comparable to that covered by the Lebanese MoPH for Lebanese citizens i.e. 85%.
- Additionally, coverage improved in cardiovascular surgeries for elderly (60 years and above), whereby UNRWA's contribution for these patients is now aligned with the contributions made to younger refugees (e.g. a contribution of $3000 instead of $1500 for open heart surgeries).
- Around 4554 patients benefited from tertiary hospitalisation during 2012 with an increase of 1.8 times (almost doubling) the number of patients who benefited from tertiary hospitalisation in 2009.

Table 14 – Results of satisfaction survey regarding hospitalisation services conducted in 2012

Satisfaction survey was administered in summer 2012 to a random sample of 600 patients who benefited from hospitalisation services during that year. The main results are as follows:

- The overall satisfaction rate was 81.8%
- The highest satisfaction rate was in governmental hospitals (85%), followed by private hospitals (84%) and finally by PRCS hospitals (79%).
- 91% of the respondents were satisfied with the nursing care in general.
- Only 74% were satisfied with the medical care. This does not include the clinical practice of the physicians, but it includes the frequency of visits conducted by the treating physicians to the patients during hospitalisation and the length of these visits.
- 88% were happy with the hospital environment in terms of comfort, cleanliness and general environment of the hospital.
- 89% reported easy accessibility to hospitalisation in terms of finding a place in hospital easily, convenience of the location of the hospital, and the speed in receiving the needed service.
- Only 67% reported that they received clear information about their condition as well as clear instructions regarding their follow up care after discharge.

However, additional provision of tertiary care remains a challenge due to the escalating prices of these services and the high financial burden that patients face, notwithstanding the UNRWA support. Additionally, the regular UNRWA health programme does not yet cover the treatment of long-term chronic diseases like multiple sclerosis and blood diseases. Due to the lack of sufficient and sustainable funding, other tertiary care services are also not yet covered by UNRWA including dialysis. These challenges have given rise to the Catastrophic Ailment Relief Programme (CARE) which was established to support patients suffering from catastrophic health conditions and to try to bridge some of the gaps left by the regular UNRWA tertiary care programme.

Catastrophic Ailment Relief Programme (CARE)

Patients faced with catastrophic health conditions suffer twofold, from the health condition itself and from the financial shock of treatment. The financial burden of lengthy and costly treatment worsens what is often already a very precarious financial situation amongst such Palestine refugee families. These conditions encompass a wide variety of medical conditions which require admission to Intensive Care Units (ICU) and/ or long-term and expensive treatment in tertiary care hospitals (i.e. cancer treatment, cardiovascular interventions, neurological diseases, massive gastrointestinal bleeding, cerebrovascular accidents, etc.). Those suffering from chronic conditions which require life-long expensive medications like patients with cancer, multiple Sclerosis and blood diseases, are also among these patients.

The reduced financial coverage forces patients or their families to search out organisations in order to solicit financial support. If their efforts are unsuccessful, many patients end up falling deeply into debt or must forgo life saving treatment if costs exceed the amount the UNRWA's regular health programme is able to provide.

On April 15, 2011 in an attempt to redress the situation, UNRWA launched the Catastrophic Ailment Relief Programme (CARE) as a joint initiative between UNRWA and the Private Sector (including individuals, organisations and enterprises) and is supported also by the international community namely Italian Government, the Italian Development Cooperation Office and the German Government. CARE was designed to complement the Agency's regular scheme that provides financial assistance for those who require lengthy and very costly treatment. The main four pillars of CARE programme are: 1. Fundraising activities, 2. Providing financial support to patients based on set criteria, 3. Coordination with the government and other organisations and 4. And negotiated specialised agreements with health care providers that will improve the access of patients to the care needed.

The programme is managed by staff members from UNRWA's Health Department with no additional overhead or administrative costs, where all donations and funding from different sources channelled directly to cover the costs of hospitalisation and/or medications for eligible patients. CARE has an Advisory Board that

"From my little heart to your big heart, thank you!"

A thank you card from the friends of Hadi (2 years old) to thank his donor who fully covered his heart procedure.

aims at assisting the Programme in planning its activities and reaching its goals. The Advisory Board is composed of members from the private sector, representatives of partner organisations supporting CARE such as Welfare and Health Care Society in addition to UNRWA staff. The CARE programme functions according to clear defined criteria for supporting patients. Detailed reports including financial statements and statistical data are issued periodically and shared with the donors as requested.

It is important to note that since its launching in April 2011 and up to the end of December 2012 (i.e. over 21 months), the CARE programme succeeded in supporting 425 Palestine refugees suffering from catastrophic health conditions through its regular packages:

- 243 patients were supported in expensive hospitalisations
- 18 cancer patients benefited from the additional support in cancer medications.
- 104 cancer patients benefited from additional support in radiotherapy sessions.
- 22 patients with Multiple Sclerosis benefited from 80% coverage in the cost of their medications. It is worth noting that the Italian Government and the Italian Development Cooperation Office funded this coverage for several months.
- 9 patients with Thalassemia and 29 patients with sickle cell anemia benefited from the additional support in the cost of treatment, which is supported by the German Government.

