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Department of Health

annual report 2020

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Cover photo: UNRWA nurse preparing to vaccinate a Palestine refugee child at the Sheikh Radwan Health Centre in Gaza, implementing the COVID-19 pandemic emergency requirements. *© 2020 UNRWA Photo by Mohammad El Hennawi*

table of contents

table of contents

acronyms and abbreviations

ANC	Antenatal care
ANERA	American Near East Refugee Aid
BDS	Behavioural development scales
BFR	Breast feeding room
CMM	Common Monitoring Matrix
COI	Cooperazione Odontoiatrica Internazionale
CSSD	Central Support Services Division
DM	Diabetes mellitus
DMFT	Decayed/Missing/Filled Teeth
DPA	Department of Palestinian Affairs
DRU	Doners Relation Unit
DS	Decayed surface
DT/Td	Tetanus-Diphtheria
ECD	Early Childhood Development
ECHO	European Commission Humanitarian Aid
E-MCH	Electronic - Mother and child handbook
EPI	Expanded Programme on Immunization
ESRF	End-stage renal failure
FBG	Fasting blood glucose
ESRF	End-Stage Renal Failure
FHT	Family Health Team
FMDP	Family Medicine Diploma Programme
FOs	Field Offices
FP	Family planning
FS	Filling surface
GAPs	Gender-action plans
GBV	Gender-Based Violence
GES	Gender Equality Strategy
GHQ-12	The 12-item General Health Questionnaire
GMR	Great March of Return
HBA1c	Hemoglobin A1c
HCs	Health Centres
HCS	Health Care Society
HD	Department of Health
Hib	Haemophilus Influenza Type B
HP	Health Programme
HQ	Headquarters
HSP	Hospitalization Support Program
HWG	Health Working Group
IMR	Infant Mortality Rate
IUD	Intrauterine device
LBW	Low Birth Weight
LTA	Long Term Agreement
MCI	Micro-clinic International
MCH	Maternal and Child Health
MCH App	Maternal and child health mobile application
mhGAP	mental health Gap Action Programme
MHIS	Management Health Information System
MHPSS	Mental Health and Psychosocial Support
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MTS	Medium-term Strategy
NCDs	Non-communicable Diseases
NCHRD	National Center for Human Resources Development
NGOs	Non-Governmental Organisations
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPV	Oral polio vaccine
PCC	Pre-conception care
PRCS	Palestine Red Crescent Society
PRS	Palestine refugees from Syria
PGDM	Postgraduate Diploma in Family Medicine
PHC	Primary Health Care
PNC	Post-natal care
PLD	Procurement and Logistic Division
QMS	Queuing Management System
RRB	Research Review Board
RSS	Relief & Social Services
SAP	Systems Applications and Products
SFD	Saudi Fund for Development
SSN	Senior staff nurse
SSNP	Social Safety Network Programme
ToT	Training of Trainers
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief & Works Agency for Palestine Refugees in the Near East
USG/PRM	United States Government by Bureau for Population, Refugees and Migration (PRM)
WDD	World diabetes day
WDF	World Diabetes Foundation
WHO	World Health Organization
WISN	Workload Indicators for Staffing Need
WLUs	Workload Units
WNTD	World no tobacco day
WPCs	Women Programme Centres

message of the unrwa commissioner general and of the who regional director

The COVID-19 pandemic touched every corner of the world, causing a drastic loss of life and economic opportunities and social disruption. The pandemic took a devastating toll on the most vulnerable populations, among them Palestine refugees, striking vulnerable people more harshly and accentuating pre-existing social vulnerabilities. COVID-19 plunged many Palestine refugees into abject poverty, making them more dependent on UNRWA essential services: health, education, as well as food and cash support.

In 2020, UNRWA had to confront both the pandemic and a drastic financial shortfall, while responding to anxious expectations for support by the Palestine refugees. UNRWA responded to the additional needs of Palestine refugees from the social and economic consequences of the COVID-19 pandemic, which led to a further cost to be borne by the Agency.

Yet UNRWA has maintained quality primary health care through 141 health centres across five fields of operation during the pandemic to ensure that Palestine refugees always continue to access primary health care. This effort has been greatly supported by the World Health Organization (WHO) partnership, one of the most enduring UN system partnerships.

UNRWA quickly introduced several preventive measures at its installations to align with guidelines from WHO and host authorities. Many health indicators were maintained compared to the pre-pandemic years. During the pandemic, non-communicable disease medications were delivered to patients' homes, pregnant women continued to receive antenatal and postnatal care, and family planning service continued. All these services were not interrupted thanks to the remarkable dedication of UNRWA staff.

Despite the current rapid rolling out of the vaccination programme, the risks and impact of COVID-19 will remain part of our lives until most of the world population is vaccinated. During these uncertain and unpredictable times, and as UNRWA operates in complex environments, it remains committed, together with WHO and other UN agencies and partners, to its mandate to provide protection and assistance to Palestine refugees. It is a commitment to upholding the human rights and dignity of Palestine refugees until there is a fair and lasting solution to their plight.

Mr. Philippe Lazzarini
UNRWA Commissioner General

Dr. Ahmed Al-Mandhari
Regional Director, WHO/EMRO

foreword of the director of health

The year 2020 was an exceptionally tough year for all UNRWA services, including health services, as the COVID-19 pandemic continued to spread across the world, affecting the most vulnerable populations significantly. Palestine refugees are among the most vulnerable, living in overcrowding camps and areas with insufficient sanitation facilities and constantly threatened by political instability, protracted conflicts, and blockades to access necessary services. The challenges and difficulties they faced in 2020 are imaginable.

In all UNRWA fields of operation, lockdown and other preventive measures were introduced to limit the transmission of COVID-19. During this time, UNRWA needed to continue providing primary health care to Palestine refugees to access health care and reduce indirect morbidity. UNRWA introduced new ways of operating services such as a triage system with full PPE, telemedicine, home delivery of life-saving medications. However, the purchase of personal protective equipment (PPE) and many other procurement issues were challenged initially due to the global shortage and transportation constraints caused by the closure of borders.

Despite all the challenges faced, Health Programme managed to continue providing health care, meeting the health needs of Palestine refugees. None of UNRWA health centres was closed, except in Jordan for a few weeks during the first strict lockdown. Types of services were reviewed and adjusted mainly targeted to urgent case, but maintaining most important essential life-saving services. While COVID-19 led to a steep decline in the number of medical consultations. Key indicators and outcomes were maintained in 2020.

COVID-19 did not let us stop what we planned and set as priorities. An e-NCD mobile application was launched in October 2020. The non-communicable diseases (NCD) burden resulting from sedentary lifestyles, smoking, and unhealthy diet has been a rising issue among Palestine refugees in the past decade. The application allows NCD patients registered at UNRWA health centres to access their electronic health records in real-time and be aware of their up-to-date health status. e-NCD also sends health awareness messages to remind patients healthy lifestyle. During the COVID-19 pandemic, the application was also utilized to send messages on preventive measures and health information to users.

This year, we would not be able to achieve such successes and changes we have introduced against all odds without dedicated UNRWA health staff who devoted their commitment and passion to the health of Palestine refugees. Front line health workers faced high risk of infection during their daily duty, however, they never stopped operations and continued providing care. I cannot express my appreciation and gratitude to my colleagues who are tirelessly working in Health Centers in all fields. I am confident that we will continue our progress in 2020 with unforeseeable future with COVID-19, to protect the right to health and the dignity of Palestine refugees.

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

executive summary and report overview

In 2020, despite the unprecedented challenges caused by COVID-19, UNRWA Health Programme (HP) continued to deliver comprehensive primary health care (PHC) services to Palestine refugees through its network of 140 Health Centres (HCs) in Jordan, Lebanon, Syria, West Bank and Gaza. Additionally, the Agency also supported the patients' access to secondary and tertiary health care services, including COVID-19 hospitalization. The total number of Palestine refugees who are eligible for UNRWA services reached 5.7 million in 2020, out of whom; about 48% are served at our HCs. The decline of refugees served at UNRWA HCs compared with 2019 is due to COVID-19 measures, including national lockdown and prioritizing health services available to control the footprint inside the HCs.

The Department of Health Annual Report 2020 highlights the health services provided to Palestine refugees during 1st January and 31st December 2020. It includes all relevant health indicators set out to achieve the Strategic Outcomes of the Agency's Medium-Term Strategy (MTS) 2016-2021. Strategic Outcome for health is "Refugees' Health is Protected, and the Disease Burden is Reduced".

The Annual Report also showcases achievements in the programmatic and resource mobilization targets set out in the MTS Common Monitoring Matrix (CMM).

Section 1 – Introduction and health profile

This section gives an overview of UNRWA, the Department of Health, and the current health situation of the Palestine refugees served by the Agency. The health profile contains demographic information, disease trends, the impact of COVID-19, the protracted and acute conflicts, and the occupation, in addition to UNRWA's responses to these situations.

Section 2 – UNRWA health response to COVID-19 pandemic

The unprecedented impact of COVID-19 challenged the ability of UNRWA to continue providing health care to Palestine refugees. In response to this, UNRWA has established timely preventive measures in Health centres to continue providing services. This section describes UNRWA's health response to COVID-19, adopting modality of service provision, innovative actions and preventive measures introduced during the pandemic. This section also provides a COVID-19 infection in host governments and Palestine refugees, collected through UNRWA fields offices.

Section 3 – Strategic Outcome 2: Refugees' health is protected, and the disease burden is reduced

This section highlights outcomes based on the MTS 2016-2021 set by UNRWA. The activities and achievements under all sub-programmes by the Department of Health are presented. These include the introduction of the mental health and psychosocial support (MHPSS), and the Family Health Team (FHT), outpatient care, non-communicable diseases (NCDs), communicable diseases, maternal health services, child health services, school health, oral health, physical rehabilitation and radiology services, disability care and pharmaceutical services. It also outlines information and data about inpatient care, outsourced hospital services, and crosscutting issues.

Section 4 – Data

Major health indicators are presented in four parts, followed by annexes. These include Agency-wide trends for selected indicators, CMM indicators 2016-2021, data tables from 2020, selected survey indicators, a list of published papers, and donor support to UNRWA health programmes.

UNRWA heath staff at Rimal Heath Centre in Gaza at the triage point checking the beneficiaries' temperature before entering the HC.
© 2020 UNRWA Photo by Khalil Adwan

section1–introduction and health strategic approach

UNRWA

The Agency's mission is to assist Palestine refugees in Jordan, Lebanon, Syria, Gaza and West Bank to achieve their full potential in human development, pending a just solution to their plight. The Agency's services encompass education, health care, relief and social services, camp infrastructure and improvement, microfinance and emergency assistance. UNRWA is funded almost entirely by voluntary contributions. UNRWA has its Headquarters (HQ) in Amman, Jordan, and Gaza, coordinating the five field offices' activities (FOs).

The Agency's health system has three tiers:

- The Department of Health (DH) at UNRWA HQ in Amman: handles policy and strategy development.
- Five Departments of Health at Field offices: concerned with operational management.
- 140 Health Centres: provide primary health care services directly to Palestine refugees.

The DH employs around 3,013 staff throughout the three tiers, including about 436 medical officers working in 140 HCs, 31 specialist doctors, 109 dental surgeons, 1,001 nurses, 591 paramedical staff and 838 auxiliary staff. Out of the some 5.7 million registered Palestine refugees, about 2.87 million Palestine refugees, the served population or beneficiaries, are registered at UNRWA HCs and receive health services free of charge. UNRWA does not operate its hospitals (except for one, Qalqilia Hospital, in West Bank), but instead, the Agency conducts a reimbursement scheme for its beneficiaries.

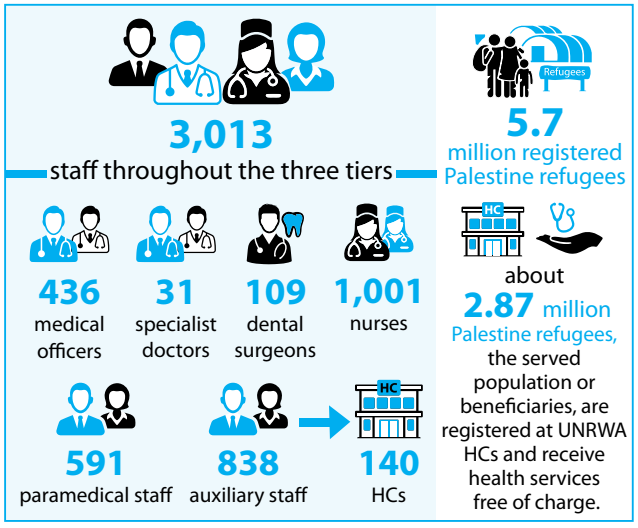


Figure 1: Distribution of the numbers of UNRWA registered Palestine refugee populations in the five fields of operations

Health profile

UNRWA has contributed to sizeable health gains for Palestine refugees since the beginning of its operations in 1950. UNRWA continues to provide quality health services to fulfil the health needs of Palestine refugees, and it strongly relies on partnerships with host countries and other stakeholders. The health needs of Palestine refugees have changed over the past decades; however, the Agency continued to evolve and improve its services. Today, it is estimated that 50.3% of served Palestine refugees remain highly dependent on UNRWA services. This suggests that more than half of the population still face great economic hardships, particularly those living in conflict areas, high unemployment rates and worsening poverty levels. Agency-wide, approximately 27.9% of registered Palestine refugees live in and around 58 official UNRWA camps, with most of the population living side-by-side among host countries' communities.

In 2020, the world faced the coronavirus disease (COVID-19) pandemic that caused significant loss of lives, affected well-being and disrupted health gains worldwide. This crisis has proved that no matter how prepared and strong the health system is, progress towards Sustainable Development Goals and Universal Health Coverage can be negatively impacted by a global health issue. We have realised that preparedness and response capacities are relevant than ever before, and health promotion and disease prevention had yet again proven their worth within the Agency's health services. During 2020, UNRWA health services have shown a declining trend in service delivery indicators due to the COVID-19 situation, related preventive measures such as triage, partial suspension of specific health services, mandatory lockdowns imposed by host authorities and other targeted action specific to UNRWA, including home delivery of medicine for NCD cases and introducing telemedicine service.

The same as for most of the populations worldwide, increasing life expectancy among Palestine refugees has resulted in an ageing population. However, high fertility rates have seen a marked increase in the youth population, with 30.0% of registered Palestine refugees currently below the age of 18 years-old. Maternal and child health care is a crucial focus of the Agency. Women of reproductive age have universal access to contraceptive (family planning) care, antenatal care, safer delivery care with referrals to and subsidies for hospital delivery, post-natal care and infant and child care (0-5 years old). In 2020, UNRWA provided family planning care for 176,574 women, 75,851 pregnancies and 426421 infants and children (0-5 years old). Although still relatively high, a slight reduction in the overall fertility rate has been recorded and stabilised overtime over the past few decades.

Triage point at the entrance of Baqaa Main health centre in Jordan. The nurse screens patients for high temperature and respiratory symptoms. *© UNRWA 2020 Photo by Dr Rabie Naqa*

Though significantly decreased, maternal mortality rates (MMR) and infant mortality rates (IMR) among Palestine refugees remain relatively high. Among Palestine refugees in Gaza, MMR has decreased from 23.4 per 100,000 live births in 2008 to 16.2 per 100,000 live births in 2019 (there is a need to conduct additional research to understand this decline in MMR in Gaza better). Moreover, the estimated IMR in Gaza has not declined since 2008. IMR had slightly increased from 20.2 per 1,000 live births in 2008 to 22.7 per 1,000 live births in 2015. The stagnation of IMR indicates that further efforts are needed to investigate causes for this stagnation and ways of addressing the potentially preventable causes among Palestine refugee children in Gaza. The socio-economic situation has deteriorated dramatically in the past decade following a blockade's imposition in 2007 by the Israeli government. It affected Gaza's health sector as hospitals continued to lack adequate physical infrastructure, drugs, supplies, and infection prevention materials[1].

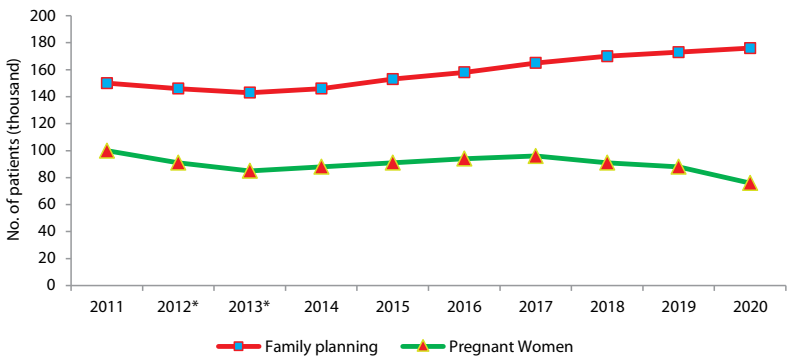


Figure 2: Total number of family planning and newly registered pregnant women
(*data not available from Syria)

[1] Maartje, M. et. al. (2018). Stalled decline in infant mortality among Palestine refugees in Gaza Strip since 2006. PLOS ONE, June 2018 ,13.

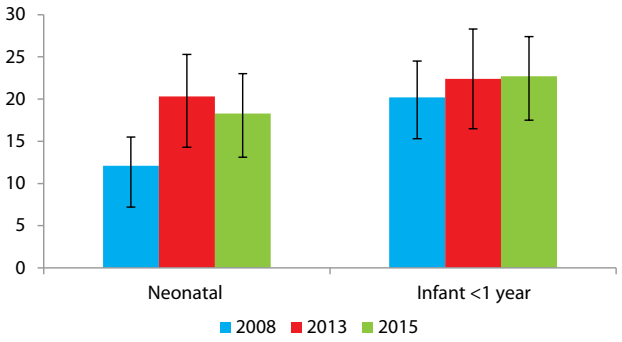
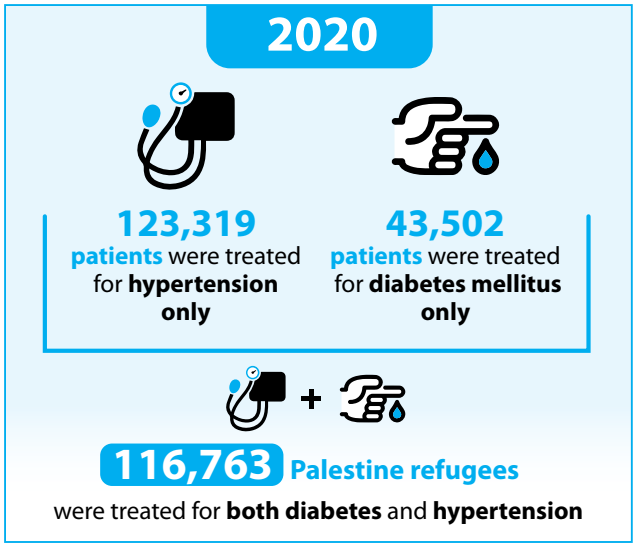


Figure 3: Mortality rate per 1000 live births among palestine refugees in gaza (Source: UNRWA surveys conducted in 2008, 2013 and 2015, with reference times of 2006, 2011 and 2013, respectively).

A reduction in communicable diseases incidence, combined with a longer life expectancy and lifestyle modifications, has led to a change in refugees' morbidity profile. Cardiovascular diseases, chronic respiratory diseases, diabetes mellitus, hypertension and cancer are today's leading non-communicable diseases (NCDs) among Palestine refugees, representing the highest financial burdens on UNRWA health services. In 2020, 123,319 patients were treated for hypertension, 43,502 patients were treated for diabetes mellitus, and 116,763 Palestine refugees were treated for diabetes and hypertension. The significant risk factors for NCDs among the Palestine refugee population include sedentary lifestyles, obesity, unhealthy diets and smoking.



To target NCDs, UNRWA applies a strategy that focuses on three dimensions: the first one is disease surveillance that consists of collecting, analysing and interpreting health-related data on NCDs and their determinants. Second, health promotion and prevention interventions combat NCD major risk factors or determinants among Palestine refugees across their life cycle. The third is the provision of cost-effective interventions for the management of established NCDs. In 2019, UNRWA HD invested in developing NCD mobile application to contribute to health promotion efforts and help ensure compliance to follow-up check-up and health advice for NCD patients.

Multi-decade provision of health services to Palestine refugees has primarily enabled the control of communicable diseases, mainly through high vaccination coverage and early detection and management of outbreaks. Communicable diseases related to personal hygiene and poor environmental sanitation are also almost entirely eradicated. Nevertheless, food insecurity and the burden of micronutrient deficiencies remain prominent risk factors for Palestine refugees' diseases, especially since we are now in the middle of the COVID-19 pandemic.

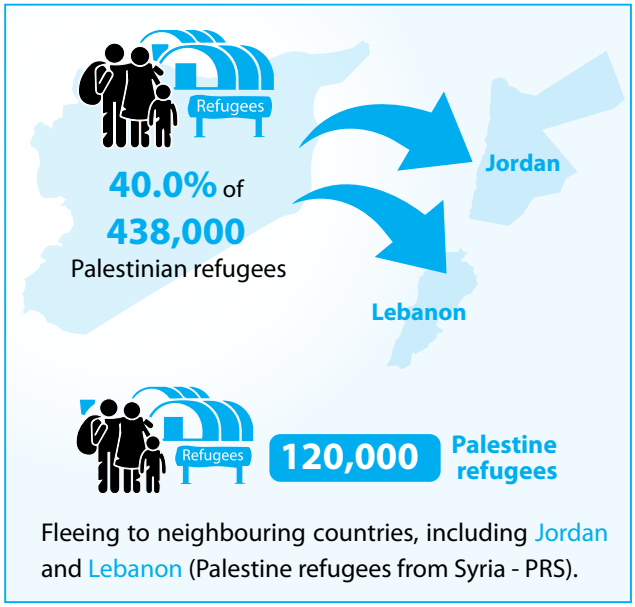
Ongoing protracted and acute conflicts, occupation, and the lack of a just and durable solution for Palestine refugees' status and added burden of COVID-19 continue to affect the population's physical, social and mental health. Assessment, diagnosis and treatment of mental health and psychosocial-related disorders show that their

UNRWA nurse testing the blood pressure for a Palestine refugee inside Beddawi health centre in Lebanon. *© 2020 UNRWA photo by Maysoun Mustafa*

A doctor at Baqaa Main health centre in Jordan offering medical consultation for a Palestine refugee amidst the COVID–19 pandemic. *© UNRWA 2020 Photo by Dr Rabie Naqa*

prevalence is increasing throughout the fields of UNRWA operations. As a result, UNRWA has implemented an MHPSS programme in all five fields, aiming to identify and address mental illnesses, particularly in the Gaza field. MHPSS services are heavily integrated into UNRWA primary health care services and work towards ensuring that all Palestine refugees enjoy the highest attainable health level. In 2020, HD successfully integrated MHPSS in all 140 health centres across five fields of operations.

The Syrian crisis has entered its tenth year and has seen 40.0% of 438,000 Palestinian refugees residing in Syria internally displaced and more than 120,000 Palestine refugees fleeing to neighbouring countries, including Jordan and Lebanon (Palestine refugees from Syria - PRS). Being doubly displaced, PRS are often identified as highly vulnerable and more reliant on UNRWA services. Despite the ongoing conflict, UNRWA has restored and strengthened its operations in Syria, including rehabilitation of damaged health centres and reinstatement of the provision of health services in previously largely inaccessible areas. The protracted blockade and recurrent emergencies in Gaza and West Bank's occupation remain significant obstacles to the ongoing provision of services and access to health care for Palestine refugees residing in these fields. In 2020, Lebanon saw continued political protests, increasing financial crisis, August 2020 blast, political turmoil and COVID-19, making matters worse and posing challenges to delivering services in terms of restricted travel, roadblocks, prices hikes and access to UNRWA HCs. UNRWA continued



Fleeing to neighbouring countries, including Jordan and Lebanon (Palestine refugees from Syria - PRS).

providing services in all field of operations despite the challenges mentioned above.

The Family Health Team (FHT) model has been rolled out in health centres Agency-wide to continue to adapt to the changing needs of Palestine refugees and improve the quality of healthcare. FHT model focuses on improving the quality of medical consultations, especially for NCDs. It also includes providing staff with training on family health approaches, providing MHPSS services, engaging the community in health prevention and promotion activities and improving hospitalization support to ensure financial protection for the most vulnerable. UNRWA will continue to strengthen the health information system, e-Health, improve the FHT primary healthcare model, and will implement the new norm at all health centres across all five fields.

section 2 – UNRWA's health response to COVID-19

UNRWA's health response to COVID-19

COVID-19 is by far the most significant shock to UNRWA health services and, equally, if not, more importantly, the immense shock to Palestine refugee communities. COVID-19 affected all aspects of health services, from the continuity of primary health care services to the continuity of the provisioning process of medicines. COVID-19 also affected Palestine refugees profoundly while they were already vulnerable and impoverished before the COVID-19 pandemic. In this regard, it is remarkable that UNRWA managed to continue providing primary health care in 2020 without stoppage of any critical services. The data showed below indicate the negative impact of the COVID-19 pandemic and the resilience of UNRWA health services.

COVID-19 came to the UNRWA fields of operation in March 2020, starting from Jordan on 2 March 2020) and eventually expanding to all five operations (lastly was Syria by 23 March 2020). In 2020, 643,485 cases and 7,533 deaths were reported from the four host countries (Jordan, Lebanon, Palestine and Syria) combined; of them, 35,023 cases and 415 deaths were reported among Palestine refugees. The number of confirmed cases had increased dramatically in all fields. Deteriorations of the epidemiological situation are expected to continue in 2021. Many more Palestine refugees are suffering from the consequences of lockdown and health measures that were put in place to control the virus›s spread. Palestine refugees were already a vulnerable population before the COVID-19 pandemic, and the pandemic has aggravated the existing poverty and vulnerability.

COVID-19 situation in host countries as of 31 December 2020

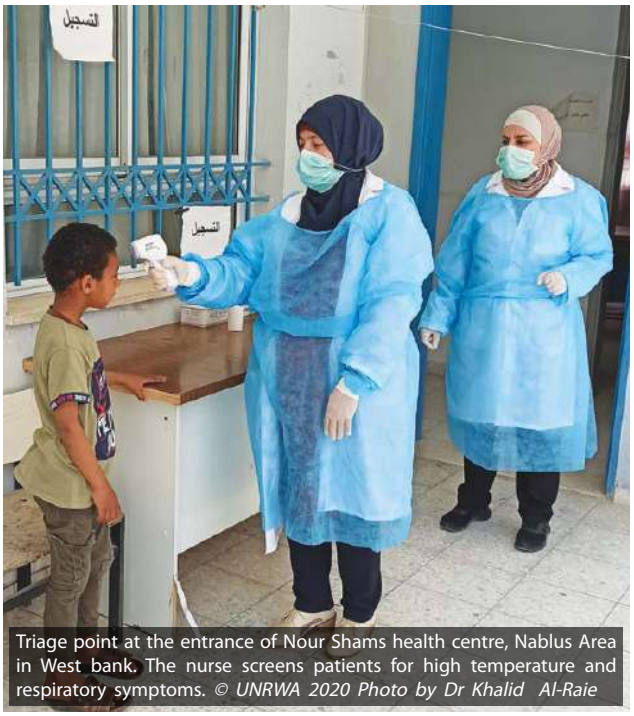
There were 643,485 COVID-19 cases reported in the five fields of UNRWA operations (Jordan, Lebanon, Syria, Gaza and the West Bank, including East Jerusalem). Jordan reported 294,494 cases and 3,834 deaths, with a spike of cases in November 2020. Lebanon reported 181,503 cases and 1,455 deaths, with the first case reported on 21st February 2020. In Syria, there were 11,434 cases and 711 deaths in 2020. Gaza reported 41,264 cases and 375 deaths, with the first case reported on 22nd March 2020. While first community transmission was reported much later, the worsening situation placed severe pressure on an overstretched health system. West Bank reported 114,790 cases and 1,158 deaths with spikes of confirmed cases several times in a year. There have been challenges in accessing testing throughout the year in all fields,

Table 1: Number of COVID-19 cases reported in host countries- 2020

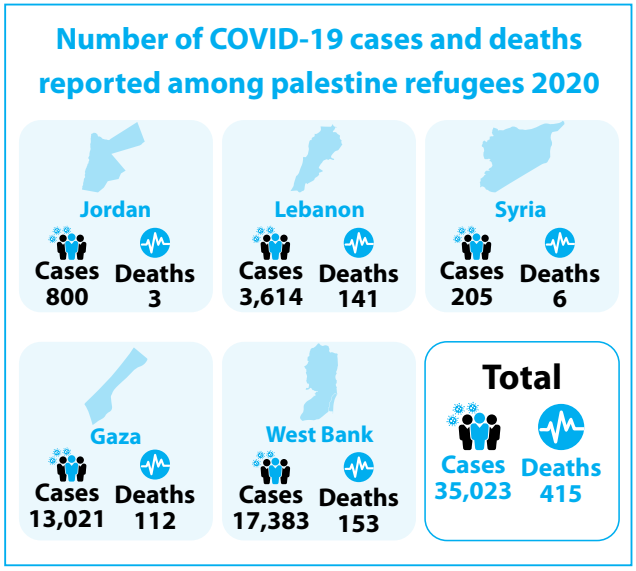
UNRWA fields of operations	Number of cases	Number of deaths
Jordan	294,494	3,834
Lebanon	181,503	1,455
Syria	11,434	711
Gaza	41,264	375
WB (including East Jerusalem)	114,790	1,158
Total	643,485	7,533

COVID-19 situation among palestine refugees as of 31st december 2020

Among Palestine refugees, there were a total of 35,023 and 153 COVID-19 cases and deaths, respectively reported in 2020. There were some challenges in collecting data on Palestine refugees due to the unavailability of segregated data in Jordan and Syria's difficult access to testing. Thus, these numbers represent underreporting. The figures of Jordan are mainly obtained through UNRWA camp officers.



Triage point at the entrance of Nour Shams health centre, Nablus Area in West bank. The nurse screens patients for high temperature and respiratory symptoms. *© UNRWA 2020 Photo by Dr Khalid Al-Raie*



Jordan reported 800 cases and three deaths. Lebanon reported 3,614 cases and 141 deaths, Syria reported 205 cases and six deaths, Gaza reported 13,021 cases and 112 death. Finally, the West Bank has the most significant number of cases among Palestine refugees and reported 17,383 cases and 153 deaths. These numbers include UNRWA staff who are part of refugee communities.

Table 2 : Number of COVID-19 cases reported among palestine refugees- 2020

UNRWA fields of operations	Number of cases	Number of deaths
Jordan	800	3
Lebanon	3,614	141
Syria	205	6
Gaza	13,021	112
WB (including East Jerusalem)	17,383	153
Total	35,023	415

UNRWA health services in 2020 under COVID-19 pandemic

In all of the Agency's fields of operations, the COVID-19 pandemic placed additional strain on an already overstretched and fragile health system. the Agency's effort to respond to the pandemic is a continuous process to mitigate the cases that will affect the overall health system and reduce the socio-economic consequences resulting from the pandemic. UNRWA coordinated and worked together with host governments since the beginning of the pandemic. UNRWA response is crucial to the public health system in the five fields of the Agency's operations. It will continue to align its response to the national plans of the host countries' authorities. COVID-19 response across the five fields prioritises continuity of primary health care and protection of Palestine refugees.

In all UNRWA fields of operation, the epidemiological situation has been different. There have been immense challenges in containing the virus's spread due to the pre-existing humanitarian crisis and socio-economic hardship. From the beginning of the COVID-19 pandemic, the UNRWA Health Programme has been balancing between the demands of responding to COVID-19, and simultaneously maintaining primary health care service deliveries, mitigating the risk of morbidities from a preventable and treatable condition. For many Palestine refugees, UNRWA Health centres are the only health care system they can access free of charge.

UNRWA maintained life-saving primary health care services for Palestine refugees by taking the following preventive measures:

- Home delivery of life-saving medicines directly by UNRWA health staff or volunteers from the local community or both to almost 170,000 patients with NCDs in 2020. Patients received their needs of NCDs medicines of up to 2 to 3 months, ensuring that they are equipped with adequate medicine quantities during the lockdowns. Flexibility to hand such medications to patients' close relative was also practised avoiding possible exposure to COVID-19 infection to NCD patients.

- Establishment of a triage system in all Health centres, screen patients with high temperature and respiratory symptoms, and minimise contact with staff and others visiting H/Cs for other services.

- Telemedicine via telephone hotlines reduced patients' visits to the health centres by providing them with medical advice and relevant information remotely. The total number of medical consultations dropped by 34.0% compared with those in 2019 Agency-wide.

