Near East Council of Churches: Department of Service to Palestinian Refugees

Evaluation of Gaza Community Health Program

External Evaluation- Second Draft

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September 2013

Funding Agency	Act for Peace Norwegian Church Aid
Implementing Agency	Near East Council of Churches
Program Locations	Gaza and Rafah
Duration	3-years
Type of Intervention	Health services-Emergency and humanitarian
Date of Evaluation	July 12 to August 12
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List of Abbreviations

Antenatal care	ANC
Health and Clinical Excellence	NICE
Iron deficiency anaemia	IDA
Maternal and Child Health	MCH
Ministry of Health	MoH
Millennium Development Goals	MDGs
Near East Council of Churches	NECC
Post Traumatic Stress Disorders	PTSD
Primary Health Care	PHC
United Nations Children's Fund	UNICEF
United Nations Relief and Works Agency for Palestine Refugees in the Near East	UNRWA
World Health Organization	WHO

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Executive Summary

The NECC believes that good health is incredibly important to achieve social and economic development. Thus, to improve the health status of Palestinians and to improve the quality of health care services, the NECC launched Gaza Community Health Program in 1952. The overall objective of the Gaza Community Health Program is to improve and to promote the health and the wellbeing of Palestinian people, particularly women and children.

Currently, the NECC operates three family health care centres in the Gaza Strip. These three centres are located in El Daraj, Shajaia, and Rafah. The three family health centres serve a population of 80,000, 100,000, and 13,000 in Daraj, Shajaia, and Rafah, respectively. The NECC's health program offers a comprehensive package of health services, with a particular focus on primary health care services. The bundle of the provided services include essential maternal and child health services such as antenatal care, postnatal care, health education, family planning, well-baby care, psychosocial services, home visits, treatment for malnourished and anemic children, and dental services. Additionally, the NECC health program offers laboratory testing and medication.

This evaluation aimed at assessing the appropriateness, relevance, and timelines of the NECC health program, the attainment of goals and objectives, the effectiveness and sustainability of the program, for the period from June 2010 to July 2013. Also, the evaluation has considered assessing organizational issues such as organizational capacity, management, capacity building and transparency. This evaluation largely entailed collecting qualitative data; the qualitative data were collected through desk review, participatory observations, focus group discussions, and in-depth interviews with beneficiaries, including women, children, health providers, and community leaders. In total, 20 in-depth interviews and 12 focus groups were conducted. Additionally, the evaluation team did analysis of the program quantitative data including the anthropometric measures and hemoglobin level.

In order to assess the appropriateness and relevance of this program, the evaluation team assessed three aspects: health services including MCH services, nutritional services, and psychosocial services. Concerning the appropriateness and relevance of the NECC health program, the NECC health program contributed and linked directly to the long-term development of the Gaza Strip. The relationship between health and development is well known; improving health of a population is a means to the end of development. Given the fact that the NECC centres in the Gaza Strip provide a wide range of services including maternal and child services, care of communicable diseases, and other preventive and curative services, this program contributed to the overall development through its impact on improving children health, improving maternal health, and combating major diseases. In an area that is characterized by political hostility and has been under occupation for more than four decades, the need to offer health services is unquestionable. The NECC program is a response to such increasing need for health services particularly in poor, marginalized, and deprived areas. The NECC health program is consistent with the NECC mission, strategies plan, and objectives, in which strategic plan of 2011-2015 is incorporating health intervention as a key component of the NECC intervention in the Gaza Strip

With regard to nutritional aspect, within the Palestinian context—and given the fact that not only the rates of under-nutrition are high, but also are increasing in alarming way—-there is pressing need to implement programs that could help in reducing the rates of nutritional problems among the most vulnerable groups, children and women. The nutritional component of the NECC health program is a response to such a pressing need.

Also, giving the fact that the NECC health program serves people in the marginalized areas of Shajaia, Daraj, and Rafah, which suffer from poverty and food insecurity, this makes this invention very important and much needed.
Finally, concerning the psychosocial component of the NECC health program, people of the Gaza Strip have been born into one the most complicated, unfair, and protracted conflicts in the world, involving 65 years of conflict and 46 years of military occupation. Children of the Gaza Strip do not have chance to experience and live a normal childhood, as most of the children in the world. The psychological and social problems facing the Palestinians in the Gaza Strip, particularly children reflect the dark picture of living under occupation with frequent exposure to military operations, blockade, long-lasting poverty, and unbearable stress. In such context and giving the fact that in Gaza nearly half of the population is under 15 years old (49.1%) and 10.6% is between 15 and 19 years old, there is a need to provide psychological services to most of the children in the Gaza Strip The psychosocial component of the NECC health program is relevant and appropriate response to such dire need.

With regard program activities and effectiveness, there was a consensus among the Program's staff, community leaders, and beneficiaries including women and children that the program was very effective, efficient, and has achieved most of the desired outcomes including the three most important objectives: promoting the health status of Palestinian people, in particular women and children; reducing the prevalence rates of malnutrition and anaemia among children under 6 years of age, and promoting the psychosocial wellbeing of the Palestinian people. Examples of program effectiveness include, but are not limited to:

- *Across three centers, the number of women who did have antenatal care visits exceeded the required number. Furthermore, the vast majority of pregnant women (95.5%) commenced antenatal care in the first trimester of pregnancy.*
- *The percentage of women in targeted localities who received timely postnatal care is outweighed the desirable 70%, as in the program log frame*
- *Annually, on average, about 1,288 pregnant women received dental checkup and dental care during pregnancy*
- *Annually, on average, about 1,250 children did have dental checkup*
- *The prevalence rate of iron deficiency anaemia among children is reduced by 50%*
- *The NECC health program achieved its desired outcomes in reducing the burden/prevalence of anaemia and malnutrition in the targeted areas. Remarkably, the program has achieved high recovery rates in treating nutritional problems, including stunting, which is widely used to measure long-term nutritional deprivation.*
- *The psychosocial program has positive impact on children's behavior as it reduced the level of violent behavior, and improved the academic achievement for children*

With regard to the involvement of stakeholders and community leaders, the interaction with different program staff indicates that the program activities are coordinated with the main health provider, particularly the MoH. There is a need to strengthen coordination with UNRWA and other local community based organizations.

Regarding to management and institutional capacity, the NECC enjoys a very committed, dedicated and effective management. Since its establishment in 1952, the NECC is committed to improve the health status of Palestinian people in the Gaza Strip. This is clearly reflected on the mission of NECC and the strategic goals. The organizational capacitates supported implementing this program included the availability of qualified staff, well-established centres, good procurement, financing, auditing, and logistics departments. To summarize, the health program is very responsive to the NECC capacities, and it is consistent with the work themes, mission, and strategic goals of the NECC.

Regarding effects and sustainability, this program is contributing to the long-term development of the Gaza Strip. Given the fact that the NECC health program provides a wide range of services including maternal and child services, care of communicable diseases, and other preventive and curative services, the program will have positive long-term impacts on the beneficiaries of the NECC centres and the whole community as well. With regard to human resources, this program has a very sustainable impact through strengthening the capacity of the NECC staff. Currently, the NECC staff members have important technical skills; they are capable and have the ability to offer high quality services. This component of the program will have positive long-term impacts on the whole community. Finally, as health education is a core component of the NECC health program, the effect of health education is generally positive and sustainable. Through health education, community people including women and children become more aware of healthy nutritional habits and practices. The impact of adopting appropriate nutritional behaviours is long-term sustainable investment that will have long positive impacts.

The relevancy of the NECC health program is very high as it focused on promoting the overall health of Palestinians. Promoting health will have positive long-term impacts on the beneficiaries of the NECC centres and the whole community as well. Thus, it is very important to continue implementing such activities. The NECC health program emphasis on nutrition is very relevant and appropriate, thus, it is very important to continue offering such services. Finally, the relevancy of the psychosocial component of the NECC health program is very high as it focused on the promoting mental health and increasing psychological wellbeing of Palestinians, NECC should continue implementing such activities in the future.

1. Program Description and Context: NECC Gaza Community Health Program

Program Description

Well-known and highly reputable, the Near East Council of Churches (NECC) in Gaza is strongly committed and dedicated to the improvement of the health status of Palestinian people. The NECC believes that good health is incredibly important to achieve social and economic development. Thus, to improve the health status of Palestinians and to improve the quality of health care services, the NECC launched Gaza Community Health Program in 1952. Currently, the NECC operates three family health care centres in the Gaza Strip. These three centres[1] are located in El Daraj, Shajaia, and Rafah. The three centres serve a population of 80,000, 100,000, and 13,000 in Daraj, Shajaia, and Rafah, respectively. The NECC's health program offers a comprehensive package of health services, with a particular focus on primary health care services. The bundle of the provided services include essential maternal and child health (MCH) services such as antenatal care (ANC), postnatal care, health education, family planning, well-baby care, psychosocial services, home visits, treatment for malnourished children, and dental services. Additionally, the NECC health program offers laboratory testing and medication (NECC, 2013).

To avoid duplication of services and to ensure best use of scarce resources, since launching the health program, the NECC enjoys high level of cooperation and coordination with other health providers including the Ministry of Health (MoH) and other relevant organizations. The NECC health services are considered as the complementarily services for poor marginalized people.

The overall objective of the Gaza Community Health Program is to improve and to promote the health of Palestinian people, in particular women and children. Additionally, the program has the following specific objectives:

- To reduce the prevalence of malnutrition and anaemia among children under 5 years through a targeted nutritional program.

- To contribute to promoting the psychosocial well-being of the Palestinian population through support to traumatized patients/persons particularly women and children.

Annually, the three clinics offer health services to about 28,000 beneficiaries, including 2,300 families in the three marginalized areas.

[1] Within the context of this evaluation, the word centre refers to family health centre

Program Context

Palestinians in the Gaza Strip have been experiencing periods of protracted blockade imposed by the Israeli authorities since the uprising of the second intifada in September 2000. Closures have intensified since Hamas seized control in June 2007. The ongoing blockade has been widely described as "collective punishment" resulting in a humanitarian crisis. The UN officials have described the situation as "grim", "deteriorating" and a "medieval siege." The ongoing blockade has caused irreversible damage to the Gaza Strips' economy. As a consequence of the ongoing blockade, the unemployment rate has soared to 44% of the Gaza workforce. Seventy percent of the population lives on less than a dollar a day, and 80% of Palestinians households rely on some kind of food aid (Siddique, 2010). Sixty-one percent lack daily access to safe water. Living under a blockade places health security at risk as it makes it difficult to obtain basic life requirements for a healthy life such as food and water. According to a study conducted by the World Food Program, Food and Agriculture Organization and the Palestinian Central Bureau of Statistics (2010), about 52% of the Gaza Strip households suffer from food insecurity. Another 13% of the households are vulnerable to food insecurity, and only 19% of Gaza households are food secured. In absolute numbers, an estimated 821,109 people living in the Gaza Strip are food insecure. Unsurprisingly, food insecurity affects rural areas and marginalized areas, as well as areas suffering from incursions and destruction of assets or buffer zone areas. Without a doubt, the main reason for food insecurity in Gaza is political. The above numbers indicate that food insecurity a chronic persist issue that disrupts the basics of life for the Palestinian people. A large number of households in the Gaza Strip are currently unable to afford essential food items as the Israeli siege on the Gaza Strip continues with additional restrictions on food and fuel. As a consequence, about 10% of Gaza Strip households had poor food consumption. Nineteen percent had borderline consumption, and 71% had acceptable consumption. The low percentage of household who had poor food consumption is due to relying on food assistance, in which food assistance is playing a major role to enable Gaza households to secure a diet with an acceptable amount and diversity of food.

With regard to health status, according to the World Health Organization (WHO), the blockade has led to a general "worsening of the health conditions of the population" and "accelerated the degeneration" of the health system. The worsening and/or the slowdown of health improvement in the Gaza Strip is caused by many factors. Most importantly, the current blockade on the Gaza Strip is causing a serious deterioration in the social, economic, and environmental determinants of health and weakening the current healthcare system to a low never previously experienced. Secondly, the Palestinian healthcare system is well known as a fragmented system with limited coordination between its main players. Furthermore, the current political division between the Gaza Strip and West Bank has weakened the already fragmented system. The current health care system is characterized by poor governance, weak institutional capacity, limited regulation and supervision, lack of long-term plans, and lack of coordination between the different providers and funders. All of the above weaknesses in the current healthcare system make the improvement in the health status of Palestinians in the Gaza Strip or even maintaining the current status very hard. Third,

due to the current political leaderships in the Gaza Strip and the international embargo on the Gaza Strip's government, donors have shifted from aiding development projects to emergency relief; thus, no improvement in health status can be expected. Even to maintain the status quo of the current crippled system in the Gaza Strip would be impossible, and it could collapse at any point of time (Abed, 2007; Giacaman et al., 2009; RAND, 2007; Roy, 2008).

With regard to nutritional status among children, food security and adequate feeding practices are basic components of children's nutritional status. Thus, with the high prevalence of food insecurity, long-lasting household poverty, high unemployment rates, and movement restrictions, it is expected to have high rate of anaemia and malnutrition among Palestinian children in the Gaza Strip. The prevalence rate of iron deficiency anaemia among Palestinian children is among the highest rates in the Mediterranean region. According to a study conducted by Save the Children and Medical Aid for Palestinians-UK (2012) to assess the effect of the blockade on child health in Gaza, the prevalence rates of anaemia among the children of Gaza Strip are: 58.6% among school children, 68.1% among of children 9-12 months. Along with anaemia, stunting is a nutritional problem that reflects long-term exposure to chronic malnutrition. According to the Palestinian Central Bureau of Statistics, in 2006 the percentage of stunted children in the Gaza Strip was 13.2%. This finding was confirmed by a study conducted by the United Nations Children's Fund (UNICEF) in 2009. Consistently, World Vision indicated that around 13% of children in the Gaza Strip are either severely or moderately stunted (Palestine Monitor, 2011). Worldwide, nutritional disorders are the primary leading factors to the global burden of disease and impede the overall economic development of a country. Generally speaking, nutritional disorders have deleterious consequences on human well-being, health, and overall development. In particular, nutritional disorders have the most significant deleterious impact on children, for whom malnutrition leads to further poor health, poor school readiness and performance, and results in fewer years of schooling and reducing productivity. During adulthood, nutritional disorders diminish adult intellectual ability and work capacity, thus causing economic hardships for individuals and their families.

2. Objectives of the Evaluation

This evaluation aimed to[2]:

- Assess the relevance and appropriateness of the program design and specific activities to meet the program's stated objectives
- Assess the link between the program theme and the long term activities and strategic plan of the NECC
- Assess the degree in which the program achieved its objectives and outcomes
- Assess the program's outcomes at different levels, including beneficiaries, community members, and health providers
- Determine the main strengths and benefits of the program, in particular the quality of the provided services
- Identify the main challenges that rise during the program implementation
- Assess the longer-term sustainability and impact of the project
- Assess the program efficiency in relation to the use of resources and outcomes achieved
- Assess the program incorporation of cross cutting issues such as gender and disability
- Propose recommendations on the most appropriate design, implementation, and areas for improvement for future programs

3. Evaluation Methodology

Methods of Data Collection:

In order to develop a deep understanding of the programs purposes, relevance, appropriateness, efficiency, adherence to standards and principles, and impact, this evaluation largely entailed collecting qualitative data. Also, this evaluation entailed secondary analysis of the program quantitative data, particularly anthropometric measurements. The qualitative data were collected through desk review, participatory observations, focus group discussions, and in-depth interviews with beneficiaries, including women, children, health providers, and community leaders. Also, the evaluator team conducted a series of in-depth interviews with NECC key informants and the program's staff including, the program coordinators. Annex (1) shows the evaluation tools and the schedule of evaluation team visits.