Table 15- Care Programme Packages

- **Hospitalisation Package:** for patients with catastrophic conditions for whom the cost of admission for in-patient treatment is of US $8,000 or above, additional support from CARE programme is provided depending on the total value per admission in both contracted and non-contracted hospitals.
- **Cancer Package:**
  - **Cancer Medications**: for cancer patients whose medication costs reach the US $8,000/year ceiling, covered by UNRWA's regular health programme, the CARE programme supports them with an additional 25% of the medication's bills up to a ceiling of US $4,000/year.
  - **Radiotherapy:** for cancer patients benefiting from UNRWA's regular health programme which covers US $750 per radiotherapy course, an additional US $500 is provided from CARE.
- **Multiple Sclerosis Package:** CARE, with other partner organisations cover 80% of the cost of the two main medications used for multiple sclerosis.
- **Thalassemia Package:** For patients who are 11 years old and below, CARE will totally cover (100%) the costs of treatment and testing at the Chronic Care Center. Additionally, the programme will provide them with 70% coverage for some of the specific chronic medications needed.
- **Sickle Cell Anemia Package:** through this package CARE will partially support all Palestine refugees suffering from sickle cell anemia, where UNRWA will cover 80% of the total bill of some specific expensive medications they need.

> "CARE is khair (Blessing). Thanks to it, I am again leading a normal life."
>
> Maysa A. Burj Barajneh camp

Table 16- Care Programme special appeals

CARE programme launched so far two special appeals to cover patients in need of transplant procedures or cardiovascular surgeries. The first appeal in 2011 succeeded in ensuring funds for 5 patients in need of transplant procedures: three did the procedures successfully, the fourth will be travelling to Italy soon to do the transplant in collaboration with UNICEF and the fifth one could not do the transplant due his medical condition, so the funds were used to cover the partial cost of a kidney transplant for two other patients.

The 2012 special appeal succeeded in ensuring partial support to three patients: two completed the surgeries; a third is due to undergo treatment soon. The funds gathered were however insufficient for the fourth patient in need of bone marrow transplant.

4.2.4 Health Information System

Inherent to the reform and to the implementation of the Family Health Team approach is enhancing primary health care data by computerisation of records and the introduction of an integrated E-Health module.

An improvement was introduced to the connectivity in the health centers. Computers and other Information technology equipment were added in the health centers, facilitating the implementation of the E-health modules

By the end of 2011, the NCD E-Health module was operational in all 28 UNRWA health centers in Lebanon. An updated and integrated E-Health module is being developed in house at UNRWA headquarters in collaboration with the Lebanon Field Office and is expected to be rolled out in phases starting 2013. The new E-Health module is based on the Family Health Team concept, integrating the different services provided and allowing better documentation of information in a more comprehensive way.

It is worth noting that all these improvements in the health information system in UNRWA centers were possible thanks to the generous donations of the Government of Denmark and the Government of the United States of America.

4.2.5 Communication

Improving communication is a cornerstone of the reform. As of the end of 2009, UNRWA invested heavily in communication, both with other NGOs and with the community. A combination of different communication tools were utilised in order to ensure transparency; and systematic community access to information about services, patients' rights, and new developments introduced in the Health Programme. This includes meetings with community leaders, local NGOs and international NGOs; awareness sessions at UNRWA health centers; community newsletter; celebrations of the International health days; and public health campaigns.

Meetings with community leaders have proved to be a constructive space to maximise the reform benefits for Palestine refugees in Lebanon. Since 2011, the management team within the UNRWA Health Programme has been holding meetings on a regular basis with the community leaders within the camps in all areas in Lebanon. During these meetings, community leaders share their demands and concerns as well as get updated about new services and development in UNRWA health programme.

Similarly, a regular collective meeting with local and international NGOs working in health services has been taking place regularly. In this meeting, NGOs and UNRWA share their most important updates about health services offered to Palestine refugees. The meeting allows UNRWA and other NGOs to coordinate their work in order to avoid duplicated efforts. In fact, the participants get a chance to join efforts to engage in new collaborations that cater to rising health needs of the community.

Moreover and as part of improving communication with the community, a hospitalisation booklet was developed at the launching of the new hospitalisation strategy in 2010. This booklet aimed at informing the community regarding their rights in hospitalisation as well as the new services provided and the procedures that they need to follow. This was accompanied hand in hand with several meetings where the components of the hospitalisation programme were discussed in detail with the community. These meetings are being repeated on periodic basis including in addition to regular community members, UNRWA staff from other departments and NGOs.

Last but not least, a specific communication strategy is used to develop health education materials, organize public health campaigns and celebrate International Health Days aiming at increasing community knowledge on disease prevention and healthy life styles.

In this respect, a comprehensive booklet on nutrition during preconception, pregnancy, lactation and the weaning period was developed with a generous support from MAP. Health staff also organized and participated in several health awareness campaigns during the last years, which are highlighted below.

- **Fighting iron deficiency anemia "as strong as iron"**

The prevalence of anemia was found to be high among pregnant women and children one year old. In order to address the high prevalence of iron deficiency anemia among this population, the Agency has instituted screening tests for vulnerable groups namely one-year old children and pregnant women, as well as provided free prophylactic iron supplements to infants starting at age of six months and free iron supplements to anemic patients.

Despite these measures, the prevalence of anemia remained high among the aforementioned vulnerable groups. To better understand the reasons behind this, focus groups were conducted in 2010 and revealed low levels of knowledge regarding iron-rich nutritional sources, wrong practices in preparing food and in feeding infants, as well as misconceptions regarding iron supplements.

Based on these results, the Communication Unit and the Health Programme at UNRWA designed and launched a campaign entitled "as strong as iron" in partnership with UNICEF, MAP, ANERA and five local NGOs (Naba'a, NISCVT, PARD, GUPW and PWHO). The campaign targeted Palestine refugee women at reproductive ages with a unified message and several tailored activities. These activities included: messages during individual doctor/patient sessions, home visits, group counseling sessions, cooking sessions/health festivals. Several communication and educational tools were used during these activities as well.

The "as strong as iron" campaign was implemented from December 2010 to February 2011 in all the 12 refugee camps and surrounding areas (gatherings) across five different areas in Lebanon. Towards the end of February 2011, UNRWA and partner NGOs had reached 13,244 women.