- Urgent cases identified through the hotlines were still able to access the health centres, such as for urgent outpatient care, antenatal care for high-risk pregnancy, family planning services except for IUD insertion for some time, post-natal care, and child health services, mainly immunization and others.

- Provision of Personal Protective Equipment (PPE); masks, gloves, gowns, protective eye goggles and face shields have been procured and distributed to almost 3,000 health service providers.

- On line meetings (on weekly basis at the start then on biweekly) involving senior staff in all fields and HQ to follow on updates and exchange experiences and ensure relevant recommendations reflected in practice. The Department of Health conducted 33 COVID-19 meetings in 2020.

Reflection of UNRWA health services under COVID-19 pandemic with data

Maintaining essential primary health care and focusing on the most vulnerable

While lockdown and restrictive measurement imposed across the fields, UNRWA maintained primary health care to Palestine refugees by taking several preventive measures and focusing on emergency and high-risk group patients. The total number of medical consultations in 2020 declined by 34.0%, and the total was 5.7 million compared with 8.7 million medical consultations in 2019. Among essential services, UNRWA continued to keep providing family planning services except for IUD. Family planning users stayed almost the same compared with 2019, with a slight increase of 2.0%.

Quality of care during COVID-19 pandemic

As a result of the reduction in physical visits during the lockdowns and social restrictions, the average consultation time per doctor increased by 10%, from 3 minutes in 2019 to 3.3 minutes in 2020, which could be due to decreased numbers of outpatient visits that allowed Medical Officers to have more time with patients, who. Patients are more likely to be satisfied with longer contact and consultation time with health workers. During the pandemic, a total of 325,811 telemedicine calls were received in all five fields except Lebanon. Telemedicine was introduced to enable patients to continue to have access to medical consultations remotely.

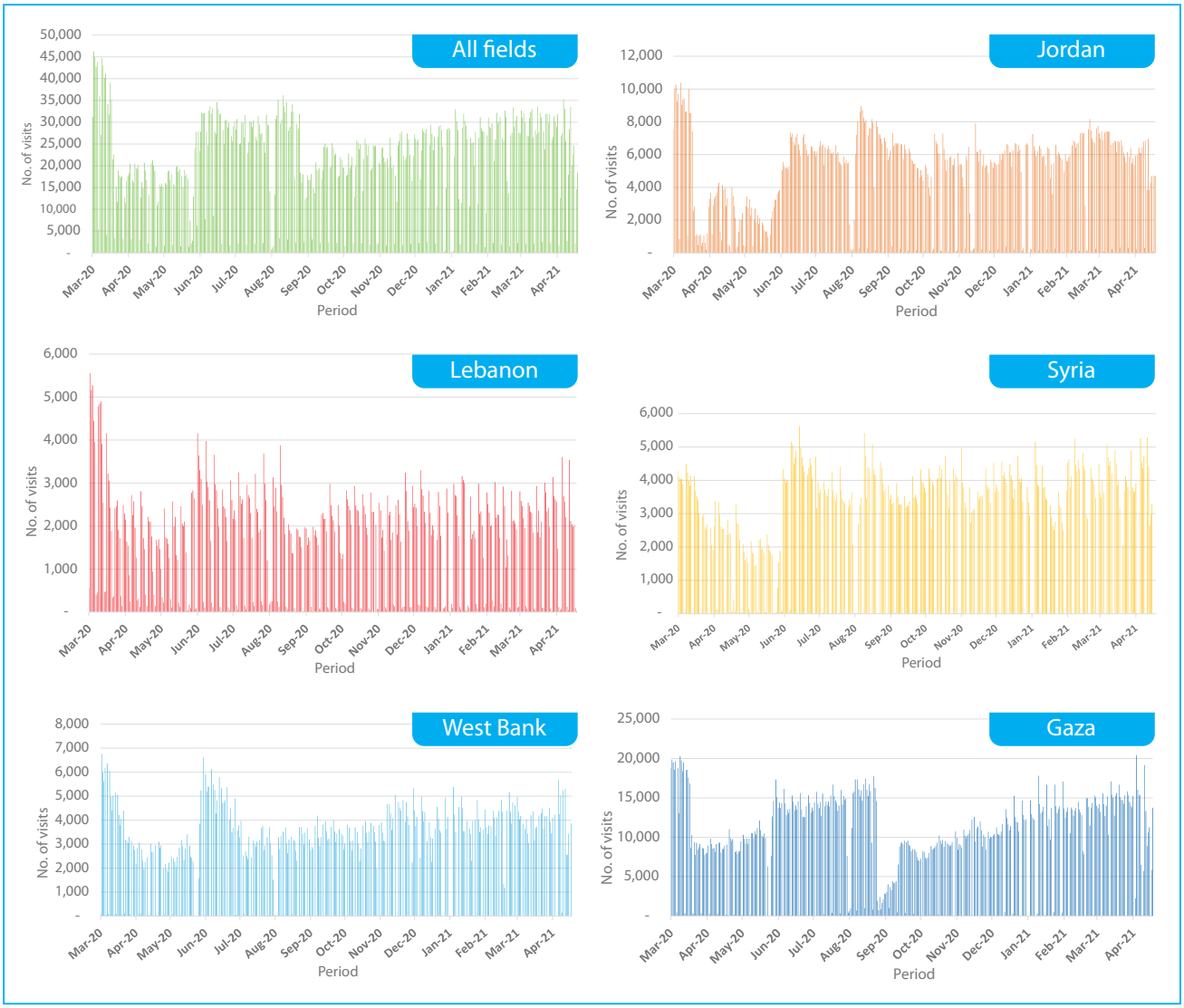
Even during the challenging time of the COVID-19 pandemic, UNRWA managed to maintain several important indicators to the health outcomes of Palestine refugees. The percentage of diabetes mellitus patients under control stayed approximately the same (40.0% in 2019 and 38.7% in 2020). The percentage of women with a live birth who received at least 4 antenatal care (ANC) visits were slightly declined but maintained 75.5% in 2020, compared with 87.0% in 2019.

Since the COVID-19 crisis was declared a global public health threat by WHO, the Agency has focused on reducing the number of in-person visits to the health centres to reduce the risk of potential COVID-19 transmission without compromising the quality of the critical lifesaving primary health care services.

Using its e-Health data for monitoring, the Health Programme continued since 1 March 2020 to monitor the overall number of medical consultations across all services at each health centre in each field. Besides, it observed the number of medical consultations per service type. In general, and as might be expected, there was continuous fluctuations in the number of visits to the health centres. The main reasons for these fluctuations include the recurrent closure of UNRWA health centres during nationwide lockdowns, besides the decisions taken by the UNRWA Health Programme to cope with the epidemiological situation in each field by prioritizing the delivery of specific services based on the situation there. Field-specific individual indicators are available for further analysis by the Health Programme management. The figures on the next page represent the number of visits to UNRWA health centres for all fields and each field during the period from 1 March 2020 until 18 April 2021.

A dentist at Maen health centre in Gaza while offering service to a Palestine refugee child. *© UNRWA 2020 Photo by Dr Khaled Al-Raie*

number of visits to UNRWA health centres (total and by field) during the period from 1 March 2020 to 18 April 2021



Communication with communities: risk communication and community engagemen

Effective Risk Communication and Community Engagement (RCCE) is a critical component to increase compliance with preventive measures to control the spread of COVID-19 with communities. COVID-19 has been a significant global health crisis and is now an information crisis as well. UNRWA actively engaged Palestine refugee communities to provide correct information and raise awareness on preventive public health measures (mask-wearing, hand hygiene, physical distancing, cough etiquette etc.). Also, communication and responsibilities of individuals to protect them and their own family and communities.

Out of 58 official Palestine refugee camps, 49 camps were reached with RCCE activities with health messages across all fields of UNRWA operations, except in Syria. In the camps, community volunteers with UNRWA staff carried out awareness-raising activities. Reflet with information about COVID-19 has been produced and distributed to refugee communities. Other tools, such as TV screen in health centres and hotlines, were also utilised to inform correct information about COVID-19 and preventive measures. Due to Syria's prevailing security situation, the method was adjusted by conducting structured awareness sessions at each health centre, two times a month, in addition to telemedicine hotlines. Social media have also been used to reach wider communities and to post messages on preventive measures.

COVID-19 among UNRWA staff

UNRWA staff, especially those working in the frontlines, particularly health staff who contact patients, and the most valuable resource for UNRWA. This is why the

first actions were taken since WHO recognized the COVID-19 pandemic was to ensure their protection. UNRWA provided all standard Personal Protection Equipment (PPE) and sterilising materials with all equipment used by its staff in all installations. The main challenges faced were the lack of enough funds to purchase and the scarcity of such materials with proper specifications in the local markets due to the enormous demand that appeared suddenly for them by all the concerned. The first challenge was dealt with via flash appeals that were raised at the agency and fields' levels. The other challenge was dealt with via quick actions taken by different UNRWA departments in cooperation with the procurement and logistic staff to make the purchase quickly. Moreover, a comprehensive communications campaign was initiated and many health education and health awareness materials and messages were developed and distributed to educate staff and Palestine refugees about the disease and the preventive measures to be taken. Moreover, health staff in all fields received comprehensive training about COVID-19 disease, and many guidelines were developed and used to deal with the situation.

Being part of the communities in the host countries, unfortunately, until 22 April 2021, the Agency reported 4,811 confirmed cases of COVID-19 among UNRWA staff from all the programmes in the five (males 41.7%, females 58.3%), most of them were 40-49 years, followed by 30-39 years, then 50-59 years. Until that date, 4,327 completed their recovery. Sadly, by 22 April 2021, 23 UNRWA staff in the five fields lost their lives due to their COVID-19 condition.

Challenges

UNRWA provides direct primary health services to Palestine refugees through 140 health centres. These health centres are the first line of the response to the pandemic, and health workers running them are exposed to the risk of being infected with the COVID-19 virus. Other frontline workers such as sanitation workers, cash and food distribution workers, social workers and teachers are also at increased risk of exposure to the infection in community transmission phases. In 2020, 2,280 UNRWA staff were infected; of those, 305 (13.0%) were health staff. Strengthening the Infection Prevention Control (IPC) level at UNRWA health centres was critical to protect both front line health workers and Palestine refugees.

UNRWA doctor on duty in Sheikh Radwan health centre in Gaza treating refugees during the COVID-19 pandemic. *© 2020 UNRWA Photo by Mohammad El Hennawi*

During the pandemic's initial phase, the timely procurement of adequate PPE supplies was a big challenge due to the global shortage. Grant support from the Government of Japan and WHO solidarity fund and in-kind donation of PPE from the Government of China enabled UNRWA to secure adequate PPE supplies.

Rapidly changing epidemiological profile, changing national preventive measures, and the unknown ending of the pandemic caused fatigue among staff. Adherence to safety measures (mask-wearing, social distancing, cough etiquette etc.) and other IPC measures in health setting was a priority. UNRWA conducted IPC training targeting health workers of five fields with technical support from WHO/EMRO. The training was first delivered online in the Jordan field for 241 health workers, 49 health-centre cleaners, and 220 non-health workers. The IPC training enabled UNRWA staff to reaffirm and recapped the importance of IPC measures both at work and outside of work. Other fields will also be part of this training in 2021.

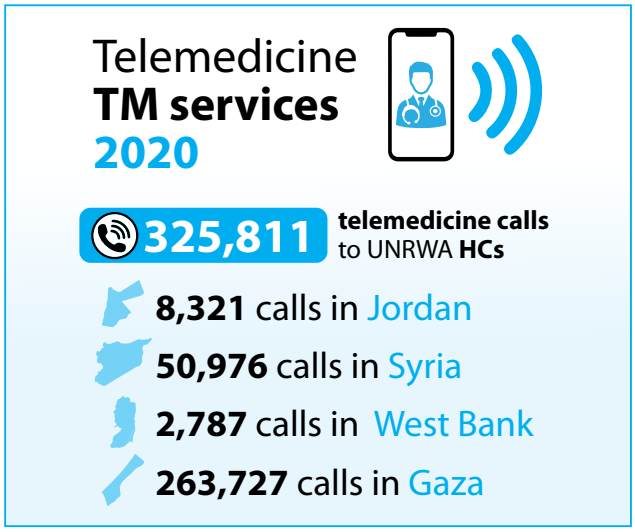
UNRWA doctor examining a patient in Beddawi camp health centre, Lebanon. Due to the spreading of the COVID–19 virus, she is wearing complete personal protective equipment (PPE). *©2020 UNRWA photo by Maysoun Mustafa*

In 2021, UNRWA will strive to ensure UNRWA staff's safety and that of Palestine refugees during the pandemic times by adopting service delivery modalities. This includes the expansion and systematisation of telemedicine services, continuity of triage systems, and flexibility in service delivery changes depending on each host country's epidemiological situation.

At the time of writing in March 2021, the number of COVID-19 cases has drastically increased in all UNRWA fields of operation, reaching the high level of community transmission and influencing all aspects of UNRWA work. It is expected that the COVID-19 pandemic will remain with us in the foreseeable future, even though the vaccination programme started, and UNRWA is committed to implementing the necessary measures to coexist with the virus while minimising the risk of transmission.

Telemedicine services

In 2020, the UNRWA Department of Health was faced with a dilemma of ensuring the continued provision of health services, maintaining patients and health providers safety, and avoiding unnecessary exposure of high-risk patients to COVID-19. The Agency's highly committed front line health workers and field management introduced the telemedicine service that constituted mobile phones or dedicated hotlines served patients remotely using voice calls to address this challenging situation. This solution for a remote medical encounter became an efficient solution for safe patient care during the COVID-19 pandemic. It allowed patients immediate access to UNRWA health services without the need for an in-person visit. UNRWA successfully piloted a time-sensitive, practical and effective scale-up of this intervention in four out of five fields of operations: Gaza, West Bank, Jordan and Syria. During 2020, patients made 325,811 telemedicine calls to UNRWA HCs, following the establishment of medical hotlines at the beginning of the pandemic. These included 8,321 calls in Jordan, 50,976 in Syria, 2,787 in the West Bank and 263,727 in Gaza[2]. E-health platform played a significant role in ensuring telemedicine consultations are accounted for and are recorded in the system. The phone log, consultations, refill functionalities were updated in the existing OPD module, and a uniform guideline on e-Health for telemedicine consultation and home delivery of medicines was circulated among all staff to ensure uniformity of approach standardized reporting. As this solution can minimise the risk of COVID-19 transmission, preventing any sort of direct physical contact, ensuring continuity of care to the Palestine refugees, the Agency has decided to continue with telemedicine services in the future. Department of Health is now adapting a revised standard operating procedure for telemedicine in 2021 and beyond. It will also undertake a review of resources needed for the effective incorporation of telemedicine into mainstream service provision.




A nurse at Jerash health centre in Jordan using a telephone line to contact patients as part of the telemedicine service during the COVID–19 pandemic. *© 2020 UNRWA Photo by Dr Rabie Naqa*


By telemedicine service, staff at Nuseirat health centre communicate with Palestine refugee patients about delivering their medicines to their homes. *© 2020 UNRWA Photo by Mohamed El Hennawi*

[2] Please note that telemedicine hotlines were not created in Lebanon.

Field innovations

Jordan

From the onset of the pandemic, UNRWA Health Programme in Jordan has responded to the emergency by adapting its operational modalities to the crisis, guaranteeing service continuity while protecting the refugee community's safety, health, and well-being. On 17th March, the Government of Jordan activated several measures to contain the spread of COVID-19, including the imposition of a curfew, closure of many business and public offices, and restriction of movements. The complete lockdown extended from 17th March till 5th May 2020, during which UNRWA HCs were closed in line with the measures imposed by the Jordanian authorities to limit the spread of the virus. The provision of healthcare services was limited to government authorities by rescuing emergency cases through civil defence and the Ministry of Health.

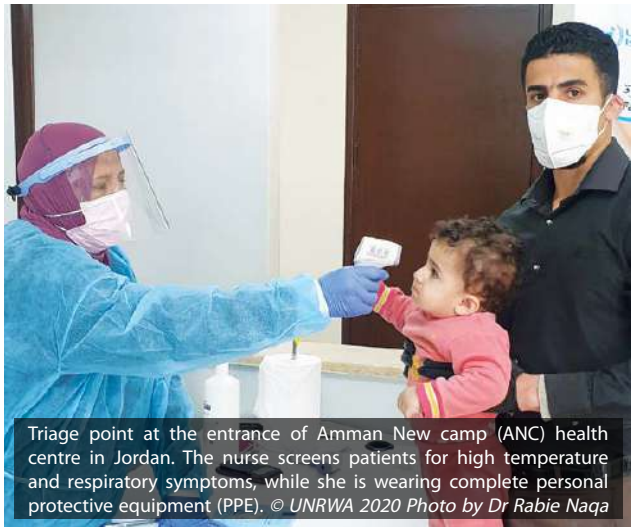
We hold a huge responsibility for our client's health during all conditions. Meeting patients' needs during lockdown was our Nobel mission. In Jordan, the UNRWA Health Programme initiated the NCD medication delivery to patients' homes, exploring all possible resources inside and outside the Agency. Despite the enormous challenges faced in the working environment during the pandemic and the lockdown with severe movement restriction, Health teams in Jordan were able to create a volunteer matrix from inside and outside camps. Doctors from the whole country also volunteered to participate in this activity to move freely during the lockdown. With UNRWA HQ's support, the data for all NCD patients was extracted from the e-Health system, categorised into priorities according to their risk factors and illnesses.

Also, pregnant women and mentally ill patients were considered a priority. Health staff who could not move during the lockdowns took the responsibility of contacting the patients to confirm their addresses and later to do post-delivery checking. Those who were granted movement permits came to the clinics, packed the medications and made proper arrangements with the distribution volunteers. UNRWA staff from other departments contributed much to this process as they were residing adjacent to the clinics. A total of 74,798 Palestine refugee patients received two-month essential NCD medication packages at their doorstep, including 722 Palestine refugees from Syria.

Community volunteers at Amman New Camp (ANC) in Jordan supported the ANC health centre staff in distributing medicines to the homes of patients with non-communicable diseases. *© UNRWA 2020 Photo by Dr Mustafa Ammoura*

On gradual easing of the closure measures, the health services were dynamically adapted according to the epidemiological status. The process was reviewed and evaluated systematically, with proper modifications implemented accordingly.

The health team at Amman New Camp (ANC) health centre in Jordan just finished packing the medicine for distribution to the homes of patients with non-communicable diseases by community volunteers. *© UNRWA 2020 Photo by Dr Mustafa Ammoura*



Triage point at the entrance of Amman New camp (ANC) health centre in Jordan. The nurse screens patients for high temperature and respiratory symptoms, while she is wearing complete personal protective equipment (PPE). *© UNRWA 2020 Photo by Dr Rabie Naqa*

Eventually, outpatient services were partially resumed in June-2020 in line with the MoH instructions and extreme reservations. Though IPC was crucial in this stage, we recorded many cases of infection among our health staff (about 20.0% of the total staff), most of which were sourced from outside the working environment as the country entered the community spread stage. UNRWA HCs performed 60% of their usual workload during Q4 mainly because of the pandemic and its implications on service provision in terms of patients' attendance and prioritisation of services. This decrease in the outpatient consultations was generalised across the whole country and in all health providing sectors.

Late in 2020, telemedicine was introduced to serve refugees in their homes to the best extent. This service proved to be a valuable investment, and JFO is working in parallel with all concerned stakeholders to upgrade it with a robust and sustainable infrastructure to meet the operational requirements of refugees UNRWA remains an active member of the National Health Development Forum and its four working groups (Coordination and Planning, Risk Communication, Technical support for COVID-19 Management, and Procurement) that bring together all health partners in Jordan of MoH response to COVID-19.

Lebanon

Due to the COVID-19 pandemic's eruption, a strategic decision was taken by Lebanon Field Office (LFO) leadership that no Palestine refugee patient is left alone without treatment and that UNRWA will coordinate within the country response plan to COVID-19. Hospitalization contracts were signed with hospitals announced by the Ministry of Public Health (MoPH) in the five areas capable of providing COVID-19 infection treatment. Additionally, UNRWA was the first to rehabilitate two buildings in the Siblin training centre to become an isolation centre for COVID-19 mild and suspected cases. Moreover, two other premises; a school in the Ein Hilwa camp and one abandoned Palestinian Red Cross Society (PRCS) hospital in El Buss camp. These were rehabilitated to become isolation centres that can be functioning upon need. However, only Siblin is operational for the year 2020.

The Health Programme has faced challenges during the containment of the COVID-19 outbreak and ensuring resources to do this vast task sustainably.

For example, the health staff must be protected physically and mentally to serve the beneficiaries and to be able to offer them health awareness and health education. It was critical to implement the standard preventive measures to provide essential and basic health services to the Palestine refugees since UNRWA is the first resort for Palestine refugees in Lebanon. The lesson learned from the pandemic COVID-19 is that the health staff (medical and the paramedical) are the most precious element in all of the health system delivery of services. All of the work will be plans on papers, with no improvement in the people's lives. The Health Programme at LFO could secure PPEs to HCs' staff throughout the year, hoping for sustainable supplies arriving from UNRWA HQ through the flash appeal funds. Also, staff care was done through peer support groups remotely and over the phone with the psychologist participation when needed for individual counselling. The triage system was supported by physical renovation work at the health centre premises to separate the pathway of patients coming with

UNRWA staff In Tyre Area in Lebanon provides cleaning and sanitization to UNRWA facilities, including this health centre. *© 2020 UNRWA photo by Maysoun Mustafa*

A doctor while examining a newborn baby at NBC health centre in Lebanon. Due to the carnivorous epidemic, he adheres to preventive safety standards. *©2020 UNRWA photo by Maysoun Mustafa*

respiratory symptoms from those who do not, therefore making the potential to transmit the virus among health centres' visitors limited to the minimum possible.

On community awareness and risk communication, UNRWA Health Programme led a Health Coordination Group composed of main partners and NGOs working on delivering services to the Palestine refugee communities to complement and coordinate the COVID-19 response and serve the refugees better. This group met biweekly to discuss and agree on resource distribution and who is doing what, when and where, and lobbying to address the Lebanese Palestinian Dialogue Committee (LPDC) for their support.

Syria

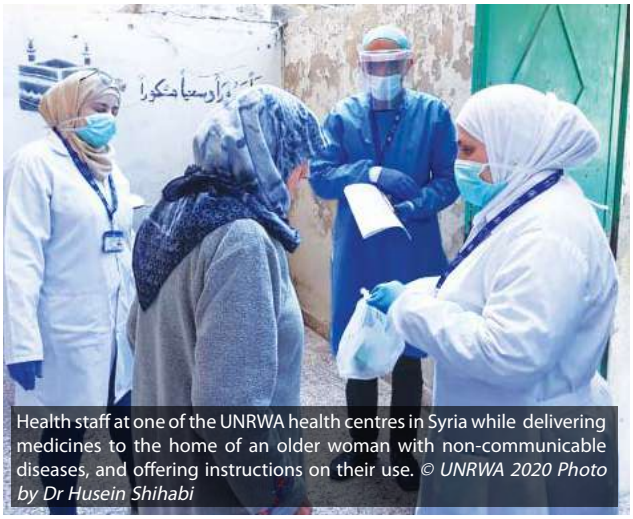
During the COVID-19 pandemic, and as an essential part of Syria's health sector, UNRWA has played a vital role in controlling COVID-19 transmission. UNRWA insisted on continuing to provide its services, including food and cash assistance, education, health services, and adapted and invented several mechanisms to provide these services and to control COVID-19 transmission at the same time. Below are two examples of innovation done in the health care centres to adjust to the COVID-19 pandemic:

- Reporting and tracking system for COVID-19 patients and suspected cases.
- Since the pandemic was new to the world, WHO and UNRWA HQ issued instructions concerning tracking and reporting the confirmed cases based on the situation and the virus's behaviour. Before receiving the WHO instructions for reporting and monitoring the COVID-19 confirmed cases, the UNRWA Health Programme in Syria created its tracking and reporting system. This system allowed to contain and follow the COVID-19 suspected and confirmed cases. Using this system may have helped reduce the transmission of COVID-19 to the Palestine refugees and UNRWA staff.
- Infection control majors in the health care centres.

COVID-19 infection control management was not an easy task in Syria UNRWA health care centres, especially that few of these centres are rented clinics (residential houses) and not built as health centres. Creating the physical distance between patients themselves and health care staff needed much to be done, especially with the limited space. Health centres staff installed transparent plastic barriers on the pharmacies and clerks' windows. They also posted signs and made marks on the floor and seats to encourage patients to keep physical distancing when standing and sitting in the health centre. These actions were first implemented in Khanelsheh health centre, and then we shared this experience with all other health centres.

The health staff is offering an awareness session for the patients about COVID–19 in the waiting area at Deraa health centre in Syria. *© UNRWA 2020 Photo by Dr Husein Shihabi*


Amidst the COVID-19 crisis, UNRWA continued to provide health services to Palestine refugees in Syria. The pharmacist at one of the UNRWA health centres dispenses medicines to patients with preventive measures. *© UNRWA 2020 Photo by Dr Husein Shihabi*


Health staff at one of the UNRWA health centres in Syria while delivering medicines to the home of an older woman with non-communicable diseases, and offering instructions on their use. *© UNRWA 2020 Photo by Dr Husein Shihabi*

Gaza

Telemedicine

By the end of January 2020, the WHO declared COVID-19 a public health emergency of international concern; later on, a pandemic was declared. This challenge to health care systems across the world necessitated the implementation of innovations to continue providing the services and avoid any fallback on what has been achieved over the past few decades in health care, mainly primary health care. Gaza Health Programme (GHP) was one of the pioneers in responding to this pandemic to minimise patients' footprints inside the health centres, decrease the number of non-urgent visits, and ultimately reduce the transmission of COVID-19. To deal with these issues, the idea of providing telemedicine appeared.

Following the WHO's broad guidelines as one of the main principles that have to be strictly maintained in all phases of the COVID-19 response, telemedicine was implemented on 8 April 2020 in all UNRWA health centres in Gaza. The overall aim of telemedicine modality was to ensure the smooth running of health services provision and respond to the most urgent health needs during the pandemic. HP had to ensure the availability of all needed resources, toll-free lines, other logistical needs like networking, computers, headphones, and the most critical human resources. Doing this for the first time is the real challenge. One of the Palestinian societies in Canada conducted virtual training for UNRWA medical officers to increase their awareness of this service type.

Gaza HP developed the first version of the Standard Operating Procedures on telemedicine (SOPs). It included guidance for medical officers on how to respond to phone calls and the needs addressed by Palestine refugees, document the e-Health system's service, manage cases through the toll-free lines, and what community awareness messages to send in addition to other issues. In addition to the above, the SOPs included an Operational Plan for curative services via a toll-free UNRWA Medical Consultation line.

Monitoring the daily reports of the incoming calls and response rate by health centre has shown the community's progressive acceptance of these services. Additionally, it has helped determine the need for upgrading the system to respond to the high calling rates and the high response rates achieved by the end of the year. The number of calls has progressively jumped from 8,500 calls in April 2020 to reach approximately 117,000 phone calls. This indicated a high degree of acceptance of this service by Palestine refugees and telemedicine's efficiency to decrease the number of patients physically attending the health centres. Based on that, HP decided to integrate this new modality into the health service during the post-COVID-19 time, as this could be one of the innovations that will change the future of UNRWA health services.

The increase in the number of calls could have never been achieved without the measures taken to upgrade the system through increasing the number of channels for the incoming calls, besides the actions taken by Gaza HP to secure the needed logistics. Despite all of the challenges faced, telemedicine was successfully implemented in Gaza. It has played an essential role in controlling the outbreak and maintaining the service provision, particularly during the complete lockdown.

Health staff from Shaboura health centre in Rafah, Gaza, deliver the prescribed medicines to the homes of older people and those with non-communicable diseases. *© UNRWA 2020 Photo by Khalil Adwan*

Health staff from Shaboura health centre in Rafah, Gaza, deliver the prescribed medicines and provide instructions for their use to one of the older people. *© 2020 UNRWA Photo by Khalil Adwan*

One of the quotes by UNRWA medical officers providing telemedicine: *"Telemedicine is a new innovative service that the HP at UNRWA in Gaza implemented to support Palestine refugees and protect them from the current COVID-19 disease. Through this service, many visitors to our health centres were protected and were offered the best services, and they were directed in the right way to get high-quality health service."*

Using unrwa schools near to the health centre as triage centres for patients with respiratory symptoms

The global outbreak of COVID-19 puts further pressure on the already overstretched health system in Gaza, which is still suffering from the Great March of Return (GMR) injuries. Years of the blockade and movement restrictions on people and materials, including medical supplies, have led to a severe deterioration in the availability and quality of health services in Gaza; hospitals continued to lack adequate physical infrastructure, drugs, supplies and infection prevention materials.

As one of the world's most densely populated areas, the outbreak of COVID-19 could be disastrous to the 1.9 million Gaza inhabitants, especially with the current fragile and exhausted public health system. Should there be community transmission cases in such a densely packed area of high poverty, the prognosis is grim.

On 18 March, HP started implementing its emergency plan as a response to the COVID-19 pandemic. The HP opened 22 Medical Points (18 at UNRWA schools and four inside the HCs) to manage cases with respiratory symptoms after triage and separation at the HC main gate to minimise patients' exposure to the possibly infected patients and as a measure of infection prevention and control.

The medical points at both the nearby schools and the HCs were equipped with the needed telephone and internet networks, waste management, etc. According to WHO guidelines, all health staff working at the HCs and the triage centres were well equipped with personal protection equipment.

The health centres medical officers managed and referred suspected cases, according to WHO definition, to the MoH to be evaluated and tested accordingly. By implementing the triage, the Gaza HP reduced the enormous usual crowd at the HCs, which should not be accepted at health facilities dealing with a high number of patients, many of whom are vulnerable to COVID-19.

Utilising the closed UNRWA schools because of COVID-19 as medical points to treat the separated respiratory cases was a very successful and vital step that released the situation and made it more practical to deal with that epidemic. UNRWA HP stakeholders in Gaza, especially the MoH, appreciated this measure and copied the experience and implemented it at their health installations.

Health Staff at Nusierat health centre in Gaza answering phone calls via the hotlines that were activated in all UNRWA health centres to facilitate communicating with patients. *© 2020 UNRWA Photo by Hussein Jaber*

Triage point at one of the schools nearby UNRWA health centre in Gaza. The nurse screens patients for high temperature and respiratory symptoms. *© UNRWA 2020 Photo by Khalil Adwan*

West Bank

Operational planning guidelines platform to support preparedness and response to combat COVID-19 pandemic

UNRWA, as an Agency in general and the Health Programme (HP) in particular, has successfully kept supporting Palestine refugee's needs, despite tremendous operational and financial challenges during the COVID-19 crisis.

UNRWA HP at West Bank (WB) is considered one of the significant healthcare providers to the Palestine refugees, representing 37.0% of the Palestine population. Throughout the COVID-19 pandemic, the HP played a crucial role at the high level of leadership in planning and managing the COVID-19 response. This included the development of the Emergency Preparedness Plan, which was consistent with the working principle in emergencies: prepare, prevent, detect and respond. UNRWA HP cooperated with all stakeholders and proactively responded to this public health crisis to guarantee the undisrupted provision of essential services to Palestine refugees.

In the COVID-19 pandemic, all the Occupied Palestinian Territory (oPt) was put under precautionary measures imposed as preventive measures to prevent the spread of the COVID-19 Infection. The COVID-19 emergency has increased pressure on an already overburdened health system, amplifying the challenges of the UNRWA health system.

UNRWA HP developed a comprehensive strategy to guide the provision of health services and ensure serving the health and well-being of the Palestine refugee population, in addition to preventing the spread and transmission of the COVID-19 infection. The first step was to track the procurement, delivery and distribution of critical medical supplies, including the Personal Protective Equipment (PPE) and medical supplies for Infection Prevention and Control (IPC).

To minimise the number of patients travelling to health centres, health centres' staff delivered essential medications to NCD patients' homes and conducted home visits to the most vulnerable cases among Palestine refugees.

In addition to all essential health services provided, including the Reproductive Health (RH) and Child Health Care (CHC) services with the full schedule of Expanded Programme of Immunization (EPI), and since March 2020, a triage system which was implemented at all 43 health centres. To guarantee the safety, protection and security of health staff, a rotation system was applied to ensure ongoing health services by support teams. The HP introduced telemedicine into UNRWA health services through telephone hotlines to provide counselling to Palestine refugees and answer their questions. The Agency's HP response continuity and the need for a steady supply of PPE and medical supplies to all health workers increased the volume of medical wastes and the need to clean and disinfect health centres. Additional health workers and cleaning staff were recruited to ensure continuity of services. Moreover, the UNRWA HP coordinated with the Ministry of Health as a host country authority to manage COVID-19 cases among Palestine refugees in their designated hospital free of charge based on the country's public health rules.

