

MODERN AND EFFICIENT UNRWA HEALTH SERVICES

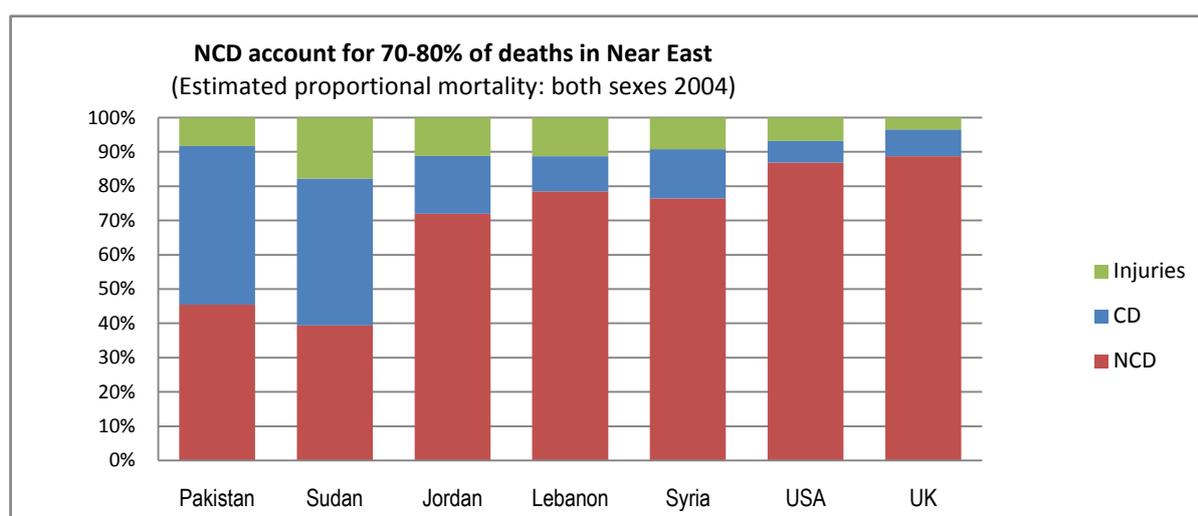
Family Health Team Approach

1. Background

The UNRWA health program has delivered comprehensive primary health care services (PHC) to Palestine refugees for over 60 years, achieving some remarkable health gains particularly in relation to maternal and child health. For example, the infant mortality rate among UNRWA's served beneficiaries has declined from 160 per 1000 live births during the 1950s, to less than 25 in the first decade of the 21st century. However, the context in which the health program operates is evolving, bringing with it new challenges and opportunities that require new ways of providing health services. Maintenance of the status quo in current health services will not be able to address the changing environment. Thus, without introducing new approaches, UNRWA health services will become less relevant and unable to respond to the growing health needs of the Palestine refugees.

Demographic and epidemiological transition

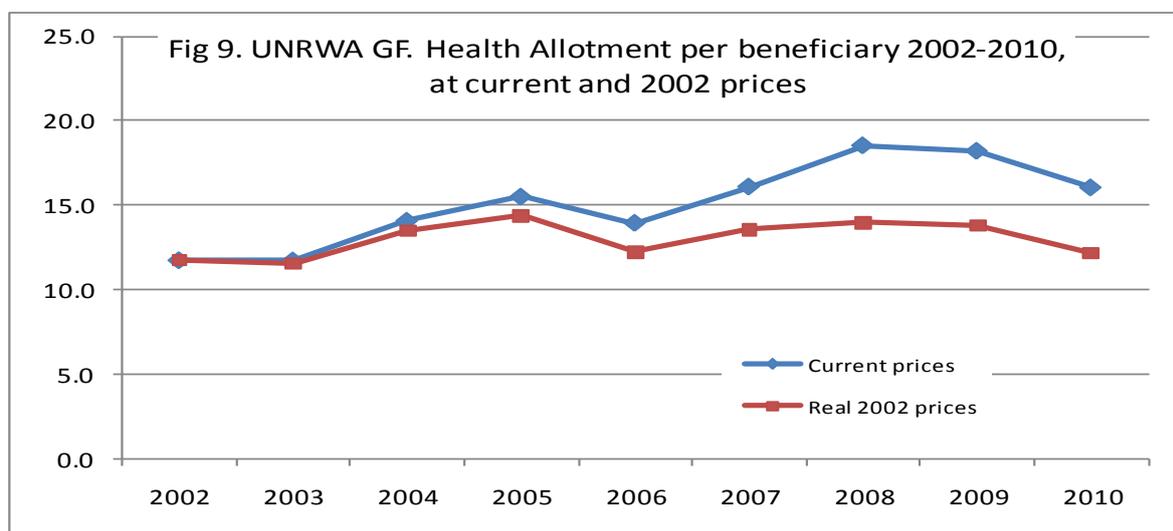
The demographic transition is underway in UNRWA's beneficiary populations. People are living longer and aging populations have changing health care needs. The epidemiological transition has already taken place. The main causes of mortality and morbidity in UNRWA's beneficiary populations are no longer communicable diseases, traditionally managed through interventions such as improved water and sanitation, immunization and short term medical treatment. The health priorities of today and tomorrow are non-communicable diseases (NCD): chronic conditions requiring lifelong care, such as diabetes, hypertension and cancer. In addition, people have changing expectations about health services: clients have more access to information concerning treatment options, are more aware of their rights and want to be more actively involved in their health care than in the past.