Table 17- Anemia Awareness Campaign in Palestinian Camps & Gatherings: Impact assessment after 2 years

Following the active campaign that lasted from December 2010 to February 2011, only the group discussions and one-to-one counseling continued at different paces in UNRWA health centers. A study was conducted end of 2012 aimed at determining the impact of the anemia awareness campaign after two years since its launch.

Different methods were used to evaluate the long- term impact of this campaign. These included the following:

- A comparison was performed of the incidence of new onset iron deficiency anemia among one year old children in UNRWA health centers (a total of 28 centers) in the third quarter of 2010, 2011 and 2012.
- Focus group discussions were conducted among women of reproductive age group in UNRWA health centers, Burj Barajneh and Burj Shemali, to assess behaviors relevant to iron-rich food consumption and supplementation. These 2 centers were chosen because the former was least effective at decreasing the incidence of anemia among one year old children (lowest drop in incidence and activities not conducted regularly at Burj Barajneh), while the latter was most effective (highest drop in incidence and activities conducted regularly at Burj Shemali).
- A short test was administered to a sample of 50 women in each of these two centers. The test was composed of 15 true or false questions; the same knowledge questions as those included in the assessment of the campaign in 2010.

The incidence of new onset iron deficiency anemia decreased from 37% in the third quarter 2010 to 31.7% in 2011 and to 27.4% in 2012. This shows an improvement of around 26% in controlling the onset of iron deficiency anemia. The focus group findings showed that most women have correct behaviors at Burj Shemali center. Even those who had not altered their iron-consuming behaviors had adequate knowledge and were planning on implementing changes soon. For Burj Barajneh, focus group results showed that participants were not engaging in behaviors recommended during the campaign; mothers were not giving their infants prophylactic iron supplements at 6 months and were not avoiding dairy products or tea during or after consumption of iron-rich foods.
In comparison with the 2010 results, the short-test results revealed a 23.5% improvement in knowledge among the women surveyed in the Burj Shemali center, compared to only 6% improvement among women in Burj Barajneh center.

In conclusion, the long term impact of the community-based awareness campaign on iron deficiency anemia seems to be positive. The decrease in the incidence of new onset iron deficiency anemia can be attributed to improvement in the level of mothers' knowledge as well as a change in their related behaviors. Moreover, the role of health care workers is important in improving the knowledge of beneficiaries regarding health issues as well as their practices. This was proven through the difference between the short-test results from the center (Burj Shemali) where counseling & educational sessions regarding iron deficiency anemia continued and those of the other center (Burj Barajneh) where sessions were conducted on an irregular basis. It is worth noting that changing behavior is a long term process and does not depend solely on knowledge improvement; other factors, such as social or economical, can affect behavior change as well.

- **Rational use of medicines "Zaka Wa Dawa" campaign**

This Lebanon campaign started as an initiative by the international NGO American Near East Refugee Aid (ANERA). UNRWA participated as one of the leading partners in this project and handled the implementation of the campaign in the 12 Palestine refugee camps. For UNRWA, the launch of the campaign was on Thursday, April 7th, 2011 which was on the same day as the World Health Day of that year, with a special theme of "Sensible Use of Medicine".

The Rational use of medicine campaign, "Zaka wa Dawa", was designed with the aim to raise awareness among the Palestine refugees about the adverse effects of the irrational use of medication and the impact of its abuse on physical and mental health. It targeted health service providers, educators, students, youth and children, women and mothers, elderly, and the media.

To enhance the effectiveness of implementing the campaign in the field, over 22 health staff and a few teachers participated in a training workshop by ANERA. Those served later as focal points in the 12 refugee camps and offered training and assistance to other participating staff.

Overall, the campaign has apparently been a success as a first step. Many sessions were held in the various areas (CLA, North, Saida, Tyre and Beqaa). A substantial number of attendees were recorded for each health center.

- **World diabetes day and diabetes walk**

World diabetes day is the primary global diabetes awareness campaign set out to inform the general public, healthcare professionals, policy makers and the media about diabetes and its serious complications. The Day is celebrated on 14th November from each year. Set by the International Diabetes Federation (IDF) and World Health Organisation (WHO), the campaign slogans for year 2011 were "Launch A Global Diabetes Walk" and "Act On Diabetes Now".

In celebration of that day, two major activities were run by most UNRWA health centers in the areas: the screening campaign and the walking campaign. The screening campaign consisted of screening Palestine refugees aged 35 years and above that are not registered at the NCD

programme for hypertension, diabetes, and hypercholesterolameia. Most health centers participated with some staff visiting homes of elderly for screening purposes.

The walking campaign was mostly prominent in Tyre area camps. It consisted of a walking ceremony run by health centers' staff, diabetic patients, Area office senior staff, schools (a group of teachers and students), NGOs working in the camps, clubs, local community and popular committees in all of Tyre area camps. Participants held posters and stands that highlighted various issues related to diabetes. The walking campaign highlighted the importance of walking and physical activity as an important pillar to be considered in the prevention and management of diabetes.

Overall, this event had a great success. Palestine refugees in camps and gatherings and those visiting the health centers, including persons at risk of the disease, diabetic patients, were able to gather new information on various issues related to diabetes. The screening campaign was able to detect many cases which got registered at the NCD clinics for further follow-up and management.

- **Healthy spring days**

During May and early June 2012, ANERA Lebanon launched and sponsored the celebration of Healthy spring days with the participation of UNRWA among other NGOs. These activities came after the success of "Zaka Wa Dawa" campaign in 2011. Again, the event aimed at raising the awareness of the Palestine refugee community towards the rationalisation of medication use; antibiotic use in specific. Additionally, it included educational activities about healthy nutrition and other behaviours necessary for a healthy lifestyle.