The health team at Arroub health centre in West bank just finished packing the medicines for distribution to the homes of patients with non-communicable diseases. *© UNRWA 2020 Photo by Dr Khaled Al-Raie*

Patients gathering at the waiting area to be served at Bethlehem health centre in West Bank, where physical distancing and other preventive measure are taken. *© UNRWA 2020 Photo by Dr Khaled Al-Raie*

section 3: strategic outcome 2: refugees' health is protected and the disease burden is reduced

Output 2.1: people centred primary health care system using the Family Health Team (fht) model

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

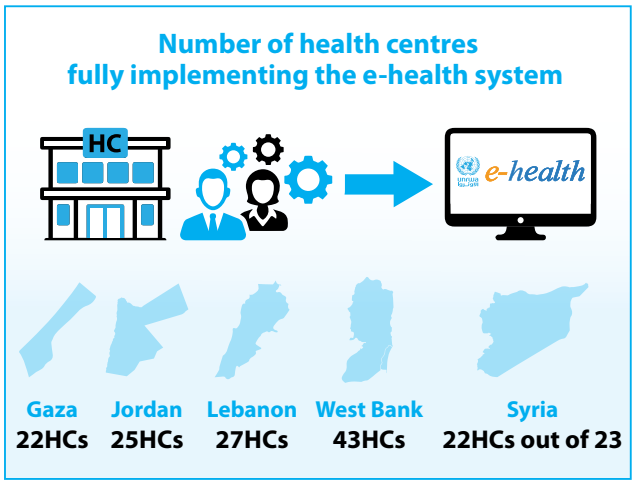
FHT model and the e-health (electronic health records) system

The Family Health Team (FHT) approach represents a system of delivering PHC through a multidisciplinary team of health professionals who work together to serve a defined population's comprehensive health needs across the life cycle and in a community setting close to the client. FHT approach design aims to improve the quality, efficiency, and effectiveness of health services.

Each FHT is composed of a doctor, nurses, and other health workers. The FHTs work together and are responsible for providing health services for the families who registered with them.

In 2020, the performance of the family health team's approach was affected by the precautionary and preventive measures taken by the Department of Health to mitigate the spread of the Coronavirus in most health centres in the fields. The UNRWA Health Programme has taken various steps to ensure health services provision in the safest way to protect its staff and beneficiaries.

Despite the extraordinary challenges, UNRWA has continued providing PHC services and has successfully kept supporting Palestine refugees in need. The PHC centres continued delivering essential health services to refugees through implementing Triage system in all the clinics to segregate patients complaining from respiratory like symptoms and the others, including curative care to acute conditions, vaccination to children, maternal health care, NCD medication.



The e-Health system, introduced in 2009, has streamlined service provision and improved efficiency and enabled high-quality data collection. In 2020, e-Health was upgraded to cope with the new requirements of the COVID-19 pandemic. It was operational in all HCs in Gaza (22 HCs), Jordan (25 HCs), Lebanon (27 HCs) and West Bank (43 HCs), and some HCs in Syria (22 HCs out of 23). E-Health implementation in Syria is challenged due to the ongoing conflict and the resulting connectivity issues in some areas. Further expansion of e-Health in Syria is expected in 2021, contingent upon security, infrastructure and connectivity, allowing the expansion.

Table 3: Number of health centres fully implementing the e-health system

Field	2017	2018	2019	2020
Jordan	20	25	25	25
Lebanon	27	27	27	27
Syria	3	11	20	22
Gaza	22	22	22	22
West Bank	42	43	43	43
Agency	114	128	137	139

The e-Health system has been further developed in collaboration with WHO to include mainly revision 11 of the International Classifications of Diseases (ICD-11). This development aims to strengthen and streamline the operations at the service delivery level

that are supported by e-Health. Currently, the system is operational across 98.0% of all UNRWA HCs. The full implementation of e-Health will improve patient care quality by swift access to medical records, improved appointment system, and better patient flow. Besides, it will support physical distancing, strengthen supervision of health services, and enhance monitoring and reporting capabilities. Ultimately, by 2021, the system will reduce staff workloads and result in better patient care.

The Mother and Child Health mobile application "e-MCH App" has been used by around 180 thousand mothers in all fields, allowing registered Palestine refugee mothers to view their electronic health records and those of their children on their smartphones. E-MCH App notifies mothers about their appointments and provides additional health advice according to their health status and their children's age. Also, a new NCD mobile application, "e-NCD App", has been officially launched for patients suffering from NCDs, not only for UNRWA NCD patients but for non-UNRWA NCD patients, as well. It provides the users with a self-assessment and monitoring tool for their health. E-NCD App enables UNRWA NCD patients to access their electronic health records, notifies patients about their appointments and medications, in addition to providing health information and education according to their health status and risk factors.

Outpatient care

UNRWA provides comprehensive primary health care (PHC) through a network of 140 health centres, of which 68 (48.6%) are located inside Palestine refugee camps. Besides, UNRWA operates six mobile health clinics in West Bank to facilitate access to health care in those areas affected by closures, checkpoints, and the barrier and two mobile clinics in Syria to cover minor refugees' gatherings and not easy to reach areas.

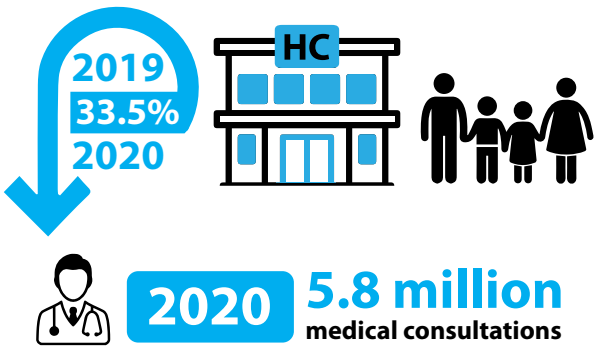
The Agency's outpatient health services have been affected by COVID-19 pandemic. The host countries' took preventive measures against COVID-19, including imposing curfews, restricting movement, and closing public and private health centres, including UNRWA health centres. These measures have affected patients' access to health centres. Moreover, UNRWA also took preventive measures against COVID-19 and introduced several crowd-control measures like triage, appointment, and telemedicine. All the above actions led to a decrease in the number of medical consultations.

At the same time, UNRWA developed a comprehensive emergency response plan to ensure the uninterrupted provision of services. One primary way was implementing a "Triage system" in all health centres to identify COVID-19 suspects among outpatient visitors and segregate them from curative care to acute conditions, vaccination to children, maternal health care, NCD medication, emergency oral health, and laboratory services. This is for the protection, safety, and health of staff and refugees community as well.

Besides, the provision of health services using telemedicine through the hotlines played a significant role in assisting the Health Programme to provide its services professionally and safely.

Utilization

The utilization of outpatient services Agency-wide in 2020 decreased by 33.5% compared to 2019, with a total of approximately 5.8 million medical consultations. This reduction is due to the situation and interventions mentioned above. Of these consultations, 69,271 were specialist consultations (including those offered by gynaecologists/ obstetricians and cardiologists). All fields showed a decrease in utilization, with an apparent variation among them.



69,271
medical consultations
were **specialist consultations**
(including those offered by
gynaecologists/ obstetricians and cardiologists).

Table 4: Number of medical consultations, agency-wide in 2020

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
2019	1,695,966	881,064	804,542	4,215,247	1,126,299	8,723,118
2020	1,127,805	556,511	672,008	2,683,834	758,746	5,798,904
Variance %	- 33.5%	- 36.8%	- 13.3%	- 36.3%	- 32.6%	- 33.5%

Table 5: Total number of first and repeat visits, and the ratio of repeat to first visits, agency-wide in 2020

Field	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Total first visits	364,487	156,979	163,179	751,843	240,312	1,676,800
Total repeat visits	741,773	385,060	503,262	1,906,238	516,500	4,052,833
Ratio of repeat to first visits	2.0	2.5	3.1	2.5	2.1	2.4

There are two groups of outpatient medical consultations at UNRWA health centres: first visits and repeat visits. First visits re-flect the number of persons attending a health centre during a calendar year, while repeat visits measure service utilization frequency.

The ratio of repeat visits to first visits decreased from 3.2 in 2019 to 2.4 in 2020, with slight variation among fields and between health centres in the same field. The interpretation of this ratio within and between fields reflects that patients have access to other health care providers, and the effect of the COVID-19 situation had on reducing patients' visits to the health centres. It is higher in health centres located inside camps where people can easily reach services and in the fields with limited access to other health care providers – like Gaza, Syria, and Lebanon.

Workload

Agency-wide, the average number of medical consultations per doctor per day was affected by the precautionary and preventive measures taken. The daily workload has decreased significantly across the five fields in 2020 compared to 2019, mainly du to the consequences of the COVID-19 pandimic.

West Bank reported the highest workload with 63.6 medical consultations per doctor per day and the lowest in Lebanon with 50.8 consultations per doctor per day.

Despite the variation throughout the fields, the FHT approach has helped reduce the overall workload on medical officers and PHC services. This reduction has been achieved mainly by shifting some preventive tasks from medical officers to nurses, like offering nurses the authority to approve monthly refills of medicines for controlled NCD patients. Besides, the ed in an evenly distributed workload for all health staff at these HCs. Moreover, individualised care provided through the FHT approach and the provision of health services using telemedicine through the hotlines played a significant role in reducing the workload.

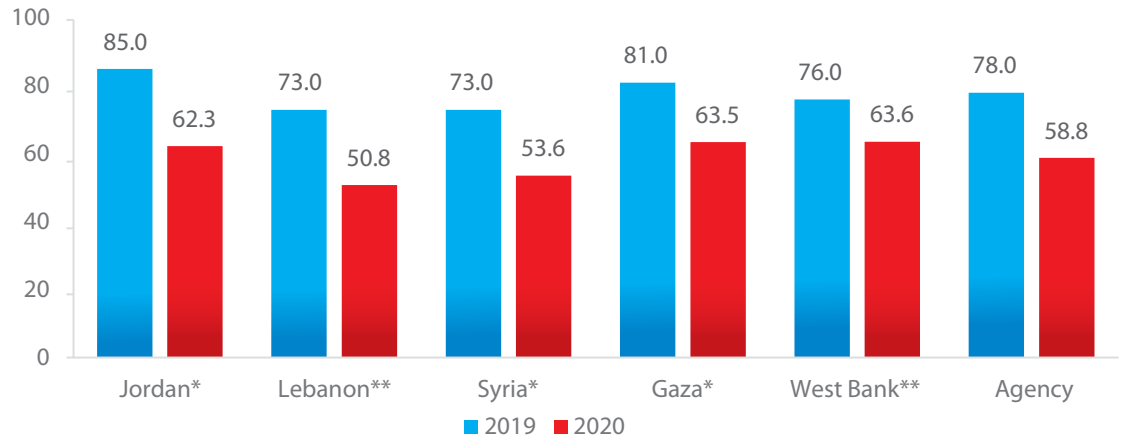


Figure 4: Average daily medical consultations per doctor in 2019 and 2020

(*HCs open for six days/week, **HCs available for five days/week)

Non-communicable diseases (ncds)

The burden of ncds

Despite the challenging year and COVID-19 pandemic, the number of patients with NCDs registered at UNRWA HCs continued to increase during 2020. By the end of the year, a total of 283,584 Palestine refugee patients with diabetes mellitus, or hypertension, or both were registered at UNRWA NCD services at all HCs across the five fields of UNRWA operations. The Agency-wide prevalence rates of diabetes mellitus and hypertension were higher than in 2019; it was 16.5% versus 14.9% in 2019 for diabetes and 24.3% compared to 21.8% for hypertension among those above 40 years old. The prevalence of diabetes in patients 18 years and older was higher (8.2% versus 7.4%) in 2019 and was 12.4% for hypertension. This increase may be due to the decrease in the served population reported in this report and, on the other side, the increase in cases detected and registered at UNRWA HCs. Age group disaggregation showed that patients 40 years of age and older represented 90.9% of all patients under UNRWA NCD care in 2020. The percentage of males was at 40%, compared to 60% of females, which reflects the continued demand and attendance of both females and males to UNRWA NCD clinics.

Risk scoring

A risk assessment system that UNRWA HCs use is a tool to assess the risk status of NCD patients and to help staff on the management of the condition of every patient with NCDs. The system evaluates the presence of modifiable risk factors such as smoking, hyperlipidemia, physical inactivity, blood pressure, blood sugar, in addition to non-modifiable risk factors such as age and family history concerning the disease. In 2020, patients registered with the NCD programme at all UNRWA HCs were assessed using the risk scoring assessment system. The data was recorded in their electronic health records in the e-Health system. The risk scoring assessment of all NCD revealed that 37.4% were at high risk on average, which is higher than in 2019, at 34.0%, mainly related to the deterioration of some variables specifically increased Body Mass Index, obesity rate showed 47.4%. The percentage of patients at moderate risk was 51.4%, and those with low risk were only 11.2%.

Treatment

The UNRWA Department of Department of Health distributed the updated guidelines for NCDs to all Fields

Table 6: Patients with diabetes mellitus, or hypertension or both by field and by type of morbidity

Morbidity type	Jordan	Lebanon*	Syria	Gaza	West Bank	Agency
Type II diabetes mellitus	1,148	300	451	1,551	644	4,094
Hypertension	11,704	3,400	3,652	14,265	6,387	39,408
Diabetes mellitus hypertension	30,342	13,971	18,190	45,864	14,952	123,319
Total	35,633	11,427	12,816	36,693	20,194	116,763
Type II diabetes mellitus	78,827	29,098	35,109	98,373	42,177	283,584

* PRS included

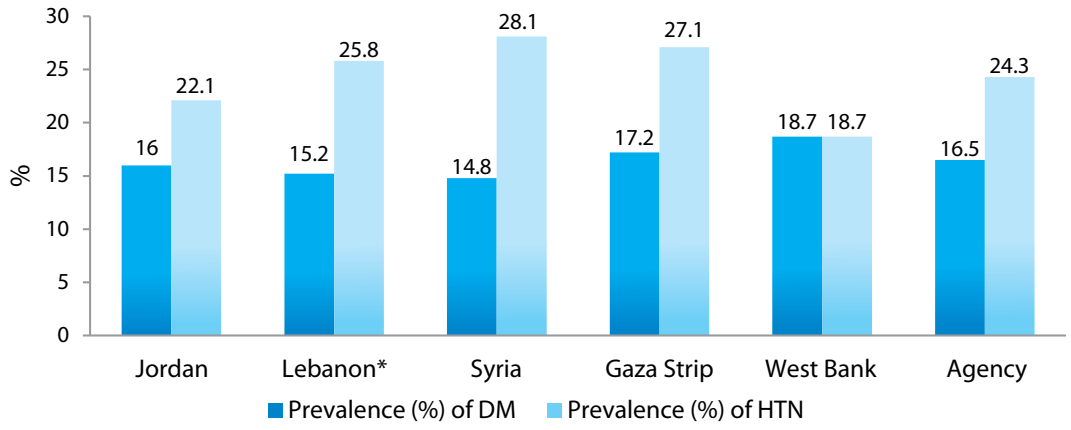
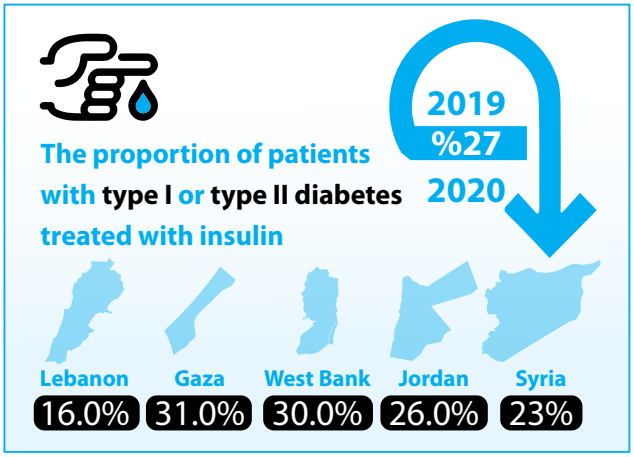


Figure 5: Prevalence (%) of patients diagnosed as Type I and Type II diabetes mellitus and hypertension among served population ≥40 years of age, 2020
(* PRS included)

in 2019 and conducted training of trainers (ToTs) for concerned staff in most Fields in 2020. However, due to the COVID-19 pandemic, face-to-face training was not possible and was replaced by online training in some fields. There was great emphasis on using treatment protocols based on WHO evidence-based guidelines during the training activities.

The proportion of patients with type I or type II diabetes treated with insulin as part of the management of their condition also varied among fields, with an average of 27% Agency-wide, which is the same in 2019. This proportion ranged from 16.0% in Lebanon to 31.0% in Gaza, 30.0% in the West Bank, 26.0% in Jordan and 23.0% in Syria. The low rate of insulin prescription in Lebanon compared to the other fields needs assessment. Uncontrolled patients on a maximum dose of oral hypoglycaemic drugs must be enrolled in combination therapy or total insulin treatment.



Late complications

Late complications of NCDs include cardiovascular diseases (myocardial infarction, or congestive heart failure, or both), cerebrovascular disease (stroke), end-stage renal failure (ESRF), above-ankle amputation and blindness. Agency-wide, the late complications rate in 2020 was 10.4%, which is almost similar to that in 2019 (10.4%), while the highest rate was in Syria (12.9%) and the lowest rate was in Lebanon (6.6%).

As projected, patients with both diabetes mellitus and hypertension had the highest incidence of late complications (14.4%), followed by patients with hypertension only (7.9%) and patients with diabetes mellitus type 2 only (5.6%). There were some differences in the distribution of late complications of diseases between the fields. These variations are due to different doctors' treatment and possible variation in recording the complications in patients' files and subsequently reporting.

Defaulters

UNRWA Health Programme defines "Defaulters" as patients who did not attend to the HCs to get NCD care for one calendar year, neither for follow-up nor for collecting medicines (in person or via relatives for those unable to travel to the health centre). During 2020, and due to COVID-19 pandemic, reaching patients faced more challenges. This outreach problem resulted in the increased numbers of defaulters who miss follow-up appointments. Health staff used many different means, including possible home visits (with more precautionary and safety measures to avoid possible infection with COVID-19), telephone calls and notifications via family members. Despite using these means, the Agency-wide rate of defaulter NCD patients increased from 7.0% in 2019 to 7.2% during 2020. The field-specific defaulter rate ranged from 4.3 % in Lebanon to 11.8 % in Jordan. Jordan›s defaulter rate was still the highest. It increased from 7.0% in 2019 to 7.2% in 2020. According to the Jordan Field feedback, it is due to the availability of more than one healthcare provider in the country and possible dissatisfaction among some patients and the prevailing COVID-19 that needed management at Field and HC levels.

Case fatality

The mortality rate among NCD patients registered at the Agency's HCs showed a similar rate as of 2019 at 1.4%. In 2020, a total of 3,812 of the Agency's NCD patients died, mainly due to COVID-19 and to the

A nurse from one of the UNRWA health centres in West Bank conducts a follow-up visit to one of the disabled, elderly patients registered at her health centre and delivering to him his medicines. *© UNRWA 2020 Photo by Dr Khaled Al-Raie*

UNRWA nurse testing the blood pressure for a Palestine refugee with a non-communicable disease at Beddawi health centre in Lebanon while adhering to the preventive safety standards. *© 2020 UNRWA Photo by Maysoun Mustafa*

The Agency's innovative e-NCD mobile phone application developed and launched for the use by Palestine refugee patients with and without non-communicable diseases. *© UNRWA 2020 Designed by Balkees Akhobrash*

complications related to the chronic conditions that these patients had. The field-specific death rate was the highest in Gaza at 1.7% (1,591). This rate is mainly attributed to the two factors mentioned before: the lack of advanced hospitalization services and the availability of few intensive care units.

The way forward for ncd care

Despite all measures and projects supporting UNRWA NCD care for the last ten years, the burden of such conditions and their complications increases. UNRWA is strengthening its primary prevention approach through health education and raising awareness of risk factors among Palestine refugees and staff about diabetes mellitus and hypertension. In the future, the Department of Health will focus on a continuous update of its technical guidelines and essential lists of NCD medications to adhere to the new guidelines recommended by WHO and adopted globally.

The use of an e-Health-based cohort monitoring system helps to monitor NCD care in UNRWA HCs. It enables comprehensive follow-up of NCD care, including incidence, prevalence, treatment compliance, and patients' control status. One innovative action introduced the e-NCD application in 2020 as a new tool to improve self-care for the patients and monitor overall health status. Another tool is Power PI and related dashboards under development to better understand and identify both achievements and weaknesses to ensure implementing corrective actions.

UNRWA will continue cooperation with ministries of health in hosting countries, UN organisations, NGOs and diabetes associations for technical support and exchange of experiences and seek funding of related projects and activities. This cooperation aims to scale up diabetes and hypertension care provided to Palestine refugees. In 2020, all fields continued implementing the project supported by World Diabetes Foundation (WDF). In the Jordan Field, a project for diabetic foot care also continued and included training medical officers and nurses and providing related equipment for early diagnosis and better care of patients' feet.

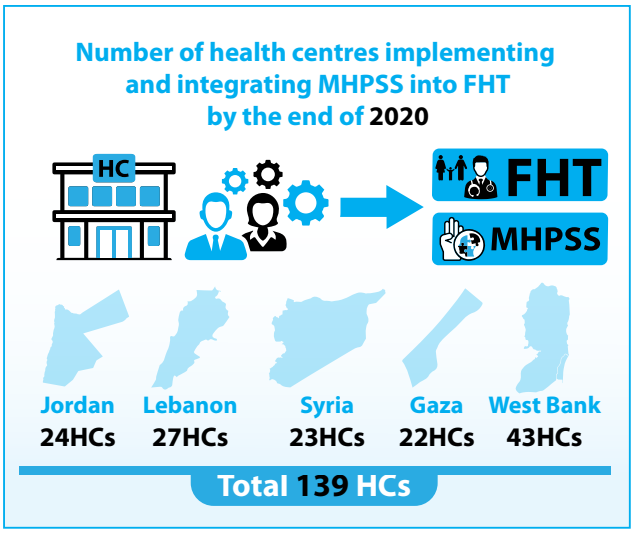
As evidence is accumulating, it is hoped that after the COVID-19 pandemic time, the impact of long COVID-19, or acute post-COVID-19 syndrome complications would be minimal given that most of them are chronic.

Integrating Mental Health and Psychosocial (mhpss) programme into unrwa primary health care (phc) system

UNRWA aims to protect and promote the mental health of Palestine refugees through its MHPSS program that became implemented in almost all Health Centres (HCs) Agency-wide during 2020. Recent studies and reports from fields during the last three years have confirmed a high prevalence of mental health problems and psychological distress among Palestine refugees. Well-structured integrated services to address these problems were previously lacking in UNRWA HCs.

MHPSS programmes seek to address and enhance individuals and their communities' psychological well-being and empowering the community and individual resilience. Implemented in coordination with the Family Health Team (FHT) approach, MHPSS programme implementation consisted of providing training for all URNWA health staff as the basis for the next steps. MHPSS and WHO's

mental health Global Action Programme (mhGAP) training is offered comprehensively to medical officers, senior staff nurses and midwives. It is also provided to all other health staff categories based on their roles at their HCs. MHPSS is being integrated based on a three-year plan into all UNRWA HCs supported by the Japanese government's generous donation. MHPSS was integrated into 139 HCs, (please see table below), and this includes all health centres in each of Gaza, West Bank, and Lebanon. Only one health centre in Jordan still to start the implementation; due to the ongoing COVID-19 pandemic, this could not happen in 2020. Health staff received MHPSS training based on their roles. Medical officers and senior staff nurses, and midwives received comprehensive two-week training on MHPSS and mhGAP. Practical nurses received one-week MHPSS training, and other support and paramedical staff received at least one day of orientation training.



Technical instructions based on WHO and scientifically sound resources were developed as reference and guidance to staff during the implementation.

Moreover, in 2019, UNRWA introduced a management health information system (MHIS), digital information management and assessment tool to facilitate the reporting of MHPSS indicators used in 2020 and helped staff build indicators accordingly.

As the MHPSS/mhGAP in UNRWA HCs covers treatment within FHT, UNRWA medical officers can refer patients with more severe mental health issues to Psychosocial Counsellors available in some HCs/fields or to external specialists (psychiatrists) contracted by the Agency or both. Such referral needs sustainability and more specialist care backing in coming years for what UNRWA is seeking additional funds and support mainly for Lebanon and Syria Fields.

In 2020, many challenges appeared due to the COVID-19 pandemic, despite which health staff managed to reach those in need either through visits to health centres, telemedicine, and using other available means of communications; from the other side, on-the-job training was possible virtually most of the year. Health staff managed to screen 50,810 persons out of which 10,838 were identified as positive according to WHO standard questionnaire used in UNRWA (21% detection rate), in other words, almost one out of five needs psychological or mental health assistance, care and follow up. The above figures were nearly double from that in 2019 with but similar detection rate (98,401 screened and 21,981 were identified as positive).

Table 7: Total number of health centres implementing and integrating MHPSS into FHT by the end of 2020

Field	Number
Jordan	24
Lebanon	27
Syria	23
Gaza	22
West Bank	43
Total	139

At Rafah health centre in Gaza, and as an initiative to appreciate the efforts of the health staff there, gifts (bunches of roses) were distributed to each of these heroes as a gesture of appreciation and as a part of staff wellbeing efforts. *© UNRWA 2020 Photo by Khalil Adwan*

UNRWA doctor examining a patient at one of the health centres in Syria. Due to the spreading of the COVID–19 virus, he is wearing complete personal protective equipment (PPE). *©2020 UNRWA photo by Dr Husein Shihabi*

A nurse at Main Baqaa health centre in Jordan providing vaccination to a newborn child while adhering to the complete personal protective equipment (PPE). *© UNRWA 2020 Photo by Dr Rabie Naqa*

As part of staff care, several health centres in the five fields conducted creative activities during the working hours for their staff to releive the stress and burnout caused by the COVID-19 situation and the increased burdens on their shoulders to protect themselves and their patients.

Communicable diseases

Except for the ongoing COVID-19 pandemic that affected the whole world and addressed in a separate section in the report, there were no reports on polio cases or other emerging diseases among Palestine refugees. Mumps and measles cases were reported from Gaza with fewer numbers than in 2019 (311 and 156 respectively), while the other fields reported similar numbers for 2019. On the other side, there was a decrease in the incidence of other communicable diseases related to refugees' adherence to safety measures because of the ongoing COVID-19 pandemic. During 2020, fields conducted close supervision of the work at the health centres, strict monitoring of confirmed cases, implementation of preventive measures, and awareness-raising among staff and refugees.

UNRWA continued its cooperation with host authorities and with WHO and participated in immunization campaigns across all fields. Besides, UNRWA focused on strengthening the surveillance of emerging and re-emerging diseases continued to be active. Close coordination with the host countries' Ministries of Health continued the surveillance of communicable diseases, outbreak investigation, and supply of vaccines and exchange of information.

Expanded Programme on Immunization (epi): vaccine-preventable diseases

The Agency's immunization services follow the host country's Expanded Programme closely on Immunization (EPI). In 2020, challenges related to the COVID-19 pandemic did not affect the immunization coverage in all fields for 12-month-old and 18-month-old children registered with UNRWA, which continued to be above the WHO's target (95.0%). Factors contributing to the Agency's success in immunization coverage include a consistent supply of vaccines, the enforcement of an appointment system for vaccination and continuous follow-up of defaulters by health centres' staff. UNRWA will continue using e-Health in the coming years to assess the immunization coverage

Other communicable diseases

Viral hepatitis

The Agency-wide incidence of suspected cases of viral hepatitis (mainly hepatitis A) decreased from that in 2019; the reported cases from Gaza was 53 versus 371 cases in 2019, same for Syria at 184 versus 239. At the same time, Lebanon reported 50 cases in 2020. In comparison to 199 cases in 2019, Jordan and West Bank reported 19 and 2 cases, respectively. Agency-wide incidence dropped from 25.99 in 2019 to 10.73 per 100,000 in 2020. Such drop is most probably related to lessons learned from the last year, and the improvement in infrastructure, as well as better monitoring of water quality in addition to overall personal hygiene and better awareness.

Typhoid fever

The Agency-wide incidence of suspected typhoid fever cases decreased from 11.6 per 100,000 populations in 2019 to 9.4 in 2020. The highest and significant incidence was observed in Syria (85.3 per 100,000 populations), with a total of 252 out of 269 cases Agency-wide. This high incidence is also attributable to poor water quality and hygienic conditions and the challenging environmental conditions caused by complex economic status and refugees' displacement. At the same time, Gaza reported the other 17 cases, Lebanon, Jordan and West Bank fields reported zero cases.

Tuberculosis

Similar to 2019, reported cases of tuberculosis were 26 versus 28 cases last year Agency-wide. In Syria, 15 cases were reported, which represented 58.0% of all reported cases. The number of cases reported in the other fields was: 8 cases in Lebanon, 2 cases in Gaza, 1 case in Jordan, and no cases in the West Bank. Of the 28 reported cases, 13 cases were smear-positive, four were smear-negative, and nine were extra pulmonary. Patients diagnosed with tuberculosis are managed in close coordination with the national tuberculosis programmes in the fields, while in Lebanon, UNRWA supports anti-TB drugs through reimbursement. It is essential to highlight that the figures above are most probably underreported, and therefore, close follow-up with the Ministries of Health in host countries is required.

Brucellosis

In 2020, a total of 223 brucellosis cases were reported Agency-wide compared to 300 in 2019. Out of these cases, and similar to 2019, most of these cases were from Syria (221). All other fields reported zero cases, except the Lebanon field who reported 2 cases. The relatively high prevalence of the disease in Syria indicates the need to identify the source of infection. Also, there is a need for more awareness-raising activities for Palestine refugees on the importance of safe food handling, especially handling of milk and its products.

Maternal health services

UNRWA MCH services include family planning, preconception care, antenatal care, delivery care and postnatal care. All these services have been affected by the precautionary and preventive measures taken by the host countries to mitigate the spread of Coronavirus, including imposing curfews, restricting movement and closing public and private health centres, including UNRWA health centres. These measures have affected women's access to health centres, which has led to a decrease in the number of women benefiting from maternal and child health services. This decrease varies between fields as well as between health centres in the same field.

Family Planning (fp)

UNRWA health centres provide universal access to family planning. Women can access counselling services and get modern contraceptives. Family planning is implemented as part of the maternal health services and encourages male participation and engagement. In 2020, utilization of family planning services Agency-wide was affected by the host countries' lockdown and the closing of health centres due to the COVID-19 pandemic and considering FP as a less priority service during some time, which was maintained except IUD insertion. The total number of new family planning users decreased by 21.0% (24,582 in 2019 versus 19,532 in 2020), while the total number of continuing users of contraceptive methods increased by 2.0 % (173,346 in 2019 versus 176,574 in 2020). This increase is possibly due to the decrease in the discontinuation rate among family planning users in all fields.

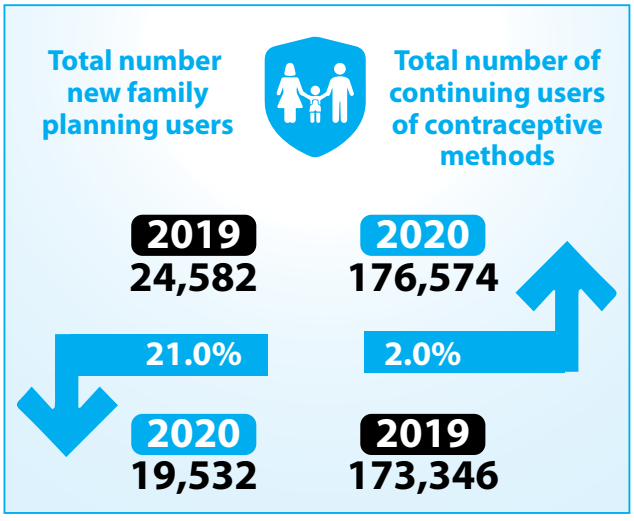


Table 8: Utilization of UNRWA family planning services, 2020

Indicator	Year	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
No. of New family planning users	2019	6,650	1,996	2,763	10,758	2,415	24,582
	2020	4,651	1,238	2,976	8,817	1,850	19,532
	Variance %	-30%	-38%	+8%	-18.0%	-23%	-21%
Total No. of continuing users at year end	2019	37,675	15,822	11,018	87,841	20,990	173,346
	2020	34,438	16,509	11,229	93,206	21,192	176,574
	Variance %	-9%	+4%	+2%	+6.1%	+1%	+2%
Discontinuation rate (%) *	2019	5.4	6.1	5.5	6.0	4.6	5.5
	2020	4.8	3.7	4.4	3.5	2.9	3.9

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

The distribution of family planning users according to contraceptive method remained stable. In 2020, the intra-uterine device (IUD) continued to be the most common method (49.8% of users), followed by condoms (23.7%), oral contraceptives (Pills) (23.3%) and injections (3.2%).