Financial realities

Health services the world over are constantly challenged by financial realities. Expanding and aging populations mean that increasing numbers of people need care. Non-communicable

diseases often require expensive long-term medications as well as hospitalization for complications. While the costs of health care continue to escalate worldwide, the global financial crisis has negatively impacted the availability of donor funding. Funding for UNRWA health services has not increased at the same pace as the needs. For example, UNRWA lacks the funding to provide essential cholesterol lowering medicines to its increasing numbers of NCD patients.



Health care systems worldwide are facing similar challenges: the demographic transition, the increasing non-communicable diseases burden, the financial crisis and the need to be responsive to the demands of users. In response to this, health system reforms based on a Family Health Team approach have been developed and implemented in countries in Western Europe and Northern America. At the same time, many countries in the Middle East have also adopted, or are planning to adopt, such an approach to address similar challenges. These countries include those directly relating to UNRWA such as Palestine, Jordan, Syria, Lebanon, and Egypt, countries in the Gulf Cooperation Council, and others, for example, Iraq and Morocco.

Health programme reviews

During 2009 and 2010 comprehensive reviews conducted in all five Fields revealed a number of challenges and opportunities for strengthening UNRWA health services:

- Non-communicable disease care and preventive services are limited. UNRWA should increase its focus on these areas while still maintaining its successful core health services.
- Health centers are over-crowded. There is an urgent need to address over-use of health facilities in order to ensure quality of care.
- The closed organizational culture within UNRWA limits exposure to new opportunities. UNRWA should actively engage in fora where host country health policy is discussed and continually seek creative ways to improve access to quality health care for its beneficiaries through negotiating with the MOH and other service providers.

- Future changes in host country policies could result in greater reliance on UNRWA to fund or subsidize hospital care. There is a lack of detailed information available on the types of hospital cases referred and the services received. The establishment of a data base to manage hospital related information was recommended, to better enable UNRWA to negotiate the services costs, and to monitor the quality of services received.
- While UNRWA health programs collect a wealth of data, information is fragmented along vertical lines. Revisions are needed to rationalize the current health information system and to facilitate comprehensive analysis of health information at facility level, including financial and human resources data. Knowledge of refugees' living conditions, including health seeking behavior and expenditures, is also limited.
- Current reporting lines within UNRWA's health departments are vertical, confined to technical divisions and with little responsibility at facility level. Changes in the health department structure at field office level are recommended, to better reflect the support needs of an evolving primary health care system.

The Family Health Team approach aims to address all these issues. The reviews also emphasized that changes should be introduced incrementally, maintaining a focus on quality and ensuring that decisions are based on adequate information and on experience gained through the piloting of new interventions. Field health departments have already commenced implementation of various reform activities that are part of or complementary to the Family Health Team approach. For example, the Lebanon program has developed a hospital data base; the Syria office has negotiated better contracts with hospital service providers; the Jordan office is piloting an appointment system; all fields are placing an increased emphasis on non-communicable diseases; and the health department headquarters is conducting a review of agency-wide health data needs.

2. The Family Health Team Approach

The Family Health Team approach offers comprehensive primary health care services based on holistic care of the entire family, emphasizing long term provider-patient relationships. This approach is needed to effectively prevent and manage chronic non-communicable diseases. At the same time, the Family Health Team approach provides a multi-faceted platform from which to address crosscutting issues, such as diet and physical activity, education, gender-based violence, child protection, poverty and community development.