The celebration of Healthy Spring Days was held in Burj Shemali, Rashidieh, Burj Barajneh and Shatila camps, where the feedback from the community was positive as they asked for further similar activities. During these days, UNRWA staff from the respective health centers participated actively in preparing related posters, games and delivering lectures to audience.

- **In-school teeth brushing campaign**

The campaign was launched in October 2011, with the aim of educating UNRWA students in the first, second and third grades regarding the importance and benefits of teeth brushing as well as instilling teeth-brushing as a habit for them by doing it collectively during school time. This campaign was launched in several UNRWA schools and included free distribution of toothbrushes to children in grades 1, 2 and 3 throughout schools in the five areas, as well as demonstrations of the proper teeth brushing techniques.

- **Thalassemia & sickle cell anemia campaign**

This campaign was launched during December 2012 in Burj Shamali camp, one of the camps with the highest reporting of thalassemia and sickle cell anemia. The campaign is an important component of the project "prevention and

treatment of thalassemia and sickle cell anemia among Palestine refugees in Lebanon", which is generously funded by the German Government. The launch of the campaign was an open day aiming at informing Palestine refugees of the newly established services for thalassemia and sickle cell anemia patients, engaging the community and promoting key messages regarding the prevention of these diseases, and holding a screening event for 100 community members. The event proved to be a great success, with a large youth involvement and theatrical performances by the community. This event enabled the diagnosis of few cases of sickle cell anemia as well as identify several trait carriers for targeting of preventative messages.

This campaign will continue throughout 2013 and 2014 and will expand to all other Palestine refugees' camps and gatherings in Lebanon.

4.2.6 Partnerships

Strengthening partnerships with other stakeholders that work with Palestine refugees is important for an efficient delivery of services. UNRWA continues to collaborate with the Lebanese Government, Palestine Red Crescent Society, the International Community, Non-Governmental and International Organisations, private sector including pharmaceutical companies, private healthcare providers, private companies and enterprises as well as individuals. These collaborations have been successful in improving the accessibility of patients to medical care such as mental health services, and medications for some catastrophic diseases at better rates.

4.3 Gaps and Challenges

During the last few years, the UNRWA Health Programme in LFO worked on strengthening its existing services and introduced new ones to improve the quality of care provided to patients as mentioned earlier in this report. However, gaps still exist as follows:

- **Elderly care:** accounting for around 11.5% of the Palestine refugees in Lebanon, elderly patients require specific care at the physical, psychological, social and functional levels. This comprehensive approach is still not fully implemented in UNRWA health centers.
- **Disabilities care:** individuals suffering from disabilities (accounting for four percent of the population) receive the regular care provided in UNRWA health centers. However, specialised care for this vulnerable group is not provided by UNRWA at this stage.
- **Preventive services for non-communicable diseases:** it is true that secondary and tertiary preventive services (such as mammography, pap smear, colonoscopy, prostate specific antigen, Hba1c among others) are made available to Palestine refugees through the contracts of UNRWA with external health facilities and are partially supported by the Agency (50% of the price); however, their utilisation needs to be better enhanced. Several limiting factors for the utilisation of these services can be highlighted: 1. The financial burden on the patients, 2. The need to build the culture of prevention within the community not only to secondary and tertiary preventive services but also to primary prevention namely lifestyle modifications, and 3.

The health education component of the clinical encounters at the level of the health centers. This latter will be hopefully addressed through the complete implementation of the FHT approach as well as with building the capacity of the staff in this respect.

In addition to finding solutions to these gaps, the Health Programme at LFO faces several challenges at the different levels of delivery of care.

- **At the primary care level**
  - Improving the quality of the services provided in UNRWA's health centers;Lengthening doctor-patient consultation time;Ensuring continuous availability of medications, while enhancing rationalisation in prescription and utilisation;
  - Strengthening preventive services;
  - Full implementation of the FHT Approach in all the health centers in Lebanon Field.

    It is worth noting that the increasing number of Palestine Refugees displaced from Syria has increased the burden on the health centers and affected the smooth implementation of the reform activities.

- **At the secondary care level**
  - The increased utilisation of secondary health care services associated with the improved access of Palestine refugees to quality hospitalisation care resulted in an increase in the hospitalisation bill, causing an additional burden on the limited budget of the Agency.
  - The need for continuous monitoring of the hospitalisation services to avoid any abuse.

- **At the tertiary care level**
  - The escalating prices of the tertiary care services;
  - The high financial burden patients bear: often patients' families are forced to solicit organisations and individuals known to support hospitalisation costs to cover their share of the bill or risk indebtedness;
  - Absence of financial protection for refugees: UNRWA partially covers the hospital bill, leaving the patient responsible to pay a considerable part of the share.
  - The main challenges for the CARE programme remain when it comes to the ability to ensure the sustainability of financial resources in order to continue with the programme. In addition, challenges remain in the ability to respond to the needs of all patients suffering from catastrophic diseases and include new packages for liver hepatitis B & C, chronic renal failure, post-transplant treatment and more.

5 Health Programme Budget

The budget of the Health Programme at LFO increased in the last few years in order to respond to the growing health needs of the Palestine refugees (an increase of 48.9% in 2012 as compared to 2009). This increase extended to all the sections of the budget and especially the hospital services' coverage. Moreover, additional project funds were allocated to hospital services, which are not reflected in the below table, and amount to $ 500,000 in 2010, $854,497 in 2011 and $273,330 in 2012.