Qualitative Methods of Data Collection

The qualitative data were collected through desk review, site visits, participatory observations, in-depth interviews, and focus groups. The data collection started by desk

[2] This evaluation focused solely only on a three year period from July 2010 to June 2013.

review and field visit, as the evaluation team carefully reviewed and analyzed most of the program’s documents including the original proposals of the first grant period, the second grant period, and the third grant period, beneficiaries’ database and fields monitoring reports, financial documents and administrative manuals. Additionally, the evaluation team reviewed sample of beneficiaries' electronic files, guidelines manuals, and other program relevant materials. Additionally, observations were used to assess the interaction between health providers and clients, and the interaction among health providers. The evaluation team interacted with beneficiaries during the observation and observed the implementation of program activities.

Concerning in-depth interviews, the evaluation team conducted a series of in-depth interviews with the program’s key informants from the NECC office and the three centres. In addition, in-depth interviews conducted with key program staff. The evaluation team interviewed the executive director of the NECC-Gaza, the NECC-Gaza clinical consultant, the health field coordinator, senior accountant, the three supervisors of the NECC health centre, a medical doctor specializing in nutrition, a medical doctor specializing in family planning, a general practitioner, a registered nurse, pharmacists, and three psychologists. Additionally, the evaluation team interviewed the chief of UNRWA's health program in the Gaza Strip, the general director of PHC directorates-Ministry of Health, and three community leaders. In total, 20 in-depth interviews were conducted.

Finally, the evaluation team conducted several focus groups with beneficiaries, including women, men and children. Each focus group was assembled of an average of nine participants per group. In summary, 12 focus groups were conducted; two focus groups were assembled to evaluate the overall impact, effectiveness, and relevance of the program. Participants of these focus groups were beneficiaries from the three target areas, both women (two groups) and men (one group), shows the evaluation tools and the schedule of evaluation team visits.

Additionally, three focus groups were conducted to evaluate the impact and effectiveness of the program in improving the nutritional status of children under 5 and reducing the prevalence of anaemia. Participants of these focus groups were female beneficiaries from the three target areas. Four focus groups were assembled to evaluate the effectiveness, relevance, appropriateness of the program in improving the psychological wellbeing of Palestinians, in particular women and children. Participants of these focus groups were beneficiaries from the three target areas, both women (two groups) and children (two groups) in the targeted areas. Finally, two focus groups were assembled to evaluate the effectiveness and relevance of the afternoon activities.

The evaluation team memabers conducting qualaitive data colection incuding three focus froups: children, womem, and men, and indepth interviews with a pscholoisgt from Shajaia centre

Quantitative Methods of Data Collection: Analysis of Secondary Data

With regard to quantitative data, the evaluation team did analysis of the program data including the anthropometric measures and hemoglobin level, annex (1) shows the evaluation tools and the schedule of evaluation team visits.

4. Key Findings of the Evaluation

4.1. Situational Analysis, Appropriateness, and Relevance

Currently, the NECC operates three family health care centres in the Gaza Strip. Established in 1967, the first family centre is located in the Shajaia area. Al Shajaia neighbourhood is located in the East of Gaza City and it is one of the largest neighbourhoods in the Gaza Strip, with around 100,000 residents. Residence of Al Shajaia neighbourhood is a mixture of refugees and non-refugees and it has one of highest population densities in the Gaza Strip (Maan news, 2013). Al Shajaia neighbourhood is considered as a border area and it had been targeted several times by the Israeli Army. With regard to health services, in addition to the NECC family health care centre, the MoH operates a small PHC centre. However, this centre is not well developed and it offers only essential services such as immunisation. The centre does not offer essential services such as dental care, nutritional services, and regular family planning services. To access the MoH-PHC, residence should have health insurance. In-depth interviews with community members from Al Shajaia area revealed dissatisfaction with the health services provided by the MoH-PHC centre. The main reasons of dissatisfaction are: poor quality of the provided services, shortage of drug, and the lack of essential services such as family planning. Generally, 60% of the population of the Gaza Strip are insured by the governmental health insurance, which means 40% do not have access to the MoH-PHC (MoH, 2009). UNRWA, the second main health provider, does not provide health services in Al Shajaia neighbourhood. In sum, the existence of the NECC family centre in Al Shajaia neighbourhood is very important as it services large number of marginalized people, the presence of high population density, the limited availability of MoH health services, the lack of UNRWA services.

The second family centre is located in Daraj area. This centre was established in 1973. Daraj neighbourhood is located northern quarter of Gaza's old city. With a total population of 80,000 people, Daraj neighbourhood has a high population density. The residences of Daraj neighbourhood are a mixture of refugees and non-refugees; however, Daraj neighbourhood has more of non-refugees (Maan news, 2013). With regard to health services, in addition to the NECC family health centre, the MoH operates a PHC centre, however, this centre is not accessible to all residence of Al Daraj neighbourhood as the centre is located in the West part the neighbourhood and only insured people can access its services. UNRWA operates another PHC centres. However, UNRWA provides services only to refuges and its centre is located on the East part of the neighbourhood. Residence of other areas of the neighbourhood needs to pay for transportation in order to reach the UNRWA centre. Giving the high poverty rate, cost of transportation might hinder the utilization of the UNRWA PHC services. Contrary to the UNRWA and MoH PHCs, the NECC centre is centrally located in Al Daraj neighbourhood and it is within walking distance to other remote areas in the neighbourhood.

Finally, the third centre is located in Rafah area in the Khrbet Al Addas area. The centre was established in 2002 and it is located in a very remote border area that has a majority of non-refugee Bedouin population. The NECC family health care centre serves a

population of 13,000. Poverty and a high level of unemployment characterize the area. Both MoH and UNRWA do not provide PHC services in Khrbet Al Addas area, but they do in the surrounding neighbourhood. To access MoH and UNRWA PHCs in the surrounding neighbourhood, residents of Khrbet Al Addas need to pay a transportation cost. With the high poverty rate there, this is considered to be a huge barrier that could prevent people from utilizing services. In other words, the presence of NECC family health care centre is very vital as it services a vulnerable poor population.

As mentioned earlier, the NECC health program offers comprehensive package of health services with particular focus on primary health care services. In order to assess the appropriateness and relevance of this program, the analysis will cover three main aspects: health services including MCH services, nutritional services, and psychosocial services.
Concerning the appropriateness and relevance of the NECC health program, the NECC health program contributed and linked directly to the long-term development of the Gaza Strip. The relationship between health and development is well known; improving health of a population is a means to the end of development. Given the fact that the NECC centres in the Gaza Strip provide a wide range of services including maternal and child services, care of communicable diseases, and other preventive and curative services, this program contributed to the overall development through its impact on achieving three out of the eight Millennium Development Goals (MDGs): reducing child mortality (MDG4), improving maternal health (MDG5), and combating major diseases (MDG6). In an area that is characterized by political hostility and has been under occupation for more than four decades, the need to offer health services is unquestionable. The NECC program is a response to such increasing need for health services particularly in poor, marginalized, and deprived areas. As mentioned earlier, the primary focus of the NECC health program is on primary health care (PHC). There has been an acceptance of and emphasis on the important role of PHC. Health services that are efficient, effective, and responsive to population health are known to be highly conducive. According to the World Bank, health interventions at the primary care level are able to deal with 90 percent of health care demands; only 10 percent of demands for health services require the services and skills typically available in hospitals. Furthermore, primary care services have a significant advantage over hospital care because they are more accessible to the community, less costly, and more easily able to provide comprehensive, integrated, personalized and continuous care. Thus, the implementation of this program is very appropriate and relevant. The NECC should continue focusing on the PHC.
With regard to MCH services, the NECC health program offers integrated MCH services. Recently, there has been increasing interest in implementing MCH through integrated programs. This renewed interest in services integration was sparked in 1994 at the International Conference on Population and Development in Cairo, where countries committed themselves to providing a comprehensive package of MCH services. The integrated packaged might include ANC, postnatal care, child care, family planning, and women health. The integration of health services is a proactive approach to meeting clients’ broader health needs by assisting a client to obtain two or more health services for the cost of one in terms of time and money. The NECC health program offers integrated MCH services. Thus, this is consistent with the WHO

recommendation and the first and second MoH strategic plans that underlined the importance of providing integrated MCH services. The NECC health program is consistent with the NECC mission, strategies plan, and objectives, in which strategic plan of 2011-2015 is incorporating health intervention as a key component of the NECC intervention in the Gaza Strip. For more than six decades, the NECC has been offering Palestinian people good quality health services.

Concerning the appropriateness and relevance of nutritional component of the NECC health program, it is well known that malnutrition greatly hinders countries socio-economic development and the capability of reducing poverty. At a national level, many of the Millennium Development Goals (MDGs)—in particular MDG1: eradicate extreme poverty and hunger; MDG4: reduce child mortality; and MDG5: improve maternal health—could not be accomplished without reducing rates of malnutrition among children and women.

Within the Palestinian context—and given the fact that not only the rates of under-nutrition are high, as mentioned before, but also are increasing in alarming way—there is pressing need to implement programs that could help in reducing the rates of nutritional problems among the most vulnerable groups, children and women. The nutritional component of the NECC health program is a response to such a pressing need. Also, giving the fact that the NECC health program serves people in the marginalized areas of Shajaia, Daraj, and Rafah, which suffer from poverty and food insecurity, this makes this invention very important and much needed.

In brief, the nutritional component of the NECC health program aims to improve the overall nutritional status of children in the three targeted areas by assessing the physical growth parameters of all children who attend the well-baby clinics and assess their haemoglobin level. Accordingly, malnourished and anaemic children will receive appropriate treatment in the NECC centres and the intractable severe cases will be referred to specialized institutions, including hospitals and advanced laboratory services. Additionally, the program aims to increase people's knowledge about healthy nutritional habits and behaviour through health education programs inside and outside the NECC centres. The aim of nutritional component of the NECC health program is consistent with the Palestinian Nutrition Strategy (2005), which underlined the importance of improving the nutritional status of the Palestinian people particularly children and women. It is also consistent with the outlines of the Palestinian Reform and Development Plan 2008–2010 that aims to promote the health status of Palestinian children by improving their nutritional status, and it is consistent with the objectives of the first and second MoH strategic plans, which include reducing the rates of under-nutrition among children, and thus reducing the rates of child mortality. The nutritional component to the NECC health program is consistent with the NECC mission, strategies, and objectives. Importantly, the NECC health program staff has remarkable experience in diagnosing, dealing, and treating nutritional problems. A few years ago, the NECC implemented a household screening survey to diagnosis then treat malnutrition problems among all the children in the three targeted areas. This survey was a tremendous success as it helped in reducing the prevalence rates of malnutrition

including anaemia. The current nutritional interventions are a continuation of similar activities through the well-baby clinic.

The psychosocial component of the NECC health program is very relevant within the context of the Gaza Strip. People of the Gaza Strip have been born into one the most complicated, unfair, and protracted conflicts in the world, involving 65 years of conflict and 46 years of military occupation. Children of the Gaza Strip do not have chance to experience and live a normal childhood, as most of the children in the world. Instead, as they grow up, they are exposed to frequent barbaric military operations, home demolition, displacement, and even death. Not only is Palestinian children's access to normal life is very restricted, but also, the basic life requirements are lacking such as clean water, food security, and good nutrition. The last barbaric military operation was conducted in November 14, 2012, and it lasted for 8 days. During this heavy operation, the Israeli military forces conduced hundreds of airstrikes, naval, and artillery shootings. As a result, more than 150 people were killed including 42 children and 11 women. During those 8 days, like the rest of all the Palestinians in the Gaza Strip, children lived under life threatening condition with no safe place to go.

The psychosocial component of the NECC health program is a response to such dire need. The NECC psychosocial program offers diverse services including psychosocial support, emotional support and debriefing, recreational activities, and individual and group counseling. The psychosocial program has started after 2008-2009 war, and it is still ongoing. Recently, immediately after the 2012 war, the NECC health program implemented psychosocial activities that were funded by the pontifical mission. These activities lasted from December 2012 to May 2013.

Living in the war-torn Gaza Strip is a reality for Palestinian children. This has devastating consequences on almost all Palestinians, particularly children. A study conducted by Altawil and his colleagues (2008) to explore the long-term effects of war and occupation on the Palestinian children in the Gaza Strip found that every child in the Gaza Strip had been exposed at least three traumatic events. The most common type of trauma exposure is humiliation, in which 99% of children had suffered humiliation (either to themselves or a family member). Also, 97% of children had been exposed to the sound bombs, 85% witnessed a martyr's funeral, and 84% had witnessed shelling by tanks, artillery, or military planes.

More importantly, the same study found that 41% of children suffered from Post Traumatic Stress Disorders (PTSD). Out of the 41% of children with PTSD, 20% of children suffered from an acute level of PTSD, 22% suffered from moderate levels, and 58% suffered from mild PTSD. Unsurprisingly, the most prevalent symptoms of PTSD were cognitive symptoms in which 25% of children suffered from sleeping problems, feeling unsafe, and keep thinking of trauma to which they have been exposed. Emotional symptoms of PTSD were also prevalent, in which 22% of children suffered from nightmares, feeling sad and fearful, bedwetting, and easily getting tense and nervous. With regard to social behavioral disorders, 22% of children suffer from aggressive behavior and rejecting teachers and parents authority. Other symptoms

include academic behavioral disorders with involves difficulties in concentration, poor academic performance, and somatic symptoms, which encompass psychosomatic symptoms such as headaches and stomachaches. The psychological and social problems facing the children of the Gaza Strip reflect the dark picture of living under occupation with frequent exposure to military operations, blockade, long-lasting poverty, and unbearable stress. In such context and giving the fact that in Gaza nearly half of the population is under 15 years old (49.1%) and 10.6% is between 15 and 19 years old, there is a need to provide psychological services to most of the children in the Gaza Strip, which encompassing about 60% of the total Gaza Strip population. The provided services should include counseling, rehabilitation, and medical treatment.
The psychosocial component to the NECC health program is consistent with the NECC mission, strategies, and objectives.

4. 2. The Added Value of NECC Health Program

The overall objective of the Gaza Community Health Program is to improve and to promote the health and the wellbeing of Palestinian people. The NECC health program supports and contributes to the development of health sector. The added value of NECC health program include the followings:

1. Providing Comprehensive Integrated Services Through Family Health Care Centres: In 1952, the NECC health program was the first health program that established Family Care Health Centres in the Gaza Strip. The NECC Family Centres are dedicated to providing comprehensive integrated primary health care services to the residents of served areas. It is well known that Family Care Health Centers offers patients convenience, quality and innovation in primary care services. Currently, the NECC health program provides comprehensive integrated PHC services including ANC, postnatal care, family planning, well-baby care, general clinic, and to lesser extent, communicable and noncommunicable diseases. Recently, UNRWA has decided to follow the NECC steps through adopting the family health approach in its MCH centres.

2. Provision of Psychosocial Service Within the Family Health Care Centres: The Palestinian culture has its own traditional explanations for mental disorders. The common belief is that psychological disturbance and mental illness are the result of possession by supernatural forces. This possession has cultural roots that cannot be explained scientifically. Within the context of the Gaza Strip, people view mental disorders as a source of stigma and fear. Thus, people feel stigmatized by utilizing psychosocial service. To overcome this, NECC integrates psychosocial service as a core component of the Family Health Care centres. In the Gaza Strip, most psychosocial and psychiatric services are provided through vertical programs that only provide psychosocial and psychiatric services. The main drawback of this is that vertical programs may be ineffective in reaching a wide range of the population. Thus, the integration of psychosocial service in the NECC Family Health Care Centres is a great value added. The NECC integrated approach is consistent with UNICEF’s approach in offering psychosocial services through integrating them with education services through a network of 21 family centres. (UNICEF works for children's rights, their survival, development and protection, guided by the Convention on the Rights of Child.) Recently, UNRWA started offering psychosocial support service within its PHCs. MoH offers psychosocial service in vertical clinics, which might be not that effective within

the context that has been chronic exposure to a series of traumatic events, frequent wars, house demolitions, imprisonment, and movement restrictions.