3. The reform proposal

a. Overall Objective of UNRWA Health Reform

Improve and modernize UNRWA primary health care services into a comprehensive, efficient, people-centered primary care system by introducing a Family Health Team approach that can meet the evolving needs of the refugee population now and in the future.

b. Target for the Health Reform

By 2020:

- All 137 UNRWA health centers will implement the Family Health Team approach.

By 2015:

- At least 63 health centers in refugee camps will implement the Family Health Team approach.
- Field offices will be empowered to support health centers in implementing and expanding the Family Health Team approach.

c. Strategy of the Health Reform

1. Modernizing PHC services

UNRWA Primary Health Centers will be improved through the implementation of a community-oriented Family Health Team approach, following the principles of the UNRWA Medium Term Strategic Plan: universality, quality, equity, efficiency and sustainability. This is an *improvement* in care for refugees, not a reduction in health care services.

The Family Health Team approach represents a system of delivering primary health care through a **multidisciplinary team** of health professionals that works together to serve the **comprehensive health needs** of a **defined population** across the **life cycle** and in a community setting that is **close to the client**.

This means that:

- A patient will always be seen by the same doctor, the same nurses and the same midwife, who form the ‘family health team’. This team takes collective responsibility for the care of the families registered with them.
- The team manages the health care needs of their registered families, regardless of the patient’s age or their reason for visiting the health center. The team does not only focus on curing illnesses, but also on helping patients to stay healthy.
- The team approach is viewed as a partnership between the provider, the patient and the patient’s family.
- The team also arranges care for the patient in other parts of the health system or other sectors, e.g. hospitals, social services, education system, community organizations.
- The team will provide comprehensive care through teamwork of doctors, nurses and midwives. During a visit, the patient will be seen by a doctor, nurse and/or midwife as needed.
- The team ensures quality time with their patients through use of an appointment system that will allow more time per visit and will also reduce waiting time for the patient.

2. Values

The Family Health Team approach has its foundations in the modern values of Primary Health Care indicated by the World Health Organization in 2008, such as person-centeredness, comprehensiveness and continuity of care.

Person-centeredness: Health service delivery is centered on the patient as a person rather than on the system; the patient has their needs attended to in a defined geographical location by a familiar team, rather than having to visit multiple providers in different locations for different services. As the patient builds a relationship with the team over the course of their life, the team is increasingly able to understand the specific context and needs of the whole person, and so to provide holistic services tailored to the individual.

Comprehensiveness: The team cares for all family members, across the life-cycle and the disease spectrum. This care does not only address curative aspects, but focuses also on promotive and preventive health care. The team coordinates and follows the client's referral to hospitals and other parts of the health care system.

Continuity of care: The patient is seen by the same team at each visit to the health center and a system of family files provides a continuous record of the patient's health history. In addition to fostering the partnership between the patient and the provider, this continuity of interaction and information improves the quality of clinical care.

3. UNRWA Health Reform Package

The UNRWA Family Health Team Package will include the following key components:

An essential package of PHC services

The Family Health Team approach will continue to provide the current range of services that UNRWA provides. This comprehensive package of PHC services includes general outpatient consultations, maternal and child health care, non-communicable disease prevention and management, and communicable disease prevention, management and surveillance. The package also includes complementary services such as radiology and physiotherapy, according to contextual needs and resource availability.

Family Health Team development

The hierarchical and functional structures of UNRWA health centers will be re-organized to implement the Family Health Team Approach. Currently, overall responsibility for the health center is assigned to the senior medical officer, with some duties delegated to the senior staff nurse. Within the facility, the general outpatient section, the Maternal and Child Health (MCH) section and the Non-Communicable Diseases (NCD) section operate independently of each other.

The Family Health Team is composed of a multidisciplinary, multipurpose team consisting of a medical officer (MO), one or more nurses and a midwife. Other members could be added to the team, depending on the context, e.g. mental health worker, dietician. The MO is responsible for leading the team. The team attends to all the needs of their registered patients, including general consultations, MCH and NCD. This means that patients no longer have to visit different sections of the health center to receive different services.