Table 18 - UNRWA Health Programme Budget, General fund

	Expenditures 2009 (1000$)	Expenditures 2010 (1000$)	Expenditures 2011 (1000$)	Expenditures 2012 (1000$)
Programme Management	**776**	**569**	**581**	**650**
Medical Care Services				
Laboratory Services	517	455	558	643
Outpatient Services	5,114	4,816	5,504	6,587
Maternal & Child Health	502	406	494	563
Disease Prevention & Control	1,186	648	1,196	1,345
Oral Health	553	559	573	756
Hospital Services	4,665	6,745	6,964	9,275
Total	**13,313**	**14,199**	**15,870**	**19,819**

6 Future Steps

UNRWA's vision is to ensure that Palestine refugees in Lebanon lead a long and healthy life. In this respect, the reform activities will continue in the Health Programme at LFO over the coming years namely 2013-2014, which will hopefully positively impact the efficient and effective delivery of services. After focusing on improving hospitalisation services during the early phases of the reform, UNRWA is now focusing on improving the primary health services. This means that more work will be exerted to improve the preventive services provided to the refugees.

The Agency's strategy in the coming years revolves around the following three pillars:

- **Strengthening the primary health care services provided by UNRWA through:**
  - Implementing "Family Health Team" Approach in all UNRWA health centres in Lebanon;
  - Improving the quality of the primary health care services in terms of quality of the consultations, quality of medications, and quality of other diagnostic services;
  - Working towards accreditation of the health centers by renowned organisations;
  - Modernising the health centers of UNRWA;
  - Being more responsive to the needs of the population by introducing new services such as an asthma clinic, elderly care;
  - Integrating mental health services within UNRWA health centres and building capacity of UNRWA staff in recognizing and addressing these illnesses;
  - Improving preventive services provided in health centers and raising community awareness about healthy lifestyle;
  - Improving the referral mechanism to and from the health centers;
  - Ensuring a safe and healthy working environment.

- **Improving Palestine refugees access to quality secondary and tertiary care through:**
  - Ensuring contracts with hospitals providing quality hospitalisation services;
  - Facilitating the referral process;
  - Strengthening the monitoring and evaluation of the services provided;
  - Facilitating the access of patients suffering from catastrophic health conditions to the care needed.

- **Strengthening Partnerships with stakeholders:** including governmental, non-governmental and international organisations as well as the private sector. This will enable providing better services through more coordination and less duplication of resources.

UNRWA will continue exerting all efforts to raise funds in order to sustain newly introduced services and improve the access of Palestine refugees in Lebanon to quality healthcare while at the same time strive to ensure the efficient and effective delivery of these services. The Agency has assumed its responsibility towards improvements in access, quality and size of services, and has been undergoing reforms to cater to these needs. While some targets are being achieved, others still have to be urgently addressed. Yet, many challenges need to be faced: UNRWA's limited available financial resources, increasing health care costs in Lebanon, the growing needs of a vulnerable population compounded by the Palestine refugees' worsening socioeconomic conditions in Lebanon, and the displacement of Palestine refugees from Syria accompanied by substantial political instability of the region and financial instability worldwide.

It is worth noting that the relief of Palestine refugees from Syria is posing a considerable challenge on the operations of the Health Programme at LFO. However, the details of this issue are not discussed in this report. Another important challenge is the relief special programme for the Internally Displaced Population from Nahr el-Bared Camp (ongoing since 2007), which has also its significant impact on the Health programme. Yet, this will not be addressed within the context of this report.

The following issues still need to be addressed:

- UNRWA has been advocating for more funding and support from the international community and the host Government of Lebanon. However, more engagement with them is necessary in order to raise attention and funding for the health programme.
- Finding a sustainable financing is a major limiting step to expanding UNRWA's health programmes.

- It is important to understand the sensitivity of the Palestine refugees' situation, where they are unable to access needed services because of their refugee status in Lebanon; while at the same time these services are abundantly available with very high quality and sophisticated care.

- Various partners need to join efforts to achieve improvement and reform targets. In this respect, Palestinian Liberation Organisation (PLO) still has a role to play in improving the delivery of health services to Palestine refugees in Lebanon, despite its limited budget for health and medical care. The International NGOs as well as the local NGOs have an important role to play in conjunction with other parties. Such role includes providing complementary services to UNRWA as well as spreading awareness and knowledge through campaigns, research, etc. Finally, the Lebanese MoPH has been supportive in facilitating the provision of services; UNRWA will continue working with the Government of Lebanon in order to improve the provision of health services for Palestine refugees, a basic right that they are entitled to. The role of the community is and remains crucial in determining and shaping the health services that are provided to its members.

Annex I: Fact Sheets- General Indicators

Table 1. Demographic Indicators

Indicators	2009	2010	2011	2012
Population of Lebanon	4,017,095	4,125,247	4,140,289	4,228,000
Registered Palestine Refugees	425,640	455,371	465,798	474,053
Proportion of refugees in Lebanon (%)	10.6	11	11	11.2
Number of refugees accessing UNRWA health services	249,459	254,604	267,105	273,740
Proportion of refugees accessing UNRWA health services (%)	59	55.9	57.3	57.7
Percentage living in camps (%)	53.2	50	50.1	50.3
Fertility rate	2.3	3.2	3.2	3.2
Male/Female ratio	1.03	0.94	1.06	1.05
Growth Rate of registered refugee (%)	0.82	6.9	2.2	1.7
Percentage of children <18 years (%)	25.5	24.3	25.6	27.0
Percentage of women of reproductive age group (15-49 years) (%)	27.4	27.8	27.2	27.0
Percentage of population 40 years and older (%)	36.2	39.4	38.4	38.4