3. Providing Financial Assistance to Deprived Families: As consequence of the ongoing protracted blocked, a high percentage of Palestinian households rely on some kind of food aid. The poverty rate is increasing, and the need for humanitarian assistance appears to be rising. Through its health program, NECC helps alleviating poverty through using diverse measures including distributing cash to needy families, depends on budget availability, submitting lists of poor families to Ministry of Social Affairs to get cash and food assistance, and submitting lists of poor families to Cooperative Housing Foundation to get food parcels through the food Security Program.

4. Involving Community in Designing Making and Prioritizing Health Needs: Community involvement is an essence of PHC and Family Health Care. The involvement of community members to such a degree is not a common behaviour of health providers in the Gaza Strip. Since launching its health program, NECC involves community members constantly in identifying community needs, prioritizing the identified needs, and implementing activities. For instance, during launching the nutritional program in the three-targeted areas, NECC involved community leaders in order to reach, educate, and convince people to adopting healthy habits. Another example is the inclusion of family planning services to the NECC health services. Community members demanded the service; community leaders expressed the need to NECC, and NECC responded to the community need and included the service within NECC bundle of services. With no doubt, community involvement is not only value added to NECC, but it gives creditability, acceptability, and suitability of NECC provided services.

5. Creating Electronic Health Record and Centralized Database: In 2008, NECC health program is the first program that developed electronic health records and that fully transformed the paper-based system to electronic computerized system. Currently, UNRWA is in the process of transforming the paper-based system to electronic system.

6. Offering Systematic Well-Organized Postnatal Care: NECC health program is the most successful and among the few systematic, well organized postnatal care services in the Gaza Strip. The NECC postnatal program involves conducting home visits to all newly delivered women, mostly in the first six days after delivery. Contrary to the NECC postnatal program, UNRWA and MoH postnatal programs involve visiting only defaulters and high-risk pregnancy cases. Also, the MoH postnatal program is not a sustainable program, it is a project funded by UNICEF with particular emphasis on child health rather than women's health.

7. Providing Growth Monitoring for Children up to Six Years Old: In the Gaza Strip, the NECC health program is the only program that provides growth monitoring to children up from birth to six years old. Both NURWA and MoH provide growth monitoring for children up to three years old.

8. Conducting Systematic Follow up for Beneficiaries: NECC is the only health provider that implements systematic follow up for their beneficiaries. For instance, NECC refers severe cases of anaemia and malnutrition to MoH and other local organizations. NECC conducts systematic follow up of referred cases through home

visits, and follow up with physicians at the referral organizations. Additionally, NECC conducts regular follow up that involves home visits for children suffer from anaemia and malnutrition.

9. Tackling Anaemia and Malnutrition Problems among Children: Anaemia and malnutrition are common health problems among Palestinian children. NECC is among few organizations that committed and dedicated to reduce the prevalence rate of anaemia and malnutrition among children. In brief, NECC is the first organization that implemented a household screening survey to diagnose and then treat anaemia and malnutrition among children from birth up to six years old. More importantly, NECC ranks in the top among organizations that achieved high recovery rate of anaemia and malnutrition among children. The NECC works on anaemia and malnutrition is not only value added to NECC, but also to all providers that work on nutritional problems.

10. Conducting and Disseminating Impact Assessment: NECC is among a very few organizations that conduct and disseminate impact assessments in order to identify future consequences of a current policies and activities and to make sure that the implemented activities are economically viable, socially equitable, and sustainable. For instance, NECC conducted impact assessment for the nutritional program, this impact assessment was published in a peer-reviewed journal and disseminated to other local and international actors, this is value added to NECC and other relevant organizations.

11. Presenting the Existence of Christianity in the Gaza Strip: The presence of Christians in the Holy Land of Palestine, including the Gaza Strip is extremely important. In the Gaza Strip, Muslim and Christian have a common culture and live in the same circumstances, same struggle, and same economic hardship. NECC has been committed to nurturing the Christian presence in the Gaza Strip. The presence of NECC in the Gaza Strip gives great feasibility and support to Christians in the Gaza Strip. Guided by Christianity teaching:

“Do to others as you would have them do to you.“ Luke 6:31

"Serve one another with love." Galatians 5:13

“You shall love your neighbor as yourself. There is no other commandment greater than these.” Mark 12:31

“Truly, truly, I say to you, a servant is not greater than his master, nor is a messenger greater than the one who sent him.” John 13:16

“Give justice to the weak and the fatherless; maintain the right of the afflicted and the destitute.” Psalms 82:3

NECC provides services to all Palestinians without regard to any discriminatory factor including religion, though interestingly, there are no Christians living in the areas where NECC provides its services.

4. 3. Goals, Activities, and Effectiveness

There was a consensus among the Program's staff, community leaders, and beneficiaries including women and children that the program was very effective, efficient, and has achieved most of the desired outcomes including the three most important objectives: promoting the health status of Palestinian people, in particular women and children; reducing the prevalence rates of malnutrition and anaemia among children under 6 years of age, and promoting the psychosocial wellbeing of the Palestinian people. The following sections briefly illustrate the project's aims, implemented activities, and analyzed the main specific program outcomes, as reported in the program's log frame.

1. General Impact on achieving the MDGs

With regard to the impact of the NECC health program on achieving the MDGs, most of the available data and indicators are available in the aggregate level such infant mortality rate in the Gaza Strip and over all poverty rate; the lack of break down of data/indicators by locality such as a neighborhood is one of the main limitations of the current available indicators, thus, the evaluation team was unable to measure the impact of the NECC health program in achieving the MDG4, 5, and 6. This is also true with regard to nutritional indicators. However, the below analysis reflects that, at the aggregated level-Gaza Strip, there is slowdown in health improvement and that the Palestinian health care system (PHCS) is struggling to deliver the acceptable level of health services to Palestinians.

Although the PHCS has made many positive steps to achieve the MDGs, the biggest problem always hindering the PHCS is the political instability, which has negative impact on the delivery of health services. In relation to reducing the child mortality, between 1990 and 2000, the infant mortality rate declined from 27.3 deaths to 22 deaths per 1,000 live births. In 2009, infant decreased to reach 21.5 per 1,000 live births. With regard to under-five mortality rate, between 1990 and 2003, the rate declined from 33.2 to 28.5 per 1,000 per live births. In 2007, the under-five mortality rate was 24.6 per 1,000 live births (MoH, 2006). With regard to maternal mortality, it is unfair to draw a trend from 1990 up to the current date as there is underreporting. In 2007, the maternal mortality ratio was 20 per 100,000 live births (Ministry of Health, 2007). The abovementioned numbers clearly reflects that reduction in the infant mortality rate and under-five mortality rate stalled and that PHCS still faces challenges to achieve these goals. This could be attributed to the current deteriorating conditions in the Gaza Strip and the slowdown of health improvement (Giacaman, 2009). The slowdown of health improvement is caused by many factors, most importantly, first by the fact that the current blockade on the Gaza Strip is causing a serious deterioration in the social, economic and environmental determinants of health and weakening the current healthcare system to a low never previously experienced. Secondly, the Palestinian healthcare system is well known as a fragmented system with limited coordination between its main players. Furthermore, the current political division between the Gaza Strip and West Bank has weakened the already fragmented system.

The above analysis clearly shows that the NECC investment in health and health services is very important and much needed. With regard to activities and achieved outcomes in the NECC three family health care centres, the following section explores the main implemented activities and quantifies the outcomes according to NECC log frame.

2. Provide Adequate PHC Services in Poor and Overcrowded Localities According to Priorities/ Women, Children and Youth in Poor and Overcrowded Localities Enjoy Improved Health Conditions

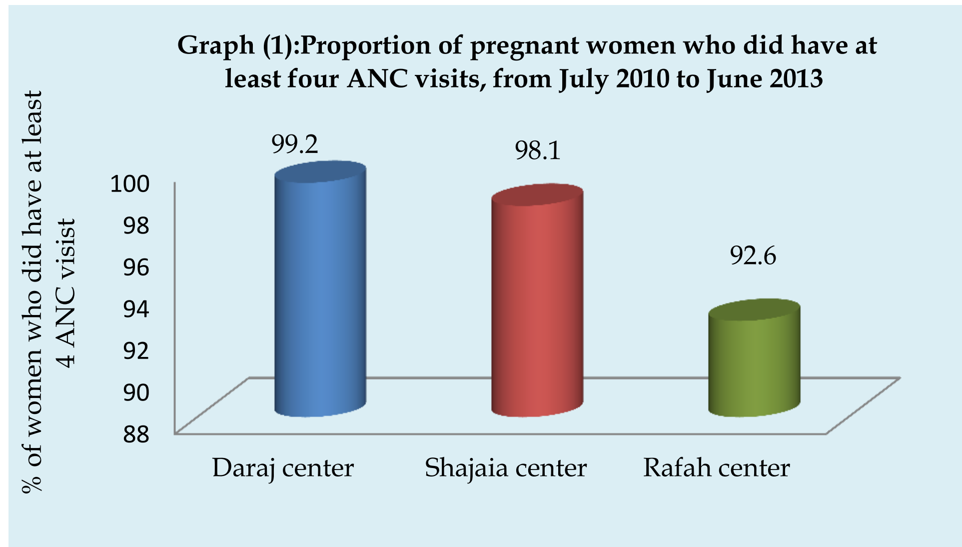
Indicators: At least 90% of pregnant women in targeted localities receive timely ANC of at least four visits, and at least 70% of women in targeted localities receive timely quality postnatal care at least twice.

Implemented activities and effectiveness

As reported in the program log frame, this outcome will be achieved by providing pregnant women with at least four timely ANC visits, offering timely and quality postnatal care, and improving women's overall knowledge of nutrition, ANC, natal care, and postnatal care.

ANC care provides incredibly important opportunities for pregnant women with a wide range of interventions including treatment, education, counselling, screening, and promoting the well-being of the mother and foetus. ANC is effective when sought early, and when followed with quality care that continues until delivery. The NECC three health centres adopted the MoH-ANC protocols for follow up visits. These protocols are in line with the WHO protocols. According to the ANC protocol, each pregnant women may have ANC visits on the following schedule: (1) every month, from the first through the end of the sixth month of pregnancy (the first 28 weeks), (2) every three weeks in the seventh and eighth months (from week 28 to week 36), and (3) every week in the ninth month (from week 36 until birth). The schedule of ANC visits enables the three NECC centres to offer a continuum of care that is accessible and of high quality.

As reported in the program log frame, at least 90% of pregnant women should have at least timely four ANC visits. Graph (1) shows that this outcome has been achieved. The vast majority of pregnant women did have a minimum of four ANC visits as recommended by the WHO. It is important to note that most pregnant women commenced receiving ANC in the first trimester.



The above graph reveals that Al Daraj centre has the highest proportion of pregnant women who received at least four ANC visits (99.2%). Interestingly, from July 2012 to June 2013, all pregnant women received at least four ANC visits. This is considered a remarkable success and reflects high compliance of staff with guidelines and protocols, and women's satisfaction with the provided care.

Compared to the rate at the Al Daraj centre, the lowest proportion (92.6%) of pregnant women who had at least four ANC visits was reported in Rafah centre. From July 2010 to June 2011, the lowest proportion was 83.6%. Then, the proportion increased to 97.5% and 100% in the periods from July 2011 to June 2012, and from July 2012 to June 2013, respectively. It is worth mentioning that women may visit other health providers to receive ANC service; visits to other health providers are not listed here.

With regard to Shajaia centre, from July 2010 to June 2013, about 98% of pregnant women had at least four ANC visits. The highest proportion (99.7%) was reported in the period from July 2012 to June 2013. The overall proportion is also considered a substantial success.

From the aforementioned information, we can conclude that the utilization rate of ANC service in the three NECC-PHC centres is amazingly high as the three NECC centres have achieved the desired outcome. The main reasons behind this success and effectiveness of the provided ANC are:

- ANC guidelines are in place, and all NECC staff abide by unified protocols and guidelines. As mentioned earlier, these guidelines are in line with the WHO-tested and proven effectiveness guidelines.
- All staff members are skilled attendants, midwives and physicians able to provide high quality services.
- According to the WHO, an effective ANC package depends on competent health care providers in a functioning health care facility with referral services and adequate supplies and laboratory support. The three NECC centres have the capacity to deliver effective ANC services as the centres are equipped with the necessary equipment, have the ability to refer cases to specialized facilities if

there is a need to do so, and offer suitable laboratory tests and treatment free of charge.

- Services are available and acceptable to all the women in the three catchment areas, regardless of socioeconomic status and religious background. All the provided services are free of charge.
- Currently, the three centres are using SMS technology to remind women of their appointments. According to the women, the use of SMS reminders helps them not miss their appointment.

Women in targeted localities receive timely postnatal care services

Implemented activities and effectiveness

Postnatal care is the core medical care that every healthy woman and healthy baby should be offered during the first 6-8 weeks after the birth. In the Gaza Strip, postnatal health care has been a neglected aspect of women's health care, in which the main health providers UNRWA[3] and the MoH do not offer systematic postnatal care services. Currently, UNRWA health centres conduct postnatal care in the first week after delivery when newly delivered women visit a health centre to immunize their babies. This is also the case in the MoH centres. Both the MoH and UNRWA conduct home visits only in high-risk cases.

The postnatal care provided by the NECC health program is among few systematic, well-organized postnatal care services in the Gaza Strip that includes home visits to all newly delivered women. In brief, the NECC postnatal services targets all delivered women who attended ANC services in the three health centres through providing home visits. Ideally, the home visits should be within the first six days after delivery; if that is not possible, within the 40 days after delivery. During home visits, the health professionals, mostly midwives, conduct physical examinations including a uterine and abdominal examination, checking blood pressure and assessing breastfeeding practices, and educating women about different issues like nutrition and hygiene. With regard to newborn care, health professionals check the umbilical cord, conduct a physical examination, and check for any health problems. In terms of visiting the NECC centres, during the home visits, NECC health professionals advise women to come to the centre and register their babies in the well-baby clinic, preferably within 30 days after delivery.

According to the program log frame, at least 70% of women in targeted localities receive timely postnatal care. As will be discussed in the following paragraphs, this indicator along the lines of ANC services has been achieved and the percentage of women who had postnatal care outweighed the desirable 70%. Table (1) shows that across the three years, from July 2010 to June 2013, the highest percentage of women who were visited by the NECC staff in the first six days after delivery was 84.4% in Daraj centre, followed by 66.9% in Shajaia centre, and then the lowest percentage was reported in Rafah centre with a 63.1%. With regard to the percentage of women who were visited by the NECC staff in 40 days after delivery, the three centres have achieved high percentages, in particular in Daraj centre with 98.6%. In Rafah centre, the percentage was 90.8%. More efforts are needed to reach the 10% that the team was unable to reach.

[3] United Nations Relief and Works Agency for Palestine Refugees in the Near East

Table (1): Percentage of women who received postnatal care through home visits

Centre	July 2010 to June 2011	July 2011 to June 2012	July 2012 to June 2013	Total, June 2010 to July 2013
Percentage of women who received post natal care through home visits in first six days after delivery				
Shajaia	54.5	62.0	84.2	66.9
Daraj	76.4	86.5	90	84.4
Rafah	41.8	64.5	83.1	63.1
Percentage of women who received post natal care through home visits between day 7 and 40 after delivery				
Shajaia	34.7	32.4	13.5	26.9
Daraj	20.1	12.4	10	14.2
Rafah	38.9	26	18.1	27.7
Percentage of women who received post natal care through home visits in 40 days after delivery				
Shajaia	89.2	94.4	97.7	93.8
Daraj	96.5	98.8	100.0	98.6
Rafah	80.7	90.5	100.0	90.8

With regard to percentage of women who visited a centre within 40 days after delivery, table (2) shows that, across the three centres, on average about 52% of women visited the NECC centres and registered their babies in the well-baby clinics. This percentage is not high. With more efforts this percentage could increase. Although the core of this visit is to register the newborns in the well-baby clinics, as this visit occurs in the puerperium period and could be utilized as the second postnatal follow-up visit, according to log frame, each women should receive postnatal care twice.