In principle, the number of family health team(s) in a health center is equal to the number of MOs in the center. When there is one MO, there will be one family health team with existing nurses and midwife(s). When there are three MO, there will be three family health teams, formed by assigning the existing nurses and midwife(s) into three teams. Each team will cover a section of the population registered at the health center.

Task shifting is a central idea within the Family Health Team approach. Task shifting means that:

- health services are organized in such a way that each staff member performs the tasks for which they are best qualified, and
- staff do not routinely engage in tasks that could be performed by a lower cadre of worker.

In practical terms this means that responsibility for particular tasks is assigned to other members of the team, e.g. nurses would ‘shift’ their clerical tasks to clerks. Similarly, some of the tasks currently performed by MOs could be ‘shifted’ nurses. In this way, time is “freed up” for both MOs and nurses, enabling them to have quality time with priority patients and to achieve longer average consultation times.

Standardized lists of infrastructure, equipment, medicines and supplies

The Family Health Team approach is based on standards for health center infrastructure and equipment and on an essential medicines list. UNRWA has such standards in place. The essential medicines list was recently updated to ensure that treatment regimens are commensurate with current international standards.

System of family folders and an improved health information system

There will be a one family health folder containing all the health records of a family. UNRWA currently uses a hardcopy family folder system. However, additional separate folders are currently created for NCD patients, women of reproductive age and children under the age of five years. The Family Health Team approach will consolidate the various folders so that all the health records of a family are maintained within a single family folder. Within the family folder, a unique record will be maintained for each family member. The e-Health system for a family health folder will be developed to facilitate the management of this patient information.

The Family Health Team approach also presents an opportunity to improve the concept of data use at facility level and to empower the management capacity at health centers. The routine health information system will be streamlined to reduce the burden of data collection for health center staff while the focus will be on indicators that are relevant to their decision-making. The management of aggregate data will be improved and teams will be trained to analyze their own data against their own targets. The expansion of e-Health will further enhance data management and use.

Registration of families with family health teams

Refugee families are already registered at UNRWA health centers. For implementation of the Family Health Team approach, families will also be registered with one of the teams operating within the facility when there is more than one family health team in the facility.

Implementation of an appointment system

The Family Health Team approach is a valuable opportunity to ensure an effective appointment system to address the ever-increasing demand. Staff members in health centers are currently overloaded with excessive numbers of patients. Doctors see on average 100 patients per day, with average contact times of between 2 and 3 minutes per patient.

A well-functioning appointment system is intended to: ensure more contact time per patient; improve consultation quality; reduce congestion and waiting time; and, reduce visits for minor ailments. A triage system will be in place along with the appointment system to ensure that emergency cases receive timely care while any presenting non-urgent cases may be directed to make an appointment to be seen later.

As the Family Health Team approach is based on a relationship of understanding and trust between the family and the team, the approach facilitates the introduction and enhancement of appointment systems.

Referral and feedback system with higher levels of health care and other health services

UNRWA currently subsidizes selected hospital treatments for refugees. Information on utilization patterns and quality of care in referral facilities is however limited. The Family Health Team approach emphasizes a continuum of care between levels of the health care system. Health teams will follow up on the progress and outcomes of clients referred to hospitals and outpatient specialist care. In addition, contractual arrangements with hospitals will be reviewed and monitoring mechanisms improved through creation of a hospital management unit at field office level as well as a hospital data base.

Strengthening of Field Office support capacity

The organizational structure of the health department in the field offices will be updated based on the needs to optimally support and supervise the Family Health Team approach. Two potential major areas of management support include: comprehensive first level primary health care and hospital care. Responsibilities could be assigned based on these areas. For example, two new divisions could be created (primary health and hospital care). Health information manager and health administrator positions can also be created to support the divisions.

Coordination with other sectors and partners

Coordination with other departments within UNRWA will be improved through the Family Health Team approach. Long-term relationships between health workers and their clients increase the likelihood that sensitive issues such as family or gender violence will be detected and addressed. This will require close coordination with the response and referral mechanisms being established in all UNRWA Fields to deal with GBV and other family and child protection issues. This approach is fully in-line with UNRWA's commitment to protection and with UNRWA's Protection Standards. Furthermore, as the same team follows the growth and development of a child from birth over the course of childhood and adolescence, physical, developmental and learning disabilities will be detected and managed early. The close relationship between providers and families can also help to identify vulnerable families and can potentially allow UNRWA to take measures to alleviate poverty and minimize the risk of catastrophic health expenditure.