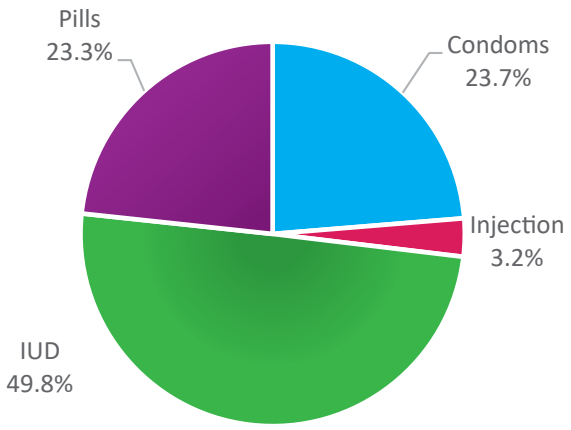


Figure 6: Contraceptive methods use, agency-wide, 2020

Preconception Care (pcc)

Over the past few decades, infant and maternal mortality rates have focused on providing health care at UNRWA. To further control infant and maternal mortality among Palestine refugees, in 2011, the Agency implemented the preconception care programme. Today, this programme is an essential element of maternal health care integrated within the primary health care system in UNRWA HCs.

Preconception care intends to prepare women of reproductive age for pregnancy with an optimal state of health. Women are assessed for risk factors, screened for hypertension, diabetes mellitus, anaemia, and oral health diseases, and are provided with folic acid supplements to help prevent congenital malformations (such as neural tube defects).

Health staff offering an awareness session for the patients about COVID–19 in the waiting area at one of the health centres in Gaza. *© UNRWA 2020 Photo by Khalil Adwan*

In 2020, preconception care services were affected by the precautionary and preventive measures taken by Health Programme to mitigate the COVID-19 virus spread, where most health centres in the fields suspended PCC services for certain periods.

A total of 13,686 women registered at HP's preconception care programme in 2020, compared to 42,441 in 2019. A series of health awareness sessions on preconception care targeting women attending UNRWA health centres for medical, dental and NCD consultations during the reporting year increased the number of women enrolled in this programme. The figure below shows the percentage of newly registered pregnant women who attended preconception care in 2020.

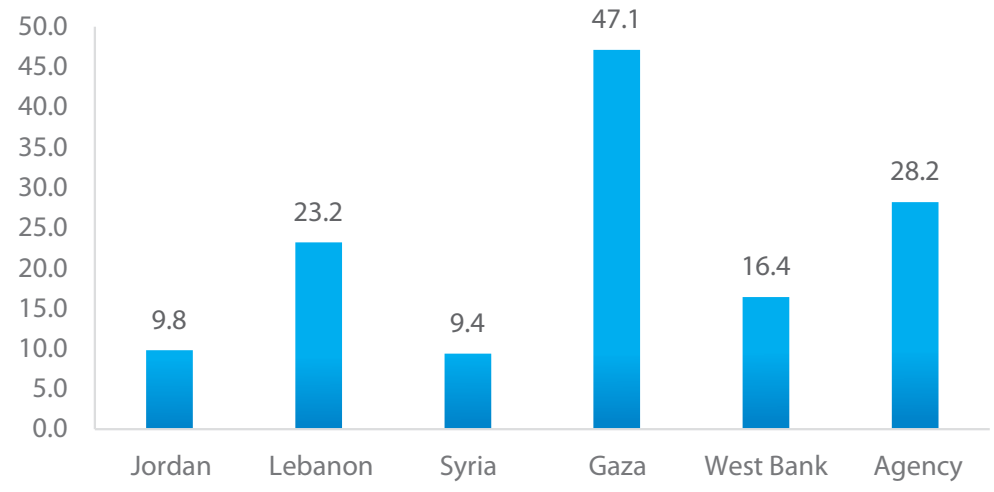


Figure 7: Percentage of newly registered pregnant women attended PCC in 2020

Health staff offering an awareness session for the patients about COVID–19 in the waiting area at one of the health centres in Gaza. *© UNRWA 2020 Photo by Khalil Adwan*

Patients in the waiting area at one of the health centres in Gaza seeking to receive different mother health services while practising social distancing. *© UNRWA 2020 Photo by Khalil Adwan*

Antenatal Care (anc)

To promote early detection and management of risk factors and complications, UNRWA encourages pregnant women to access an initial antenatal assessment as early as possible and attend at least four additional prenatal care visits throughout their pregnancy. Pregnant women receive a comprehensive initial physical examination and regular follow-up care, including screening for pregnancy-related hypertension, diabetes mellitus, anaemia, oral health problems and other risk factors. Women are then classified according to their status of pregnancy risk for individualised management. Besides, all pregnant women are provided with iron and folic acid supplementation. UNRWA uses selected indicators of coverage and quality to monitor the performance of antenatal care services, including antenatal care coverage, percentage of pregnant women registered for antenatal care in the 1st trimester, number of antenatal care visits during pregnancy, tetanus immunization coverage, pregnancy risk status assessment and diabetes mellitus and hypertension in pregnancy. ANC was one of the services affected by the COVID-19 situation and by the decisions that required the closure of the health centres or the reduction of the number of visits to them over the past time since the pandemic was declared.

Antenatal Care coverage

Utilizing antenatal care services Agency-wide was also affected by the precautionary and preventive measures taken by the host countries and UNRWA to mitigate the spread of COVID-19 virus.

In 2020, the total number of pregnant women registered for antenatal care Agency-wide decreased by 13.8% (88,060 in 2019 to 75,851 in 2020). The coverage rates decreased in all fields in 2020 compared with 2019; the total coverage rate Agency-wide was 50.0% of all expected pregnancies among the registered refugee population, calculated based on the registered population's expected number of pregnancies. Of course, the main reason was the reduced access to this service due to the COVID-19 situation and preventive measure. Coverage remains the highest in Gaza.

Registration for antenatal care in the 1st trimester

Increasing the likelihood of positive outcomes for mothers and children is a key focus area for providing antenatal care for Palestine refugee women. UNRWA seeks to safeguard this by ensuring timely detection and treatment of risk factors and complications, achievable through early

Table 9: UNRWA antenatal care (ANC) coverage, 2020 registration for antenatal care in the 1st trimester

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Registered population	2,463,130	543,824	655,729	1,643,546	1,082,664	6,388,893
Expected No. of pregnancies*	56,135	7,260	15,246	46,184	26,850	151,674
Newly registered pregnancies	19,722	4,021	5,135	33,192	13,192	75,851
ANC Coverage (%)	35.1	55,4	33.7	73.1	49.1	50.0

* Expected No. of pregnancies = Total No. of registered population (from UNRWA registration system) x crude birth rate

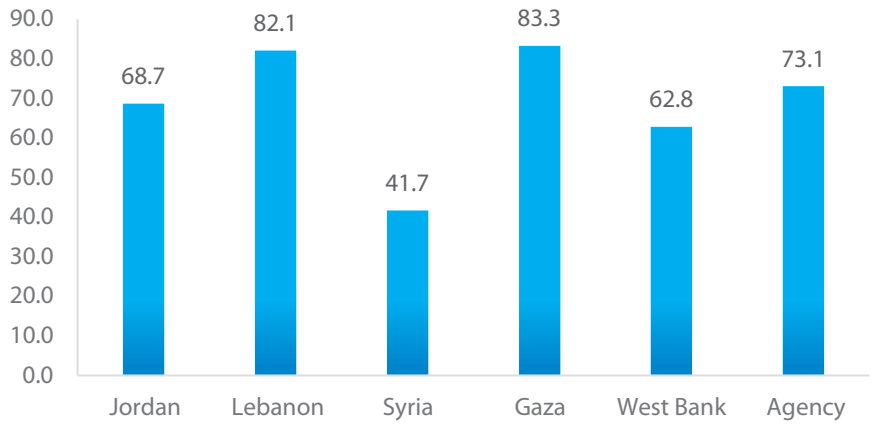


Figure 8: Percentage of pregnant women registered durin the 1st trimester 2020

registration for antenatal care in the first trimester of pregnancy. During 2020, the proportion of pregnant women who registered for antenatal care in UNRWA HCs during the 1st trimester of pregnancy was 73.1% compared with 80.7% during 2019. The ratio of pregnant women registered during the 2nd trimester was 22.4%, and during the 3rd trimester was 4.5%. The variation of this rate within the fields reflects that patients might have had access to other health care providers.

The clerk (receptionist) at the triage point in Deraa health centre/ Syria is opening a ticket in the e-Health system for this patient to start receiving the service she needs. *© UNRWA 2020 Photo by Dr Husein Shihabi*

Number of antenatal care visits

The antenatal care programme's key objective is to ensure that pregnant women are registered for antenatal care as early as possible when they are pregnant. This early registration would allow ample time for risk identification, follow-up, management as per their needs and encouraging them to attend at least four antenatal visits during pregnancy.

To improve antenatal care quality and reduce maternal and perinatal mortality and pregnancy complications, WHO has issued, in 2016, new guidelines for antenatal care. These new guidelines increase the number of visits (contacts) a pregnant woman has with health providers throughout her pregnancy from four to eight[3]. However, due to the host countries' precautionary and preventive measures to mitigate the spread of the COVID-19 virus and closing UNRWA health centres, the Department of Health kept the four antenatal visits indicator for 2020.

In 2020, the average number of antenatal visits per client was 4.8 visit Agency-wide. The lowest was in West Bank with an average of 3.8 antenatal visits, and the highest in Gaza with six antenatal visits. 75.5% of pregnant women attended four or more antenatal visits, the highest in Gaza at 90.4%, and the lowest is in Syria at 52.5%.

Table 10: % of pregnant women who paid ≥ 4 antenatal visits or more, 2020

Indicator	Year	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
% of pregnant women who paid ≥ 4 antenatal visits or more	2019	77.9	81.9	67.5	97.4	87.1	87.0
	2020	62.9	71.2	52.5	90.4	69.3	75.5
Average number of antenatal visits per pregnant women	2019	4.9	5.4	4.0	7.4	5.0	6.0
	2020	3.7	3.9	3.6	6.0	3.8	4.8

[3] Based on UNRWA Department of Health Technical Instructions on the "Provision of Maternal Health And Family Planning Services» 2020. This technical instruction is in-line with WHO recommended standards.

At this triage station in one of the health centres in Gaza, the health Staff screens patients for high temperature and respiratory symptoms. *© UNRWA 2020 Photo by Khalil adwan*

Tetanus immunization coverage

In 2020, 97.8% of pregnant women received adequate immunization against tetanus. As a result of the optimal immunisation coverage, no tetanus cases have been reported during the last two decades among mothers and newborns attending UNRWA antenatal care services.

Risk status assessment

The WHO model of antenatal care separates pregnant women into two groups: those likely to need only routine antenatal care (50.2% of pregnancy cases), and those with specific health conditions or risk factors that necessitate special care (49.8% of pregnancy cases). UNRWA classifies pregnant women into three categories based on risk: low, alert, and high risk.

During 2020, Agency-wide, 50.2% were classified as low risk, 30.1% were an alert risk, and 19.7% of women were high risk. The rates varied from one field to another, with the highest high-risk rate of 25.4% in Jordan, followed by 19.7% in Gaza and 16.0% in the West Bank. The high and alert risk pregnancies receive more intensive follow-ups than low-risk pregnancies, including referral to specialists as needed.

Diabetes mellitus and hypertension during pregnancy

Pregnant women are regularly screened throughout their pregnancy for diabetes mellitus and hypertension. Agency-wide, in 2020 the prevalence of diabetes mellitus during pregnancy (pre-existing and gestational) was 5.3%.

Almost 15.5% of women with diabetes during pregnancy had pre-existing diabetes, 48.5% had gestational diabetes with recovery after delivery, 7.6% diagnosed during pregnancy and not recovered after delivery, and 28.4% were still pregnant at the end of 2020. Globally, reported rates of gestational diabetes range between 2.0% to 10.0% of pregnancies (excluding pre-existing diabetes mellitus) depending on the population studied and the diagnostic tests and criteria employed.

The prevalence rate of hypertension during pregnancy (pre-existing and pregnancy-induced hypertension) was 6.6%. Approximately 30.7 % of hypertension cases had pre-existing hypertension and recovered after delivery, 10.4 % were identified during pregnancy, and the condition persists after delivery, and 15.0% were still pregnant at the end of 2020.

The health staff is offering an awareness session for the patients about COVID–19 in the waiting area at Deraa health centre in Syria. *© UNRWA 2020 Photo by Dr Husein Shihabi*

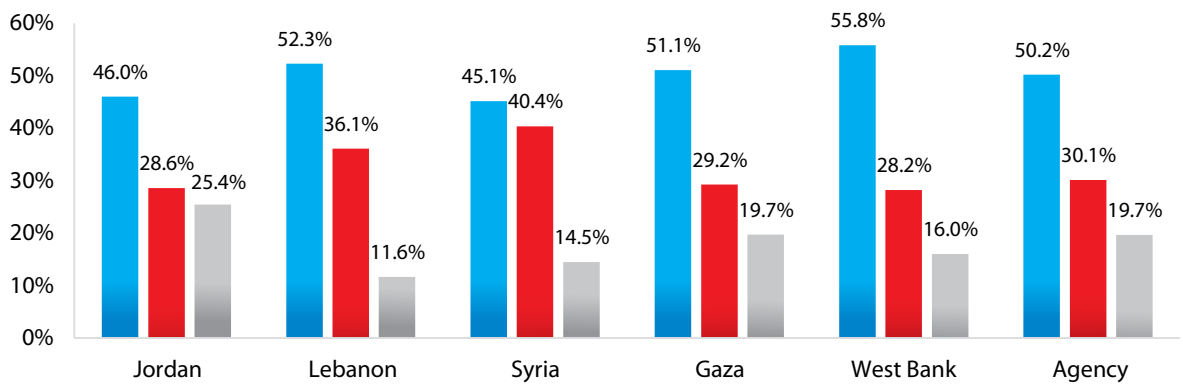


Figure 9 : Percentage of ANC risk assessment

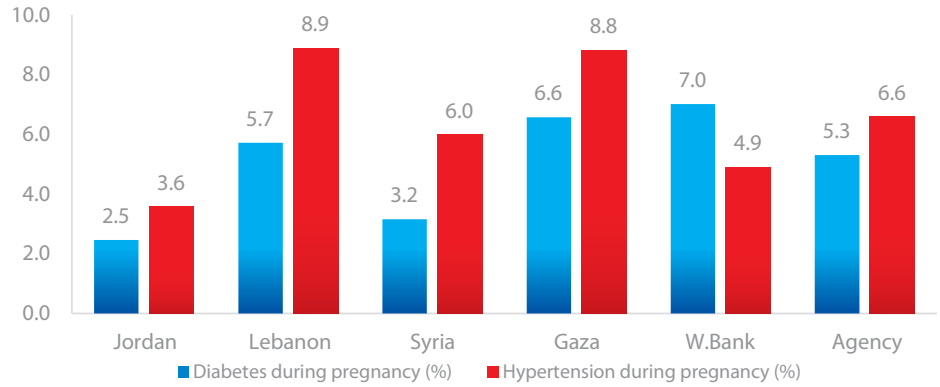


Figure 10: Prevalence of diabetes mellitus and hypertension during pregnancy

Delivery care

Place of delivery

UNRWA subsidises hospital delivery for all pregnant women. In 2020, Agency-wide, 99.9% of all reported deliveries took place in hospitals, while home deliveries only represented 0.1%. The vast majority of these home births were in Syria.

Caesarean sections

In 2020, the caesarean section rate among pregnant women assisted through the UNRWA hospitalization schemes was 31.1%. The rate varied widely from one field to another. These rates, however, relate to women in the high-risk category and not to all reported deliveries. The highest rate was in Syria at 62.2%, and the lowest rate was 23.8% in Gaza. This wide variation among the fields is due to several reasons, particularly client preference and prevailing medical practice.

Despite a wide variation among regions and countries, the worldwide caesarean section rates are estimated in 2015 at around 21.41%, while in the Middle East and North Africa, the estimation is at 29.6%[4].

Table 11: Caesarean section rates among UNRWA reported deliveries, 2020.

Field	Total deliveries	Caesarean section rate (%)
Jordan	19,558	29.9
Lebanon	4,097	52.0
Syria	6,296	62.2
Gaza	33,455	23.8
West Bank	13,694	29.9
Agency	77,100	31.1

Monitoring the outcome of pregnancy

UNRWA closely monitors and registers births through a registration system (active surveillance) since 2002 (based on the expected delivery date). The outcome of each pregnancy, including details of the newborns, is recorded in each health facility.

In 2020, the expected number of pregnant women to deliver was 82,356. Among these women, 77,081 infants were born (93.6%), and 5,004 births resulted in miscarriages or abortions (6.1%). The outcome of 263 pregnant women who received antenatal care at UNRWA health facilities (0.32%) was unknown.

The percentage of unknown pregnancies' outcomes dropped from 6.8% in 2002 to 0.2% in 2007 and remained constant. Lebanon field reported the highest prevalence of unknown pregnancy outcomes, with 3.43% of unknown pregnancy outcomes. That might be due to the host countries' preventive measures to mitigate the spread of the COVID-19 virus, including imposing curfews, restricting movement; besides, closing UNRWA health centres resulted in the difficulty to track the outcomes of the pregnancies among registered women by health staff.

A doctor is examining a newborn baby at El Buss Camp health centre in Tyre, Lebanon. *© 2019 UNRWA Photo by Abeer Nouf*

[4] The Lancet, "Global epidemiology of use of and disparities in caesarean sections", October 2018.

Monitoring maternal deaths

Pregnancy is a normal, healthy state which most women aspire to at some point in their lives. However, if quality health services provided is not good enough, this process carries with it severe risks of death and disability. Most of these deaths or disabilities are avoidable if it was possible to take timely preventive measures.

In 2020, a total of 12 maternal deaths were reported across the five fields, which is equivalent to a maternal mortality ratio (MMR) of 15.5 deaths per 100,000 live births. Four deaths were reported from each of Gaza and Syria, two deaths were reported from Jordan and one death from each of the West Bank and Lebanon.

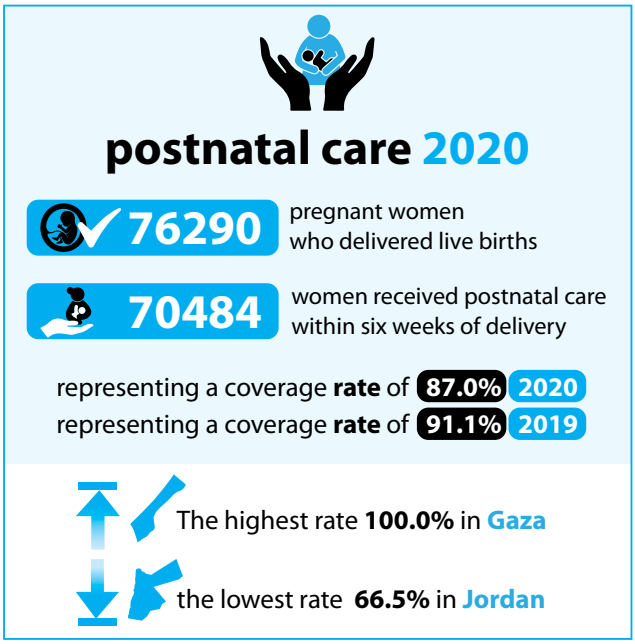
All cases of maternal mortality were registered in UNRWA antenatal care services. Following a maternal death report, UNRWA health staff conduct a thorough inquest and assessment using a standardized verbal autopsy questionnaire.

Out of the 12 deaths, one woman died during pregnancy, and 11 deaths occurred during the postnatal period.

Most maternal deaths were of multi-parity. The causes of death varied and included: 41.7% were due to pulmonary embolism (5 cases), 25.0% were due to postpartum bleeding (3), 16.7% were due to pregnancy-induced hypertension (Preeclampsia, 2), 8.3% were due to septicemia, and 8.3% were due to cardiac disease (cardiomyopathy, 1). Through extensive assessment of cases, the six maternal deaths (50.0%) were due to preventable causes, including three cases of bleeding, two cases of pre-eclampsia, one case of septicaemia.

Postnatal Care (bc)

The Agency encourages all women to attend postnatal care as soon as possible after delivery. Postnatal care services include a thorough medical examination of the mother and the newborn, either at UNRWA health centres or during home visits, and include counselling on family planning, breast feeding and newborn care. In 2020, out of the 76290 pregnant women who delivered live births, 70484 women received postnatal care within six weeks of delivery, representing a coverage rate of 87.0% compared to 91.1% in 2019. The highest rate was 100.0% in Gaza, and the lowest rate was 66.5% in Jordan.



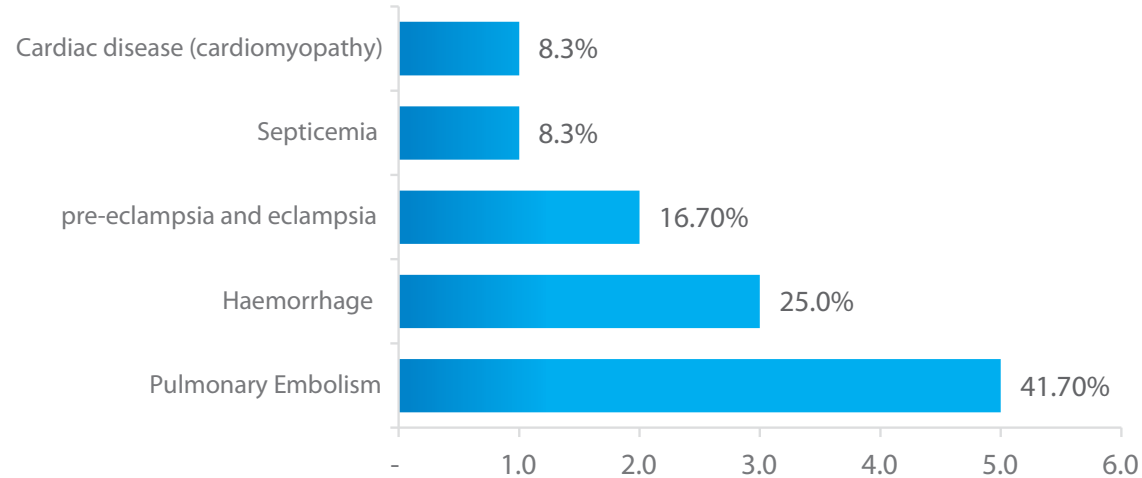


Figure 11: Underlying causes of maternal mortality cases, 2020 (%)

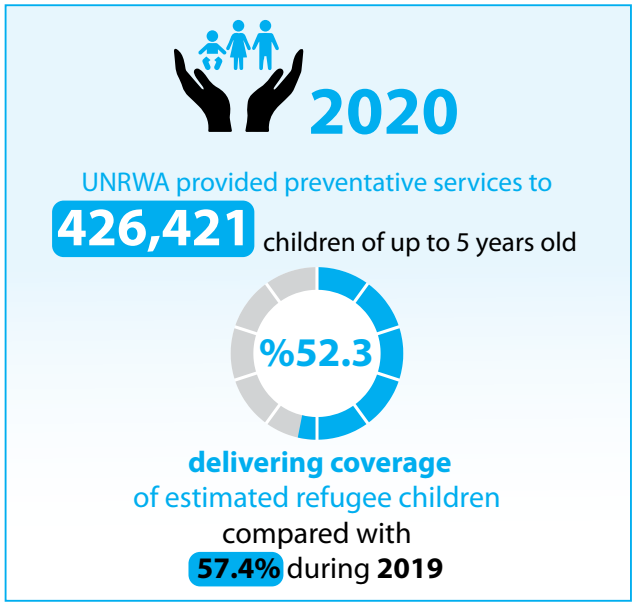
Child health services

UNRWA Department of Health continued to provide comprehensive health care services to maintain and improve Palestine refugee children's health, especially during the COVID-19 pandemic. It used multiple approaches to maintain its services and keep Palestine refugee children safe while visiting its health centres. The Family Health Team approach implementation continued at the health centres where there was sporadic or low community transmission. These keep our ability to provide health care services for children early during maternal care (preconception care and antenatal care) and continue for newborns, infants under one year of age, children from one to five years of age and school-aged children and adolescents. the Agency's child health services include newborn assessment, periodic physical examinations, immunization, growth monitoring and nutritional surveillance, micronutrient supplementation, preventive oral health, school health services, and referrals for specialist care. UNRWA health centres modified their services to focus mainly on child's immunization, growth monitoring (mainly for high-risk children), and micronutrients supplementation.

The Agency's child health services are one of the essential investments in health. The impact of the child's health improvement will decrease their morbidity and mortality in the future and extend to improve their health and wellbeing during later periods of their life cycle. The age of children covered with child health services was raised from 3 to 5 years old in 2010 to enhance child health outcomes. This decision enabled filling the gap in child health services until the child reaches school age and improve growth monitoring, nutritional surveillances, micronutrients supplementation and fluoride varnish coverage.

Child care coverage

In 2020, UNRWA HCs continued to provide our preventative services to 426,421 children up to 5 years old. The COVID-19 pandemic did not cause interruptions of these services, as these HCs succeeded in delivering coverage to 52.3 % of estimated refugee children, compared with 57.4% during 2019. The basis for this estimation was the number of infants below 12 months of age who have been registered, and the expected number of surviving infants, which is calculated by multiplying the crude birth rates (as published by the Host Authorities) by the number of registered refugees in each country.



Immunization

Due to the importance of immunization as the most reliable primary prevention method, UNRWA health services continue to provide immunization against Tetanus, Diphtheria, Pertussis, Tuberculosis, Measles, Rubella, Mumps, Polio, Haemophilus influenza type

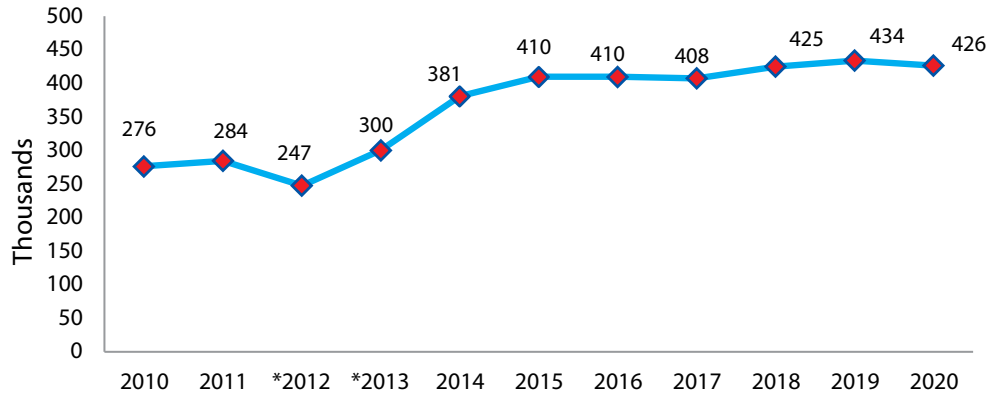


Figure 12: Children 0-5 years under supervision at UNRWA health centres, 2010 – 2020
(*Data not available for Syria)

B (Hib), and Hepatitis B. Moreover, the UNRWA Health Programme provides the Rota vaccine in all fields except Syria and the Pneumococcal vaccine in West Bank, Gaza and Lebanon. In 2020, the UNRWA Health Programme started to provide Hepatitis A vaccine in Jordan as part of Jordan's National Vaccination Program. In 2020, despite the closures in some fields and some UNRWA health centres due to the COVID-19 pandemic, the UNRWA Health Programme maintained high immunization coverage for children aged 12 months (99.7%) and for children aged 18 months (99.4%) against all diseases mentioned above that are preventable by immunization. The use of the e-MCH mobile application by mothers supported this coverage. The e-MCH mobile application sends reminders to the mothers to vaccinate their child according to each child's vaccination schedule. This tool's use decreased the number of defaulters and the nurse's need to follow up on the mother for bringing their child to the clinic for vaccination.

Growth monitoring and nutritional surveillance

UNRWA health services regularly monitor the growth and nutritional status of children under five years of age. It is considered as the second strategy to improve the health of Palestine refugee children. In 2020, the Health Programme tried to balance the need for growth monitoring and protect the children from COVID-19 during the community transmission stage. The focus was on the most vulnerable and high-risk children. Available data shows a decrease in the percentage of malnutrition among children. This decrease is mainly due to a reduction in the number of evaluated children compared with 2019. At the same time, it continues to show the double burden of malnutrition among monitored children. To prevent malnutrition and promote a healthy lifestyle, HCs' staff encourage mothers to properly practice breastfeeding and provide them with proper counselling on infant and child nutrition. The health education includes information about the appropriate use of complementary feeding and micronutrient supplements and the importance of avoiding fast food and sweetened drinks, especially with the socio-economic effect of the COVID-19 on the Palestine refugee situation.

The electronic growth monitoring system is integrated within e-Health and is based on revised WHO growth monitoring standards. This integration enabled HC staff to plot the data and interpret growth monitoring results. If the electronic system detects one or more of the four significant growth and nutrition-related problems among children under five years (underweight, wasting, stunting, and overweight/obesity), it sends an alarm.

Table 12: Prevalence of malnutrition among children 0-5 years during 2018, 2019 and 2020 (%)

	underweight	Wasting	Stunting	overweight/ obesity
2018	5.56	5.60	9.17	7.36
2019	6.26	6.40	11.00	8.96
2020	5.12	5.00	8.90	6.92

All children were provided with iron and vitamin A supplementation starting from 6 months of age, and this supplementation continues until they turn five years old. Once a child reaches 12 months of age, they are screened for anaemia. Anaemic children who are unresponsive to the supplementation are screened for hereditary anaemias, mainly thalassemia and sickle cell anaemia.

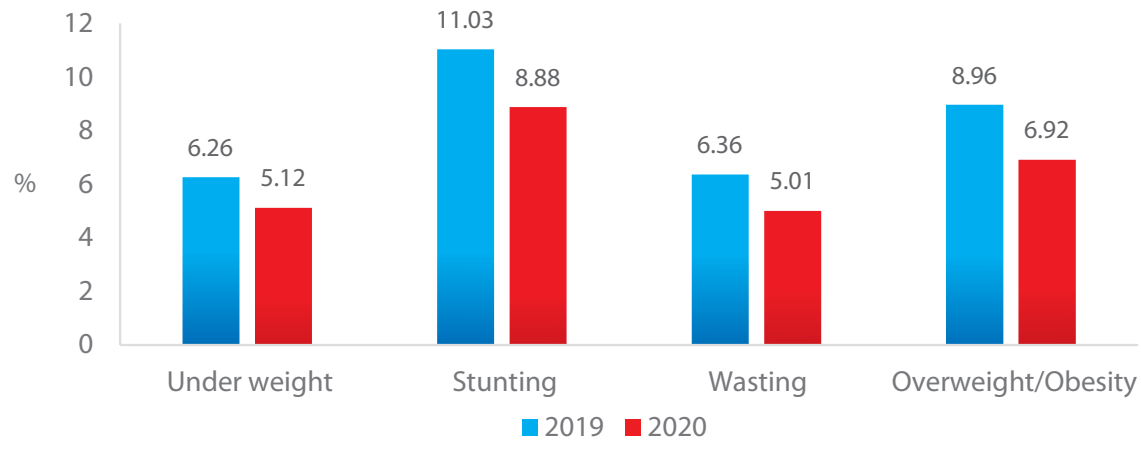


Figure 13: Prevalence of malnutrition among children 0-5 years

Surveillance of infant and child mortality

Infant mortality

In 2020, there was a slight decrease in the number of reported deaths among registered infants who were less than one year of age across all fields. In 2020, the number of reported deaths among infants reached 401 as compared to 427 in 2019. This data shows no direct effect on the COVID-19 outbreak or focus on the health services on vulnerable and high-risk infants on their morbidity or mortality, with continued and close follow-up of the infants through telemedicine. The leading causes of infant death included: congenital malformations or metabolic disorders (24.9%), respiratory infections and other respiratory conditions (21.9%), Low Birth Weight (LBW)/Prematurity (20.7%), congenital heart disease (12.0%), septicaemia (4.2%), accidents (2.1%) and gastroenteritis (1.7%). Compared with previous years, there was a slight decrease in respiratory infection, and this may be due to applying respiratory prevention measures due to COVID-19.