Table (2): Percentage of women who visited the NECC centres in the within 40 days after delivery

Centre	July 2010 to June 2011	July 2011 to June 2012	July 2012 to June 2013	Total, June 2010 to July 2013
Shajaia	49.6	51.8	58.8	53.4
Daraj	49.2	58.4	65.6	57.8
Rafah	34.8	48.5	43.4	42.2

3. Pregnant Women Should Receive Adequate Primary and Procreation Health Care Services

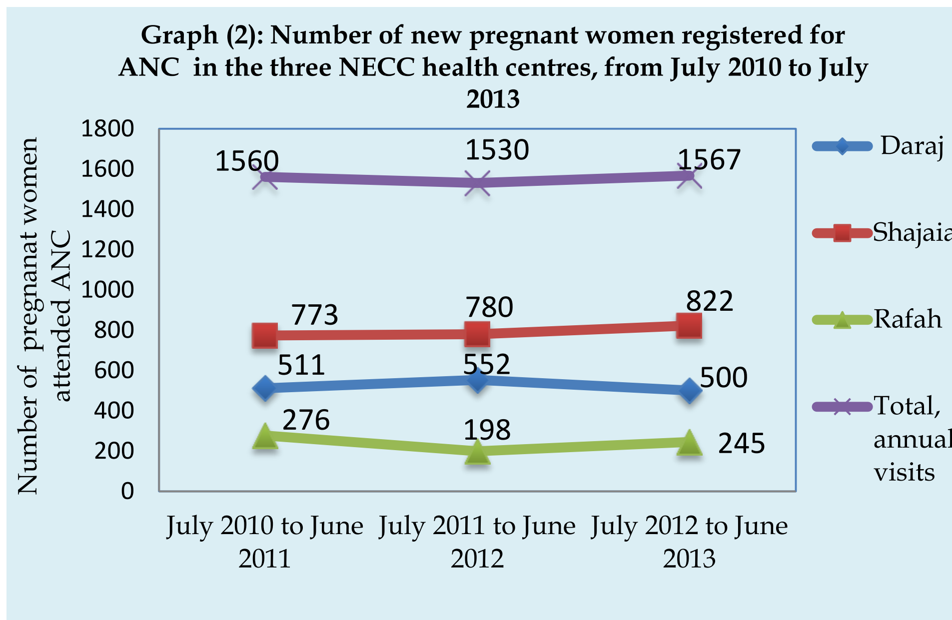
Indicator: New pregnant women registered for ANC services, number of ANC visits, and health education activities

As reported in the program log frame, this outcome will be achieved by providing ANC services to 1,200 new pregnant women, offering follow up ANC care to pregnant women, and conducting health education sessions to mothers.

Implemented activities and effectiveness

The main purpose of ANC follow-up visits is to prevent or identify and treat any health problems that may threaten the health of a pregnant woman and her foetus. It also aims to prepare a woman to birth and to enjoy the experience of birth.

According to the program log frame, 1,200 new pregnant women registered for ANC services annually. During the ANC follow-up visits, pregnant women receive a bundle of services that include physical examination, uterine and abdominal examination, weight measurement, urine analysis, and blood sugar measurement. In addition to the first ultrasound that confirms pregnancy in the first visit, every pregnant woman performs two ultrasound examinations: at the sixth month and ninth month. The main purposes of the ultrasound examinations are to check foetal and placenta position, check the fluid around the foetus, and check the growth and well-being of the foetus. Furthermore, provided ANC services include health education and advice on a healthy pregnancy, a high-risk pregnancy, safe childbirth, and postnatal recovery including care of the newborn, promotion of early breastfeeding, and health education on family planning methods and available services.



From graph (2), it is noticeable that in across the three years, the total annual number of new pregnant women registered for ANC services exceeded the expected number: 1200. Thus and somewhat incredibly, the first indicator has been achieved. Across the three years, a total of 4,657 new pregnant women were registered for ANC services.

The breakdown of the total new registered cases across the three centres shows that the highest number of new registered cases was reported in Shajaia centre with a 51% of the total visits. Out of the total 4,657 newly registered pregnant women, 34% and 15% were registered in Daraj and Rafah centres, respectively. With regard to Rafah centre, as graph 2 shows, there is fluctuation in the total number of new registered cases and the highest number was reported from July 2010 to June 2011. Reasons that explain why Rafah centre has the lowest number of newly registered cases include the low population density in the centre area compared to Daraj and Shajaia areas; the difficulty in reaching the centre as the area is remote, public transportation are not available, and the size of centre is smaller than the size of the other two centres.

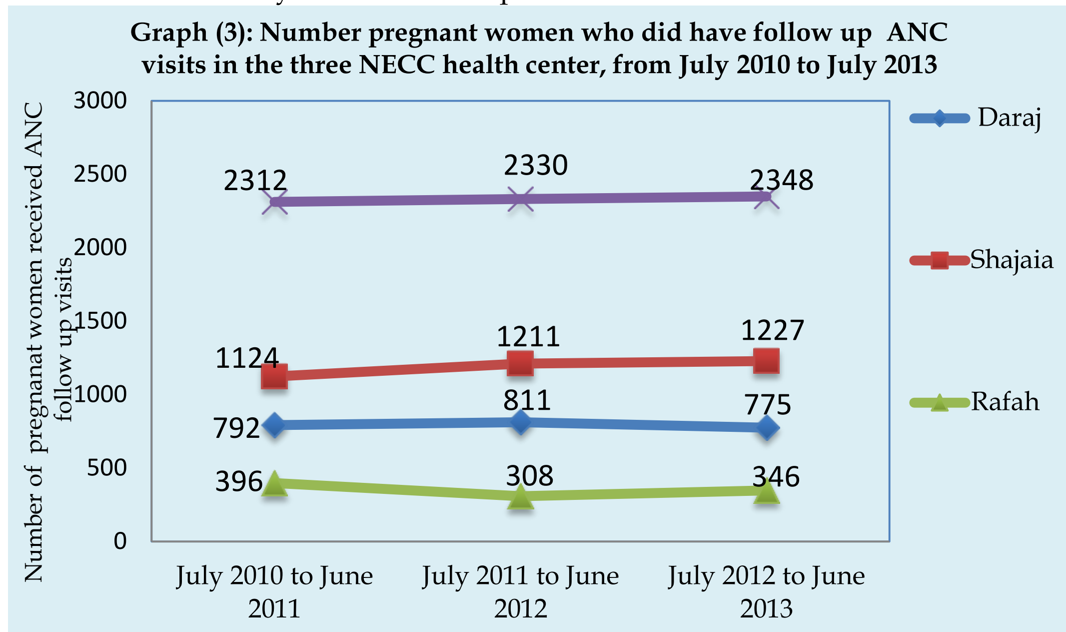
With regard to the annual ANC visits, according to program log frame, annually, 1,600 visits should be made by pregnant women.

- From June 2010 to July 2011, 11,720 ANC visits were reported in the three centres. Out of the total ANC visits, 6,021 visits were reported in Shajaia centre, which comprises 51.3% of the total visits. The Daraj centre reported 4,125 ANC visits, which comprises 35.2% of the total visits. Finally, in Rafah centre reported 1,503 ANC visits, which comprises about 13.5% of the total ANC visits.
- From June 2011 to July 2012, 13,653 ANC visits were reported in the three centres. Out of the total ANC visits, 7,205 ANC visits were reported in Shajaia centre which comprises 52.8% of the total visits. The Daraj clinic reported 4,792 ANC visits, which comprises 35.1% of the total visits. Finally, in Rafah centre, 1,656 ANC visits were reported which comprises about 12.1% of the total ANC visits.
- From June 2012 to July 2013, 13,895 ANC visits were reported in the three centres. Out of the total ANC visits, 7,420 ANC visits were reported in Shajaia centre, which comprises 53.4% of the total visits. In Daraj centre reported 4,690 ANC visits, which comprises 33.8% of the total visits. Finally, in Rafah centre, 1,785 ANC visits were reported which comprises about 12.8% of the total ANC visits.

From the abovementioned numbers, it is obvious that the three centres have achieved the expected results.

With regard to follow-up visits, according to the program log frame, 1,200 pregnant should receive ANC follow up visits annually. Graph 3 shows that across three years, the number of women who did have ANC follow-up visits exceeded the required number of 1,200. Consistent with the number of newly registered women and across the three years, the highest number of pregnant women who have had ANC follow-up visits was reported in Shajaia centre, followed by Daraj and Rafah centres.

Graph (3) shows that Shajaia centre is the only centre where the number of women who attend ANC follow-up visits is increasing from one year to the next. While there are fluctuations from year to year in Daraj and Rafah centres. To conclude, the three NECC centres have successfully achieved the expected results.



Health education during pregnancy has been advocated as a crucial component of health practice to improve pregnancy outcomes. Generally, health education during pregnancy has several aims including and not limited to: reinforcing emotional support, improving knowledge about pregnancy and delivery, enforcing adequate health services utilization, improving knowledge on proper nutrition during pregnancy, preparing women to give birth, educating women about signs of high-risk pregnancy, and increasing knowledge on baby care. Providing health education to pregnant women is a vitally important component of the NECC health program. According to the program log frame, annually, 200 health education activities should be delivered to 4,500 mothers. In order to achieve the expected results, from July 2010 to June 2013, 1,024 health education sessions were conducted in the three NECC centres, and 25,602 women attended the health education sessions. The breakdown of health education sessions by years shows that across the three years, the three centres achieved the expected results as follows:

- From July 2010 to June 2011, the number of health education sessions was 202 sessions, and 6,808 women attended the sessions.
- From July 2011 to June 2012, the number of health education sessions was 229 sessions, and 7,823 women attended the sessions.
- From July 2012 to June 2013, the number of health education sessions was 593 sessions, and 10,971 women attended the sessions.

From the above numbers, it is clear that the centres are putting great emphases on health education as the number of sessions is increasing from a year to another. Comparing the number of sessions and number of women who attended the sessions a cross the three

clinics shows that Shajaia centre ranked number one with 667 sessions with participation of 13,653 women, followed by Daraj centre with 269 sessions with participation of 10,569 women, and finally, Rafah centre with 88 sessions with participation of 1,380 women.

A midwife from Rafah centre delivery health education to pregnant women. Health education material, brochures-Shajaia center

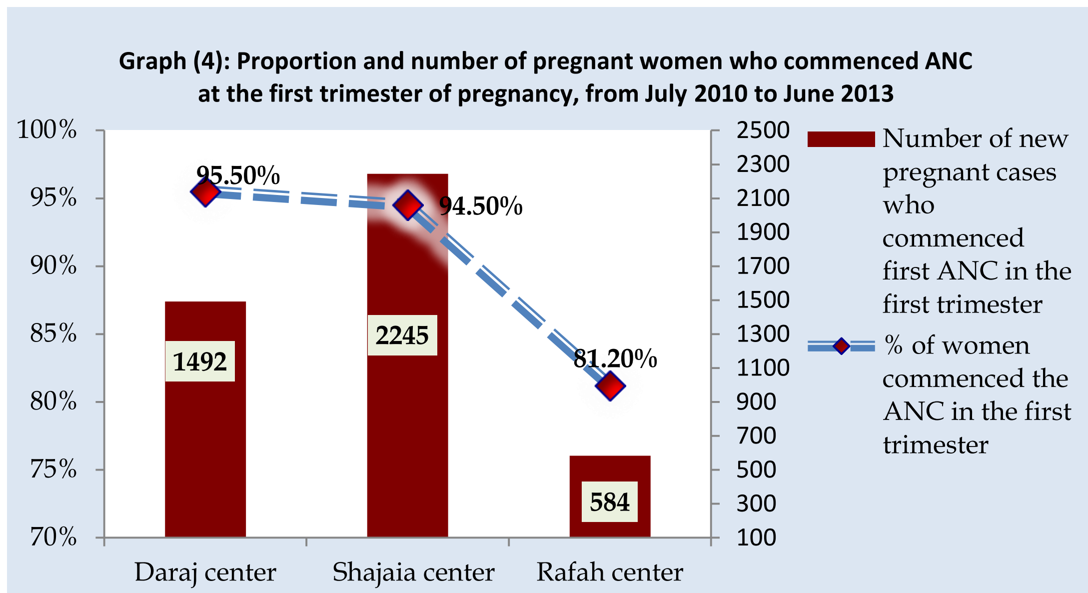
Comments on the ANC visits and health education sessions

- With regard to the following indicators: 1,600 ANC visits are made annually. This indicator needs to be revised in order to match with the other indicators. For instance, the first indicator says that 1,200 new pregnant women registered for ANC annually. If each new pregnant will have the minimum number of four ANC visits, it means that on average ANC visits should be around 4,800 visits.
- Although the NECC health education sessions covered diverse topics including proper nutrition during pregnancy, care of a newborn baby, and the importance of health services utilization, the impact or success of the given health education needs to be assessed. Ideally, it is very important for NECC centres to conduct pre- and post-tests to assess the effectiveness of the health education activities.
- The NECC staff uses leaflets as the main source of information. This might be not enough. The NECC staff needs to use multiple sources to deliver the health education sessions and activities. Reinforcing the use of different sources such as drawings and educational films might increase the effectiveness of health education activities.
- Given the fact that the three NECC centres implement and offer similar activities, it would be very important of the NECC develop standardized material that could be use by all the NECC staff.

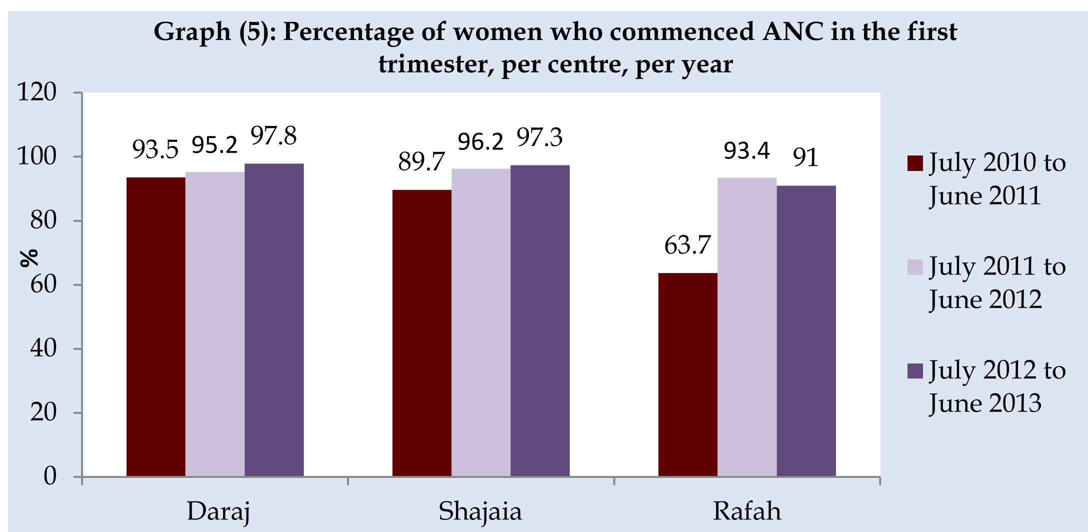
Proportion of pregnant women who commenced ANC during the first trimester of pregnancy

Along with receiving ANC visits at regular intervals, the WHO underlined the importance of commencing ANC visits as early as possible in the first trimester. For many of the essential interventions in ANC, it is very important to have early identification of underlying conditions or diseases including controlling anaemia and preventing its complications. In the first visit, physical examination—including pelvic, medical, and family history; present and past pregnancies history, and laboratory tests—are performed to screen, diagnosis, and treat any health problems. Also, it involves identifying risk factors and planning for the rest of the ANC visits.

Along with the physical examination and detailed personal and family history, in the first ANC visit, the three NECC centres offer a comprehensive package of services including measuring body weight and checking blood pressure, doing complete blood count and urine analysis, performing a dental screening and ultrasound examination. The provided services are consistent with the NECC guidelines and WHO protocols.