Through the family health approach, UNRWA will become an active participant in all venues within host countries and also in international arenas where the health of refugees is discussed, to ensure that opportunities for partnership, collaboration and funding are maximized. This will include participation in coordination meetings and activities such as joint assessments whenever possible, as well as the provision of input, where appropriate, to UN Cluster and Working Group coordination mechanisms addressing advocacy issues relevant to health. Furthermore, wherever relevant, the approach will facilitate UNRWA's coordination with service provision with other providers targeting the same beneficiary groups.

4. Key operations

Modernization of the current UNRWA system of PHC service delivery into a Family Health Team approach will involve three phases: preparation, piloting and expansion. A pilot will be conducted in only one (or two) UNRWA health center(s) to identify the optimal way(s) of introducing the Family Health Team approach, and based on the experiences and lessons learned in the pilot, the approach will be expanded to other health centers in a stepwise manner. This sequence will be followed in each field based on their specificities and needs.

The first phase thus consists of comprehensive preparation for the start of the pilot. This phase is extensive with a series of preparatory activities for the pilot including technical and teamwork preparation, health information systems review and introduction of an appointment system. The second phase is the initiation of the pilot and its subsequent evaluation. This phase is to assess in detail the appropriate way(s) of implementing and evaluating the Family Health Team approach. The third phase is the expansion of the approach based on the outcomes of the pilot. Throughout the phases, communication with refugees, host countries and donors remain extremely important. The three phases will be complemented by supporting activities: optimizing hospital care and conducting operational research.

Phase 1: Preparation for pilot

Health center staff will require training on the new way of working necessary for implementing the Family Health Team approach. Both technical and teamwork preparation and training are needed before re-organization of services can begin.

- **Technical preparation**

Technical guidelines for important health conditions will be updated to ensure technical soundness as well as efficiency according to international standards. The various aspects involved in managing particular conditions, will be defined with a view to allocation of tasks among team members. This will be based on the official regulations of the host country on the scope of work particularly for nurses. This step is a prerequisite to any task shifting within UNRWA health centers. The health department headquarters will take the lead in revision of the technical instructions, in close collaboration with the Fields. Medical officers and nurses will require additional training on the revised technical instructions, on the management of common medical conditions and on the person-centered patient management approach.

- **Teamwork preparation**

As the implementation of the Family Health Team approach involves a substantial shift away from the traditional UNRWA way of delivering services, the rationale and practical implications must be thoroughly communicated with health staff at all levels.

A team work analysis and teamwork training needs assessment in the pilot health facility need to take place in close collaboration with all relevant parties, including field offices, headquarters, communities and host countries. Based on the findings of the analysis, a team work training package will be developed and delivered to the staff of the pilot health facility.

- **Optimize infrastructure, equipment, medicines and supplies**

Facilities should be reviewed for any infrastructure and equipment changes needed to facilitate implementation of the Family Health Team approach. The UNRWA essential

medicines list was reviewed during 2010. However, further revision may be necessary in order to ensure the availability of medicines for optimal management of non-communicable diseases.

- **Register families with teams, reorganize the family folder system, and improve the routine health information system**

The total number of refugees currently registered at each facility is the target population for the Family Health Team approach. A significant number of facilities have only one medical doctor, therefore registration with a team occurs de facto. In facilities with more than one doctor, distribution of the population among the teams will usually be done according to geographic areas of residence. The demand for female doctors should also be considered.

The system of filing and record retrieval, based on unique patient identification numbers, will be streamlined by the introduction of the comprehensive eHealth package. In the interim, the existing hardcopy system will be adapted to the requirements of the Family Health Team approach. A unique patient record must be established for each family member. General outpatient, MCH and NCD folders that are currently stored in different locations will need to be consolidated and stored in a central location or in a location specific to each team. The physical infrastructure supporting the folder storage system may require adaptation and clerks will require training on the new filing system.

Management of health information at all levels will be streamlined. The health department headquarters will undertake a detailed review of all data requirements in order to minimize the reporting burden at facility level. Data collection tools will be revised and adapted to the Family Health Team context. Furthermore, facility teams will be trained in analysis of their own data and in setting of their own targets, thus furthering decentralized decision making and accountability.

In order to promote facility based data management and to implement e-Health, health centers will need to be equipped with appropriate computer infrastructure and staff will require training.