Child mortality

In 2020, 130 deaths among children between 1-5 years of age were reported across all fields agency-wide. The leading causes of child death were: congenital malformations (31.5%), respiratory tract infections and other respiratory conditions (17.7%), congenital heart diseases (13.1%), accidents and poisoning (14.6%), and septicaemia (3.1 %). There is no apparent difference between causes of death between children living in camps or outside the camp. Most children died in hospitals, and only some children died at home and were not hospitalised (17.5 %). In terms of the distribution of deaths by gender, there were slight differences between child mortality among males (55.9 %) than females (44.1%).

Oral health

Preventive oral health services start as soon as the child reaches one year of age by conducting awareness sessions for parents on preventing oral diseases, mainly dental caries and fluoride varnish needs, every six months. Oral health services during the COVID-19 outbreak were suspended, mainly due to the N95 masks shortages. Besides, in high community transmission times, the number of screened children at the age of two became less (70,421 in 2019 to 21,067 in 2020).

A group of Palestine refugee children and youth enjoy their time at the Summer Camps (Theme: "My identity is my dignity") as a part of the UNRWA Community Mental Health Programme (CMHP) in the West Bank. *© UNRWA 2020 Photo by Iyas Abu Rahmeh*

School health

During the 2019/2020 academic year, more than 500,000 Palestine refugee students enrolled in UNRWA schools. UNRWA Health Programme, in coordination with the Education Department (ED), implements the School Health Programme (SHP) to improve school children health through planned meetings, school health committees, training on health awareness materials and ensuring availability of first aid supplies. SHP provides different services, including medical examinations for school new entrants, immunizations, hearing and vision screening, dental screening, de-worming, and vitamin A supplementation. The SHP provides guidelines for doing the follow-up of children with special health needs and procedures for inspections to improve the school environment and school canteen. These school health services are provided to UNRWA schools by health centres and school health teams (medical officers, nurses and dentists) through scheduled visits to UNRWA schools during the academic year.

New school entrants medical examination

UNRWA schools registered 55,318 new entrants in the 1st grade. These newly registered students provided with screening medical examinations, immunization and specialist follow-ups as needed. UNRWA successfully provided a medical examination for 98.8% of them during the first semester before the declaration of COVID-19 as a global pandemic. Morbidity diseases detected among newly registered students included: dental caries and gingivitis (32.3%), speech defect (10.4%), vision problems (7.8 %), heart disease (1.1%), bronchial asthma (1.0%) and epilepsy (0.2 %). There is an increase in the proportion of students found to have health diseases related to personal hygiene, including pediculosis (3.5%) and scabies (0.4%) compared with 2019. Newly registered students identified with

disabilities or in need of assistive devices received assistance or both towards providing eye-glasses, hearing aids and other prosthetic devices according to their condition and available resources.

Based on the SHP activities in 2020, there was a decrease in the number of referred students for further care to UNRWA health facilities from 5,539 in 2019 to 4,489 students in 2020. Besides, the number of students referred for special assessment was 3,101. During the academic year 2019/2020, UNRWA Health Programme assisted 8,575 students in covering eye-glasses costs, and assisted 57 students in covering hearing aids costs, which less than the number of supported students in 2019 (74 students).

Table 13: Total number of assisted towards the cost of eyeglasses

Field	2018/2019	2019/2020
Jordan	2,932	1,699
Lebanon	19	6
Syria	648	794
Gaza	583	4,531
WB	888	1,545
Total	5,070	8,575

Screening

Health care screening during the school year 2019/2020 targeted pupils in the 4th and 7th grades in all fields and involved vision and hearing impairment and oral health assessments. Usually, screening of 4th and 7th grades done during the 2nd semester, closure of schools in March 2020 due to COVID-19 pandemic, decreased the screening coverage compared by 2019. Despite this decrease, we screened the majority of the students. For 4th grade, 84.52% of the students were screened. The most prevalent morbidity conditions were vision impairment (12%) and hearing impairments (0.4%). Among students in the 7th grade, (81.8%) of the students were screened with the significant morbidities found to be vision impairment (13.67%) and hearing impairments (0.3%).

Oral health screening

In 2020, 67,027 students in the 1st, 4th and 7th grade in all fields, and 3rd grade students in the West Bank, received oral health screening; of those, 33.5% received the sealant. Oral health screening is coupled with other dental caries prevention methods such as pit and fissure sealant for 1st graders, erupted molar for students for 1st and 2nd graders, in addition to general fluoride mouth rinsing and teeth brushing campaigns. Oral health screening for UNRWA students has been a significant focus for oral disease prevention due to the reorientation of the Oral Health Programme towards prevention.

Children with special health needs

In the 2019/2020 academic year, the Health Programme's School Health Teams, in cooperation with schools' staff, identified 4,607 students with special health needs. Their school registration records are maintained and monitored by both the HD and the ED staff to ensure close follow-up since the school health team provide the needed specialised medical care. These special health needs cases include 465 students with heart disease, 484 students with behavioural problems, 908 students with bronchial asthma, 120 students with type 1 diabetes mellitus and 348 students with epilepsy.

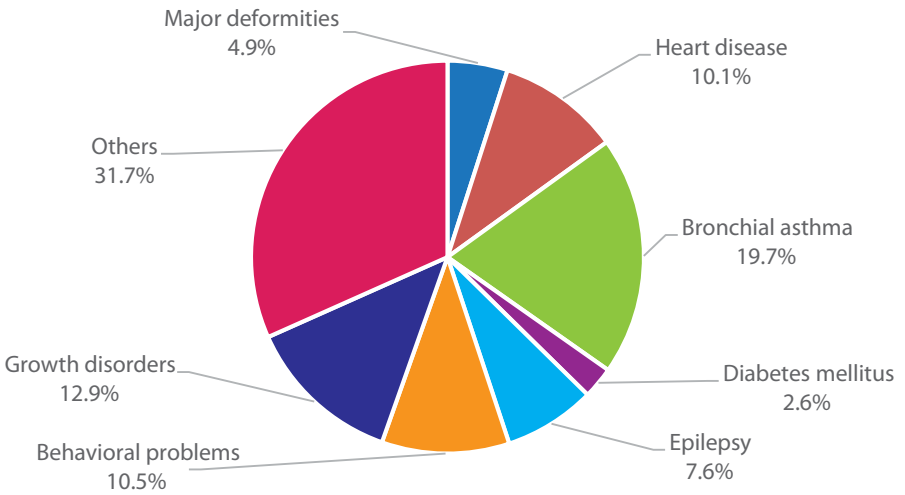


Figure 14: Children with special health needs

Immunization

The UNRWA immunization programme for school students is streamlined and is following host countries' requirements. During the 2019/2020 school year:

- New entrants in all fields received a booster dose of tetanus-diphtheria (DT/Td) immunization, with a 95.3 % Agency-wide coverage rate.
- New school entrants received the oral polio vaccine (OPV) with a 99.0 % coverage rate.

The coverage rates were affected by the schools' closure during the 2nd semester, even though school health teams worked closely with schools to catch up with vaccine defaulters and provide vaccination for them.

De-worming programme

Following WHO recommendations, UNRWA maintains the de-worming programme for children enrolled in UNRWA schools across all five fields. The programme targets students from 1st grade to 6th grade, and it consists of the application of two rounds of a single dose of an effective wide-spectrum anti-helminthic medicine.

During the 2019/2020 academic year, school health teams provided the first dose of the de-worming drug for 160,681 students through the first application rounds conducted during September - December 2019. The plan was to apply the second dose during March - April 2020, and it was stopped as schools were closed due to the COVID-19 pandemic. Usually, health awareness campaigns accompany the de-worming drug application at schools to emphasize the importance of personal hygiene in preventing the transmission of these vectors of diseases.

Oral health

UNRWA provides oral health care to Palestine refugees Agency-wide. One hundred twenty-three dental clinics, integrated within the Agency's primary health care facilities, in addition to 11 mobile dental clinics, provide these services. The oral health services aim to prevent, detect, and manage dental and periodontal disorders among Palestine refugees with particular attention to the risk groups.

UNRWA health services continued to reinforce the necessary preventive oral health components, including delivering awareness on the importance of preventative oral health during routine maternal and child health care. This includes dental screening for women during their first preconception care visit and all pregnant women. Comprehensive oral health assessments were conducted for all children at the age of one and two years, in addition to the application of fluoride varnish starting from one year of age, applied twice a year until they turn five years old. The oral Health Programme's staff conducted oral health assessments among pre-school children and regular dental screening for new school entrants and for 2nd, 4th and 7thgrade students, in addition to the application of pit and fissure sealant for 1stgrade students. Oral hygiene education continued for school students in all fields as a prevention measure for oral health problems.

A dentist at the Sheikh Redwan health centre in Gaza offers service to a Palestine refugee while wearing complete personal protective equipment (PPE). *© UNRWA 2020 Photo by Dr Khaled Al-Raie*

An assessment of the oral Health Programme's staff workload, needs, productivity, and efficiency is conducted in all five fields annually. The Health Programme uses a standardized counting unit to measure the technical workload of its oral health programme's staff. The workload assessment is based on the standardized counting unit and is carried out as part of a periodic evaluation of performance. This is also used to identify staffing requirements and the need for the reorganization of oral health services. An additional assessment was conducted with the support of WHO-EMRO to assess the impact of oral preventive services, and this assessment enabled UNRWA to explore some improvement opportunities.

In 2020, due to the shortage of N95 masks locally and internationally, to protect UNRWA staff and Palestine refugees from transmitting the COVID-19 virus, the Health Programme suspended the oral health services to be only for emergency case. It also stopped oral

preventive services during community transmission, and the focus was only on essential health services to decrease crowdedness at the health centres. This has reduced, by 51.0%, the number of curative dental consultations and by 58.0% the number of screening activities compared to 2019.

In 2020, the average daily consultations per dental surgeon per day reached 23.6, which is less than the agency target of 25 daily consultations per dental surgeon per day as recommended by WHO.

Physical rehabilitation and radiology services

Physiotherapy services

In 2020, UNRWA facilitated physiotherapy services to 7,035 Palestine refugees through 88,415 physiotherapy sessions in 18 physiotherapy units by 46 physiotherapists in Gaza, West Bank and Jordan (58 per cent decrease compared to 2019). In Gaza, 5,909 patients received 77,919 physiotherapy sessions through 11 physiotherapy units by 34 physiotherapists. In the West Bank, 823 patients received 7,973 physiotherapy sessions through six physiotherapy units by 11 physiotherapists. In Jordan, 303 patients received 2,523 physiotherapy sessions through one physiotherapy unit and by one physiotherapist. A general decline in the utilization of physiotherapy services was observed in all fields due to the COVID-19 crisis.

Physiotherapists provide a wide range of treatments and rehabilitation services. These include manual treatment, heat therapy, electrotherapy, and gymnastic therapy. These physiotherapists provide Palestine refugees with permanent disabilities accessing these services and their family members with education and training on handling the physical aspect of their disability in their daily lives. These services aim to provide Palestine refugees with disabilities with more independence and self-reliance.

Radiology services

UNRWA operates 21 radiology units across all HCs Agency-wide (seven units in Gaza, nine units in West Bank, four in Lebanon and one in Jordan). These units provide plain X-ray services to patients attending HCs. Other X-ray services and specific types of diagnostic radiology services, such as mammography, urography, ultrasounds, are provided upon referral by UNRWA HCs to contracted services via contractual agreements with hospitals and private radiology centres.

In 2020, 47,701 patients had 50,983 X-rays; of those, 39,138 patients had (52.5 per cent decrease as of 2019) 43,495 plain x-rays in UNRWA HCs, and 8,563 patients had (14 per cent decrease as of 2019) 7,488 X-rays and other radiology services in contracted health facilities. This reduction in service utilization is in line with an overall decline in the health service utilization pattern due to the COVID-19 pandemic.

Disability care

The Agency adopts the definition of disability presented in the UN Convention on the Rights of Persons with Disabilities (UNCRPD). This definition states that “persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various attitudinal and environmental barriers hinder their full participation in society on an equal basis with others” . One of the Agency’s principles of disability inclusion is non-discrimination, ensuring that all Palestine refugees with disabilities have equal opportunities to access and benefit from UNRWA services and programmes, including healthcare.

Department of Health adopted the “twin-track” approach to disability, which requires working on the social environment (ensuring non-discrimination health services and accessibility to these services) and strengthening services-targeted disability prevention and support persons disabilities.

In 2020, the Department of Health, in cooperation with the protection unit continue to adopt a specialised training module on disability inclusion for the health staff at the three levels; Headquarters level, Field and Policymaker level, and frontline staff (HC) level. The training goal was to develop UNRWA health managers and frontline staff’s capacity to provide health services that address or meet the needs of persons with disabilities or both. The training focused on improving participants’ understanding of disability, their knowledge about the Agency’s principles of disability inclusion, their knowledge of how to address the needs of persons with disabilities within the FHT approach, and motivating participants to identify the current gaps and necessary actions in the provision of inclusive health services to persons with disabilities. To increase the accessibility to health services, many health centres improved their

infrastructure to be more user-friendly for people with disabilities. These improvements included having ramps, elevators, and special restrooms for physical disability and elderly persons, implementing a Q-tag system and tactile ground surface indicators for the blind and visually impaired.

To improve communication with persons who have a hearing disability, the protection unit and the Health Programme conducted sessions to identify the familiar words used in the communication between healthcare providers and beneficiaries. Several videos were produced to be used as a method for future training that will be accessed for front line health staff.

The second track focuses on disability prevention through the FHT approach through the implementation of maternal health services (quality family planning services, antenatal care, postpartum care, postpartum care) and child health services (child growth monitoring, immunization, and screening), as well as prevention, early detection and increased control of patients for NCDs. Jordan field implemented a new hearing test for newborns to detect hearing problems early. This test enabled the health teams to discover and support three cases for cochlear implant operations that prevented disability.

The Health Programme updated its e-Health (electronic health records) system to enable the screening of the beneficiaries for disabilities and monitor the services offered to them. This is done at two levels: one is for children below five years as a continuous medical evaluation for the children. The second is integrated within the medical file of beneficiaries above five years. This evaluation system is based on Washington Group Questions. It enables tracking the usual services utilised by persons with disabilities and the time needed to get complete assistance. The data gathered can be used for improving the process of disability inclusion within the HCs.

In addition to prevention, the HD also provides other essential services to registered refugees whose permanent physical, visual and hearing impairments have been identified via screening in UNRWA health centres. They are eligible for financial support from the HD to cover the costs of assistive devices such as hearing aids, eyeglasses, artificial limbs, wheelchairs etc. These services were affected by COVID-19 preventive measures, as most of the screening to identify the person in need were done at schools. Simultaneously, HCS stooped screening at HCs most of the time to open the space to follow up life-threatening or complicated conditions or both as uncontrolled NCD patients and high-risk pregnancies prevent further deterioration that leads to disability. In 2020, we assisted only 8,575 URNWA students with eyeglasses' cost due to deceased donation, and 57 students received assistance to cover the cost of hearing aids.

Physiotherapy centres operating in Jordan, Gaza and the West Bank do not target persons with permanent disabilities. However, it is recognized that a significant proportion of beneficiaries treated at these HCs are likely to be considered "persons with disabilities"under the definition of the UNRWA Disability Policy (2010) and UNCRPD. However, it is essential to note that data collection regarding physiotherapy services does not differentiate between beneficiaries with and without permanent disabilities.

Pharmaceutical services

Total expenditure

In 2020, the total funds spent on medical supplies and equipment from all the funds (General Fund and projects), was approximately US$ 17.52 million. Of this amount, US$ 11.88 million (67.8%) was from the General Fund, and US$ 5.64 million (32.2%) was from project funds.

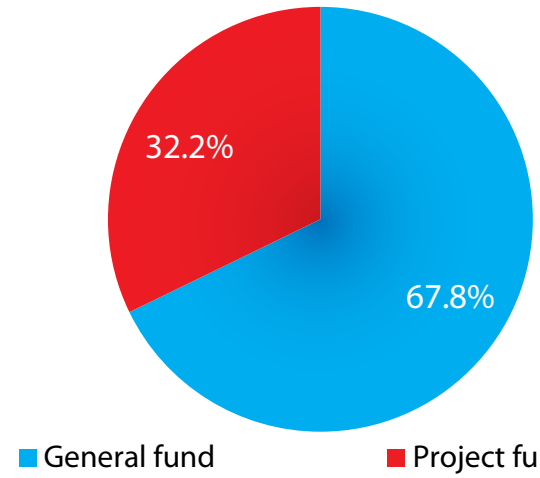


Figure 15: Total expenditure of medical supplies and equipment from the general fund and project funds, 2020

Among the fields, the highest expenditure on medical supplies and equipment was in Gaza (US$ 5.93 million), and the lowest was in Lebanon (US$ 2.14 million).

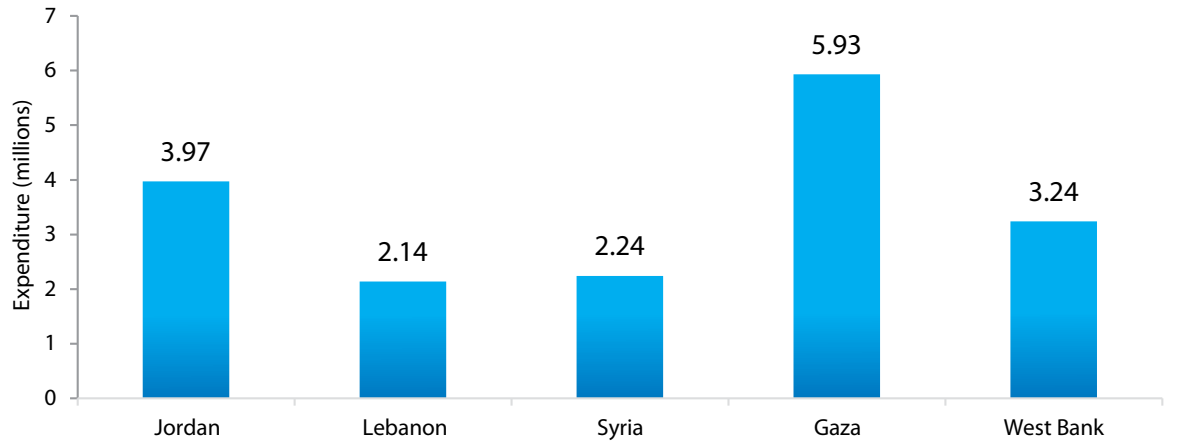
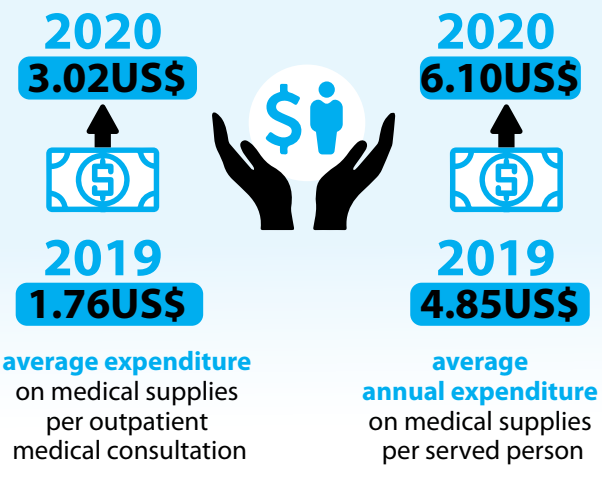


Figure 16: Expenditure on medical supplies, by field 2020 (US$ million)

Expenditure on medical supplies

In 2020, the average expenditure on medical supplies per outpatient medical consultation Agency-wide was US$ 3.02, which is more than that in 2019 (US$ 1.76). The average annual expenditure on medical supplies per served person Agency-wide was US$ 6.1, which is increased compared with US$ 4.85 in 2019. The increase of annual expenditure on medical supplies per medical consultation is due to decreased medical consultations across the fields specifically observed during the COVID-19 pandemic. The rise in the expenditure on medical supplies per a served refugee is mainly owing to procuring PPE supplies with almost US$ 4.2 million spent on them.



The pharmacists at one of the UNRWA health centres in Syria dispense medicines to patients with preventive measures amidst the COVID–19 pandemic. *© UNRWA 2020 Photo by Dr Husein Shihabi*

Expenditure on medicines

The total expenditure on medicines in 2020 was US$ 11,359 million. Analysis of the expenditure on different medicines revealed that 41.0% of the funds were spent on medications used to treat NCDs, and 12.0% were spent on antimicrobial medications. Further analysis of the expenditure on NCD drugs revealed that 49.0 % of the funds were spent on hypoglycemic medications, 23.0% on antihypertensive medications, 14.0% on cardiovascular medications, 6.0% on diuretics, and 8.0% on lipid-lowering agents.

Table 14: Average medical product expenditure (US$) of medical supplies per outpatient medical consultation and per served person, 2020

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency-wide
Expenditure for medical supplies per medical consultations (US$)	3.52	3.85	3.33	2,21	4.27	3.02
Expenditure for medical supplies per served person (US$)	5.12	10.02	7.57	4.99	8.18	6.1

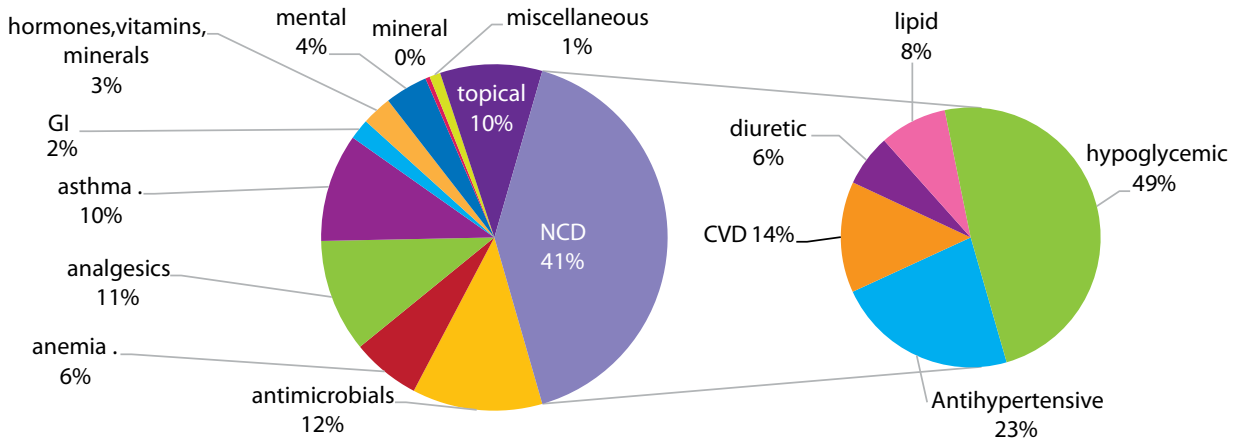


Figure 17: Drug expenditure, 2020

During 2020, medical equipment and related supplies accounted for 13.3 % (US$ 2.33 million) of the total expenditure of medical commodities (US$ 17. 52 million).

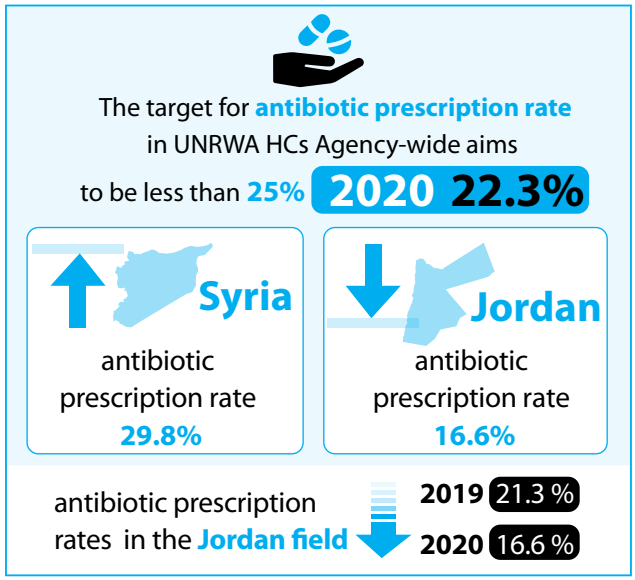
Donations of medical supplies

In 2020, UNRWA received several in-kind donations of medical supplies (medicines, medical equipment and others) from critical partners and stakeholders, including the following:

- Novo Nordisk donated UNRWA with its half annual requirement of insulin vials.
- The Ministry of Health of the Palestinian Authority provided Gaza and West Bank fields with vaccines, iron drops and tablets, and disposable syringes, needles and modern contraceptives.
- UNFPA donated contraceptives for Lebanon and West Bank Fields.
- The Ministry of Health in Jordan provided in-kind donations of vaccines and contraceptives.
- UNICEF and Health Care Society (HCS, an NGO) provided Lebanon with vaccines, medications, disposable syringes and needles.
- The Ministry of Health in Syria and UNICEF provided the Syria field with vaccines, tuberculosis medicines.

Antibiotic prescription rate

In line with the WHO recommendations, the target antibiotic prescription rate in UNRWA HCs Agency-wide aims to be less than 25.0%. In 2020, the antibiotic prescription rate Agency-wide was 22.3%, ranging from 16.6% in Jordan to 29.8% in Syria. It is worth mentioning that antibiotic prescription rates in the Jordan field decreased in 2020 at 16.6% compared to 21.3% in 2019, resulting from lockdown periods at Jordan and lower medical consultations due to the COVID-19 pandemic. Antibiotic prescription is a critical focus in UNRWA HCs, to ensure the rationalisation and control of antibiotics usage among the Palestine refugee population.



UNRWA health team at Nusierat health centre in Gaza packing medications to be delivered to the homes of older people and those with non-communicable diseases. *© 2020 UNRWA Photo by Khalil Adwan*

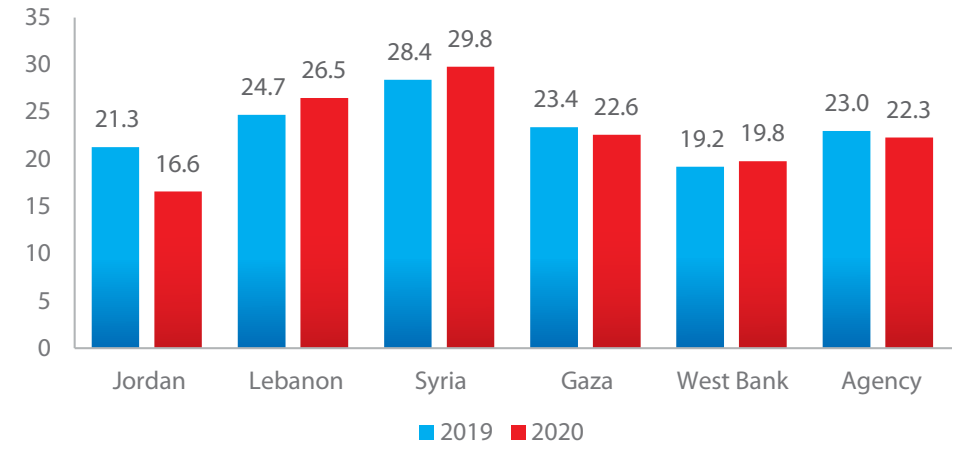


Figure 18: Antibiotic prescription rates (%) by field, 2020-2019

Output 2.2: Efficient hospital support services

In-patient care

The COVID-19 pandemic has made UNRWA Hospitalization Support Program (HSP) even more critical for Palestine refugees. In 2020, the program continued to complement the primary health services offered by UNRWA to ensure that Palestine refugees have access to hospital services in the hosting country without incurring catastrophic health expenditure.

Outsourced hospital services

UNRWA provides hospitalization to Palestine refugees contracting services at discounted prices in governmental, private and NGO hospitals and covering the expenditure with different percentages according to the policy in place in each field. The Agency's hospitalization policy is defined by the users' eligibility that depends on their access to alternative services, their case's medical urgency, and their economic status. Ensuring the effectiveness and efficiency of HSP has become essential given the Agency's constrained finances in the protracted fragile context UNRWA is operating and has been stressed by the current situation of COVID-19, which exacerbated access problems to hospitals.

In 2020, a total of 77,324 Palestine refugees benefited from UNRWA supported hospitalization services. The hospitalization support program (HSP) expenditure was US$ 21.5 million including programme budget, emergency and projects (second highest health-related expenditure after personnel), with an average length of in-patient stay of 1.8 days across the five fields of UNRWA operations. Of all hospitalization cases, approximately 68% were women, 43.8% were between 15 and 44 years old, and 30.4% were children below the age of 15 years.

Table 15: Patients who received assistance for outsourced hospital services during 2018 and 2019 in the five fields

	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
2019	8,904	26,698	14,415	10,966	20,747*	81,730*
2020	5,330	19,500	15,503	13,924	18,469*	77,324*

*Numbers exclude Qalqilia Hospital

The HSP implementation is closely related to the access to hospital services for Palestine refugees and the host countries' governments' health policy. For this reason, caseload, targets, utilization rate per served population, the unit cost of the services, number and type of contract with health service providers and staff involved in monitoring are different in each field.

During the first months of 2020, as usual, the priority was given to contain the expenditure, particularly in Lebanon and the West Bank, where financial pressure

Staff at one of the health centres in Gaza doing relaxation and stretching exercises as a part of the staff support and wellbeing activities. *© 2020 UNRWA Photo by Khalil Adwan*

A Palestine refugee patient is receiving treatment at Qalqilya hospital in West Bank. *© 2020 UNRWA Photo by Dr Khalid Al-Raie*

is high. Continuous follow-up and reconciliation of numbers between Health and Finance Departments were in place. The use of an information data collection system has allowed keeping expenditure and caseload under control. This, in turn, allowed performing strategic analysis to confirm or correct the containment measures in place.

As soon as COVID-19 started to spread in host countries and consequently in Palestine refugee communities, the urgency was to assure hospitals' access. These were granted for free in Jordan, the West Bank and Gaza as COVID-19 was considered as a public health threat. Simultaneously, in Syria, hospitalization was supported at contracted hospitals according to the policy in place. In Lebanon, new contracts with hospitals had to be signed to cover hospitalization for COVID-19 patients.

In Jordan, the number of hospitalised patients decreased again (-40%) this year. The reason for this is due to the COVID-19 crisis. During the prolonged lockdown that Jordan experienced (March-June), hospitals accepted only emergency cases, so generally, the number of admissions decreased. Moreover, all the HCs were closed during this period, so they did not issue hospitalization referrals. Some patients asked for reimbursement once HCs opened again, but most found other sources to cover their expenditure.

The effort in place in Lebanon, including increasing discounted prices, enforced monitoring by Lebanon Field Office, increasing referrals to PRCS hospitals, reducing Average Length of Stay, reinforcing UNRWA medical officers' gate-keeper role and strict auditing of hospitals' bills, continued during 2020. Still, the main reason for the 27.0% decrease in the number of patients' referrals was the stop to non-urgent cases that all hospitals implemented during the first months of the pandemic. Cold cases started to be admitted again end of June. Unit cost per patient increased a lot due to the financial crisis that Lebanon is experiencing since the end of 2019. Moreover, COVID patients (571 in 2020) require high intensity (and therefore high price) care levels. Consequently, UNRWA expenditure for HSP decreased only by 9% compared with last year.

In Syria, the 7.0% increase in the number of patients is compatible with the support to COVID-19 cases provided even if most of them could be only clinically diagnosed and not confirmed by PCR for the unavailability of test in the country due to the conflict.

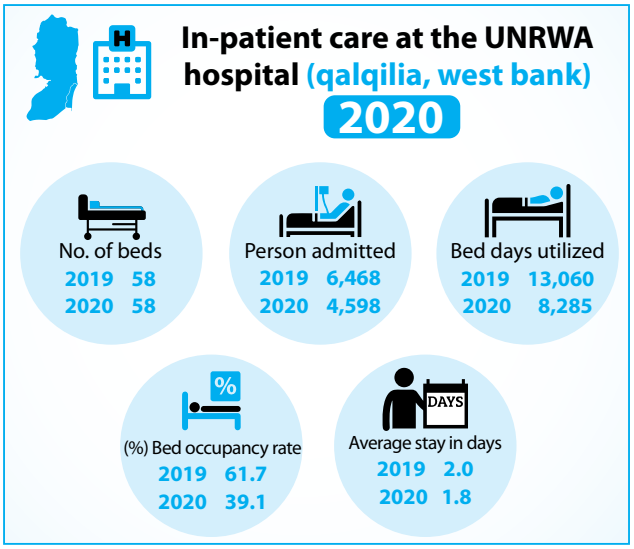
In Gaza, patients' numbers increased by 27.0% following the increase in HSP's available budget secured to protect maternal health after some years of increase in maternal deaths registered in this field. The focus has been the coverage of more Caesarean Section procedures, and not only emergency ones as in the past. This is why patients went to contracted hospitals instead of public hospitals that were overwhelmed by COVID-19 cases. Support was also provided to other non-urgent health conditions to release the Ministry of Health hospitals' pressure in these challenging circumstances.