In Daraj centre, from June 2010 to July 2013, 1,563 of new pregnant women attended ANC visits. The vast majority of pregnant women commenced ANC in the first trimester with a 95.5% of the total. Daraj centre ranks number one among the three NECC centres in terms of the percentage of women commencing ANC visits within the first trimester. The highest number of women who commenced ANC in the first trimester is reported in Shajaia centre with 2,375 women; of them, 94.5 % initiated ANC in the first trimester. In Daraj and Shajaia centres, the breakdown of the percentage into a one-year interval revealed an increasing in the percentage of women who commenced ANC in the first trimester, as shown in graph (5)



With regard to Rafah centre, as shown in graph (5), from June 2010 to July 2013, 719 new pregnant attended ANC visits; the overall percentage of pregnant women who initiated the ANC in the first trimester was 81.2%. Compared to the other two centres, to some extent, this percentage is low. However, the breakdown of the percentage into a one-year interval revealed a significant fluctuation from year to another. From July 2010 to June 2011, the percentage was 63.7%. The period from July 2011 to June 2012, witness a jump in the percentage to reach 93.4%; then, the percentage slightly dropped to 91% from July 2012 to June 2013. The staff of Rafah centre needs to exert more effort to keep the percentage above 90% and try to reach the level of the other two centres. The efforts may include conducting more health education sessions and community awareness sessions inside the centre on the importance of attending ANC in the first trimester.

The program log frame did not quantify the percentage of pregnant women that is supposed to initiate ANC in the first trimester. Nonetheless, the reported percentages are high and reflect deep compliance with guidelines and protocols.

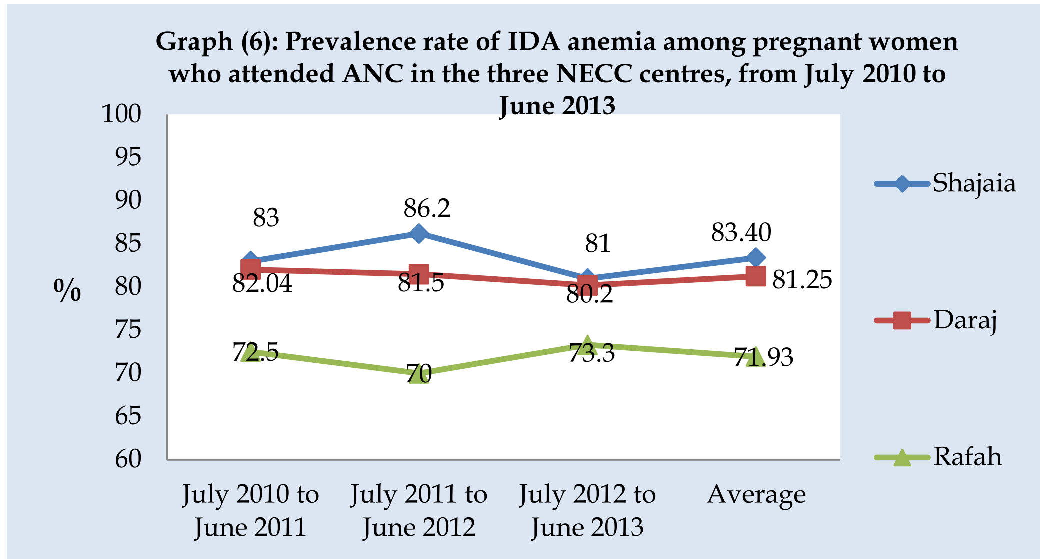
4. The Level of Malnutrition Including Anaemia in the Target Areas is Reduced

Indicator: Reduce the prevalence of anaemia amongst expected mothers by 30%

Implemented activities and effectiveness

According to the WHO, iron deficiency anaemia (IDA) is the most common nutritional deficiency worldwide. It affects approximately 3.5 billion people in developing countries, well over two out of every three persons (World Nutrition Situation, 2000; Baltussen et al., 2004). The prevalence of IDA among pregnant women is high, particularly in developing countries where an occurrence rate of 55-60% is common (Lone, et al., 2004; Iannotti et al., 2005; WHO, 1992). The consequences of IDA during pregnancy include preterm delivery and low birth weight, and it contributes to 22% of maternal mortality and morbidity cases. It also contributes to 33% of all perinatal mortality (Baltussen et al., 2004; Jasti et al., 2005). In the Gaza Strip, IDA is a prevalent health problem among pregnant women, lactating women, and children. In 2009, the

prevalence rate of IDA among pregnant women was 45.1% (MoH, 2011), while in 2004, the prevalence rate was 72.2% among lactating women (MoH, 2007).



With regard to anaemia screening and management, graph (6) shows that the prevalence rate of anaemia among pregnant women who had ANC visits in the NECC three centres is higher than the national rates. The highest rate was reported in Shajaia with an average 83.4% across the three years, and the lowest rate was reported in Daraj with an average of 71.1% across the three years. The current high unemployment rates, high poverty rates, and food insecurity could explain the high prevalence rate of anaemia among pregnant women in the three marginalized areas. In response to the high prevalence rate of IDA among pregnant women, NECC centres provide free of charge iron supplementation to only anaemic women after completing 13 weeks of gestation.

From July 2010 to June 2013, 9,172 pregnant women received iron supplementation free of charge. The distribution of pregnant women who received iron supplementation shows that, in Shajaia centre, 4,583 pregnant women received iron supplementation, 3,499 pregnant women in Daraj centre, and 1,090 pregnant women in Rafah centre.

Although iron supplementation for pregnant women is an NECC policy that aims to reduce the prevalence rate of IDA among pregnant women, IDA is still prevalent among pregnant women. Further assessments need to be conducted to deeply assess the causes of failure in reducing the prevalence rates of IDA among pregnant women including noncompliance of frontline health providers, non-adherence of women or both.

The following comments on the high prevalence rate of anaemia among pregnant women:

- Although most anaemic pregnant women receive iron supplementation and health education, the follow-up care is insufficient. NECC needs to assess women's compliance with iron supplementation and behavioral factors that hinder the recovery from anaemia.
- The prevalence rate of IDA among lactating women is very high. There are many studies that proved that the prevalence of anaemia among lactating women is higher than among pregnant women. It is recommended that NECC scan for anaemia among lactating women and provide anemic women with the needed medical treatment. Given the fact that the interval between pregnancies is short, tackling the issue of anaemia during lactation might reduce the burden of anaemia during pregnancy and shortly after delivery.
- Currently, the NECC prescribes iron supplementation only to anaemic pregnant women. Given the high prevalence rate of anaemia among pregnant women, it might be appropriate to prescribe iron to all also non-anaemic pregnant women as prophylactic after 13 weeks of gestation
- The NICE advises to screen for anaemia at first ANC visit and at 28 weeks of gestation. It is recommended that NECC include an indicator to compare the hemoglobin level at first ANC visit with hemoglobin level at 28 weeks and or at the last month of pregnancy. Comparing hemoglobin level at different cut-points could be used as a way to assess the progress of anaemia and indirectly performance of NECC staff.

5. Children Received Adequate Primary Health Services

Indicators: 15,000 children registered at the well-baby clinic and received appropriate well-baby services, 7,000 children up to six years old treated annually, and 200 awareness lectures for 3,000 mothers conducted annually

Implemented activities and effectiveness

To achieve the desired outcome, the NECC offers health services to children from birth up to six years through the well-baby clinic. The well-baby clinic offers diverse services including monitoring growth and development of the children, assessing children nutritional status, measuring hemoglobin level, and providing medical treatment, if needed. As NECC services are not supplementary services to the MoH and UNRWA services, well-baby clinics do not offer immunization services.

The well-baby clinic is systematically organized as it offers a continuum of care to children from birth to six years, according to the below schedule.

- During the first year, one visit per month
- During the second year, one visit every two months
- During the third year, one visit every three months
- During the fourth year, one visit every four months
- During the fifth year, one visit every five months
- During the sixth year, one visit every six months

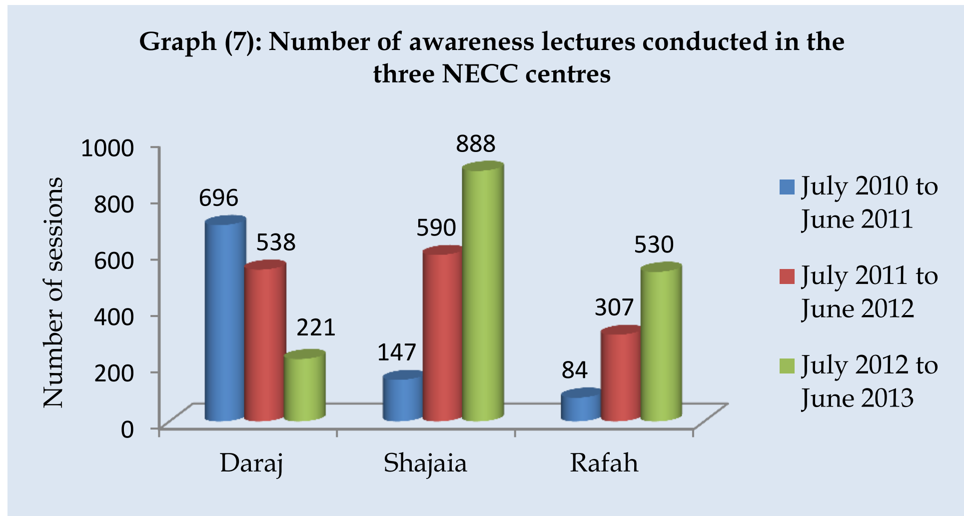
Compared to the other main health providers, the NECC health program is the only program that offers services to children up from birth to six years old. In the UNRWA PHC centres, the follow up for children starts from birth to three years old. This is also the case in the MoH PHC centres. All the above-mentioned NECC well-baby services are offered free of charge for children up to age six years, while, UNRWA and MoH offer the free services up to age three years.

According to the program log frame, 15,000 children should register at the well-baby clinic and received appropriate well-baby services. The table (3) shows that, the utilization rate of well-baby clinic is high, in which across the three years, the number of registered children at the well-baby clinic is 39,327. Most women expressed deep satisfaction with the provided services in the well-baby clinics, according to women, if the NECC well-baby clinics offer immunization; they will utilize only the NECC well-baby clinic. One woman stated, "*I go to the MoH clinic just for immunization, after my son receives all this immunization, I will only come to this centre*."
With regard to medical treatment to children, according to program log frame, 7,000 children up to six years should be treated annually in the NECC well-baby clinics. Table (3) shows that, from July 2010 to June 2013, about 20,000 children received medical treatment from the well-baby clinics. On average, each year the number of children who receive medical treatment is 6,668 children. The difference between the expected number (7,000) and the actual number of children who received medical treatment (6,668) is minuscule.

Table (3): Number of children registered at the well baby clinic and number of children up to 6 years old treated annually in the three NECC health centres

Centre	July 2010 to June 2011		July 2011 to June 2012		July 2012 to June 2013	
	Number of children registered at the well baby clinic	Number of children treated annually	Number of children registered at the well baby clinic	Number of children treated annually	Number of children registered at the well baby clinic	Number of children treated annually
Shajaia	5,641	2,705	5,842	2,748	4,384	2,987
Daraj	5,460	2,405	5,234	2,633	3,939	2,668
Rafah	1,858	856	4,188	1,474	2,781	1,529
Total, Annual	12,959	5,966	15,264	6,855	11,104	7,184

As mentioned earlier, health education is a core component of the NECC health program. The NECC health education program covers diverse topics such as care of newborn baby, proper nutrition after delivery, benefits of breastfeeding, importance of good nutritional for children, and hygienic practices among children. Most of the time, a nurse conducts the health education session while women are sitting in the waiting area. According to the program log frame, annually, 200 awareness lectures should be conducted, and 3,000 mothers should attend those lectures.



Graph (7) shows that across the three years, the three health centres conducted health education sessions more that the expected. This shows the high level of staff awareness on the importance of health education. In order to achieve the expected results, from July 2010 to June 2013, 4,001 health education sessions were conducted in the three NECC centres, with participation of 63,273 women. Graph (7) shows that Daraj and Shajaia centres are conducting awareness sessions more than Rafah centre. This might be explained by the relatively lower number of beneficiaries in Rafah area compared to the other two centres.

The breakdown of health education sessions by years shows that across the three years, the three centres achieved the expected results as follows:

- From July 2010 to June 2011, the number of health education sessions was 1,435 sessions, and 19,755 women attended the sessions.
- From July 2011 to June 2012, the number of health education sessions was 229 sessions, and 24,715 women attended the sessions.
- From July 2012 to June 2013, the number of health education sessions was 1,639 sessions, and 18,803 women attended the sessions.

NECC health education sessions cove diverse topics as mentioned above, currently, NECC centres conduct pre- and post-tests to assess the effectiveness of the health education activities, but this needs strengthening.
Currently, the NECC staff uses leaflets as the main source of information. The NECC staff needs to use multiple sources to deliver health education sessions and activities.

6. Couples Receive Family Planning Services and Awareness

Indictors: 800 partners received family planning services and awareness, and 500 women carried out clinical breast examination

Implemented activities and effectiveness

High fertility rates are associated with poverty, increased rates of infant and under-five child mortality, reduced female labor force participation, and low school enrollment for children. In order to achieve the above outcomes, the NECC health program offer family planning services in two centres: Rafah and Shajaia. The NECC family planning clinics offer free family planning methods and counseling. Interviews with beneficiaries revealed high levels of satisfaction with the provided services and the way that staff is treats patients.

According to program log frame, 800 partners receive family planning services and awareness, and 500 women receive breast examination. To quantify the outcomes of this objective, the evaluators analyzed the available data on family planning such as the number of beneficiaries and used family methods. Below is the breakdown of outcomes at the centre level.

- In Daraj centre, from June 2010 to July 2013, the total number of family planning beneficiaries was 740 women. Of them, 324 cases are newly registered cases. Across the three years, the number of family planning visits was 4,365 including 4,041 follow up visits. The most commonly used methods of family planning are condoms, progestin-only pills, and intrauterine devices. About 38% of the total beneficiaries received family planning services within 45 days after delivery, and 43.3% of the total beneficiaries received family planning services within 90 days after delivery.

- In Shajaia centre, from June 2010 to July 2013, the total number of family planning beneficiaries was 701 women. Of them, 456 cases are newly registered cases. Across the three years, the number of family planning visits was 3,826 including 3,370 follow up visits. The most common used family planning methods are condoms, progestin-only pills, and intrauterine devices. About 42% of the total beneficiaries received family planning services within 45 days after delivery, and about 50% of the total beneficiaries received family planning services within 90 days after delivery.
- With regard to Rafah centre, family planning services are not provided. There is a need to offer family planning services in the centre. Centre beneficiaries and community leaders clearly express this need. Given the remoteness of the area and limited access to other health facilities, the need to offer family planning services is substantial. In-depth interviews with the centre staff and the chairperson of the NECC revealed that the NECC is planning to offer the family planning services in the near future. It is recommended that NECC speed up the process of introducing family planning services in the center.

7. Clinical Breast Examination and Mammography services

With regard to clinical breast examinations, NECC is planning to provide the service in the three centres. The arrangement to offer the service is ongoing, but there is no precise time to start offering the services. Breast cancer is the most common cancer among women in the Occupied Palestinian Territory, including the Gaza Strip. Sadly, in the Gaza Strip, breast cancer is usually diagnosed at late stages; according to the MoH, only 20% of women with breast cancer were diagnosed in the first stage of the cancer. The main reasons that hinder early diagnosis include, but are not limited to a lack of mammogram screening services and other intervention programs that aim at early detection. In the Gaza Strip, there is only one governmental functioning mammography screening unit in the Gaza Strip. This screening unit serves about 1.6 million (800,000 women). This unit was established in 2009 with support from an international organization, and it is not fully functional due to frequent disrepair, lack of spare parts, and insufficient films. There are others units in the governmental hospitals and the private sector, but women utilize these services for diagnostics purposes, sadly, after they discover certain abnormalities.