- **Reorganize health facility teams and services**

After receiving the teamwork training, the team in the pilot facility will begin the process of establishing teams and reorganizing services accordingly. This will involve the definition of new roles, new working relationships and new supervision mechanisms. Where relevant, the idea of task shifting will be introduced and if necessary, job descriptions will be revised.

- **Develop and implement communication packages**

Community participation is integral to the successful implementation of the Family Health Team approach. Initial resistance from communities can be expected. It is therefore crucial

for UNRWA to manage the communication components of the various service changes appropriately and to engage the communities as partners. The communication campaign should start well in advance of implementation of the first changes in service delivery. Engagement with community leaders and community organizations should be sought at an early stage. Community communication packages describing the Family Health Team approach will need to be developed prior to implementation of activities in the pilot facility. In addition to introduction of the overall Family Health Team concept, specific orientation will be needed on the registration system, changes in the family file system and the appointment system. Every effort will be made to include the participation of marginalized and vulnerable individuals and groups in the communication outreach.

- **Institute an appointment system**

Appointment systems may take a variety of possible forms, as long as the desired outcomes are achieved. Triage mechanisms will also be included in the system. The system will need to evolve over time, beginning with a pilot and adapting to lessons learned and changing circumstances. The appointment system pilot should be based on an explicit document stating: objectives, activities, resource needs, persons responsible, timeline, indicators. A formal evaluation should be conducted after an agreed time period.

Phase 2: Piloting

Implement Family Health Team approach

Implementation will take place in a pilot facility. The process will be supervised by the Field Office with support from the headquarters health department. All steps will be documented and lessons learned recorded. It is expected that adjustments to the approach will be needed as experience is gained. Formal evaluations will be conducted at six months and twelve months. The findings will be presented at a review meeting involving senior staff from all Fields. Based on lessons learned during the pilot phase, it is expected that various aspects of the Family Health Team approach as well as the training packages and guidelines may require revision.

Phase 3: Expansion

Based on the experience gained during the pilot and after any necessary revision, the Family Health Team approach will be expanded to other facilities using a phased implementation plan. The approach will be adapted to the specific needs of each Field. Health centers will need to assess whether they can manage the new Family Health Team structure and functions with their existing staff. At present there are more nurses than MOs, but nurses often have a lower workload than MOs. If the workload cannot be balanced appropriately through task shifting, a different skill mix may be needed, i.e. a change in the ratio of MOs to nursing staff. UNRWA will need to consider this when planning future recruitment as current staff members retire.

Supporting activities

- **Revise hospitalization arrangements**

Referral for hospital care is an integral part of the family health approach. UNRWA will improve its ability to ensure quality and value for money for hospital care through various approaches. A hospital data base will be created in each Field to improve knowledge of the hospitalization case mix, case management and associated costs.

Establishment of a hospital management unit at Field Office level will ensure appropriate oversight of hospitalization issues. A consultant will be recruited to review contractual arrangements to ensure value for money and accountability mechanisms. Contracting with a limited number of hospitals will improve the ability to negotiate prices and to develop relationships. Explicit guidelines on entitlements will be established and made known to users and providers.

- **Conduct operational research**

In order to implement and monitor reform related activities, UNRWA requires adequate information. The UNRWA health department will seek to expand its information base through collaboration with other UNRWA departments and academic institutions. In order to inform future health department policy and decision making, further insights are needed on issues such as refugee living conditions, health care seeking behavior, health care expenditure and vulnerability status. Household surveys to obtain accurate information on these factors will be conducted in each Field, pending approval by the host authorities. Prior to implementing the Family Health Team approach in the pilot facility, UNRWA will also conduct a facility-based survey to assess client satisfaction and health care seeking behavior. A follow up survey will be conducted six to twelve months after starting the pilot, to document community perceptions of the Family Health Team approach.

5. Indicators to measure progress in health reform

The key indicators to measure the progress of the expansion of Family Health Team approach are as follows:

- Number and percentage of health centers implementing the Family Health Team approach
- Number and percentage of target population served through Family Health Team approach
- Average number of consultations per doctor per day

In addition, indicators to measure the preparatory process of the Family Health Team approach are as follows:

- Teamwork training package produced
- Health information management training package produced
- Community communication package produced
- Number of technical guidelines revised

6. Management of the health reform process

Sustainability is a key issue in the modernization of UNRWA health services. Introduction of the Family Health Team approach reflects an effort to optimize the use of existing resources. New services will not be created. Rather, existing services will be re-organized to maximize quality and efficiency. While a limited number of additional management staff will be needed for a limited duration to support the start-up of the intervention in all Fields, recruitment of additional, full-time health staff will not be necessary.