The West Bank experienced a decrease in the number of patients by 11.0% and a consequent reduction in hospitalization expenditure by 9.0% compared with the same data of 2019. This decrease is in line with a general trend in all the countries due to fear of getting COVID-19 from hospitals; patients avoid looking for hospital services if it is not an emergency.

UNRWA Qalqilya hospital building in West Bank. *© 2020 UNRWA Photo by Dr Khalid Al-Raie*

Qalqilia hospital

In addition to subsidising hospitalization services in contracted hospitals, UNRWA manages a secondary care facility in Qalqilia, West Bank. Qalqilia Hospital is the only hospital operated by the Agency and can accommodate 63 beds. However, currently, there are 58 beds available. The 58 available beds are 14 surgical, 13 medical, 15 paediatric, 14 obstetric/gynecologic, and two intensive care beds. The hospital also has an emergency room and provides outpatient services. It serves UNRWA refugees and non-refugees from the surrounding municipalities in a catchment area of around 100.000 people living in the Municipality. In 2020, 4,598 patients were admitted to Qalqilia Hospital, a decrease of 29.0% compared to 6,468 patients in 2019. The average bed occupancy in Qalqilia Hospital was 39.1% in 2019, dropping from 61.7% of the previous year. The average length of stay in 2020 was 1.8 days.



The Qalqilia hospital has adopted, since the beginning of the pandemic, a triage system at the entrance with measurement of body temperature and questions about the most common COVID-19 symptoms. In 2020, around 25.0% of the hospital staff were infected with the COVID-19 virus, and the hospital needed to be close for disinfection three times. During the closure times, patients who arrived at the hospital were directed to the Ministry of Health hospital in Qalqilia. When MoH hospital faced the same problems (staff infected and closure for disinfection), referral of cases was made to UNRWA hospital. This collaboration continued all year. Mild COVID-19 patients were admitted to the Qalqilia UNRWA hospital for less than two days to prepare their transfer to the MoH referral hospital for COVID-19 cases in the area. The significant decrease in the number of patients and bed occupancy rate is in line with similar data for all the hospitals in the area. People were afraid of getting COVID-19 from the hospitals, leading them to avoid visiting hospitals for non-urgent matters. The willingness to exit the hospital as soon as possible may also has reduced the average length of stay.

Table 16: In-patient care at the UNRWA hospital (qalqilia, west bank) in 2019 and 2020

Indicators	2019	2020
Number of beds	58	58
Persons admitted	6,468	4,598
Bed days utilized	13,060	8,285
Bed occupancy rate (%)	61.7	39.1
Average stay in days	2.0	1.8

Crosscutting services

Nutrition

During 2020, the Department of Health continued to detect malnutrition among children under five years old and the prevention and treatment of micro-and macro-nutrient deficiencies among pregnant women and children to improve Palestine refugees' health.

Children attend the Agency's health centres when they need to be vaccinated or when they are sick. It was essential to check the children's growth indicators among Palestine refugee children at the community level. This is why the Health Programme conducted a cross-sectional household-based study to determine the prevalence, determinants, and caregiver perceptions of food insecurity and over-and undernutrition in children living in two Palestine refugees' camps in Jordan, namely Jerash and Souf camps.

Differences in total food insecurity were particularly marked, with 46% of Jerash households classified as highly food insecure, versus 27.0% for Souf. The prevalence of stunting was 23.0% and 15.0% in the two camps, and overweight more common in Jerash (18.0% vs 7.0%). Besides, dietary diversity and iron-rich food consumption indicators were significantly lower in Jerash. There was no difference between camps in stunting prevalence after multivariate regression, but overweight was significantly associated with Jerash camp's residence (OR 3.25 [CI: 1.34 - 7.83]).

Higher food insecurity was associated with the lower number of months having income [aOR 1.5 (CI: 1.33-1.64)]. After completing the quantitative data

Children at one of UNRWA schools in Gaza receiving awareness via a practical session on healthy nutrition as part of the school Health Programme.
© 2020 UNRWA Photo by Dr Yassir Turki

Palestine refugee children receive health check-ups by a doctor at Ma'an health centre in Gaza during the COVID-19 pandemic.
© 2020 UNRWA Photo Khalil Adwan

collection, we conducted explanatory qualitative interviews to understand better the differences in food security, child obesity, and child dietary indicators between Jerash and Souf. In both camps, qualitative perspectives saw food insecurity and low-quality children's diets primarily mediated by job and income insecurity. These experiences were especially marked in Jerash.

This study could provide helpful scientific and programmatic insights into the process of gathering unbiased and reliable data on malnutrition among refugee children living in Jordan and other fields to aid in the translation of evidence-based public health interventions. It had guided the Department of Health in updating the Child Health Technical instructions and strengthening the active surveillance system for the child growth problems monitored at the Agency's health centres.

The Department of Health uses an evidence-based approach when it comes to updating its health policies. In 2020, the health department published an article in the Open British Medical Journal. It was conducted in 2017 to measure the prevalence of anaemia among children newly registered at UNRWA schools. This study guided the policy's update for the medical examination of the newly registered school children by including the testing for anaemia in this medical examination for school children entering the first grade at the Agency's school.

UNRWA Department of Health provides guidelines for preventing and treating iron deficiency anaemia for 12-month-old Palestine refugee children. According to the Agency's health micro-nutrient technical instructions, all children registered at UNRWA health centres should complete anaemia screening at the age of 12 months, consistent with the mandatory anaemia screening treatment instructions advised by the World Health Organization (WHO). Using the evidence-based approach, the Agency's Department of Health conducted a study, in late 2019 and early 2020, aiming to 1) measure the patients' and doctors' adherences to the anaemia UNRWA guidelines and 2) understand mothers' child feeding practices and knowledge regarding nutrition in one of the health centres in Jordan. This study found that iron supplementation improved the Hb status of anaemic children. The adherence to the UNRWA guidelines was high at the screening visits but became lower at the follow-up visits. This has resulted in the Department of Health taking steps to improve the adherence at the follow-up visits and minimise any unnecessary health centre visits and iron supplementation.

In 2020, the Department of Health developed a new nutritional guideline for health staff on proper nutrition for pregnant, nursery women, infant & toddlers. This guide aims to provide technical and dietary guidelines to the Agency's health personnel on the basic principles of preventive and curative dietary practices to Palestine refugees and their children from preconception care to weaning. It is planned to complete the design, printing and distribution of this guide in 2021. Besides, plans are in place to conduct training sessions (online or in-person) for the health staff to orient them on how to use this guide properly. It contains three sections; every section includes key messages for the UNRWA health staff to use when giving counselling messages to the Palestine refuge women and the children's parents visiting the Agency's health centres:

UNRWA health team at Suf health centre Jordan packing medications to be delivered to the homes of older people and those with non-communicable diseases. *© 2020 UNRWA Photo by Dr Mustafa Ammoura*

1) Part 1: Understanding basic nutrition and healthy diet practices.

2) Part 2: Women and Maternal Nutrition (reproductive age, preconception, pregnancy, and nursing).

3) Part3: Child nutrition (child weaning and nutrition during growth problems).

As mentioned in previous sections, in 2020, the UNRWA Department of Health launched the e-NCD application in the Jordan field. This application provides patients with helpful information on nutrition and healthy diets according to their NCD conditions.

As part of the routine maternal health services, women were screened for anaemia and are provided with iron supplements to prevent and treat anaemia during antenatal and postnatal care.

Also, folic acid supplementation was provided as prophylaxis to prevent hereditary diseases, mainly neural tube defect, during preconception and antenatal care. Vitamin A supplements were delivered to children between 6 months and five years of age twice a year. During 2020, more than 169,603 doses of vitamin A were provided for children below 5 years-old.

Laboratory services

UNRWA provides comprehensive laboratory services through 128 of 140 health centres. Out of the remaining 12 facilities, ten facilities continued to provide essential laboratory support (blood glucose, blood haemoglobin and urine tests by dipstick). The remaining two facilities are in Syria, which, due to accessibility, do not provide laboratory services.

Utilization trend

In 2020, UNRWA laboratory services provided 2.85 million Laboratory tests Agency-wide, a decrease of about 37.0% compared to 2019 (4.53 million laboratory tests). During the reporting period, laboratory services provided decreased by 23.0% in Jordan, 27.0% in Syria, 42.0% in Gaza and 35.0% in West Bank, and 63.0% in Lebanon. The decrease of laboratory services in all fields reflects the decrease utilization trend of UNRWA health services due to the COVID-19 pandemic.

The annual comparison of workload and efficiency of laboratory services was carried out based on 2020 data as part of the Agency's periodic self-evaluation of its programmes using the WHO approach for workload measurement. The WHO targeted productivity range is considered to be from 31.7 to 58.8 workload units (WLUs)/hour. The productivity of laboratory services for the reporting period was 32.8 WLUs/hour Agency-wide, within the WHO target standards. The productivity of laboratory services was 38.5 WLUs/hour in Jordan, 18.4 WLUs/hour in Lebanon, 45.2 WLUs/hour in Gaza, 39.2 WLUs/hour in West Bank and 22.6 in Syria.

Laboratory costs

Agency-wide, the overall cost of laboratory services provided across the five fields was US$ 7,331,571, out of which US$ 7,223,952 (98.5%) was secured through the Programme budget, US$ 0.012 million (0.2%) through in-kind donations, projects or emergency funds. This constitutes a lower expenditure compared to MoH laboratory service costs of host countries combined (estimated at US$ 10.68 million). This suggests that UNRWA provides cost-effective and efficient laboratory services through its HCs.


A lab technician at one of the UNRWA health centres in Gaza is conducting routine laboratory tests. *© 2020 UNRWA Photo by Khalil Adwan*

Table 17: Expenditure on laboratory services (US$) by field and Agency-wide, 2020

Cost	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Programme Budget	1,616,000	769,983	623,156	2,092,803	2,122,010	7,223,952
Non-Programme Budget	0	47,264	1,760	45,844	12,750	107,619
Total	1,616,000	817,247	624,916	2,138,648	2,134,760	7,331,571

Table 18: Comparative analysis on the annual cost of laboratory services performed at UNRWA facilities and cost of the same services if outsourced to host authorities (US$), 2020

Cost	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Host authorities	3,163,385	545,559	511,428	3,600,652	2,856,580	10,677,603
UNRWA	1,616,000	817,247	624,916	2,138,648	2,134,760	7,331,571

Health Communication

As a part of the Agency-wide and Department of Health (HD) COVID-19 pandemic response, and via the participation in the membership of the Agency-wide COVID-19 Coordination Body (team) at UNRWA Headquarters, Amman, an Agency-wide "COVID-19 Strategic Preparedness and Response Plan for UNRWA" was prepared jointly between different departments at UNRWA HQ. The plan included eight pillars defined by WHO, one of which was about "Risk Communication and Community Engagement (RCCE)" the Health Communication role prepared that.

Moreover, a Daily Health Update (Arabic and English) was prepared and widely distributed to stakeholders concerning the COVID-19 situation in all fields and the Agency's response to each case at both HQ and field level. It started as a pdf and ended with a well-designed mail newsletter that continued to be distributed with no delay.

As a part of the RCCE, communication campaigns with many kinds of materials, both for UNRWA staff and Palestine refugees, were developed and widely distributed via different communication channels (printed materials in addition to using UNRWA social media channels and UNRWA website).

At the Agency and stakeholder levels, the Health Communication role at HD has provided health updates for the weekly and monthly reports of WHO/EMRO and the Planning Department at UNRWA HQ.

During Ramadan, the HD initiated, in cooperation with the External Relations and Communications Department (ERCD), a special Ramadan campaign on UNRWA social media platforms to educate UNRWA staff and Palestine refugees about the COVID-19 pandemic and appropriate behaviours during Ramadan, on how to protect themselves and their family members against the disease.

Samples of health communication materials developed during 2020

A nurse at one of UNRWA health centres introducing The Agency's innovative e-NCD mobile application to a patient with non-communicable disease. *© UNRWA 2020 Photo by Khalil Adwan*

A doctor at Shaboura health centre in Rafah, Gaza, using a telephone line and e-Health to contact patients as part of the telemedicine service during the COVID–19 pandemic. *© 2020 UNRWA Photo by Khalil Adwan*

After being completed, the e-NCD mobile application and its associated website were rolled out and launched during an online ceremony with the participation of partners from WH/EMRO, the Japanese Embassy and the World Diabetes Foundation (WDF), and all concerned senior managers from the Agency's fields of operations. This was preceded by the preparation at the HD, HQ of the e-NCD app implementation plan. Moreover, a complete package of advocacy materials of different kinds, including printed (brochure, poster, roll-up, and booklet) and audiovisual (several videos), were distributed to the fields to advocate for the e-NCD app among UNRWA staff and Palestine refugees in all fields.

The Health Communication role planned and conducted an online ceremony for the ICD-11 integration into the e-Health system with different partners' participation, including WHO HQ and EMRO. A complete package of advocacy materials (both printed and audiovisual) was prepared and distributed on this occasion.

Overall, this role supported the preparation, production and distribution of health education and communication products, including the HD AR 2020, revised HD Technical Instructions, besides additional publications.

As a part of the HD team, this role participated in the planning, implementation, and publication of relevant research activities.

Other activities included offering support to the successful online annual meeting for the senior managers at all the fields, namely the 11th HD Retreat and the Family Medicine Diploma (FMD) graduation ceremony, including preparing all relevant communication materials (printed and audiovisual).

Lastly, and for the sixth year, this role organised for the 73rd World Health Assembly side meeting with other stakeholders including the Lancet medical journal, WHO, oPt, Minister of Health, Palestine, Medical Aid for Palestinians (MAP), UK, and International Federation for Medical Students Associations (IFMSA).

Research and evaluation activities

In June 2020, the Department of Health Revised its policy on the Research Review Process, including the establishment of HD's Internal Research Review Board (RRB) within the HD. The Internal RRB aims to provide an extensive review process, ensure the proposals' quality, and enhance the communication between the HQA and the field office before submitting the research proposals to the UNRWA Agency-wide RRB committee.

In 2020, a total of seven research proposals were approved by the UNRWA Agency-wide RRB committee, and the topics covered NCD, antimicrobial resistance, maternal health, COVID-19, and health policy.

Three articles were published in peer-reviewed journals lead by the authors affiliated with the UNRWA HD. Two oral presentations and six poster presentations were accepted to be presented at the Lancet Palestine Health Alliance Conference, which will take place remotely in the spring of 2021.

Overall, the partnerships with leading academic and research institutions continued to be strong through these projects, despite the challenges faced due to the COVID-19 pandemic.

In addition to the research activities, the year 2020 exceeded the HD milestone in introducing program evaluation concepts and framework to monitor, track continuously, and evaluate the Health Programmes

and services implemented. The HD also identified the increasing interests and further strengthened its evaluation framework by implementing research, surveillance and epidemiological methods.

In 2021, the HD aims to integrate further the evidence and science generated from research and evaluation activities to inform health services, policies, and programs at UNRWA HD.

We continue to welcome researchers and interns from across the world to collaborate to improve Palestine refugee populations' health by all possible means.

Gender mainstreaming

Gender concerns and gender mainstreaming in the Health Programme

The UNRWA Health Programme is deeply committed to gender mainstreaming in all of its activities. This is under the UNRWA Gender Policy adopted in 2007 and the UNRWA Gender Equality Strategy (GES) 2016-2021. In 2020, the COVID-19 pandemic had a profound impact on Health Programme operations. However, throughout the pandemic, essential health services, including improving gender parity and preventing sexual and gender-based violence, continued. This was pivotal as the COVID-19 pandemic directly impacts millions' lives by causing mortality and morbidity and led to an increase in mental health problems and sexual and gender-based violence.

Addressing the gender gap in the workforce

UNRWA aims to lead by example and is committed to achieving gender parity in the senior levels of health leadership and at the Department of Health at the Headquarters in Amman. Currently, three of the five fields have female-male tandem in chief and deputy chief of health. Similarly, in HQ Amman at the Department of Health, several women have been recruited to fill new senior positions. These were temporarily frozen due to the financial situation of UNRWA but will proceed in April. These steps are essential milestones for UNRWA. It underlines the commitment to achieving gender parity in the workforce and inspire future generations of women leaders.

Mainstreaming gender-based violence (gbv) concerns for the Health Programme

Gender-based violence is an issue that is at the heart of the health response of UNRWA. Every individual has a right to a life free of harassment, violence, abuse or threats. The Health Programme takes this extremely seriously and provides care at the health centres for gender-based violence survivors. It also coordinates with other departments at UNRWA to offer a holistic response. The COVID-19 pandemic has worsened the situation for individuals at risk of gender-based violence, mainly due to lockdowns that forced people to spend prolonged time in their houses. To counter this, UNRWA established hotlines in all five fields to provide support and care to gender-based violence survivors. Health centres were also always open and able to receive survivors of gender-based violence.

Improving the understanding and awareness of gender and gender-based violence among Health Programme staff

UNRWA conducted an assessment to ensure that Health Programme health staff provide the highest quality of care and assess their understanding and awareness regarding gender and gender-based violence. More than 800 staff participated in that assessment, which showed that 84.0% of the staff received gender-based violence training in the last three years. Again, the vast majority of staff, 84.0%,

Health staff offering an awareness session for the patients about in the waiting area at Beit Hanoun health centre in Gaza COVID–19. *© UNRWA 2020 Photo by Khalil Adwan*

During her visit to the Alliance health centre in Syria, a girl accompanied her mother is receiving psychosocial support as a part of the MHPSSP at UNRWA health centres. *© UNRWA 2020 Photo by Dr Husein Shihabi*

Main Baqaa health centre staff running a group awareness session about healthy lifestyle, including GBV, at Baqaa Camp in Jordan. *© UNRWA 2020 Photo by Gwendolyn Carleton*

were also comfortable referring survivors of sexual and gender-based violence to other departments to provide a holistic response to care. This emphasizes the high quality of care and professionalism by Health Programme staff. There is a plan to conduct a follow-up assessment in 2021 to ensure the continuity of high-quality care.

Over 1,300 assessed community members, one-third of whom were males, were asked their views and opinions on the Health Programme's response towards gender-based violence. The answers indicated that the Health Programme is the premier point of contact for community members when faced with gender-based violence. This highlights the trust of community members in the Health Programme. However, 40.0% indicated that they were aware of gender-based violence actions by UNRWA in the last eight weeks only at the assessment time. Moreover, approximately 50.0% of the participants reported an increase in gender-based violence during the COVID-19 pandemic in the household.

The latter issue underscores the importance and needs within the community for gender-based violence care, especially as the COVID-19 pandemic is ongoing.

Mainstreaming adolescent sexual and reproductive health rights

To develop the basis for adolescent-friendly health centres, UNRWA finalised the Sexual and Reproductive Health Rights for an adolescent project that started in June 2017 and ended in March 2020. The project's first objective is to improve sexual and reproductive health (SRH) and GBV service at UNRWA HCs. The second objective is to introduce information related to SRH and GBV at the Agency's schools. The project activities included equipping health centres with needed equipment (like ultrasound devices), building health and education staff's capacity through SRH and GBV training, and conducting outreach activities for adolescents and parents. Lastly, one main activity was conducting operational research to explore the barriers that prevent married adolescents from using modern contraceptives.

All activities were completed except for the education staff training (only 75.0% of outreach activities were completed) that was hindered by the COVID-19 situation that led to lockdowns and the schools' closures in all fields. In conclusion, the project revealed the Health Programme's need to explore the adolescents' perceptions about the SRH services needed at our HCs and fulfil their expectations. In addition to the research results showing the reluctance of young women to use modern contraceptives, it is primarily due to misperceptions regarding risk and infertility fear.

Staff at one of the health centres in Gaza doing relaxation and stretching exercises during working hours as a part of the staff support and wellbeing activities. *© 2020 UNRWA Photo by Khalil Adwan*

Health team members at one of the health centres in Syria standing proudly and with confidence as heroes supporting Palestine refugees health and wellbeing during the harsh times of the COVID – 19 pandemic. *© 2020 UNRWA Photo Dr Husein Shihabi*

Human resources for health reform

The health workforce is considered one of the critical components of an effective health system[5]. The importance of human resources is evident from the fact that the World Health Report of 2006 was dedicated to this subject. A sufficient, well trained, motivated and geographically well-distributed health workforce is required To ensure a well-performing health care system[6]. The current UNRWA FHT approach has helped reform the Agency's health care providers to be the more efficient and effective service delivery model today. Human resources form an essential part of the FHT approach; therefore, providing an appropriate staffing level in the technical and non-technical cadre is crucial for ensuring and maintaining quality health services delivery.

The e-Health system's introduction has helped reduce the workload on clerks and other health centre staff by streamlining the patient flow, more straightforward registration system, and reduced waiting time. Additional reforms were needed to achieve maximum efficiency and improve the quality of UNRWA health services. For this, UNRWA HD conducted a detailed review of posting norms for health centre clerks, cleaners and Medical Officers in 2018 and 2019. In 2020, due to the COVID-19 pandemic, the work on norms had not progressed very well; however, drafts of the norms for Nursing roles, Laboratory technicians, and Pharmacists were completed to be reviewed at the field-level Health Programmes management and by the headquarters Department of Health team. In 2021, the work on norms will continue to reflect the added needs of the COVID-19 response, including triage and telemedicine, and may require revisiting already established norms and developing new norms. The work will mainly follow WHO Workload Indicators for Staffing Need (WISN) methodology.

Table 19: Number of doctors who completed the family medicine diploma courses

Year	Gaza	Jordan	West Bank	Lebanon	Syria	Total
2015 – 2016 (First cohort)	15	-	-	-	-	15
2017- 2018 (Second cohort)	15	15	10	-	-	40
2018 – 2019 (Third cohort)	12	8	-	-	-	20
2019 – 2020 (Fourth cohort)	15	6	10	10	9	50
No. of doctors trained	57	29	20	10	9	125
No. of UNRWA doctors in 2020	164	101	76	29	71	441

[5] WHO. (2000). The World Health Report 2000: Health Systems: Improving Performance. Geneva. World Health Organization. ISBN 156198 4 92 X

[6] WorldBank. (2008). Health System and Financing: Human Resource. Retrieved March 2009 ,2, from Worldbank.org. http://web.worldbank.org/wbsite/external/topics/exthealthnutritionandpopulation/exthsd/0,,contentMDK:20190576~menuPK:438351~pagePK:148956~piPK:216618~theSitePK:376793,00.html

Family medicine training (Family Medicine Diploma Programme - fmdp)

UNRWA recognizes the importance of providing ongoing training to all staff working in UNRWA HCs, not only for the professional development of staff but also for maintaining and improving health care provision to Palestine refugees. Despite this, restrictions of movement within and between fields and the general high burden of work in UNRWA HCs often prevent this from occurring. Therefore, the Rila Institute of Health Sciences in the United Kingdom collaborated with UNRWA to tailor a 12-month training course on Family Medicine for UNRWA medical physicians. This programme is called the Family Medicine Diploma Programme (FMDP).

The Family Medicine Diploma Programme (FMDP) was tailored to the Agency's primary health care (PHC) model and its adopted FHT approach. The FMDP provides clinicians with an in-service training model that they can take without disrupting their daily work. The training is also designed to help medical doctors at UNRWA health centres meet the Palestine refugee populations' health needs in the five fields of UNRWA operations.

The diploma programme included different modalities such as face to face workshops held in field offices at the beginning of the course, an e-learning platform, regular exams after each unit, and interactive webinars. On-job practical training activities were directly provided by local facilitators who are specialised in family medicine.

Milestones of fmdp

Since the start in 2015, a total of 125 doctors of UNRWA completed the family medicine diploma courses, as shown in the following table.

The fourth cohort's evaluation was carried out based on the previous regular mini exams, situational judgemental tests, and attendances record of online webinars. The physical exams were not conducted this year due to the travel restrictions posed by the COVID-19.

The fifth cohort was expected to start in June 2020. Unfortunately, due to the COVID-19 pandemic and the delay in signing the contract with the Rila Institute, the training began in January 2021 for 50 medical doctors. Participants who already graduated with the PGDM

A screenshot from the virtual ceremony conducted by the Department of Health at UNRWA HQ to celebrate the graduation of 50 doctors (4th cohort) who completed their Family Medicine Diploma from the five fields. *© 2020 UNRWA Photo by Dr Yassir Turki*

provided positive feedback on the training that they received. Key points that they highlighted included the positive impact of their training on the quality and comprehensiveness of their health care services. They believe that they could share knowledge and skills with other colleagues and become more competent and capable of focusing on the prevention of diseases in general and on recognising psychosocial-physical related health problems.

Financial Resources

The total Health Programme Budget expenditure in 2020 amounted to approximately US$ 115.9 million, corresponding to an estimated expenditure of US$ 20.15 per registered refugee, a slight increase compared to the 2019 total expenditure of US$ 111.0 or US$ 19.7 per registered refugee. Even if a more conservative approach was used to estimate the per capita expenditure based on the number of the population served by the Agency (approximately 2.78 million) rather than the total number of registered refugees (5.7 million), the annual per capita expenditure is US$ 40.0 per capita per year Agency-wide. WHO recommends US$ 40-50 per capita for the provision of basic health services in the public sector.

A doctor at Nusierat health centre in the Middle of Gaza using a telephone line to contact patients as part of the telemedicine service during the COVID–19 pandemic. *© 2020 UNRWA Photo by Khalil Adwan*

Table 20: Health expenditure per registered palestine refugee, 2019 and 2020 regular budget (US$)

Year	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2019	8.9	41.0	16.3	23.5	31.6	19.7
2020	9.13	47.25	15.38	24.43	30.23	20.15

There is a significant expenditure gap per registered Palestine refugee between Lebanon (US$ 47.25) and Jordan (US$ 9.13). This gap is due to the heavy investment in secondary and tertiary care made necessary in Lebanon, where Palestine refugees are denied access to public health services and cannot afford treatment costs at private facilities. Conversely, in Jordan, UNRWA registered Palestine refugees have full access to the Government's social and health services.

The Agency's main focus is on comprehensive primary health care delivery through 141 HCs Agency-wide, with very selective use of hospital services at the mostly contracted hospitals in each field.

In 2020 the global outbreak of COVID-19 puts further pressure on the already overstretched health system, which is complicated the case and increases the challenges on the UNRWA health system, including support to hospitalization when needed. Allocations for hospital services in 2020 represented only 21.4% of the total Health Programme Budget. The constraints in the budget will mean a significant challenge for the Health Programme due to the population increase, worsening of leaving conditions, and rise of NCDs, which are often associated with significant complications, long-term care, and the cost of hospital services in recent years.

UNRWA - financial crisis

2020 has been a challenging year, with the outbreak of the COVID-19 pandemic, the subsequent economic and financial downfall and the unpredictable political environment, which continue to impact the lives of Palestine refugees dramatically.

In 2020 The Agency's financial situation remained critical. The Agency shortfall for the programme budget was US$ 75 million in 2020. UNRWA needed a total of an additional US$ 152 million to cover the added requirements for its COVID-19 response.

The Agency's head continued leading fundraising efforts at a high level and benefitted from solid diplomatic support from the UN Secretary-General and others. However, income did not keep up with needs that continue growing; thus, the COVID-19 pandemic. The Agency ended 2020 only with a loan and grant from the Central Emergency Response Fund (CERF) and by deferring payments to a significant number of suppliers.

The Agency's leadership grapples with chronic under-funding. It relies on solid programme performance to help preserve donor commitments and mobilise approximately $1 billion per year for all expenditures – core programmes, emergency responses, projects, and management. The Health Programme's budget represents a small fraction of the expenditures while maintaining high performance and contributing to the refugee communities' humanitarian stability and around 58 refugee camps served by UNRWA. These are attributes that the donor community values immensely and encourages them to sustain funding for UNRWA over the long term.

Staff at one of Tel sultan health centre in Gaza doing relaxation and stretching exercises as a part of the staff support and wellbeing activities. Those are our heroes, and they deserve the best. *© 2020 UNRWA Photo by Khalil Adwan*

Table 21: Breakdown of health expenditure of programme budget by sub-programme-2020

Sub Program	Sub Sub-Program description	Jordan	Lebanon	Syria	Gaza	West Bank	HQ	Total
Hospitalization Services	Qalqilia Hospital					2,940,399		2,940,399
	Secondary Hospital Services	628,691	11,901,140.60	1,732,654	2,758,449	4,497,406		21,518,340
	Tertiary Health Care		332,153.82					332,154
Total Hospitalization Services		628,691	12,233,294.42	1,732,654	2,758,449	7,437,806		24,790,893
Primary Health Care (FHT)	Communicable Diseases	16	35,040.29			1,285		36,341
	Disability Screening and Rehabilitation	66,959		106,366	1,007,031	416,974		1,597,331
	Laboratory Services	1,616,000	769,982.83	623,156	2,092,803	2,122,010		7,223,952
	Maternal Health & Child Health Services	6,695	633.49					7,328
	Mental Health		1,636.09					1,636
	Non-Communicable Diseases							
	Oral Health	1,690,340	767,596.01	404,957	1,350,518	1,011,234		5,224,645
	Outpatient Services	14,646,406.92	7,328,898.12	5,131,357	25,086,569	11,967,147		64,160,378
	Pharmaceutical Services	1,676,961.65	798,047.48	395,998	1,812,850	1,843,060		6,526,917
	Psychosocial Support Programme				941,555	513,062		1,454,616
	Radiology Services		111,418.52		135,727	165,399		412,544
	School Health Services	283,220.20			448,347	85,742		817,309
Total Primary Health Care (FHT)		19,986,597.92	9,813,252.83	6,661,833	32,875,399	18,125,913		87,462,996
Programme Management		459,151.61	613,893.89	352,724	444,515	783,844	1,017,727	3,671,855
Total Programme Management		459,151.61	613,893.89	352,724	444,515	783,844	1,017,727	3,671,855
Grand Total		21,074,440.29	22,660,441.14	8,747,211	36,078,363	26,347,562	1,017,727	115,925,745

section 4 – data

Part 1 - Agency-wide trends for selected indicators

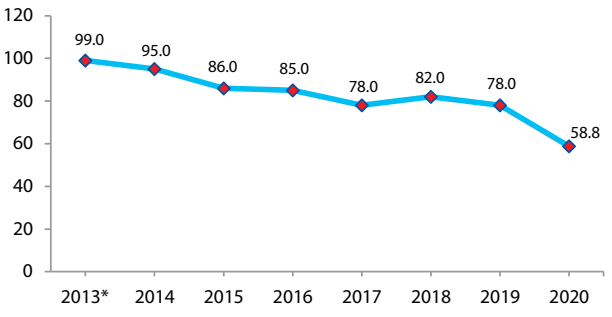


Figure 19: Average daily medical consultations per doctor

*data from Syria is not included

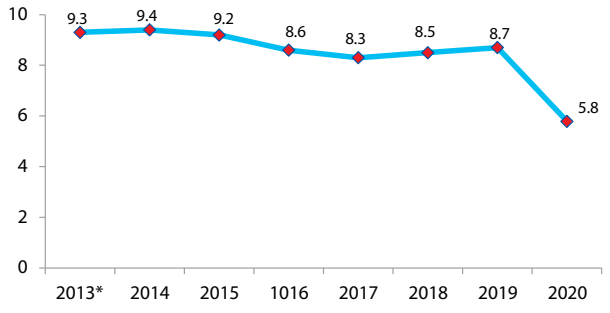


Figure 20: Number of outpatient consultations (million)

* data from Syria is not included

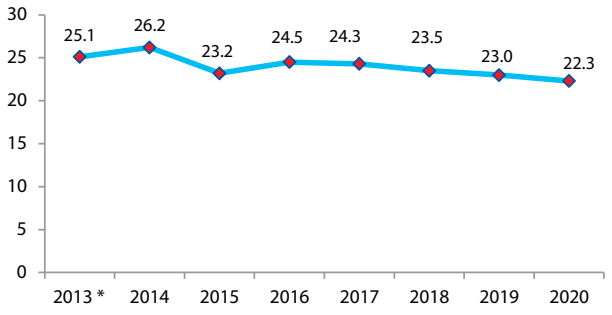


Figure 21: Antibiotics prescription rate

* data from Syria is not included

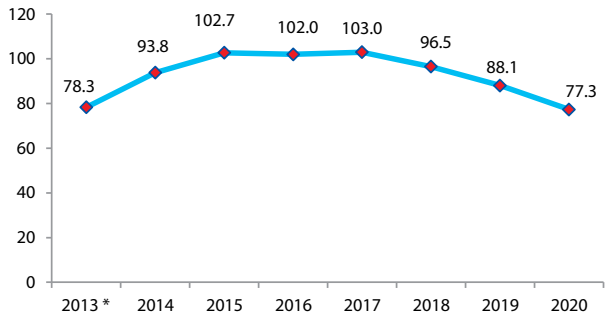


Figure 22: Number of hospitalizations, including qalqilia hospital (in thousands)