Thus, policy interventions that focus on early detection are most likely to have significant impact in improving the outcomes of breast cancer and thus improving the quality of women's life. The NECC decision to include breast examination to its bundle of services is a very necessary and correct decision, and it might encourage other providers to do the same. Before starting to offer the services, the NECC needs to address the following critical points:

- Determine time and age to conduct breast examination and mammography screening, if needed.
- Identify proactive measures to reach women and encourage them to utilize this service.
- Set clear criteria for referral mechanism for mammography screening.
- Identify facilities to referral cases for mammography screening.
- Identify who is going to pay the cost of mammography screening.
- Set clear referral mechanisms for further diagnostic tests, if any abnormalities were detected in the mammography screening.

The NECC decision to include clinical breast examination to its services is in line with the MoH policies. During writing the report, NECC got the approval to refer cases to the mammogram unit in Al-Rimal PHC centre. The mammogram- either diagnostic or screening- will be conducted free of charge. Also, it is important to mention that the NECC is a member of the reforming MoH mammogram-screening program policies and regulations.

8. People Who Have Dental Problems Received Adequate Services

Indicators: 4,000 women, children, and adults in targeted areas receive dental care annually. Also, 1,200 pregnant women receive routine checkup for the first time visit, and 700 children receive checkup during well-baby clinic.

Implemented activities and effectiveness

Dental health refers to all aspects of the health and functioning of mouth especially the teeth and gums. The health of teeth and month are linked to the overall health and well-being in a number of ways. Dental health is affected by people's nutritional status, nutritional habits, and hygienic practices. Apart from the impact on nutritional status, poor dental health can negatively affect speech and self-esteem, especially among children. Like everywhere, the cost of dental care is expensive, and it always imposes financial burdens on families. As mentioned before, the economic status of families in the targeted areas is devastated, and thus, access to dental professionals may be limited.

In response to a need that clearly expressed by people, the NECC health program decided to offer dental health services free of charge to all beneficiaries. The scope of services includes dental checkup, treatment for dental caries, teeth cleaning, treatment for periodontal disease, and minor procedures such as teeth extraction and teeth filling. Additionally, the dental clinics in the three centres routinely conduct dental checkup for all pregnant women and for all children up to 6 years.

As reported in the program log frame, this aim will be achieved by providing dental care to women, children and adults in targeted areas, conducting routine dental check for all pregnant women, in the first visit, and conducting dental checkup for children in well-baby clinics. Quantifying the outcome, as in table (4,) shows that the number of beneficiaries from children, women, and adult who received dental care from the NECC three centres across the three years has outweighed the expected number. This indicator solely reflects high utilization rates and the effectiveness of the provided dental services.

With regard to pregnant women routine dental checkup, table (4) revealed that on average, annually; about 1,288 pregnant women received dental checkup and dental care during pregnancy. Among pregnant women who did have dental checkup, most of them received treatment for dental problems. In Daraj centre, out of 1,297 of pregnant women who had a dental checkup, about 93% got treatment. In Shajaia centre, out of 1,997 pregnant women who had a dental checkup, 80% of them got treatment for dental problems. In Rafah, out of 569 pregnant women who did have dental checkup, 87% of them received treatment for dental problems. The above mentioned numbers clearly show that dental problems among pregnant women are common and that the need to conduct routine checkups is incredibly important and enormously effective.

Table (4): Distribution of cases who received dental care in the three centres

Number of beneficiaries who received dental care in the three centres				
Centre	**July 2010 to June 2011**	**July 2011 to June 2012**	**July 2012 to June 2013**	**Total, June 2010 to July 2013**
Shajaia	1,151	1,771	2,047	4,969
Daraj	1,185	2,087	2,091	5,363
Rafah	1,738	2,130	2,511	6,379
Total by year	4,074	5,988	6,649	-
Number of pregnant women who did have check up and/ or received dental care in the three centres				
Shajaia	592	579	826	1,997
Daraj	422	355	520	1,297
Rafah	153	146	270	569
Total by year	1,167	1,080	1,616	-
Number of children aged 2.5 years to 6 years who did have check up and/ or received dental care in the three centres				
Shajaia	717	1,036	684	2,437
Daraj	255	278	433	966
Rafah	66	122	151	339
Total by year	1,038	1,436	1,268	-

With regard to the number children receive dental checkup from well-baby clinic; table (4) revealed that across the three centres, the number of children who have done dental checkup exceeded that desired number. Out of the children who did have dental checkup, 50%, 36.5%, and 22% of children received dental treatment in Rafah centre, Shajaia centre, and Daraj centre, respectively. Similar to pregnant women, this indicates high prevalence rates of dental problems among children aged 2.5 years to 6 years.

The high utilization rate of dental services is explained by the beneficiaries high level of satisfaction of the dental provided dental services, in particular the quality of the services as expressed by most be most beneficiaries and community leaders in the focus group discussions. However, most beneficiaries in the three targeted areas as well as community leaders expressed a need to increase the scope of the provided services to include root canal treatments.

To conclude, the routine checkups and the dental services provided for adults are success stories for the NECC health program, further demonstrating the importance of this service and the fact the he NECC health program is the only program offering systematically organized free of charge routine checkup for pregnant women and children.

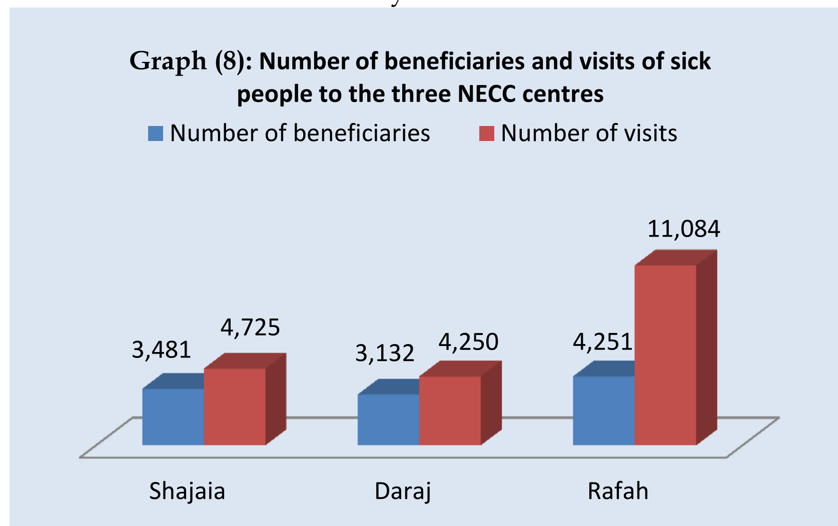
9. Patients and Sick People Received Suitable Treatment

Indicator: Over 4,000 patients examined, tested, and received treatment

Implemented activities and effectiveness

To achieve the expected outcome, the NECC health program offers health services to sick people through the general clinics. Each centre offers the services of general clinics four days per week. Due to high demand, the three centres limit the number of beneficiaries of general clinics to only 50 per day per clinic. The general clinics of Daraj and Shajaia centres offer treatment to 40 children and 10 adults, while Rafah centre offers treatment to 30 children and 20 adults. Most of the patients treated complained from respiratory infection, gastroenteritis, skin disease, and other minor health problems.

There was a consensus among the program's staff, community leaders, and both male and female beneficiaries that the services in the general clinics are very important and much needed. Additionally, as it is outlined in the below paragraphs, the three centres have successfully achieved desirable outcomes. Quantifying the outcomes shows that across the three centres, about 17,000 families received services from the three NECC centres, and 10,864 beneficiaries received services from the general clinics in the three centres. The breakdown of beneficiaries by centres shows that:



- In Daraj centre, about 5,830 families received services from the centres, and 3,132 beneficiaries received services from the general clinics and they conducted 4,250 visits, as in graph (8).
- In Shajaia centre, about 6,837 families received services from the centres, and 3,481 beneficiaries received services from the general clinics and they conducted 4,725 visits.
- In Rafah centre, about 4,411 families received services from the centres, and 4,251 beneficiaries received services from the general clinics and they conducted 11,084 visits. Graph (7) shows that, the highest number of beneficiaries and visits were reported in Rafah centre, this is contrary to most of the other indicators. The

reason behind this high number of beneficiaries could be that general clinic offers free of charge services which is not the case in the other two centres, as will be explained later.

In-depth interviews and focus group discussions with beneficiaries and community leaders revealed the following comments:

- In the general clinic, the selection of beneficiaries is based on the first come first served rule. Thus, many beneficiaries indicated that sometimes they come to the centre at 6am to register and get treatment. Therefore, there is a need to have a registration system that could facilitate the registration process and save peoples' time.
- Most beneficiaries indicated that 50 cases are not enough, and there is a need to increase the number of cases to 60 or 70 per day. Additionally, a reasonable number of beneficiaries suggested operating the general clinic six days per week, instead of the current four days per week.
- After offering medical treatment for the assigned 50 cases. Most days, additional cases come to the centres seeking medical treatment; some of the additional cases receive treatment and other cases do not. There is a need to have consistent criteria for offering medical care to the addition cases. Staff indicated that there is a criterion for emergency cases but they could not mention it.
- Currently, a general practitioner offers the medical treatment in the general clinic. From the beneficiaries point view, there is a need to have specialized physicians. However, given the fact that the NECC family health centers focus on PHC services, it is recommended that NECC stick to its strategic goals and mission in offering only PHC services.

10. Adequate Treatment in Matters Related to Nutrition Best Practice Has Been Extended

Indicators: Annually, at least 2,000 anemic and/or 500 malnourished children were treated, recovered or prevented from further deteriorating, and 200 severe cases referred to specialized institutions.

Implemented activities and effectiveness

This objective planned to be accomplished by measuring physical growth parameters of all children who attended the well-baby clinics and assessing their hemoglobin level. Malnourished and anemic children were referred for appropriate treatment in the NECC centres and the intractable severe cases were referred to specialized institutions. The below section explores the prevalence rate of anaemia and malnutrition problems among the registered children of the NECC centres.

Prevalence rate of anaemia among the registered children in the NECC centres

- Daraj centre: From July 2010 to June 2013, out of the 10,988 cases who visited the well-baby clinic, and the general clinic, 3,524 cases were diagnosed with anaemia. Thus, the prevalence rate is 32% among children who registered at

Daraj centre; most of the diagnosed cases are considered mild anaemia (62 %). Only 12 cases were diagnosed with severe anaemia.

- Shajaia centre: From July 2010 to June 2013, out of the 14,228 cases who visited the well-baby clinic, and the general clinic, 3,441 cases were diagnosed with anaemia. Thus, the prevalence rate is 24.8% among children who registered at Shajaia centre; most of the diagnosed cases are considered mild anaemia (57%). Only 15 cases were diagnosed with severe anaemia.

- Rafah centre: From July 2010 to June 2013, out of the 7,932 cases who visited the well-baby clinic, and the general clinic, 1,718 cases were diagnosed with anaemia. Thus, the prevalence rate is 21.7% among children who registered at Rafah centre; most of the diagnosed cases are considered mild anaemia (70%). Only 6 cases were diagnosed with severe anaemia.

Across the three-targeted areas, Daraj area has higher rate of anaemia compared to Shajaia and Rafah areas. The unhealthy nutritional habits and behavior could explain this high rate of anaemia, giving the fact that Daraj area has relatively higher economic status compared to Shajaia and Rafah areas.

As mentioned earlier, anaemia is a prevalent health problem among Palestinian children in the Gaza Strip; comparing the prevalence rate of anaemia among registered children in the three NECC centres with the national prevalence rates of anaemia — 58.6% among school children, 68.1% among of children 9-12 months — clearly shows the effectiveness of the NECC program in reducing the prevalence rate of anaemia among the children in the targeted areas, in which the program aims to reduce the prevalence rate of anaemia among children by 30%. Indeed, the reduction of prevalence rate of anaemia is about 50%. This is consistent with 1.3 objective, as reported in the program log frame.

Prevalence rate of malnutrition among the newly registered children in the NECC centres

- Daraj centre: From July 2010 to June 2013, the total number of newly registered children in the well-baby clinic was 6,634. The prevalence rate of malnutrition among the newly registered is 11.7%. In the same period, the total number of children registered at the well-baby clinic is 9,164; of them, 19% were diagnosed with malnutrition problems. Moderate stunting is the most common nutrition problem with 10.9% of the 19%, followed with moderate underweight with a 6.5% of the 19%.
- Shajaia centre: From July 2010 to June 2013, the total number of newly registered children in the well-baby clinic was 7,674. The prevalence rate of malnutrition among the newly registered is 13.2%. In the same period, the total number of children registered at the well-baby clinic is 10,446; of them, 26.8% were diagnosed with malnutrition problems. Moderate stunting is the most common nutrition problem with 14.9% of the 26.8%, followed with moderate wasting with 10.3% of the 26.8%.

- Rafah centre: From July 2010 to June 2013, the total number of newly registered children in the well-baby clinic was 5,048. The prevalence rate of malnutrition among the newly registered is 14.9%. In the same period, the total number of children registered at the well-baby clinic is 6,130; of them, 28.4% were diagnosed with malnutrition problems. Moderate stunting is the most common nutrition problem with 15.5% of the 28.4%, followed with moderate underweight with 12.9% of the 28.4%.

Across the three targeted areas, Rafah area has the highest rates of all nutritional problems. This could be attributed to the higher poverty rate and food insecurity compared to Daraj and Shajaia areas. The current prevalence rates of malnutrition, in particular stunting among registered children in the three NECC centres, are comparable to the national rates of malnutrition. However, this does not wipe away the implication that the program actually improved the nutritional situation of the targeted children, as will be discussed in the next section.

Activities and Effectiveness

Five years ago, the NECC implemented a household screening survey in the three centre areas. This survey involved measuring hemoglobin level and anthropometric measurements to all children up to the age of 5 years of age. During the survey, 48,000 children were screened. This survey was the first household that implemented at such large scale. Most of the diagnosed cases either malnourished or/and anemic cases got the appropriate medical treatment, including free distribution of iron supplementation and milk. After conducting the survey, the NECC continues to implement similar activities to all children up to age 6 years, but through the well-baby clinic. As mentioned earlier, during the follow up visits to the well-baby clinics, as planned, in every visit, the staff assesses the anthropometric measurements of a child. Accordingly, children receive treatment according to their cases. To assess malnutrition, in this review, three anthropometric indicators are used to measure the nutritional outcomes of this program. First indicator is the Height for Age Z-score, which is commonly known as stunting and widely used to measure long-term nutritional deprivation. The second indicator is the Weight for Height Z-score, which is commonly known as wasting and widely used to measure acute malnutrition. Finally, the third indicator is the Weight for Age Z-score, which is commonly used to measure underweight. Consistent with WHO recommendations, in this review, we used the cut-off point of <-2 SD to identify stunting, wasting, and underweight. Also, the cut-off point of <-3 SD was used to define severe stunting, wasting, and underweight. With regard to anaemia, hemoglobin level is used as an indicator to diagnosis anaemia and to assess the progress. The cut point is 11gm/dl.
To quantify the outcome of this objective across the three years, we obtained the anthropometric readings, such as Z-score and hemoglobin measurements of all children who were diagnosis as anemic and/or malnourished cases. Then, the outcomes were analyzed and interpreted at the centre level. Luckily, the NECC computerized system provides all the required measurements. However, to be sure of the accuracy and reliability of anthropometric measurements, the evaluation team randomly selected several cases and analyzed them using Epi-info program. The outcomes of the analyzed

data using Epi-info did match the readings obtained from the NECC computer system. Thus, the reliability and accuracy of the measurements obtained are very high. The breakdown of indicators by centre shows that:

Daraj centre:

- Anaemia: across the three years from July 2010 to June 2013, table (5) shows that out of the 2,900 children who suffer from anemic, 2,282 cases recovered. The success rate of treating anaemia was very high with a 78.69%. Additionally, 175 cases have improved and 388 remained the same.
- Underweight: across the three years from July 2010 to June 2013, table 5 shows that out of the 516 underweight children, 347 cases recovered. The success rate of treating underweight was 67.25%. Additionally, 16 cases have improved and 143 remained the same.
- Stunting: across the three years from July 2010 to June 2013, table (5) shows that out of the 893 stunted children, 532 cases recovered. The success rate of treating chronic malnutrition and stunting is 60%. Additionally, 46 cases have improved and 294 remained the same.
- Wasting: across the three years from July 2010 to June 2013, table (5) shows that out of the 432 children who suffer from wasting, 362 cases recovered. The success rate of treating children who suffer from wasting is 83.8%. Additionally, 14 cases have improved and 49 cases remained same.