Table 2: Millennium Development Goal Indicators

Indicators	2010	2011	2012
Neonatal Mortality Rate/ 1000 live births	14.1	14.1	14.1
Infant Mortality Rate/1000 live births	19	19	19
Percentage 12 months Infants immunised against Measles (%)	99.5	99.5	99.5
Percentage Antenatal Coverage (%)	60.8	58.4	74.5
Percentage of Deliveries attended by skilled personnel (%)	100	100	100
Maternal Mortality Ratio/100,000 births	42.1	82.8	41.5
Percentage contraceptive use among married women in reproductive age (%)	74.7	66.6	66.6
Incidence Rate of Tuberculosis/100,000	5.1	7.1	4.2

Table 3. Health Staff per 100,000 population

	2010	2011	2012
Health Staff per 100,000 served population			
Doctors	21.5	20.6	19.0
Nurses	48.5	37.8	42.7
Health Staff per 100,000 registered population			
Doctors	12.3	11.8	10.9
Nurses	26.1	21.7	24.7

Annex II: Fact Sheets-Primary Health Care

Table 1. Performance Indicators

Performance Indicators	2009	2010	2011	2012
Average daily medical consultations per doctor	107	104	117	103
Average daily consultations per dental surgeon	26.4	27.2	35	26
Actual laboratory productivity rate compared to the target of 50 workload units/ hour	41.3	38.7	38.8	38.8
Actual productivity of dental services compared to the target of 50 workload units/ hour	43.5	42.5	44.3	44.3

Table 2. Utilisation Indicators

Utilisation Indicators	2009	2010	2011	2012
Medical General Consultations (done by medical officers, nurses and midwives)				
First visits	161,709	177,791	180,582	207,215
Repeat visits	810,778	839,322	884,983	996,721
Sub-total visits	972,487	1,017,113	1,065,565	1,203,936
Ratio first to repeat visits	5.0	4.7	4.9	4.8
Specialist Care				
Obstetrics/Gynecologist	20,165	21,267	20,856	21,386
Cardiology	10,169	10,744	12,236	12,020
Others	16,070	17,436	16,216	15,671
Sub-total	46,404	49,447	49,308	49,077
Total	1,018,891	1,066,560	1,114,873	1,253,013

Table 3. Maternal & Child Health Indicators

Indicators	2009	2010	2011	2012
Percentage of pregnant women who received antenatal care (%)	64.1	60.8	58.4	74.5
Percentage of pregnant women who paid four antenatal visits or more (%)	93.2	92.3	90.9	89.5
Average number of Antenatal visits	6.9	6.1	6.6	6.6
Percentage of deliveries in health institutions (%)	98.7	98.7	99.8	99.8
Percentage of women who received postnatal care (%)	96.6	95.1	97	99.0
Incidence of growth retardation among children 0-3 years old	4	3.6	2.7	2.8
Percentage of infants 12 months old fully immunised (%)	100	99.5	99.5	99.5
Prevalence of anemia among children <3 years of age	33.4	33.4	33.4	33.4
Prevalence of anemia among pregnant women	25.5	25.5	25.5	25.5
Prevalence of anemia among nursing mothers	26.6	26.6	26.6	25.6

Table 4. Non-Communicable Diseases Health Indicators

	2009	2010	2011	2012
Number of patients with Diabetes Mellitus Type I	204	208	224	236
Number of patients with Diabetes Mellitus Type 2	2219	2268	2,304	2380
Number of Patients with Diabetes Mellitus & Hypertension	7,106	7,594	8,437	8,602
Number of patients with Hypertension	11,551	11,887	12,276	12,488
Total	**21,080**	**21,957**	**23,241**	**23,706**
Prevalence of diabetes among population served 40 years and above	10.6	9.3	9.9	9
Prevalence of hypertension among population served, 40 years and above	20.8	18.2	19	17
Percentage of late complications (%)	9.8	12.3	12.8	12.3

Annex III: Fact Sheets-Hospitalisation

Table 1. Utilisation Indicators

	2009	2010	2011	2012	% increase 2012 vs 2009	% increase 2012 vs 2011
Number of Beneficiaries in secondary care	19918	20,875	21,873	25,213	27%	15%
Number of Beneficiaries in tertiary care	1644	3275	3,835	4,554	1.8 times	19%
Number of Hospitalisation Days in Secondary Care	40323	49599	48,875	52,133	29%	7%
Total Number of Hospitalisation Days	44298	59329	63,513	71,797	62%	13%
Total Number of Beneficiaries from Hospitalisation programme	21562	24,692	26,235	30,367	41%	16%
Number of patients treated in Emergency Room	0	5656	7,502	8,776		17%
Number of patients treated in Intensive Care Units in secondary care	0	2145	2,265	2,392		6%
Average Length of Stay	2	2.4	2.4	2.5	25%	4%

Table 2. Financial Indicators

($) USD	2009	2010	2011	2012	% increase 2012 vs 2009	% increase 2012 vs 2011
Cost per admission in secondary care	150	232	231	236	57%	2%
Cost per Hospitalisation Day in Secondary care	67	114	104	114	70%	10%
Cost per Emergency Room Treatment	0	22	22	22		

Table 3. Cancer Patients in 2010 & 2011

	2010	2011
Total Number	196	176
Distribution by Age	< 20 years: 7 (4%) 20-39 years: 24 (12%) 40-59 years: 80 (41%) 60 years & above: 85 (43%)	< 20 years: 3 (2%) 20-39 years: 13 (7%) 40-59 years: 91 (52%) 60 years & above: 69 (39%)
Distribution by Gender	Females: 93 (47%) Males: 103 (53%)	Females: 100 (57%) Males: 76 (43%)
Distribution by Type (most common)	Breast Cancer: 58 (30%) Lung Cancer: 25 (13%) Colon Cancer: 20 (10%)	Breast Cancer: 56 (32%) Lung Cancer: 16 (9%) Colon Cancer: 15 (9%)