Capacity building will be conducted using a training-of-trainers approach, thus minimizing the need for external support. The shift to a Family Health Team approach reflects current global health systems thinking and represents a necessary modernization of health services delivery to meet the needs of a changing environment and changing health needs.

Nevertheless, the resource needs of the UNRWA health program will continue to grow, reflecting the expanding beneficiary population and the increasing health needs.

The reform is a joint effort of UNRWA at all levels, not only within the health departments but also with other programmes including education and relief and social services. To facilitate the process, a project manager will be recruited so as to support and coordinate the implementation of the various processes involved. As communication both within UNRWA and with communities and partners will be a key component to the success of the initiative, communication experts will also be recruited. Additional technical support for selected aspects of the reform will be provided by short term consultants, for example, for review of the technical guidelines and development of a teamwork training package.

Annex - Improving workload management through the FHT approach

Currently medical officers in UNRWA health centers each see an average of 100 patients per day with most patients presenting to the health center during the first two hours of the day. The consequences are: doctor-patient contact times that are too short to ensure high quality care, overcrowding of facilities and long waiting times.

The FHT approach will address these challenges through two strategies:

1. Managing demand through appointment and triage systems
2. Making the best use of staff skills and time through task shifting

1. Managing Demand through appointment and triage systems

Appointment systems are currently in place for selected services, e.g. MCH and NCD. The FHT approach will introduce an appointment system for all health center visits, including general curative consultations.

The aims of the appointment system are to increase doctor-patient contact times by containing the number of patients that need to be seen by the doctor each day and spreading consultations across the working day.

Appointment systems may take a variety of forms and will need to be adapted to the context. In principle, part of the health center working hours will be allocated to patients that have made appointments, while part will be allocated to “walk-in” patients. Appointments will be scheduled by calling the health center, by physically visiting the health center or by making a follow up appointment during a visit.

Patients with appointments will be given priority. However, no patient will be turned away. Patients presenting without an appointment will be assessed by a triage nurse or doctor to ascertain whether or not they need urgent attention. Urgent cases will receive timely care. Non-urgent cases will be advised to schedule an appointment or to wait until all the patients with appointments have been seen by the doctor.

Appointments will be timed to allow the doctor sufficient time to provide a quality consultation. Therefore, doctors will see fewer patients per day, but will be able to attend more comprehensively to the needs of those they do see. An appointment system will also relieve congestion in the health center by spreading attendance throughout the day. This will create an improved environment for both patients and health staff. Furthermore, scheduled appointments will reduce waiting times for patients. As patients without an appointment may have to wait several hours to see the doctor, it is hoped that this will provide an incentive for making an appointment as well as discouraging them from presenting without an appointment for minor complaints.

2. Task-shifting: making the best use of staff skills and time

Currently, most patients attending UNRWA health centers will be seen by a doctor, regardless of the reason for the visit. In practice, many patients do not need to see the doctor at each visit, for example, those requiring a prescription refill could go directly to the pharmacy, while stable hypertension patients could see a nurse for some routine follow up visits. Similarly, the time of nursing staff is often taken up by reporting tasks that could be assigned to a clerk.

The FHT approach involves re-organization of some staff tasks to ensure that the time and skills of each staff member are maximally utilized. Some of the task currently performed only by doctors can be allocated to nurses, while some clerical tasks performed by nurses can be assigned to clerks. For example, the medication refill system can be revised to allow the patient to collect certain chronic medications without being seen by a doctor at each visit. This will free up some of the time of both MOs and nurses to enable them to achieve longer average consultation times, and to reduce the number of patients that need to be seen by the doctor.

The triage system will also help to make the best use of staff time, as the triage staff member will be able to direct certain patients to nursing staff rather than to doctors, thus also contributing to reducing the number of patients that have to be seen by the doctor.

Using the combination of demand management and task shifting, UNRWA aims to reduce the total number of patients seen by a doctor every day. This will enable increased the time spent with each patient and will therefore contribute to improving the quality of the consultation and the patient's perception of the quality of care. These two strategies will be complemented by other initiatives to improve the quality and efficiency of care such as the introduction of a modern electronic patient record system and the updating of technical guidelines and staff skills.