In summary, out of the 4,741 of children who suffered from anaemia and/or malnutrition, 3,523 children recovered with a recovery rate of 74.3%. Additionally, 23.7% of cases (1,125) are either improved or remained the same.

Table (5) Distribution of anemic and malnourished cases by prognosis, Daraj centre from July 2010 to June 2013

Age per week	Recovered		Improved		The same		Deteriorated		Total cases
1. Anaemia									
	No	%	No	%	No	%	No	%	
0-60	83	31.7	29	11.1	145	55.3	5	1.9	262
61-90	169	74.1	26	11.4	29	12.7	4	1.8	228
More than 91	2030	**84.2**	120	5.0	214	8.9	46	1.9	2,410
Total number & percentage	2,282	**78.69**	175	**6.0**	388	**13.4**	55	**1.90**	**2,900**
2. Underweight									
0-60	32	57.1	1	1.8	22	39.3	1	1.8	56
61-120	60	76.9	2	2.6	16	20.5	0	0.0	78
More than 120	255	66.8	13	3.4	105	27.5	9	2.4	382
Total number & percentage	347	**67.25**	16	**3.1**	143	**27.7**	10	**1.94**	**516**
3. Stunting									
0-60	51	52.0	6	6.1	41	41.8	0	0.0	98
61-120	106	72.6	2	1.4	35	24.0	3	2.1	146
More than 120	375	57.8	38	5.9	218	33.6	18	2.8	649
Total number & percentage	532	**59.57**	46	**5.2**	294	**32.9**	21	**2.35**	**893**
4. Wasting									
0-60	43	69.4	2	3.2	15	24.2	2	3.2	62
61-120	74	91.4	2	2.5	4	4.9	1	1.2	81
More than 120	245	84.8	10	3.5	30	10.4	4	1.4	289
Total number & percentage	362	**83.80**	14	**3.2**	49	**11.3**	7	**1.62**	**432**

Shajaia centre:

- Anaemia: across the three years from July 2010 to June 2013, table (6) shows that out of the 3,136 children who suffer from anemic, 2,523 cases recovered. The success rate of treating anaemia was very high with a 80.5%. Additionally, 188 cases have improved and 375 remained the same.
- Underweight: across the three years from July 2010 to June 2013, table (6) shows that out of the 603 underweight children, 389 cases recovered. The success rate of treating underweight was 64.5%. Additionally, 31 cases have improved and 164 remained the same.
- Stunting: across the three years from July 2010 to June 2013, table (6) shows that out of the 1,250 stunted children, 615 cases recovered. The success rate of treating chronic malnutrition, stunting, is 49.2%. Additionally, 46 cases have improved and 527 remained the same.
- Wasting: across the three years from July 2010 to June 2013, table (6) shows that out of the 435 children who suffer from wasting, 363 cases recovered. The success rate of treating children who suffer from wasting is 83.4%. Additionally, 12 cases have improved and 54 cases remained same.

In summary, out of the 5,424 of children who suffered from anaemia and/or malnutrition, 3,890 children recovered with a recovery rate of 71.7%. Additionally, 25.7% of cases (1,397) are either improved or remained the same.

Rafah centre:

- Anaemia: across the three years from July 2010 to June 2013, table (7) shows that out of the 1,189 children who suffer from anemic, 908 cases recovered. The success rate of treating anaemia was very high with a 76.4%. Additionally, 61 cases have improved and 180 remained the same.
- Underweight: across the three years from July 2010 to June 2013, table (7) shows that out of the 660 underweight children, 440 cases recovered. The success rate of treating underweight was 66.7%. Additionally, 30 cases have improved and 178 remained the same.
- Stunting: across the three years from July 2010 to June 2013, table (7) shows that out of the 935 stunted children, 509 cases recovered. The success rate of treating chronic malnutrition, stunting, is 54.4%. Additionally, 67 cases have improved and 321 remained the same.
- Wasting: across the three years from July 2010 to June 2013, table (7) shows that out of the 403 children who suffer from wasting, 330 cases recovered. The success rate of treating children who suffer from wasting is 81.9%. Additionally, 20 cases have improved and 49 cases remained same.

To sum, out of the 3,187 of children who suffered from anaemia and/or malnutrition, 2,187 children recovered with a recovery rate of 68.6%. Additionally, 28.4% of cases (906) either improved or remained the same. Across the three centres, the highest numbers of anemic and malnourished cases were reported in Shajaia centre, followed by Daraj and Rafah centres.

Table (6) Distribution of anemic and malnourished cases by prognosis, Shajaia centre from July 2010 to June 2013

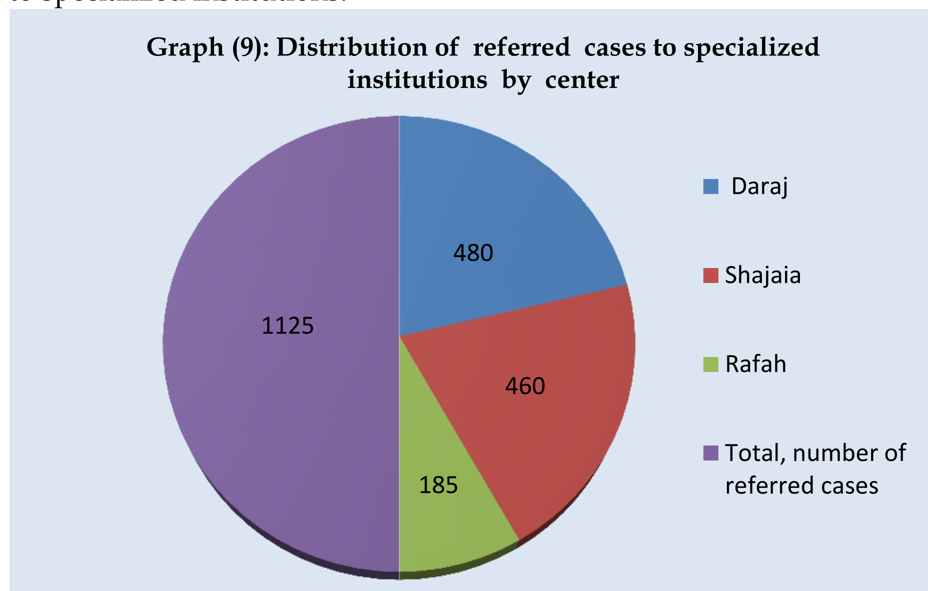
Age per week	Recovered		Improved		The same		Deteriorated		Total cases
1. Anaemia									
	No	%	No	%	No	%	No	%	
0-60	1620	78.6	121	5.9	286	13.9	34	1.6	2061
61-90	133	81.1	19	11.6	11	6.7	1	0.6	164
More than 91	770	84.5	48	5.3	78	8.6	15	1.6	911
Total number & percentage	2,523	**80.5**	188	**6.0**	375	**12**	50	**1.6**	**3,136**
2. Underweight									
0-60	180	58.1	17	5.5	104	33.5	9	2.9	310
61-120	63	67.0	6	6.4	23	24.5	2	2.1	94
More than 120	146	73.4	8	4.0	37	18.6	8	4.0	199
Total number & percentage	389	**64.5**	31	5.1	164	**27.2**	19	**3.2**	**603**
3. Stunting									
0-60	403	44.0	42	4.6	432	47.2	39	4.3	916
61-120	57	63.3	3	3.3	27	30.0	3	3.3	90
More than 120	155	63.5	1	0.4	68	27.9	20	8.2	244
Total number & percentage	615	**49.2**	46	**3.7**	527	**42.2**	62	**5.0**	**1,250**
4. Wasting									
0-60	119	75.8	6	3.8	28	17.8	4	2.5	157
61-120	75	83.3	0	0.0	15	16.7	0	0.0	90
More than 120	169	89.9	6	3.2	11	5.9	2	1.1	188
Total number & percentage	363	**83.4**	12	**2.8**	54	**12.4**	6	**1.4**	435

Table (7) Distribution of anemic and malnourished cases by prognosis, Rafah centre from July 2010 to June 2013

Age per week	Recovered		Improved		The same		Deteriorated		Total cases
				1. Anemia					
	No	%	No	%	No	%	No	%	
0-60	62	41.6	18	12.1	63	42.3	6	4.0	149
61-90	118	82.5	5	3.5	18	12.6	2	1.4	143
More than 91	728	81.2	38	4.2	99	11.0	32	3.6	897
Total number & percentage	908	**76.4**	61	**5.1**	180	**15.1**	40	**3.4**	**1,189**
				2. Underweight					
0-60	46	57.5	2	2.5	32	40.0	0	0.0	80
61-120	117	77.5	6	4.0	26	17.2	2	1.3	151
More than 120	277	64.6	22	5.1	120	28.0	10	2.3	429
Total number & percentage	440	**66.7**	30	**4.5**	178	**27.0**	12	**1.8**	**660**
				3. Stunting					
0-60	57	55.3	1	1.0	41	39.8	4	3.9	103
61-120	131	72.0	4	2.2	43	23.6	4	2.2	182
More than 120	321	49.4	62	9.5	237	36.5	30	4.6	650
Total number & percentage	509	**54.4**	67	**7.2**	321	**34.3**	38	**4.1**	**935**
				4. Wasting					
0-60	44	71.0	5	8.1	13	21.0	0	0.0	62
61-120	96	85.0	6	5.3	10	8.8	1	0.9	113
More than 120	190	83.3	9	3.9	26	11.4	3	1.3	228
Total number & percentage	330	**81.9**	20	**5.0**	49	**12.2**	4	**1.0**	403

From the above-mentioned numbers, it is obvious that the NECC health program is effective and achieved its desired outcomes in reducing the burden/prevalence of anaemia and malnutrition in the targeted areas. Remarkably, the program has achieved high recovery rates in treating nutritional problems, including stunting, which is widely used to measure long-term nutritional deprivation. This is considered a tremendous success of which the NECC should be proud. The NECC team presented this great success at one of the WHO cluster meetings and published it internationally.

With regard to referring intractable sever cases of anaemia and malnutrition, according to program log frame, 200 cases should be referred to specialized institutions. Graph (9) shows that across the three centres, from July 2010 to June 2013, 1,125 cases were referred to specialized institutions.



Most of the cases were referred to Al-Nasser Pediatric hospital, Al-Dora hospital, European Gaza Hospital, Al-Rimal PHC, and the Thalassemia centre. Interestingly, NECC is not only active in referring severe intractable cases of anaemia and malnutrition, but also in tracking the referred cases and evaluating their status through home visits, follow up with physicians at the referral organizations, and exchanging information with other specialized institutions. NECC is the only health facility that does such systematic follow up.

11. Psychosocial Services Are Provided to Women and Children Attending the PHC

Indicators: 1,500 children received psychosocial support, and 20,000 women participated in psychosocial support program

Implemented activities and effectiveness

Since April 2009, as a response to 2008-2009 war, and in order to support mothers' and children's mental health and psychosocial well-being within such complex context, the NECC has started to provide psychosocial support program across the three NECC centres with the aim of improving the level of mental health of children and women

beneficiaries. The NECC psychosocial program offers diverse services including psychosocial support, emotional support and debriefing, recreational activities, and individual and group counseling. The counselors use various counseling techniques such as: the mind and body, cognitive behavioral interventions, individual and group counseling, seminars, home visits, and community-based education through awareness programs for mothers. For cases that require medical or specialized treatment, the NECC program refers cases to the MoH mental health centres and to Gaza Community Mental Health Program.

The program objectives planned to be accomplished by offering psychosocial services and support to mainly children and mothers. With regard to children, the program offers services in selected kindergartens, three in each area, for young children ages 4 to 6 years old. The program targets children ages 6 to 12 years inside the centre. The counselors offer divers services including individual and group counseling, recreational trips, awareness sessions for parents such as dealing with aggressive behavior, dealing with bedwetting, and dealing with stress.

According to the program log frame, 1,500 children should receive psychosocial support, thus, from July 2010 to June 2013, the number of children who received psychosocial support is 11,064. Thus, the three centres have successfully achieved this outcome and outnumbered the desired number. This obviously reflects the high demand on the psychosocial services and also the general satisfaction with the provided services. Additionally, the program aims to provide psychosocial support for 20,000 women. Across the centres, about 15,000 received psychosocial services. In the reported period and across the three centres, 1,567 counseling sessions were conducted in the three centres.

Although the number of women who benefited from the psychosocial program is less than the expected number, it is expected to exceed the required number if we include the number of women who received psychosocial services in the afternoon activities. However, this does not erase the importance of using more proactive approaches to attract and encourage women to get benefits from the psychosocial program.

Impact of psychosocial program from beneficiaries' point of view

Focus group discussions with mothers (three groups) and children (two groups), and in-depth interviews with the four female counselors revealed that psychosocial program was very effective and has achieved the desired outcomes of prompting psychological well-being of children and their families. Factors that contributed to this success include:

- The integration of psychosocial support program within the PHC is one of the most effective ways to overcome the social stigma of mental illness. This integration is one of the key factors that helped the team achieve the expected outcomes. Additionally, involving mothers with the psychosocial support has contributed substantially to the effectiveness of this program.
- The integration of psychosocial in the health pogrom might impose some limitations due to the nature of the provided services within the family health

care centres. The first limitation is that the psychosocial services might be not accessible to boys and men as the vast majority of beneficiaries are women. Second, as the family centres always have large number of beneficiaries, some women and even children might feel stigmatized of utilizing the psychosocial services. This also raises the issue of privacy. Finally, the provision of psychosocial within same rooms that use of different health services, like in Daraj centre, is not appropriate. Thus, NECC needs to assess the option of providing psychosocial services outside the family health care centres, like the case in Rafah family centre. Doing so could help in overcoming most of the previously limitations.

- Counselors have high level of skills, knowledge, and experience in providing psychosocial support, counseling, and emotional debriefing. Additionally, counselors have great skills building and maintaining trust relationships with children, mothers and the whole society.
- The three centres provide an integrated and effective various services in the three marginalized areas in which there is an urgent need for psychosocial support services, as there are no other institutions that offer such service.
- Along with providing children and mothers with a comfortable and welcoming environment, the counselors respect children and mothers and deal with them in a very caring way. Additionally, home visits strengthened the relationship between program staff and parents.
- Implementing joint child-parent activities such as trips was a very effective way in engaging mothers in improving the physical well-being of their children. Also, for women such activities were much needed to vent stressors. Women have a strong desire to communicate outside the closed frame of their families, to break the silence, fear and shyness, and to create new friendships. A woman stated: "*We are mentally tired. We live in extended families and there are a lot of problems. Families are strict and always there are problems with mothers-in-law. These trips entertain us as mothers, and help us to forget the negative experience[s]. Few months ago, I went with my daughter to a trip. I never felt happy like that day. It was the first time to go for a trip with my daughter alone. Economically, we can afford doing that.*" (Female beneficiary from Rafah area, 39 years old, has 7 kids. She was accompanied with her husband).
- From children's point of view, this program helped them share their experiences other friends, brothers and mothers, and it helped them making new friends. In other words, this program is effective in reconnecting children socially and increasing their social skills.