Annex IV: Fact Sheets-CARE Programme

Table 1. Utilisation Indicators

	2011 (Apr-Dec 2011)	2012 (Jan-Dec 2012)
Hospitalisation	60	183
Cancer Medications	12	4
Special Cancer Medications*	0	2
Radiotherapy	10	94
Multiple Sclerosis	11	22
Thalassemia	0	9
Sickle Cell Anemia	0	29
Total	**93**	**343**

Table 2. Financial Indicators

Financial support committed to patients	Total in 2011 (Actual) (Apr-Dec 2011)	Total in 2012 (Jan –Dec 2012)
1) Hospitalisation Package (in-patient)	US $155,709	US $401,632
2) Cancer Package (out-patient) :		
- Cancer medications support	US $31,190	US $7,490
- Special Cancer medications*	-	US $7,177
- Radiotherapy support	US $6,800	US $49,230
3) Multiple Sclerosis Package (out-patient)	US $1,621	US $15,668
4) Thalassemia Package	-	US $21,501
5) Sickle Cell Anemia Package	-	US $101
Total	**US $195,320**	**US $505,799**

Note that the expenditures of CARE programme mentioned in table 2 do not include the contributions of the Italian Government, Italian Development Cooperation Office and the German Government to the cost of medications namely for multiple sclerosis, thalassemia and sickle cell anemia.

* Based on an agreement with pharmaceutical companies, additional support is provided to cancer patients in need of specific types of cancer medications produced by the companies.

Annex V: Hospitalisation Strategy as of 2010

Eligibility Criteria

Palestine Refugees who are eligible to receive UNRWA hospitalisation & contractual Outpatient and/ Or Inpatient Services include the following:

- Registered Palestine Refugees with UNRWA
  - Registered Palestine Refugees with UNRWA in Lebanon
  - Other Registered Persons: married to non-refugee (MNR) family members and non-refugee wives
  - Registered Palestine Refugees with UNRWA in other Fields provided they are registered with the Department of Palestine Refugees Affairs (DPRA) in Lebanon
  - Registered Palestine Refugees with UNRWA in other Fields but who are not registered with DPRA in Lebanon will receive these services if a primary approval is secured from the original field of registration

- Non-Registered Palestine Refugees
  - Palestine Refugees registered with DRPA in Lebanon and not registered with UNRWA

- Non-ID Palestinians
  - Palestinians registered with UNRWA in other Fields with an identification card issued by Sureté Générale will receive these services if a primary approval is secured from the original field of registration. This approval indicates usually the amount of financial coverage by UNRWA, which reflects the policy followed in their original field of registration.

Scope of hospitalisation services

The hospitalisation services covered by UNRWA are divided into two main categories:

- **Secondary Hospitalisation Services:** these services are covered fully by UNRWA except for a minimal co-sharing of the patients in the cost of prosthesis and some non-essential medications. These services include the following:
  - Treatment of Emergency Medical Conditions that necessitate hospitalisation and provision of medical treatment inside the hospital. These include conditions as Meningitis, Pyelonephritis, management of Diabetic Ketoacidosis, exacerbation of chronic obstructive pulmonary disease, management of severe asthmatic attack not responsive to outpatient treatment, etc.
  - Surgical Procedures to save the lives of the patients or prevent disability such as appendectomy, cholecystectomy, repair of a strangulated hernia, management of fractures, etc.
  - Delivery of pregnant women who were classified as high risk during their antenatal follow up in UNRWA health centers.
  - Emergency Room Services which include management of conditions that necessitate acute management in the emergency room such as management of a laceration, closed fracture, renal colic etc
  - Intensive Care Unit: for the management of conditions that require close observation and intensive management.
  - Coronary Care Unit: for the management of coronary accidents such as Acute Myocardial Infarction, Unstable Angina etc.
  - Intensive Care for the Neonates: for the management of newborns who are premature or are in a condition that require close observation and meticulous management.
- **Tertiary** Hospitalisation **Services:** these services are covered partially by UNRWA and the patient bears a considerable share of the bill. This includes conditions such as:
  - Cardiovascular & Thoracic Surgeries such as Open Heart Surgeries, Coronary Angioplasty with or without stent, Aortic Aneurysm surgery, vascular surgeries etc.
  - Neurosurgical Operations i.e. brain and spine surgeries such as Laminectomy, excision of brain mass, hydrocephalus surgeries, etc.
  - Joint Surgeries such as arthroscopies, joint replacement surgeries, etc
  - Complicated Hepato-biliary Surgeries
  - Specialised Pediatric Surgeries such as operation for esophageal atresia etc.
  - Laparoscopic Surgeries: such as ERCP, LaparoscopicCholecystectomy,Laparoscopic Appendectomy, Laparoscopic gynecologic surgeries etc.
  - Cancer Surgeries: surgeries to remove a mass/

neoplasm such as Mastectomy, resection of a colon mass etc.

- Specialised Eye Surgeries: such as Cataract Surgery using Phaco-emulsification, Vitrectomy etc.
- Specialised Ear Surgeries such as Mastoidectomy, Stapedectomy etc.
- Management of Burns.
- Cancer Treatment: treatment of febrile neutropenia, treatment of infections resulting from cancer treatment etc.
- Medical Treatment of higher complexity and/or treatment that requires highly specialised care such as treatment of advanced congestive heart failure, treatment of liver cirrhosis, treatment of hepatic encephalopathy, treatment of Guillain Barre etc.