Health Reform Strategy Intervention Logic

<i>Intervention Logic</i>	<i>Indicators</i>	<i>Sources of Verification</i>	<i>Assumptions</i>
Reform Goal:	Average no. of consultations per doctor per day % of NCD patients managed according to UNRWA guidelines % of health center staff that report they are able to deliver improved quality of care as a result of the FHT approach % of served patients reporting satisfaction with delivery of PHC services	<ul style="list-style-type: none"> • Routine health center reports (utilization and staff attendance) • Clinical audit of patient records • Surveys of facility staff • Facility-based patient satisfaction surveys • Quarterly project progress reports • HC activity reports • Quarterly project progress reports • HC data base • Quarterly project progress reports • Monthly health center utilization data • Quarterly project progress reports • Health Center database • Quarterly project progress reports • Annual project progress reports 	<ul style="list-style-type: none"> • Population growth continues at present rate • Epidemiological profile follows expected pattern • No significant change in refugee access to host country health services • Host government accepts family health team approach • Security situation allows health services to operate • UNRWA staff and communities support family health team approach • Funding levels are maintained
Improve the health status of Palestine refugees			
Reform Outcome:			
Improved quality of health care services			
Reform Outputs:			
1. Family health team preparation phase completed	1.1 No. of technical instructions revised 1.2 Teamwork training package produced 1.3 Health information management training package produced 1.4 Community communication package produced		
2. Family health team approach piloted in one health centre (HC)	2.1 Teamwork analysis report available 2.2 No. and % of HC staff trained on teamwork approach 2.3 No. and % of team members with revised responsibilities documented 2.4 % of registered families with consolidated family folders 2.5 No. of community meetings held on FHT approach 2.6 No. of community members attending each community meeting 2.7 % of patients seen using appointment system		
3. Family health team approach rolled out to all HCs in all Fields	3.1 No. of HCs per Field implementing the 6 defined key elements of the FHT approach (teamwork analysis, teamwork training, task shifting, consolidated family folders, community communication, appointment system) 3.2 No. & % of target population served through Family Health Team approach		
4. Hospital databases established	4.1 No. of Fields producing complete quarterly hospital report including the 5 recommended key indicators		
5. Health care seeking behavior and expenditure survey conducted in each	5.1 No. of surveys conducted		

Field		
Activities:		
1. Conduct technical preparations 2. Conduct teamwork preparations 3. Assess and adapt infrastructure 4. Re-organize family folder system (consolidated files) 5. Revise HIS 6. Conduct staff training 7. Re-organize teams and services 8. Develop communication packages 9. Implement communication packages	10. Establish appointment system 11. Implement FHT pilot 12. Conduct evaluation of FHT pilot 13. Revise materials/approach as needed 14. Phased expansion of FHT approach to all UNRWA HCs 15. Revise FO health dept management structure 16. Develop & implement hospital data base 17. Review hospital contract arrangements 18. Conduct health care seeking behavior and health expenditure survey	

NOTE:

The indicators presented here should be considered interim. The list may be revised after the 6 month and 12 month evaluations of the pilots, when lessons learned will enable UNRWA to better define feasible processes and measurable, attainable results.

It is not feasible for UNRWA to measure health status (impact) indicators (mortality, morbidity, life expectancy). Also, there are many other factors affecting health status in addition to PHC services so we cannot assume direct causal relationships between our health services and health status. However, it can reasonably be expected that appropriate, accessible, good quality health services will contribute to improving health status.

The average number of consultations per doctor per day is an accepted proxy indicator for quality of care. According to Sphere standards, the acceptable maximum is 50 consultations per doctor per day. Overutilization of UNRWA services is a significant challenge for the health program and one of the key issues that the FHT approach aims to improve, through the introduction of an appointment system and through improved relationships with the community. Literature has also shown that when patients build a long term relationship with a team of providers and feel cared for as individuals, the number of consultations for minor ailments tends to decline.

Implementation of an appointment system as well as task shifting will allow both doctors and nurses more time to spend with NCD patients than is currently the case. This will enable staff to provide improved clinical care and also to provide adequate lifestyle counseling, a key aspect of NCD care.

The project manager will be expected to report regularly on the progress of the reform process, through provision of quantitative data and narrative reports.