* data from Syria is not included

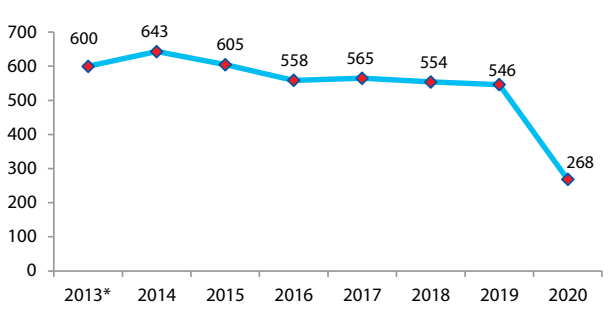


Figure 23: Number of dental consultations (in thousands)

* data from Syria is not included

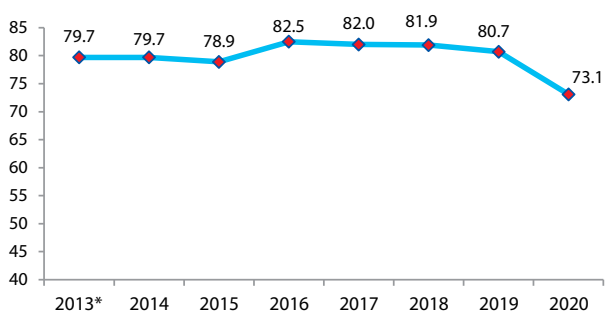


Figure 24: Percentage of pregnant women registered during the 1st trimester

* data from Syria is not included

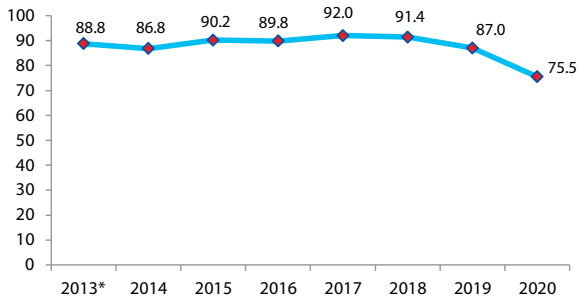


Figure 25: Percentage of pregnant women attending at least 4 ANC visits

* data from Syria is not included

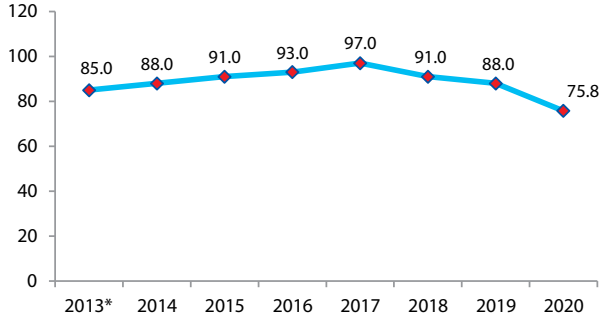


Figure 26: Number of newly registered pregnant women (in thousands)

* data from Syria is not included

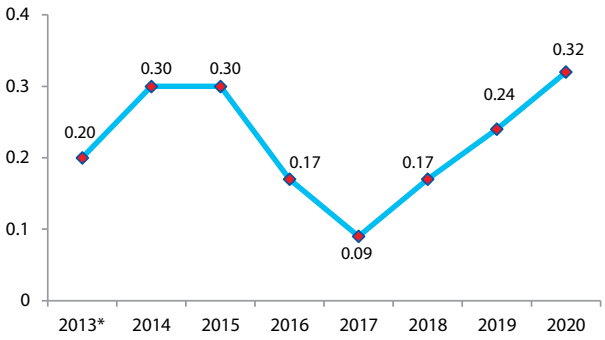


Figure 27: Percentage of deliveries with an unknown outcome

* data from Syria is not included

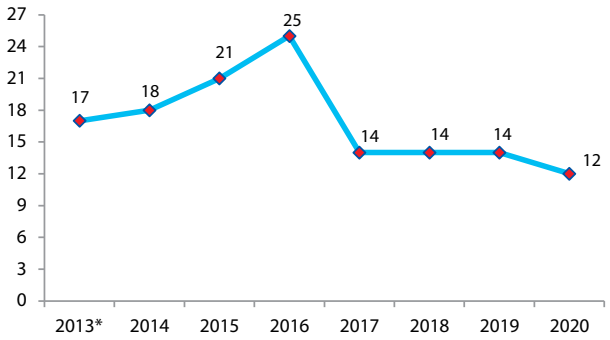


Figure 28: Number of maternal deaths

* data from Syria is not included

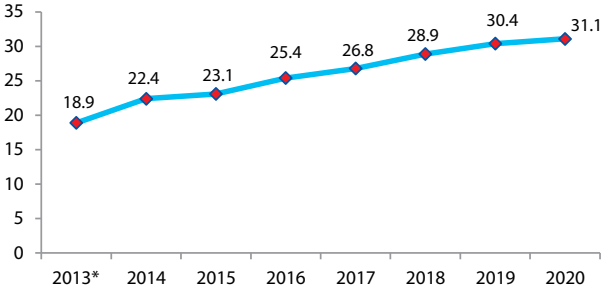


Figure 29: Percentage of caesarean section deliveries

* data from Syria is not included

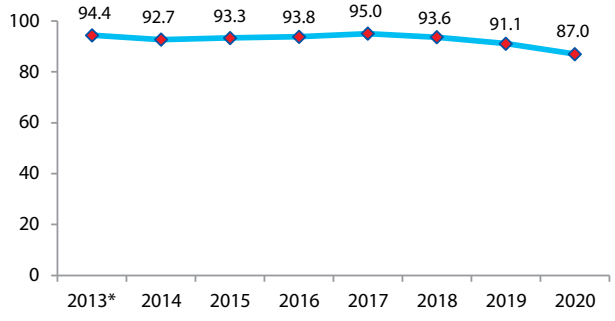


Figure 30: Percentage of women attending PNC within six weeks of delivery

* data from Syria is not included

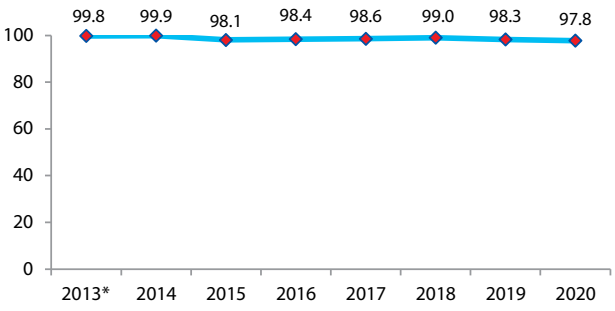


Figure 31: Percentage of pregnant women protected against tetanus

* data from Syria is not included

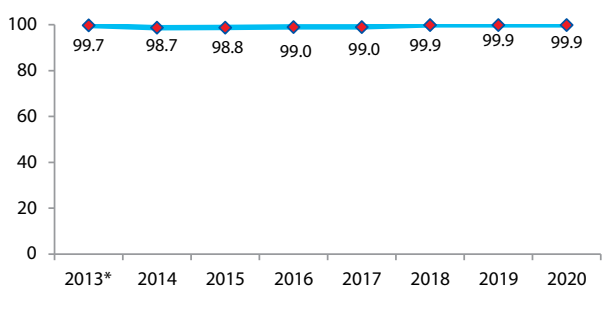


Figure 32: Percentage of deliveries in health institutions

* Data from Syria is not included

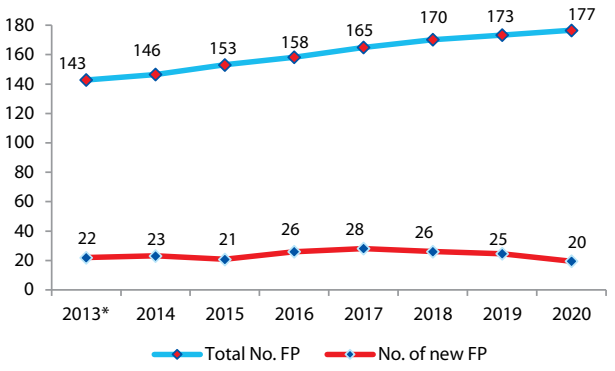


Figure 33: Total & new Number of family planning acceptors (in thousands)

* data from Syria is not included

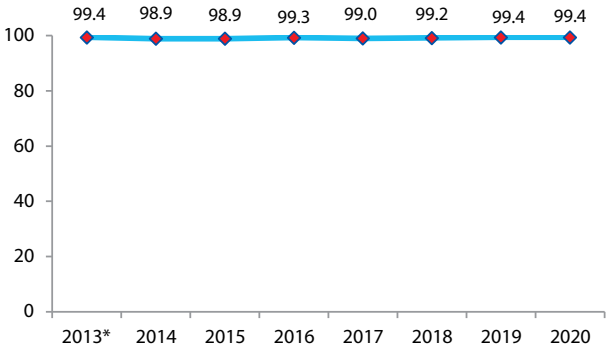


Figure 34: Percentage of children 18 months old who received all EPI booster

* data from Syria is not included

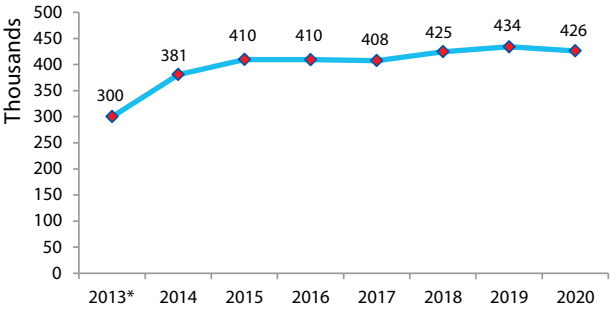


Figure 35: Number of children 0-5 years under supervision (in thousands)

* data from Syria is not included

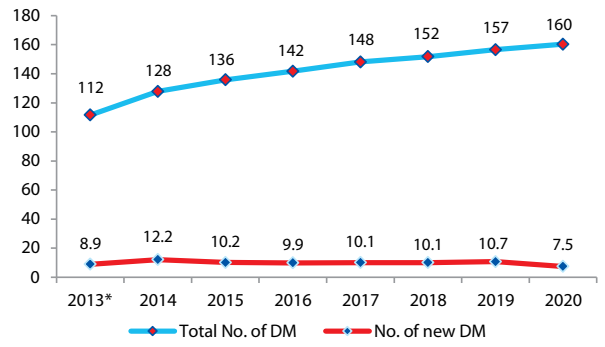


Figure 36: Total & new number of patients with diabetes mellitus DM (in thousands)

* data from Syria is not included

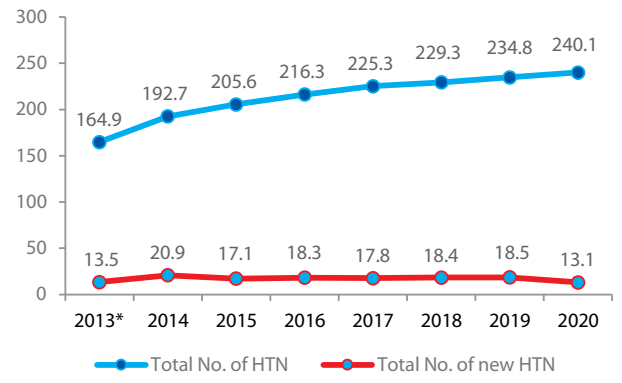


Figure 37: Total & new number of patients with hypertension (in thousands)

* data from Syria is not included

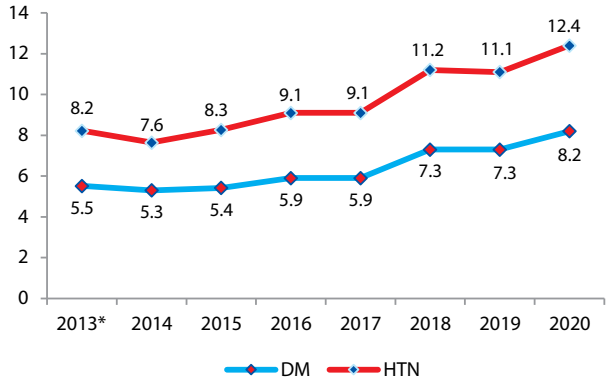


Figure 38: Prevalence of ncds (DM & HTN) among the population served > 18 years

* data from Syria is not included

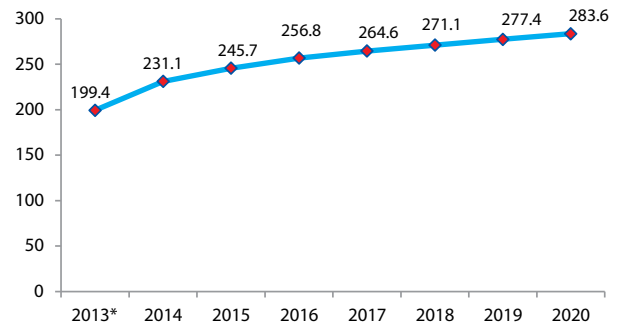


Figure 39: Total number of all patients with diabetes or hypertension or both (in thousands)

* data from Syria is not included

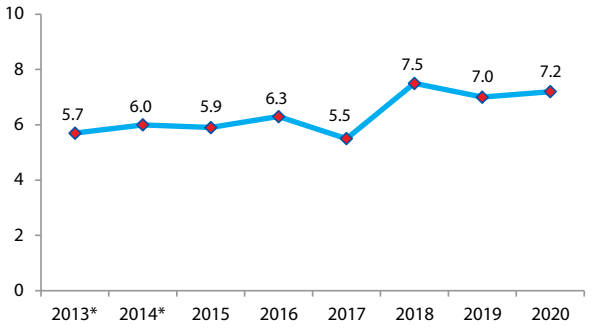


Figure 40: Percentage of defaulters among ncd patients'

* data from Syria is not included

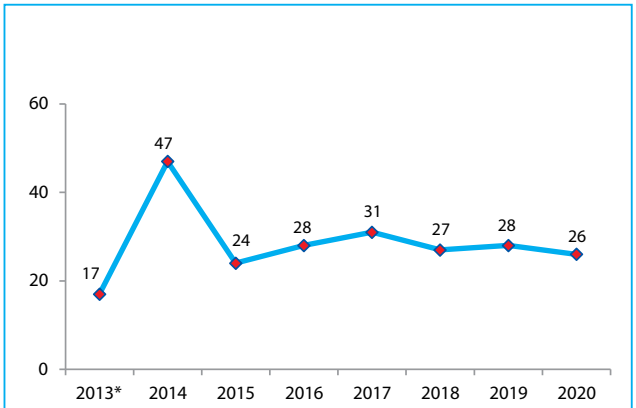


Figure 41: Number of newly reported TB cases

* data from Syria is not included

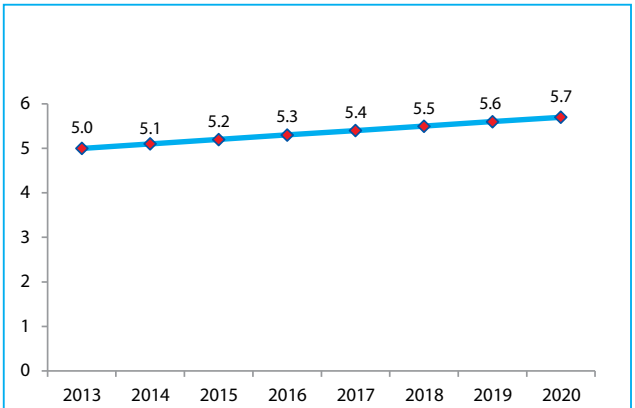


Figure 42: Total Number of registered Palestine refugees (in millions)

Part 2- cmm (2016-2021) indicators

Table 22: Aggregated 2020 data tables

SO2	Indicator	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Refugees' health is protected and the disease burden is reduced	Prevalence of diabetes among population served, 18 years and above	8.4	9.0	7.9	7.5	9.4	8.2
	Percentage of DM patients under control per defined criteria	36.2	62.5	36.0	34.9	42.3	38.7
	Average daily medical consultation per doctor	62.3	50.8	53.6	63.5	63.6	58.8
	Average consultation time per doctor	3.0	2.7	2.6	3.2	3.8	3.1
	Number of HCs fully implementing eHealth system	25	27	22	22	43	139
	Percentage of NCD patients coming to HC regularly	70.9	63.1	61.5	81.7	73.7	74.04
	Percentage of NCD patients with late complications	7.1	6.6	12.9	12.8	10.5	10.4
	Number of EPI vaccine preventable disease outbreaks	0	0	0	0	0	0
	Percentage of women with a live birth who received at least 4 ANC visits	62.9	71.2	52.5	90.4	69.3	75.5
	Percentage of post-natal women attending PNC within 6 weeks of delivery	66.5	92.0	76.1	100.0	87.7	87.0
	Percentage Diphtheria + tetanus coverage among targeted students	80.9	96.5	99.0	99.0	100	95.2
	Antibiotic prescription rate	16.6	26.5	29.8	22.6	19.8	22.3
	Percentage of HCs with no stock out of 12 tracer medicines	100	100	100	100	95.3	98.57
	Percentage of preventative dental consultations out of total dental consultations	42.5	30.7	24.6	41.7	40.6	38.3
	Percentage of targeted population 40 years and above screened for diabetes mellitus (DM)	10.3	8.6	8.5	8.1	9.5	9.1
	Number of new NCD patients (DM, HT, DM+HT)	6,477	1,491	2,983	5,112	1,835	17,898
	Total number of NCD patients (DM, HT, DM+HT)	78,827	29,098	35,109	98,373	42,177	283,584
	Percentage of children 18 months old that received all booster vaccines	99.1	97.1	99.4	99.3	100.0	99.3
	Number of new tuberculosis (TB) cases detected	1	8	15	2	0	26
	Percentage of 18 months old children that received 2 doses of Vitamin A	99.2	96.5	99.5	99.6	99.6	99.6
	Number of active/continuing family planning users	34,438	16,509	11,229	93,206	21,192	176,574
	Number of new enrolments in pre-conception care programme	2,144	825	359	8,576	1,782	13,686
	Percentage of 4th gr. school children identified with vision impairment (disaggregated by sex)	22.7	5.3	3.0	10.0	16.8	12.0
	Unit cost per capita	11.1	60.9	24.5	32.4	36.1	26.0
	Percentage of UNRWA hospitalization accessed by SSNP	16.3	33.0	36.3	40.9	1.6	24.6
	Hospitalization rate per 1000 served population	6.9	91.3	52.5	11.7	58.3	26.9
	Hospitalization unit cost	117.7	499.0	167.1	218.9	235.7	247.7

Part 3 – 2020 data tables

Table 23: Aggregated 2020 data tables

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.1 – Demographics						
Population of host countries in million[7]	10.90	5.26	20.38	1.95	2.94	41.46
Total persons eligible UNRWA health services (no.)	2,463,130	543,824	655,729	1,643,546	1,082,664	6,388,893
Total number of registered refugees	2,307,012	479,537	568,730	1,476,716	871,551	5,703,546
Refugees in host countries (%)	22.6	10.3	3.2	84.0	36.7	15.4
Refugees accessing (served population) UNRWA health services out of total number of registered refugees (%/no.)	775,898 (33.6%)	213,651 (44.6%)	295,543 (52.0%)	1,189,960 (80.6%)	395,632 (45.4%)	2,870,683 (50.3%)
Number of persons (individuals) who used UNRWA health services	402,858	136,306	179,078	784,720	234,083	1,737,045
Growth rate of registered refugees (%)	1.8	1.0	1.3	1.3	1.6	1.5
Children below 18 years (%)	25.8	22.0	28.3	41.3	27.5	30.0
Women of reproductive age: 15-49 years (%)	28.5	25.8	27.7	24.8	28.3	20.9
Population 40 years and above (%)	36.9	44.4	36.0	23.8	35.2	33.8
Population living in camps (%)	17.3	51.0	30.5	37.1	24.8	27.9
Average family size[8]	5.2	4.7	4.8	5.6	5.6	5.3
Aging index (%)	51.7	72.8	36.8	18.0	45.1	38.1
Fertility rate	3.2	2.7	2.7	3.6	3.6	3.2
Male/female ratio	1.0	1.0	0.95	1.02	0.97	1.0
Dependency ratio	46.4	47.5	49.5	75.6	50.5	54.1
23.2- Health Infrastructure						
Primary health care (PHC) facilities (no.):						
Inside official camps	12	14	12	11	20	69
Outside official camps	13	13	11	11	23	71
Total health centers	25	27	23	22	43	140
Ratio of PHC facilities per 100,000 population	1.0	5.0	3.5	1.3	4.0	2.2
Services within PHC facilities (no.):						
Laboratories	25	17	21	22	43	127
Dental clinics:						
- Stationed units	30	19	20	19	24	112
- Mobile units	4	0	2	5	0	11
Total Dental clinics	34	19	22	24	24	123
Radiology facilities	1	4	0	7	9	21
Physiotherapy clinics	1	0	0	11	6	18
Hospitals	-	-	-	-	1	1
Health facilities implementing E-health	25	27	22	22	43	139

[7] https://www.cia.gov/the-world-factbook/countries/

[8] Current contraceptive practices among mother of children 0-5 years survey conducted in 2015

Field		Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Strategic Objective 1							
23.3 - Outpatient Care							
(a).Outpatient consultations medical officer (no.)							
First visits	Male	126,800	66,062	66,082	326,246	91,222	676,412
	Female	237,687	90,917	97,097	425,597	149,090	1,000,388
Total first visits		364,487	156,979	163,179	751,843	240,312	1,676,800
Repeat visits	Male	253,396	160,149	198,099	786,190	192,834	1,590,668
	Female	488,377	224,911	305,163	1,120,048	323,666	2,462,165
Total repeat visits		741,773	385,060	503,262	1,906,238	516,500	4,052,833
Sub-total (a)		**1,106,260**	**542,039**	**666,441**	**2,658,081**	**756,812**	**5,729,633**
Ratio repeat to first visits		2.0	2.5	3.1	2.5	2.1	2.4
(b) Outpatient consultations specialist (no.)							
Gyn.& Obst.		19,524	9,918	5,567	11,520	1,934	48,463
Cardiology		2,014	496	0	9,064	0	11,574
Others		7	4,058	0	5,169	0	9,234
Sub-total (b)		**21,545**	**14,472**	**5,567**	**25,753**	**1,934**	**69,271**
Grand total (a) + (b)		**1,127,805**	**556,511**	**672,008**	**2,683,834**	**758,746**	**5,798,904**
Average daily medical consultations / doctor[9]		**62.3**	**50.8**	**53.6**	**63.5**	**63.6**	**58.8**
23.4 - Inpatient Care							
Patients hospitalized -including Qalqilia (no.)		5,330	19,500	15,503	13,924	23,067	77,324
Average Length of stay (days)		1.6	2.4	1.5	1.5	2.2	1.8
Age distribution of admissions (%):-							
0-4 yrs		3	2,661	669	1,074	3,524	7,931
5-14 yrs		111	1,251	739	659	12,797	15,557
15-44 yrs		4,937	6,335	7,972	9,647	4,974	33,865
< 45 yrs		279	9,253	6,123	2,544	1,772	19,971
Sex distribution of admissions (%):							
Male		300	8,671	6,573	3,345	5,869	24,758
Female		5,030	10,829	8,930	10,579	17,198	52,566
Ward distribution of admissions (%):							
Surgery		164	5,762	8,299	5,654	3,643	23,522
Internal Medicine		362	10,194	1,759	254	7,993	20,562
Ear, nose & throat		94	393	620	0	0	1,107
Ophthalmology		6	677	2,185	1,237	773	4,878
Obstetrics		4,704	2,474	2,640	6,779	10,658	27,255

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

* PRS data is included.

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.5 - Oral Health Services						
Dental curative consultation – Male (no.)	22,608	9,697	20,508	51,901	6,766	111,480
Dental curative consultation – Female (no.)	37,793	10,794	32,483	67,024	8,546	156,640
(a) Total dental curative consultations (no.)	60,401	20,491	52,991	118,925	15,312	268,120
Dental screening consultations – Male (no.)	12,712	3,391	7,113	20,820	3,657	47,693
Dental screening consultations – Females (no)	31,934	5,671	10,209	64,163	6,824	118,801
(b) Total dental screening consultations (no.)	44,646	9,062	17,322	84,983	10,481	166,494
Grand total of Dental consultations/ screening (a) & (b)	105,047	29,553	70,313	203,908	25,793	434,614
% preventive of total dental consultations	42.5	30.7	24.6	41.7	40.6	38.3
Average daily dental consultations / dental surgeon	20.4	12.6	18.2	39.3	13.8	23.6
23.6 - Physical Rehabilitation						
Trauma patients	-	-	-	2,423	112	2,535
Non-Trauma patients	303	-	-	3,486	711	4,500
Total	303	-	-	5,909	823	7,035
Strategic Objective 2						
23.7 - Family Planning Services						
New family planning users (no.)	8,817	1,238	2,976	4,651	1,850	19,532
Continuing users at end year (no.)	93,206	16,509	11,229	34,438	21,192	176,574
Family planning discontinuation rate (%)	4.8	3.7	4.4	3.5	2.9	3.9
Family planning users according to method (%):						
IUD	51.0	38.5	28.1	42.0	65.1	49.8
Pills	23.3	24.5	32.8	29.4	17.4	23.3
Condoms	22.0	35.5	35.0	25.4	15.8	23.7
Spermicides	0.005	0.006	0.000	0.000	0.005	0.005
Injectables	3.8	1.4	4.1	3.1	1.6	3.2
23.8 - Preconception Care						
No. of women newly enrolled in preconception care programme	2,144	825	359	8,576	1,782	13,686
23.9 - Antenatal Care						
Registered population (no.)	2,463,130	543,824	655,729	1,643,546	1,082,664	6,388,893
Expected pregnancies (no.)[10]	56,135	7,260	15,246	46,184	26,850	151,674
Newly registered pregnancies (no.)	19,722	4,021	5,135	33,781	13,192	75,851
Antenatal care coverage (%)	35.1	55.4	33.7	73.1	49.1	50.0
Trimester registered for antenatal care (%):						
1st trimester	68.7	82.1	41.7	83.3	62.8	73.1
2nd trimester	26.1	15.0	34.8	16.1	30.4	22.4
3rd trimester	5.2	2.9	23.5	0.6	6.8	4.5
Pregnant women with 4 antenatal visits or more (%)	62.9	71.2	52.5	90.4	69.3	75.5
Average no. of antenatal visits	3.7	3.9	3.6	6.0	3.8	4.8

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

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.10 - Tetanus Immunization						
Pregnant women protected against tetanus (%)	94.7	93.4	99.0	100.0	97.6	97.8
23.11 - Risk Status Assessment						
Pregnant women by risk status (%):						
High	25.4	11.6	14.5	19.7	16.0	19.7
Alert	28.6	36.1	40.4	29.2	28.2	30.1
Low	46.0	52.3	45.1	51.1	55.8	50.2
23.12 Diabetes Mellutes And Hypertenstion During Pregnancy						
Diabetes during pregnancy (%)	2.5	5.7	3.2	6.6	7.0	5.3
Hypertension during pregnancy (%)	3.6	8.9	6.0	8.8	4.9	6.6
23.13 - Delivery Care						
Expected deliveries (no.)	21,060	4,609	6,495	35,924	14,268	82,356
a - Reported deliveries (no.)	19,554	4,096	6,296	33,441	13,694	77,081
b- Reported abortions (no.)	1,506	347	147	2,461	543	5,004
a+b - Known delivery outcome (no.)	21,060	4,443	6,443	35,902	14,237	82,085
Unknown delivery outcome (no. / %)	0	158 (3.43%)	52 (0.8%)	22 (0.6%)	31 (0.22%)	263 (0.32%)
Place of delivery (%):						
Home	0.04	0.05	1.13	0.04	0.07	0.14
Hospital	99.96	99.95	98.87	100	99.93	99.86
Deliveries in health institutions (%)	100.0	100.0	98.9	100.0	99.9	99.9
Deliveries assisted by trained personnel (%)	100.0	100.0	99.9	100.0	100.0	100.0
23.14 - Maternal Deaths						
Maternal deaths by cause (no.)						
Pulmonary Embolism	1	-	2	1	-	4
Haemorrhage due (DIC)	-	-	1	1	-	2
Eclampsia in pregnancy	-	-	1	-	1	2
Septicemia	-	-	-	1	-	1
Pulmonary hypertension	-	-	-	1	-	1
Sever Haemorrhage from a ruptured artery	1	-	-	-	-	1
Pulmonary, cardiac arrest	-	1	-	-	-	1
Total	2	1	4	4	1	12
Maternal mortality ratio per 100,000 live births	10.2	24.1	63.8	11.9	7.2	15.5
C-Section among reported deliveries (%)	29.9	52.0	62.2	23.8	29.9	31.1

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.15 - Postnatal Care						
Post natal care coverage (%)	66.5	92.0	76.1	100.0	87.7	87.0
23.16 Care Of Children Under Five Years						
Registered population (no.)	2,463,130	543,824	655,729	1,643,546	1,082,664	6,388,893
Registered refugee (no.)	2,307,012	479,537	568,730	1,476,716	871,551	5,703,546
Estimated surviving infants (no.)[11]	55,335	7,208	14,998	45,463	26,429	149,432
Children < 1 year registered (no.)	19,255	4,430	5,831	38,278	10,401	78,195
Children < 1 year coverage of care (%)	34.8	61.5	38.9	84.2	39.4	52.3
Children 1- < 2 years registered (no.)	23,688	4,950	6,736	39,214	10,808	85,396
Children 2- < 3 years registered (no.)	25,074	5,255	7,208	41,516	10,575	89,628
Children 3- < 4 years registered (no.)	25,892	5,290	7,183	42,524	10,826	91,715
Children 4- < 5 years registered (no.)	24,836	4,972	6,638	42,256	10,223	88,925
Total children 0-5 years registered (no.)	118,745	24,897	33,596	203,788	52,833	433,859
23.17 - Immunization Coverage						
Immunization coverage children 12 months old (%):						
BCG	99.6	99.3	99.8	100.0	100.0	99.9
IPV	99.8	NA	99.3	99.9	100.0	99.9
Poliomyelitis (OPV)	99.6	98.3	99.1	99.9	100.0	99.9
Triple (DPT)	99.8	98.0	98.6	99.2	100.0	99.2
Hepatitis B	99.8	98.0	98.8	99.4	100.0	99.8
Hib	99.8	98.0	99.1	NA	NA	99.4
Measles	99.5	97.6	97.7	NA	NA	99.2
All vaccines	99.7	98.3	99	99.7	100.0	99.7
Immunization coverage children 18 months old - boosters (%)						
Poliomyelitis (OPV)	99.2	96.8	99.8	99.6	100.0	99.6
Triple (DPT)	99.2	97.0	98.9	98.7	100.0	98.8
MMR	98.8	97.5	99.5	99.6	100.0	99.6
All vaccines	99.1	97.1	99.4	99.3	100.0	99.3
23.18- Growth Monitoring And Nutrional Surveillance						
Infants and Children with Growth Problems (0-5) years of age						
Prevalence of underweight among children aged <5 years	4.98	4.31	8.23	5.2	3.66	5.12
Prevalence of stunting among children aged <5 years	10.45	5.65	12.20	8.2	7.37	8.88
Prevalence of wasting among children aged <5 years	4.16	7.64	5.88	5.5	3.47	5.01
Prevalence of overweight/obesity among children aged <5 years	8.84	8.76	2.95	6.1	7.30	6.92