Exclusions to UNRWA coverage

The UNRWA's Health Programme does not cover the following conditions:

- Conditions treated in the health centers run by UNRWA. Examples of these conditions include the following: Throat Pain, Ear Pain, Flu symptoms, Cough, Diarrhea with no dehydration symptoms, joint pain, sprain, any chronic condition without acute exacerbation (diabetes mellitus, hypertension, asthma, and chronic obstructive pulmonary disease). This includes also admission for investigation or general check up.
- Plastic and reconstructive surgery that does not affect the survival or improve the functional ability of the patient.
- In-Vitro Fertilisation management, tubal ligation and induced abortion.
- Long-term life sustaining tertiary care that is not on offer by the agency, such as treatment/ rehabilitation of the complications of chronic degenerative diseases, immunosuppressive treatment, treatment of hemoglobinopathies, hemodialysis, organ transplantation or bone marrow transplantation.
- End-Stage cancers that do not benefit from tertiary therapy and require palliative pain relief only.
- Medico-legal conditions with a third party liability such as a car (motorbike) accident, gunshot etc.
- Cardiac Catheterisation
- Long term treatment that necessitate nursing care.
- Normal vaginal deliveries of pregnant women who are not classified as high risk pregnancies.

Before & After

	2009	2010/2011/2012
Number of contracted Hospitals	15	35/36/ 42
Type of Hospitals	PRCS (5) Governmental Hospitals (3) Private Hospitals (7)	PRCS (5) Governmental Hospitals (13) Private Hospitals (17)/(18)/ (24)
Location of hospitals	Limited access to Refugees in gatherings	Wider Geographical Coverage
Bed days per hospital	Limited Bed days/ hospital/ month	No limitation/ No limited number of bed-days/ hospital
Emergency Room	Not covered	Covered in specified hospitals
Outpatient tests (Diagnostic Tests)	Hospital-based	Outpatient centers & Hospitals: more convenience, better rates
Intensive Care Unit/ Coronary Care Unit/ Intensive Care for the Neonates	No equity in coverage: fully covered by UNRWA in some areas versus partial coverage as tertiary care in others.	Covered completely in secondary care hospitals (with minor co-sharing of expensive medications & prosthesis) in all areas.
Heart surgeries & Angioplasty	Discrimination in coverage between patients > 60 years and those 60 years & younger.	All patients benefit from same financial coverage: No age discrimination.
Decentralisation	Approving referrals (hospitalisation, outpatient tests) in Health department LFO	Signing approvals by the medical officers at the area level
Awareness of patients about their rights in hospitalisation services	Patients not aware of their rights or their entitlements in hospitalisation services	Communication Campaign (brochures/meetings) to inform patients about their rights/responsibilities & entitlements in hospitalisation services
Controlling Hospitalisation officer	Delegated Medical Officer working both in the health centre and visiting hospitals	Full time {Area Hospitalisation Medical Officer (AHMO), Area Health Coordinators(AHC)} supervising hospitalisation services in each area
Control & Monitoring	Loose	Reinforcement of the monitoring system in all hospitals: visiting patients, checking medical records, checking hospital bills etc. The hospitalisation unit's team led by the Assistant Chief Field Health Programme /Hospitalisation, reviews all the bills both financially and clinically.
Control in Tertiary care	None	Control by UNRWA AHMO of all requested tests/ medications etc; positive impact on patient bill.
Contracts	General, non-specific contracts with hospitals	More specific contracts/patients' rights protection/ penalties in case of breach of contracts etc
Patients' complaints	No clear mechanism	Specific complaint reporting mechanism
Control of the quality of services	None	Quality Performance indicators are part of the contracts with all hospitals
Evaluation	None	Periodic evaluation/ corrective actions to be taken

Annex VI: List of Abbreviations

AHC – Area Health Coordinator

AHMO – Area Hospitalisation Medical Officer

ALOS – Average Length of Stay

ANERA – American Near East Refugee Aid

AUB – American University of Beirut

CARE Programme – Catastrophic Ailment Relief Programme

CCU – Coronary Care Unit

CLA – Central Lebanon Area

DMO – Designated Medical Officer

DPT - Diphtheria /Pertussis/ Tetanus

DPRA - Department of Palestine Refugees Affairs

ECHO – European Community Humanitarian Office

EPI – Expanded Programme of Immunisation

ERCP - Endoscopic Retrograde Cholangiopancreatography

FHT – Family Health Team

GUPW – General Union of Palestinian Women

Hba1c – hemoglobin a1c

HIB - Haemophilus Influenzae type B

ICU – Intensive Care Unit

ICN – Intensive Care for the neonates

IDF- International Diabetes Federation

JICA- Japan International Cooperation Agency

LFO – Lebanon Field Office

MAP – Medical Aid for Palestinians

MCH – Maternal and Child Health

MoPH – Ministry of Public Health

MPDL – Movement for Peace

NCD – Non-Communicable Diseases

NGO – Non-Governmental Organisation

NISCVT – The National Institution for Social Care & Vocational Training

PARD - Popular Aid for Relief and Development

PHC – Primary Health Care

PLO – Palestinian Liberation Organisation

PRCS – Palestine Red Crescent Society

PWHO- Palestinian Women's Humanitarian Organisation

QRC – Qatar Red Crescent

Td- Tetanus/ Diphtheria

UNICEF – United Nations Children's Fund

UNRWA – United Nations Relief & Works Agency for Palestine Refugees in the Near East

WHO - World Health Organisation

unrwa
الاونروا

unrwa lebanon feld office
health programme
bir hassan, beirut (opp. sports city)
po box 1107 2060, lebanon

t: +961-1-840-490/1-9
f: +961-1-840490 extension 215
www.unrwa.org