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

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.19 - School Health						
4th grade students screened for vision (No.)						
Boys	3,782	1,868	2,681	8,644	2,259	19,234
Girls	3,710	1,754	2,335	8,733	3,132	19,664
Total	7,492	3,622	5,016	17,377	5,391	38,898
4th grade students with vision impairment (%)						
Boys	19.5	4.6	2.4	8.4	15.5	10.2
Girls	26.0	6.2	3.6	11.5	17.8	13.8
Total	22.7	5.3	3.0	10.0	16.8	12.0
7th- grade students screened for vision (No.) :						
Boys	4,186	1,707	2,429	7,057	2,312	17,691
Girls	4,363	1,660	2,242	8,834	3,125	20,224
Total	8,549	3,367	4,671	15,891	5,437	37,915
7th grade students with vision impairment (%)						
Boys	18.1	5.5	3.7	10.8	12.7	11.3
Girls	22.7	9.6	4.4	17.1	13.5	15.7
Total	20.4	7.5	4.0	14.3	13.1	13.7
23.20 – NON COMMUNICABLE DISEASES (NCD) PATIENTS REGISTERED WITH UNRWA						
Diabetes mellitus type I (no/%)	1,148 (1.5%)	300 (1.0%)	451 (1.3%)	1,551 (1.6%)	644 (1.5%)	4,094 1.4%)
Diabetes mellitus type II (no/%)	11,704 (14.8%)	3,400 (11.7%)	3,652 (10.4%)	14,265 (14.5%)	6,387 (15.1%)	39,408 (13.9%)
Hypertension (no/%)	30,342 (38.5%)	13,971 (48.0%)	18,190 (51.8%)	45,864 (46.6%)	14,952 (35.5%)	123,319 (43.5%)
Diabetes mellitus & hypertension (no/%)	35,633 (45.2%)	11,427 (39.3%)	12,816 (36.5%)	36,693 (37.3%)	20,194 (47.9%)	116,763 (41.2%)
Total (no. / %)	78,827 (100%)	29,098 (100%)	35,109 (100%)	98,373 (100%)	42,177 (100%)	283,584 (100%)
23.21 - Prevalence Of Hypertension And Diabetes						
Served population ≥ 40 years with diabetes mellitus (%)	8.4	9.0	7.9	7.5	9.4	8.2
Served population ≥ 40 years with hypertension (%)	11.5	15.2	14.6	11.8	12.3	12.4
23.22 – Management						
Hypertensive patients on lifestyle management only (%)	0.7	4.5	0.4	2.9	0.2	1.8
DMI&II patients on lifestyle management only (%)	0.6	2.9	0.6	3.4	0.3	1.7
Diabetes I &II patients on insulin only (%)	13.5	9.8	16.5	13.8	8.2	12.7

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.23 - Risk Scoring						
Risk status - patients with diabetes mellitus type 1 (%):						
Low	39.8	65.1	69.9	59.5	61.9	56.2
Medium	55.5	31.5	27.8	39.5	36.4	41.5
High	4.7	3.4	2.3	1.1	1.6	2.3
Risk status - patients with diabetes mellitus type 2 (%):						
Low	10.7	21.0	26.4	21.1	20.0	18.5
Medium	58.7	53.7	56.3	61.2	60.4	59.6
High	30.6	25.3	17.3	17.7	19.6	21.9
Risk status - patients with hypertension (%):						
Low	4.0	21.0	17.	7.3	17.0	9.6
Medium	38.3	55.0	51.4	48.1	60.0	47.5
High	57.7	23.9	31.4	44.6	23.0	42.9
Risk status - patients with diabetes & hypertension (%):						
Low	8.5	6.1	16.6	20.7	4.0	13.2
Medium	48.2	48.7	50.7	59.9	44.0	52.5
High	43.4	45.2	32.7	19.5	52.0	34.3
Risk factors among NCD patients (%):						
Smoking	12.8	26.7	26.8	9.2	12.1	13.8
Physical inactivity	68.5	29.2	20.8	53.7	38.9	50.5
Obesity	40.3	45.3	39.8	53.7	50.1	47.4
Raised cholesterol	48.5	30.3	38.7	47.9	48.4	45.1
23.24 - Late Complications Among Ncd Patients (%)						
Diabetes mellitus type I	0.7	1.3	3.1	1.5	3.3	1.6
Diabetes mellitus type II	2.7	3.7	6.5	7.5	6.0	5.6
Hypertension	5.1	5.0	11.1	9.1	7.6	7.9
Diabetes mellitus & hypertension	9.8	8.7	16.7	19.2	13.5	14.4
All NCD patients	7.1	6.6	12.9	12.8	10.5	10.4
23.25 – Defaulters						
NCD patients defaulting during (no.)	9,393	1,186	2,145	4,227	3,146	20,097
NCD patients defaulting during 2020/total registered end 2019(%)	11.8%	4.3%	6.3%	4.5%	7.5%	7.2%
23.26 - Fatality						
Reported deaths among registered NCD patients (%)	867 (1.1%)	424 (1.5%)	368 (1.1%)	1,591 (1.7%)	562 (1.3%)	3,812 (1.4%)
Reported deaths among registered NCD patients by morbidity (no):						
Diabetes mellitus	60	28	27	147	56	318
Hypertension	230	160	155	497	122	1,164
Diabetes mellitus & hypertension	577	236	186	947	384	2,330
Total	867	424	368	1,591	562	3,812

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.27 - Communicable Diseases						
Registered refugee (no.)	2,307,012	479,537	568,730	1,476,716	871,551	5,703,546
Population served (no.)	775,898	213,651	295,543	1,189,960	395,632	2,870,683
Reported cases (no.):						
Acute flaccid paralysis[12]	0	0	2	2	0	4
Poliomyelitis	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Diphtheria	0	0	2	0	0	2
Meningococcal meningitis	0	0	0	0	0	0
Meningitis – bacterial	0	0	2	10	1	13
Meningitis – viral	0	2	0	20	10	32
Tetanus neonatorum	0	0	0	0	0	0
Brucellosis	0	2	221	0	0	223
Watery diarrhoea (>5years)	2883	2407	2293	1764	1446	10793
Watery diarrhoea (0-5years)	2840	2085	2944	5607	2264	15740
Bloody diarrhoea	14	7	37	210	64	332
Viral Hepatitis	19	50	184	53	2	308
HIV/AIDS	0	0	0	0	0	0
Leishmania	0	1	17	0	0	18
Malaria*	0	0	0	0	0	0
Measles	2	1	5	311	5	324
Gonorrhoea	0	0	13	0	0	13
Mumps	1	8	14	156	12	191
Pertussis	0	0	0	0	0	0
Rubella	0	0	4	0	2	6
Tuberculosis, smear positive	1	6	5	1	0	13
Tuberculosis, smear negative	0	0	3	1	0	4
Tuberculosis, extra pulmonary	0	2	7	0	0	9
Typhoid fever	0	0	252	17	0	269
Crosscutting Services						
23.28 - Laboratory Services						
Laboratory tests (no.)	742,301	133,852	293,949	1,234,121	447,847	2,852,070
Productivity (workload units / hour)	38.5	18.4	22.6	45.2	39.2	32.8
23.29 Abnormal Haemoglobin Results Among Pregnant Woman And Children 12 Months Of Age						
Abnormal Hb result for Children at one year (%)	39.6	22.0	57.5	77.2	32.1	51.1
Abnormal Hb result for pregnant women at registration (%)	24.2	16.5	34.0	35.3	21.0	29.2
Abnormal Hb result for pregnant women at 24 weeks (%)	44.2	40.8	47.0	73.8	37.1	59.5

[12] Among children <15 years

Field	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
23.30 - Radiology Services						
Plain x-rays inside UNRWA (no.)	0	15,732	0	13,752	14,011	43,495
Plain x-rays outside UNRWA (no.)	474	1,391	0	0	0	1,865
Other x-rays outside UNRWA (no.)	0	5,623	0	0	0	5,623
Total plain x-ray in and outside UNRWA (no.)	474	22,746	0	13,752	14,011	50,983

23.31- Human Resources	HQ	Jordan	Lebanon	Syria	Gaza	West Bank	Agency
Health staff as at the end of December 2020 Medical care services :							
Doctors	3	101	29	68	162	73	436
Specialist	0	7	7	5	6	6	31
Pharmacists	1	2	21	11	66	2	103
Dental Surgeons	0	30	12	23	27	17	109
Nurses	0	254	85	108	314	240	1001
Paramedical	4	129	43	87	162	166	591
Admin./Support Staff	6	70	65	65	106	75	387
Labour category	0	87	23	63	103	72	348
Sub-total	14	680	285	430	946	651	3,006
International Staff	7	0	0	0	0	0	7
Grand total	21	680	285	430	946	651	3,013
Health personnel per 100,000 registered refugees:							
Doctors	-	4.4	6.0	12.0	11.0	8.4	7.6
Dental surgeons	-	1.3	2.5	4.0	1.8	2.0	1.9
Nurses	-	11.0	17.7	19.0	21.3	27.5	17.6

Part 4 - selected survey indicators

Infant and child mortality survey, 2013

Table 24: Infant and child mortality

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

Decayed, Missed, and Filled Serfices (dmfs) survey, 2010

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

Age group	DS[13] Mean, SE (95%CI)	FS[14] Mean, SE (95%CI)	DMFS[15] Mean, SE (95%CI)8
11-12 year	3.27, 0.34 (2.61 – 3.94)	0.49, 0.13 (0.24 – 0.74)	3.83, 0.38 (3.08 – 4.58)
13 year	3.20, 0.08 (3.04 – 3.36)	0.58, 0.03 (0.52 – 0.63)	3.92, 0.09 (3.74 – 4.10)
> 13 year	3.09, 0.49 (2.11 – 4.06)	0.94, 0.24 (0.46 – 1.42)	4.22, 0.54 (3.16 – 5.29)

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

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

[13] Decayed Surface
[14] Filling Surface
[15] Decayed, Missing, Filled Surface

Table 27: DMFS, DS and FS sorted by Field

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

Decayed, Missed, and Filled Serfices (dmfs) survey, 2016

Table 28 : Prevalence of dental caries (DMFT/S>0) in the permanent dentition by field, 2016

Field	No.	%	CI 95%
Jordan	262	68.4	63.5 – 73.0
Lebanon	287	73.6	68.9 – 77.8
Syria	134	45.9	40.1 – 51.8
Gaza	309	70.7	66.2 – 74.9
West Bank	271	79.7	75.0 – 83.9
Agency	1263	72.8	70.5 – 75.0

Table 29: Prevalence of dental sealants on permanent teeth, by field, 2016

Indicator	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency	CI 95%
Prevalence of dental sealants	4.2	431.5	0.0	1.6	1.8	9.8	(CI 95%: 8.4-11.4)

Table 30: Prevalence of Dental Caries (DMFS) results from 2011 and 2016

Year	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
2011	71.1	68.5	71.8	68.8	85.1	73.1
2016	68.4	73.6	45.9	70.7	79.7	72.8

Current practices of contraceptive use among mothers of children 0-3 years survey, 2015

Table 31: Selected reproductive health survey indicators

Indicators	Jordan	Lebanon	Syria	Gaza Strip	West Bank	Agency
Mean birth interval (months)	40.4	42.4	42.9	33.7	39.4	39.2
Percentage of women married by the age < 18 years	24.6	16.6	19.0	23.7	23.6	22.0
Percentage of women with birth intervals < 24 months	27.7	30.4	26.2	38.5	30.4	31.3
Mean birth interval (months)	40.4	42.4	42.9	33.7	39.4	39.2
Percentage of women married by the age < 18 years	24.6	16.6	19.0	23.7	23.6	22.0
Percentage of women with birth intervals < 24 months	27.7	30.4	26.2	38.5	30.4	31.3
Prevalence of modern contraceptives among women of reproductive age utilizing UNRWA MCH services	64.0	67.2	59.6	52.8	55.6	59.3
Mean marital age (women)	20.3	21.4	20.9	19.9	19.9	20.4

Table 32: Total fertility rates among mothers of children 0 to 3 years of age who attended the maternal and child health clinics

Field	1995	2000	2005	2010	2015
Jordan	4.6	3.6	3.3	3.5	3.2
Lebanon	3.8	2.5	2.3	3.2	2.7
Syria	3.5	2.6	2.4	2.5	2.7
Gaza Strip	5.3	4.4	4.6	4.3	3.6
West Bank	4.6	4.1	3.1	3.9	3.6
Agency	4.7	3.5	3.2	3.5	3.2

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

Table 33: Selected anaemia survey indicators

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

Annex 1- donor support (totally / partially) to unrwa health programm in 2020

Table 34: Donor support to unrwa health program

Funding Portal	Donor	US$ Amount	Title	Fund code
Program Budget	Austria	2,208,685	Supporting UNRWA Health Programme in Gaza and West Bank	GF20033
	EU	5,495,509	Programme Budget (support Health and Relief Programmes)	GF20048
	Germany	16,809,561	Education and Health Programme UNRWA - LFO and JFO	GF20032
	Germany	17,778,710	Education and Health Programme UNRWA - Gaza and West Bank III	GF20040
	Germany	15,416,460	Support to the Basic Services in the Context of the Syria Crisis in Lebanon and Jordan, Phase II	GF20042
	Italy	2,100,939	Supporting the provision of primary healthcare at UNRWA Health Centres in Gaza III	GF20031
	Japan	1,948,482	Support to UNRWA operations in Syria 2020	GF20012
	Japan	1,066,146	Support to UNRWA Education and Healthcare to Palestine Refugees In Lebanon	GF20013
	Japan	1,900,436	Enhancement of human security of the Palestine refugees in the West Bank through the delivery of health care services	GF20016
	Luxembourg	1,176,471	Protecting the health of Youth in Gaza	GF18032
	Spain, Andalucia Government	866,580	Primary Healthcare in Syria	GF20001
	Spain, Asturias Government	69,318	Cover the Maternal and Child Healthcare program in Rimal in Gaza Strip	GF20034
	Spain, Basque & Navarra Fund	18,501	Medical staff salaries at West Nuseirat HC in Gaza	GF20046
	Spain, Catalonia Government	175,371	Preventing gender-based violence and promoting the sexual and reproductive rights of Palestinian refugee women in Deir al-Balah, Gaza Strip (MCHC)	GF20028
	Spain, Extremadura Government	234,742	Maternal and Child Health Care in Gaza	GF20045
	Spain, Gran Canaria Regional Government	165,837	Maternal and Child Health Care (MCHC) in West Bank	GF20009

Funding Portal	Donor	US$ Amount	Title	Fund code
	Spain, Gran Canaria Regional Government	55,359	Medical Equipment in Qalqilia hospital in WB	GF20023
	Spain, Navarra Government	190,308	Maternal and Child Health Care in Gaza	GF18045
	Spain, Zaragoza Regional Government	44,679	2019 Health Points in West Bank	GF20004
	Spain, Zaragoza City Council	82,780	Health Points in West Bank	GF20010
	Bancaja-Bankia Foundation	14,134	MCHC at the al-Naser health centre in Gaza	GF20039
	Kutxa Foundation, Spain	16,754	To cover MCHC in WB	GF20005
	UNRWA USA National Committee	778,000	UNRWA USA Support to WBFO Healthcare Staff	GF20047
Syria Appeal	EU	32,334,854	Strengthening the Resilience of Palestine Refugees from Syria in Lebanon (Phase III)	PQ20S01
	Italy	1,810,982	Support to UNRWA for Provision of Comprehensive Healthcare Services to Palestine Refugees from Syria in Jordan	PQ20S21
	Italy	1,173,709	Strengthening the resilience of Palestine refugees from Syria in Lebanon through cash assistance and health services	PQ20S24
	Japan	2,305,981	Support to UNRWA operations in Syria 2020	PQ20S12
	OCHA	438,720	Enhancing resilience of Palestine refugees in Syria through the provision of protection and community Services, Syria	PQ20S28
	UNHCR	255,172	Health Assistance for Palestinian persons arriving from Syria in Egypt	PQ20S14
Projects	Austria	29,412	Supporting UNRWA Health Programme in Gaza and West Bank "evaluation activity."	PQ20040
	Belgium	137,628	First-year staff costs of Neil Jan SAAD, Junior Professional Officer, assigned to Department of Health HQ UNRWA Amman, Jordan	IQ20A07
Emergency Appeal (oPt)	Spain, Baleares Government	982	Mental Health and Psychosocial Support	PR19023
	Spain, Baleares Government	146,863	Gender-Based Violence (GBV) in the Gaza Strip	PR19023
	Spain, Catalonia Government	42,056	Preventing gender-based violence and promoting the sexual and reproductive rights of Palestinian refugee women in Deir al-Balah, Gaza Strip (MCHC)	PR20012
	Spain, Galicia Government	98,592	Gender-Based Violence (GBV) in the Gaza Strip	PR20025

Funding Portal	Donor	US$ Amount	Title	Fund code
	King Salman Humanitarian Aid and Relief Centre	1,455,000	Support Health Care to the Needy Palestinians in the Gaza Strip	PR20006
	UNRWA USA National Committee	427,000	Gaza MHPSS	PR20011
	Private Sector Funding	90,738	Community Mental Health in Gaza	PR20016
COVID - 19	France	1,538,366	AFD (France) - reprogramming PQ19057 Improve access to adequate and sustainable water infrastructure and services in Palestine Refugee Camps in Lebanon	PV20035
	Brazil	75,000	COVID - 19 Flash Appeal-for the purchase of medicines and hospital supplies	PV20020
	EU	4,545,455	Enhancing UNRWA preparedness and responsiveness to COVID-19 in the Gaza Strip and West Bank	PV20025/26
	EU	4,235,294	Strengthening the Resilience of Palestine Refugees from Syria in Lebanon (Phase III) (COVID - 19)	PV20041
	Japan	1,545,454	Provision of Personal Protective Equipment and essential medicine at UNRWA Health Centres in response to COVID - 19	PV20022
	Spain, Andalucia Government	15,000	Primary Healthcare in Syria (Training on GBV) for the COVID-19 response	PV20036
	Spain, Basque Government	170,866	COVID - 19 related materials for the HCs	PV20048
	Spain, Catalonia Government	28,481	PPEs in Gaza	PV20049
	Spain, Castilla la Mancha Government	35,603	Covid health materials in Gaza	PV20055
	Spain, Castilla y Leon Government	41,186	COVID - 19 Flash Appeal in Syria	PV20050
	Spain, Galicia Government	34,168	COVID - 19 Flash Appeal in Gaza	PV20037
	Spain, Madrid Regional Government	58,793	COVID - 19 (Materials and supplies for protection and hygiene) in Lebanon	PV20066
	King Salman Humanitarian Aid and Relief Centre	1,000,000	Medical supplies and equipment for Gaza	PV20018
	OCHA	500,000	Extension of UNRWA Primary Healthcare Services to Non-Refugee to Alleviate the Pressure on the Public Health System in Gaza	PV20004

Funding Portal	Donor	US$ Amount	Title	Fund code
	OCHA	348,728	Contain the spread of COVID-19 and decrease morbidity within the Palestine refugees community in Syria by enhancing protective measures in UNRWA health services	PV20039
	OCHA	208,325	Provision of essential primary health care to remote communities of Palestine refugees in the West Bank	PV20068
	UNDP	411,322	Supporting UNRWA Quarantine and Isolation Centers in Lebanon	PV20069
	WHO	4,993,688	Reducing the risk of infection with COVID-19 and morbidity in Gaza, Jordan, Lebanon, Syria and the West Bank.	PV20046
	Hasene International e.V	21,716	Enhancing COVID-19 preparedness at UNRWA health centres, Gaza	PV20017
	Kuwait Red Crescent Society	50,000	Response to COVID-19 UNRWA Flash Appeal	PV20045
	Muslim Hands	62,495	Enhancing COVID-19 preparedness at UNRWA health centres, Gaza	PV20010
	The Big Heart Foundation	100,000	Enhancing UNRWA preparedness to coronavirus outbreak in the Gaza Strip	PV20053
	Novo Nordisk	31,500	purchase of hygiene and protective items for health centres	PV20032
	UNRWA Spanish Committee	2,172	Health Supplies under COVID in Syria	PV20029
	UNRWA USA National Committee	179,000	COVID - 19 Flash Appeal, Gaza	PV20011
	Gulf for Good	10,227	COVID - 19 response UNRWA Flash Appeal for immediate needs	PV20027
	Deutsche Bank	29,194	COVID - 19 UNRWA Flash Appeal for immediate needs March-July 2020 for HEALTH & FOOD ASSISTANCE, Gaza Strip	PV20047
	China	2,291,904	PPE and Anti COVID-19 equipment	IV20065
	Palestine	10,000	500 protection suits for health staff in Gaza	IV20021
	WHO	375,173	in-kind donation of PPEs for Gaza	IV20059
	Private Sector Funding	9,870	in-kind donation of PPEs for Gaza from Fine Co Jordan	IV20003

Annex 2 - strategic outcome 2: refugees' health is protected, and the disease burden is reduced

Table 35 : Agency-wide Common Monitoring Matrix 2016-2021 log frame

	Output 2.1 People-centred primary health care system using FHT model	Activities
2.0.a Prevalence of diabetes among the population served 18 years and above (Health) 2.0.b Percentage of DM patients under control per defined criteria (Health) 2.0.c Maternal mortality ratio (per 100,000 live births) (Health) 2.0.d Degree of alignment with UNRWA protection standards of health services (Health/Protection)	outpatient 2.1.a Average daily medical consultation per doctor (Health) 2.1.b Average consultation time per doctor (Health) 2.1.c Number of HCs fully implementing eHealth system (Health) 2.1.d Percentage of users satisfied with newly constructed health centres and new extensions that exceed 50% of the original Health Centers built-up area (ICID) 2.1.e Percentage of HCs meeting UNRWA facilities protection design standards (ICID) 2.1.f Number of health centres integrating the MHPSS technical instructions into the Family Health Team approach (Health) 2.1.g Percentage of individuals identified with MHPSS needs provided with assistance (Health) non-communicable diseases 2.1.h Percentage of NCD patients coming to HC regularly (Health) 2.1.i Percentage of NCD patients with late complications (Health) communicable diseases 2.1.j Number of EPI vaccine-preventable disease outbreaks (Health) Maternal health and child services 2.1.k Percentage of women with a live birth who received at least 4 ANC visits (Health) 2.1.l Percentage of postnatal women attending PNC within 6 weeks of delivery (Health)	Outpatient 2.1.1. a Percentage of Post Occupancy Evaluation conducted for newly constructed health centres and new extensions that exceed 50% of build-up area (ICID) 2.1.1.b Number of staff trained on comprehensive MHPSS response (Health) 2.1.1.c Number of individuals experiencing MHPSS needs identified by UNRWA in health centres (Health) oral health 2.1.1.d Percentage of preventative dental consultations out of total dental consultations (Health) non-communicable diseases 2.1.1.e Percentage of targeted population 40 years and above screened for diabetes mellitus (Health) 2.1.1.f Number of new NCD patients (DM, HT, DH&HT) (Health) 2.1.1.g Total number of NCD patients (DM, HT, DH&HT) (Health) communicable diseases 2.1.1.h Percentage of children 18 months old that received all booster vaccines (Health) 2.1.1.i Number of new TB cases detected (Health)

	Output 2.1 People-centred primary health care system using FHT model	Activities
	school health services 2.1.m Percentage Diphtheria + tetanus coverage among targeted students (Health) pharmaceutical services 2.1.n Antibiotic prescription rate (Health) 2.1.o Percentage of HCs with no stock out of 12 tracer medicines (Health) 2.1.p Percentage of individuals identified as experiencing a protection risk (general protection, GBV, child protection) provided with health assistance (Health/Protection) 2.1.q Percentage of individuals identified as experiencing a protection risk (general protection) provided with health assistance (Health/Protection) 2.1.r Percentage of individuals identified as experiencing a protection risk (GBV) provided with health assistance (Health/Protection) 2.1.s Percentage of individuals identified as experiencing a protection risk (child protection) provided with health assistance (Health/Protection) 2.1.t Percentage of protection mainstreaming recommendations from internal protection audits implemented (Health/Protection)	Maternal health and child services 2.1.1.j Percentage of 18 months old children that received 2 doses of Vitamin A (Health) 2.1.1.k Number of active/continuing family planning users (Health) 2.1.1.l Number of new enrolments in pre-conception care programme (Health) school health services 2.1.1.m Percentage of 4th gr. schoolchildren identified with vision impairment (Health) 2.1.1.n Unit cost per capita (Health) 2.1.1.o Number of individuals experiencing a protection risk (general protection, GBV, child protection) identified by UNRWA in health centers (Health/Protection) 2.1.1.p Number of individuals experiencing a protection risk (general protection) identified by UNRWA in health centres (Health/Protection) 2.1.1.q Number of individuals experiencing a protection risk (GBV) identified by UNRWA in health centres (Health/Protection) 2.1.1.r Number of individuals experiencing a protection risk (child protection) identified by UNRWA in health centres (Health/Protection)
	Output 2.2 efficient hospital support services	Activities
	2.2.a Percentage of UNRWA hospitalization accessed by SSNP (Health) 2.2.b Hospitalization rate per 1,000 served (Health)	2.2.1.a Hospitalization unit cost (Health)

Table 36: Agency-wide Common Indicators

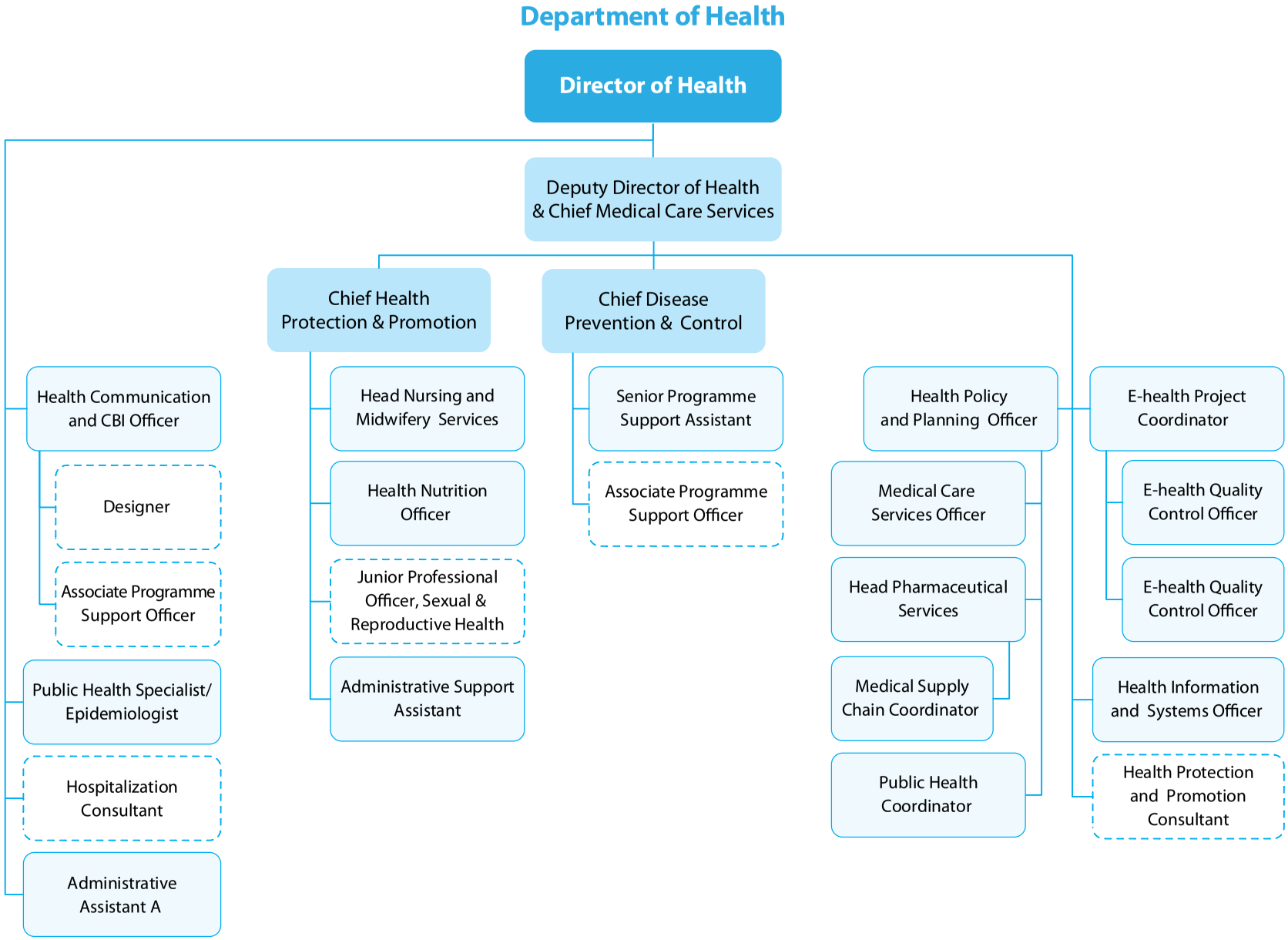
Indicator	Calculation
Average daily medical consultations per doctor	Total number of medical consultations seen by doctor during given quarter / Number of working days for the same doctor during the same quarter
Antimicrobial prescription rate	No. of patients receiving antibiotics prescription / All patients attending curative services (general outpatient clinic + sick babies + sick women + sick NCD) X100
% Preventive dental consultations of total dental consultations	No. of preventive dental consultations / Total no. of preventive & curative dental consultations X100
% 4th grade school children identified with vision defect	No. of 4th grade school children identified with vision / No. of 4th grade school children screened by UNRWA school health program X100
% Health centres implementing at least one Ehealth module	No. of HCs implementing at least one Ehealth module / Total No. of HCs X100
% Health centres with no stock-outs of 12 tracer items	No. of HCs with no stock-outs of 12 tracer items /Total no. of HCs X100
% Pregnant women attending at least 4 ANC visits	No. of pregnant women attending at least 4 ANC visits / No. of women with live births X100
% 18 months old children that received two doses of Vitamin A	No. of children 18 months old that received two doses of Vit A / Total no. of children 18 months old X100
No. of women newly enrolled in Pre-Conception Care program	No. of women newly enrolled in Pre-Conception Care program
% Women attending PNC within six weeks of delivery	No. of women attending postnatal care within 6 wks of delivery / No. of women with live births X100
No. of continuing family planning acceptors	No. of continuing family planning acceptors
Diphtheria and tetanus (dT) coverage among targeted students	No. of school children that received dT / Total no. of school children targeted X100
% Targeted population 40 years and above screened for diabetes mellitus	No. of patients 40 years and above screened for diabetes / (Total no. of served population 40 years and above) – (total no. of diabetes patients currently registered in NCD program) X100
% Patients with diabetes under control according to defined criteria	No. of DM patients defined as controlled according to HbA1C or postprandial glucose criteria / Total no. of DM patients X100
No. of new NCD patients in the programme	No. of new NCD patients in the programme (Diabetes mellitus; Hypertension; Diabetes mellitus & hypertension)
Total No. of NCD patients in the programme	Total No. of NCD patients in the programme (Diabetes mellitus; Hypertension; Diabetes mellitus & hypertension)
No. of EPI vaccine-preventable diseases outbreaks	No. of EPI vaccine-preventable diseases outbreaks
% 18-month-old children that have received all EPI vaccinations according to host country requirements	No. of children 18 months old that received all doses for all required vaccines / Total no. of children 18 months old X100
No. of new TB cases detected	No. of new TB cases detected (smear-positive + smear-negative + extra pulmonary)

Annex 3 - Department of Health research activities and published papers

Table 37: List of publications

S. No	Month of publication	UNRWA author(s)	Title	Citation	Type of publication	Language	Web site (if applicable)
1	July	Nada AbuKishk , Yassir Turki, Suha Saleh, Shatha Albaik, Majed Hababeh Zoheir el-Khatib, Nimer Kassim, Hasan Arab, Khawalah Abu-Diab, Wafaa Zeidan, Akihiro Seita	Anaemia prevalence in children newly registered at UNRWA schools: a cross-sectional study	BMJ Open, 10(9)	Journal Article	English	https://bmjopen.bmj.com/content/bmjopen/10/9/e034705.full.pdf
2	July	Yassir Turki, Suha Saleh, Shatha Albaik, Yousef Shahin, Majed Hababeh and Akihiro Seita	Assessment of the knowledge, attitudes, and practices (KAP) among UNRWA* health staff in Jordan concerning mental Health Programme pre-implementation: a cross-sectional study	International Journal of Mental Health Systems, 14(1)	Journal Article	English	https://link.springer.com/content/pdf/10.1186/s13033-020-00386-3.pdf
3	December	Masako Horino, Ghada Al-Rami Habash, Akihiro Seita	Dietary Inadequacy, Micronutrient Deficiencies, and Approaches to Preventing Poor Nutrition in the Gaza Strip	Food and nutrition bulletin,	Journal Article	English	https://journals.sagepub.com/doi/pdf/10.1177/0379572120967819

Annex 4 - Depatrtment of Health at UNRWA HQ, Amman organizational chart



Annex 5 - contacts of senior staff of the unrwa Health Programme

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Post Title	Incumbent	Telephone	E-mail address
WHO Special Representative & Director of Health	Dr. Akihiro Seita	5808300	a.seita@unrwa.org
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E-Health Project coordinator	Ms. Ghada Ballout	5808359	g.ballout@unrwa.org
Health Communication & Community Based Initiative Officer	Dr. Yassir Turki	5808395	y.turki@unrwa.org
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Chief, Health Protection & Promotion	Dr. Rami Habash	5808167	r.habash@unrwa.org
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Division of Disease Prevention & Control			
Chief, Disease Prevention & Control	Dr. Yousef Shahin	5808315	y.shahin2@unrwa.org
Division of Medical Care Services			
Medical Care Services Officer		Vacant	
Head Pharmaceutical Services	Ms. Rawan Saadeh	5808306	r.saadeh@unrwa.org

Chiefs field Health Programme

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