The psychosocial program has positive impact on children's behavior as it reduced the level of violent behavior (especially among boys), and improved the academic achievement for children. Below are examples of such improvements

- One of the mothers in the focus groups said that: "*My son was 8-years-old after the last war in 2012. His behavior has changed and started to feel frightened with hyperactivity and bedwetting at nights. His educational achievement decreased and became aggressive. I brought him with me to see the counselor. His condition [is] now*

improved with no bedwetting. He also has started to participate in activities and wakes up early at the activity days, and he returns homes happy after the activities."

- A 13-year-old girl says: "*I was one of the first students. I was exposed to psychological trauma and after that my educational achievement declined. I went to see the counselor at the Centre. She helped me a lot. I gained back my school achievement as well as enhanced my self-confidence. I became a social person especially after participating in the mind and body activities*."
- Mother of a child who participated in the focus groups stated that: "*My son was in third grade and is now in sixth grade. He was an introvert and his drawings were colored in dark black. He draws tanks and missiles, smoke and fire. He colors boys in black and girls in brown. After the counselor's intervention, his psychological condition improved and his drawings are colored with different colors*."
- Women again much confidence on themselves and learned how deal positively with and to control their daily stressors. The focus groups held with the participants in the program confirmed these findings. One participant reported that: "*We suffer and live in stressful environment with no place for recreation. I find myself in the centre because I get to know new people and exchange ideas. I started to control my temper and know how to deal with my husband's anger in a better way. I gained new information about how to deal with my kids, all this thanks to the seminars that are hold at the centre*."

Although the psychosocial program is well-organized, implemented as planned, and achieved the expected outcomes, the following weaknesses were identified:

- There are restrictions on the movement and playing of children in places where the hall is rented, in Rafah centre, for the implementation of activities as the owner of this rented place prohibits children from playing on the swings and this does not help children. Across the three centres there is a need to have more toys for different age categories.
- In places where a room is available for the implementation of activities, it is not furnished or prepared to perform activities, as there is a need for a fan and carpet.
- Children recognized the programs through mothers attending the centres for other services, or through their friends or colleagues at the school. There is a need to implement more proactive approaches in targeting children and mothers.
- Within the context of the Gaza Strip, people suffer from the stigma of mental illness. The counselors talked about difficulties for parents in accepting the referral of their children for treatment in psychological centres. There is a need to address the issue of social stigma of mental illness through awareness campaigns.
- Counselors need professional supervision and training. Training could include the following topics: psychological counseling, case management, dealing with behavioral problems among children, postpartum depression, psychological changes associated with pregnancy, stress management, dealing with trauma, counseling interviews, and the stigma of mental illness. Also, there is a need to provide counselors with useful training materials and psychological books.

- There is no room for the counselor in Rafah and Al-Daraj centres. This detracts from the privacy of the psychological work, which is fundamentally based on the confidentiality of information.
- There are children who benefited from the same activities more than once. It is better to involve them in a variety of activities and to work on organizing activities to deal with different groups of children based on the stages of growth so as to ensure continuity.

Children are performing Palestinian dancing "Dabkah" -Shajaia centre

Psychologist at Rafah centre implementing recreation activities

12. Afternoon Activities

In the reported period, about 3,623 afternoon activities were conducted. NECC offers different income generating activities such as make-up, hairdressing, manufacturing clothes from wool, embroidery, and dressmaking. Additionally, NECC regularly conducts educational activities such as first aid training and English language courses. Most interviewed women and men expressed satisfaction with the afternoon activities and they appealed for more activities, especially income-generating activities. Focus group discussions with afternoon activities beneficiaries revealed the following:

1. Duration, Time, Place, and Training Material: NECC offers the afternoon activities twice per week for the duration of three months, and each session lasts for 90 minutes. According to women participants of focus groups, the duration of courses is short and it is not enough for them to master the training skills. Women expressed interest in having the afternoon activities either for three days per week or to extend the duration of courses to four months. With regard to place, regularly the afternoon activities are conducted in the waiting hall of the three family health care centres after finishing the

regular activities. In general, the waiting hall in Shajaia and Rafah are appropriate, but not in Daraj centre. After finishing the regular activities, the employees shut down the centre main entrance, which in turn makes the waiting hall dark with no ventilation. Across the three centres, the power shortage is negatively affecting the afternoon activities, as NECC does not operate generators after the regular working hours. For instance, during the data collection, in Al Daraj centre there was a training course on hairdressing. Coincidently, the electricity went off during training session; the trainer stopped the training, as she was not able to continue the training without electricity.
Currently, NECC does not provide row material for training for instance, the training course in hairdressing requires hair dryer, many participants in the training course indicated that they do not have hair dryers, and thus, the training is not very helpful. The cost of providing training material is not costly, and at the same time, it makes the training very effective. To best make use of the afternoon activities, NECC should make the environment suitable for training and should provide important educational resources.

2. Income generating activities: Giving the high unemployment and poverty rates among Palestinians in the Gaza Strip, afternoon activities could be considered as an opportunity for women to learn skills that could enable them to generate some income. Several women expressed this view during the focus group discussions. One 33-year-old woman from Shajaia centre stated, "*From the afternoon activities I learned embroidery. Now I make embroidery products and I sell the products. Although the amount of money I earn from selling these products is not enough, it helps me secure part of my living expenses. This is very important for me as at least I can use the money to buy things without asking money from my family*."
Most participants of the afternoon activities expressed interest in establishing small enterprises. From their point of view, the main obstacles are: lack of experience in managing micro-projects, lack of experience in marketing strategies, and lack of money to start the enterprise. Few participants in focus group discussions indicated that they have cumulated products, but they do not have the ability to sell these products. NECC could help women marketing their products in different ways including: participation in national exhibitions, and organizing special exhibitions for the products of afternoon activities, and having stand in each centre where women can sell and market their products to beneficiaries of the centres and visitors. Consistent with the women's view, few participants of the men's focus group implicitly indicated that afternoon activities improved some family's income through mothers' earnings from the vocational training. Some men suggested helping mothers open their own small enterprises with interest-free loans. Finally, most beneficiaries of afternoon activities stressed the importance of receiving a certificate of training. Certificate of training might help some women to get job in other places such as hair salons. Currently, NECC does not provide any certificate of training. This issue needs to be assessed by NECC.

3. Psychosocial support: The majority of women attending afternoon activities indicated that participation in afternoon activities represent an opportunity for them to vent their stressors, shake off stress and anxiety, emotionally expressing their problems, and to get social connections with other women. Furthermore, a large portion of women indicated that the main reason that motivated them to attend the afternoon activities is to help them overcoming the psychosocial problems. For instance: one 30-year-old single

woman from Shajaia stated, "*I come to feel that I am connected with others. This place is the only place where I can laugh and enjoy a bit of life*." A married 26-year-old woman from Shajaia with two children stated, "*My mother in law treating me badly, my husband has no say in our life. When I came here first time, I felt embarrassed. Then I realized how much [it] is valuable having these women in my life. I start to feel good. I come here to vent my frustration and pain*."

Interestingly, few participants of the men's focus group explicitly indicated that afternoon activities improved the martial relationship and deceased the friction within families. One man stated, "*My wife feels psychologically better as afternoon activities gives her a chance to break the cycle of routine as she spends sometime away from home and children*."

Participants of afternoon activities during a focus group discussion with the evaluation tem leader

14. System and Routine Enhanced, regular Reporting and Communication Enhanced, Central Computerized data base in place

Indicators: All clinics and health centres are using unified protocols by 2014, regular quality reporting is received from all clinics, and health centres, and qualitative and quantitative data about services are available as computerized central database.

Implemented activities and effectiveness

According to program log frame, the three centres should use unified protocols. It is well-known that unified protocols are the key to quality delivery. Unified protocols enable healthcare providers to offer appropriate diagnostic treatment and follow-up care to patients. Currently, the NECC three centres are using the MoH protocols. These protocols were developed by the MARAM project. Examples of these protocols are antenatal protocol, postnatal protocol, anaemia protocol, and infection control protocol. From the fieldwork, the evaluation team noticed that each clinic has hard copies of those protocols and they are in use. Recently, the NECC staff members have developed protocols for the well-baby clinic, nutrition, and psychosocial services. Still, there is a need to develop protocols for other services such as home visits and health education. It is good if NECC draws upon the experience of other health providers such as UNRWA and MoH. UNRWA has developed protocols for home visits that cover the following topics: (1) defaulters such as ANC and immunization, (2) physically disabled patients such as bedridden and disabled clients, and (3) community outreach program for psychosocial services, nutritional disorders and screening programs. Also, the MoH has

developed protocols for home visits that cover wide range of topics such as ANC, postnatal, and well- baby care. With regard to health education protocols, both MoH and UNRWA have protocols in place. It is recommended that NECC build on the current available protocols or even adopting these protocols.

Concerning the electronic health record system, it has the potential to transform the health care system from a paper-based industry to one that utilizes advanced information technology to assist providers in delivering higher quality of healthcare. Several studies have approved that the use of electronic health care systems has improved the overall health of people through improving the clinical outcomes of patients, reducing medical errors, reducing financial cost, increasing patients' satisfaction, and facilitating conducting research. Within the context of the Gaza Strip, the NECC health program is first program that utilized electronic health records and it is fully transformed the paper-based system to computerized system. This system is in place since 2008, and it is under continuously updated. The NECC electronic system is a comprehensive system, efficient, and user-friendly system. It has separate form, window, for each service such as well-baby clinic form, pediatric clinic form, postnatal clinic form, family planning clinic form, gynecology clinic form, laboratory clinic form, home visit form, and dental clinic form. The NECC centres are equipped with computers and all the staff received training from the programmer who developed the system. Also, the three centres are linked by a central database in the NECC main building in Gaza city. This central database is under close monitoring by a specialized information technology expert who is doing regular pack up of all the stored data.

In-depth interviews with health providers revealed deep satisfaction with the current system. From their point view, the computerized system helps them in delivering services in very efficient and effective way, and it also helps them in offering unified care across the three centres as it saves time, reduces costs, facilitates tracking cases, facilitates following up on cases, generates reports easily, and prevents duplicating efforts. There is no doubt that the NECC health electronic system is a very efficient and promising one. Hoping to replicate the system in other places, NECC has presented its electronic system to the MoH and UNRWA.

15. Beneficiaries' Satisfaction

With regard to satisfaction about the provided services, the Centre's staff regularly collects data to assess beneficiaries' satisfaction. The evaluation team analyzed the SPSS data for the year 2012. The vast majority of the interviewed cases (99.9%) revealed that they have received health education on care during pregnancy, delivery, postnatal care, nutrition, dental care, care of a newborn, breastfeeding, and family planning. From the beneficiaries' point of view, the main reasons of satisfactions are accessibility and affordability of the NECC health services, quality of the provided services, availability of drugs, and good relationship with the centre staff. Consistent with this, participants of focus group discussions expressed high levels of satisfaction with the provided services. In addition to the above reasons, other satisfactory factors are that the staff respects clients' dignity; there is respect to confidentiality, prompt attention, the cleanliness of centres, the availability of chairs in the waiting areas, and the availability of safe water

for drinking. In other words, high satisfactions among beneficiaries are attributed to the fact that the NECC staff response to the health needs and non-health aspects. Additionally, the NECC staff regularly conducts health education on healthy nutritional behavior and habits. The NECC staff conduct pre- and post-tests to assess the effectiveness of the health education activities. However, the analysis of the effectiveness of health education program is beyond the scope of this evaluation.

4.4. Cross Cutting Issues

NECC is committed to providing equal opportunities for both men and women to benefit from the health program with a focus on the health status of marginalized people regardless of gender, race, religion and other discriminatory factors.

The health program has been implemented while maintaining respect for the gender factor. Beneficiaries of well-baby clinics and psychosocial (children) consists of males and females; both benefited from the provided services without showing any preference to a specific gender. Additionally, the NECC health program offers health services through general clinics equally to males and females; no intentional discrimination was practiced in relation to gender or any kind of discrimination.

Although it is recommended to involve males in family planning counseling, within the context of the Gaza Strip it is not socially acceptable. Other providers including the Women's Health Centre in Burej Camp have tried to conduct family planning counseling to couples, but they did not achieve any success. It is also not socially acceptable to involve males in ANC and postnatal care. Involving males in services such as family planning and ANC in such a conservative culture might have negative impact on the NECC reputation. However, in a male dominated society, involving males in decision-making is particularly important. NECC incredibly involves males in decision making process through conducting meetings with community leaders to identify and prioritize needs, mostly those of leaders, and each centre has a committee called "centre's friends," of which most are male.

With regard to NECC employees, the total number of the staff in the three family care centres is 45. Of them 64.5% are females and 35.5% are males. Given the nature of the provided services in the family care centres, it is reasonable to have more females than males. With regard to child protection issues, NECC believes in the fundamental right of children to grow up safely and enjoy a childhood that is free from exploitation and abuse. In order to protect children from exploitation and abuse, recently NECC has developed a Child Protection Policy. This policy provides a framework for protecting children from abuse and exploitation in the delivery of NECC's services. Additionally, NECC conducted 5 days training on Keep Children Safe to its employees.

4.5. Risk Facing NECC Health Program: Emergency Preparedness

In an area that is characterized by frequent wars and incursions, it is critical for any organization to have emergency preparedness to respond coherently to unplanned events. The main risks that could face the NECC health program include intensification of the blockade, Israeli escalations, and war. The NECC emergency preparation include:

- Shortage of fuel and electricity: In the five last years, residence of Gaza has been experiencing shortage of fuel and electricity, at the time of writing this report, the rolling power outages is 10-12 hours per day. In response to shortage of fuel and electricity, NECC has equipped each family health care centre with a generator and NECC has stored amount of fuel that could enable the three family centres to work for few days. Additionally, NECC has in place fuel rationing system to efficiently use the variable fuel.
- Drug shortage: It is not uncommon for health providers to experience drug shortage. NECC has mitigated this risk by having a drug stock for six months. The stock includes essential drugs such as antibiotics, iron supplements, drugs for chronic diseases such as diabetes mellitus and hypertension.
- First aid and life support: Although most of the NECC family health care centres staff have medical background, all of them have received training on first aid and basic life support. This training enables them to deal with wide range of wounds and injuries. However, NECC needs to training its on advanced life support and needs to conduct such training on regular basis. Additionally, NECC regularly conducts first aid training to community members—especially women—during the afternoon activities.

In-depth interviews with the staff revealed that during the last war on November 22, 2012, the NECC family centres suspended their activities. Although ensuring staff safety is a must, this might be inappropriate to suspend the services in the most needy time. NECC needs to develop guidelines and may be to formulate a committee that could coordinate the work during any unexpected Israeli escalation and to decide the scope of NECC work during any escalation.

4.6. Financial Resources: Allocation of Budget

The NECC fiscal year starts in January and ends in December. Although NECC has provided the evaluation team with the auditing reports of the last three fiscal years, the evaluation team decided to do the financial analysis of the year 2012 as an example of the three fiscal years. In 2012, the total budget of the three centres was $785,075 USD.

Table (8): Amount and percentage distribution of program's allocated budget by main components

Item	Total, three centers	%
Salaries and benefits	465,408	59.30%
Medical expenses	219,497	28.00%
General expenses	59,730	7.60%
Others	40,440	5.20%
Total	**$785,075**	**100%**

As shown in table (8), staff salaries and benefits constituted the largest portion of the total budget and represented 59.30% of the total budget, followed by the cost of medical expenses with a proportion of 28% of the total budget. General and other expenses constituted 12.8% of total budget. The general expenses include, but not limited to, rental cost, running cost, repair and maintenance, furniture, materials and supply, SMS cost, and computer software. While other expenses cover different items including transportation and vehicle expenses, hospitality, and tax. In general the allocated budget to salaries and benefits is fair, as most institution allocate between 50 to 60% of the total budget to salaries. However, most of the interviewed staff expressed deep dissatisfaction of their salaries. It is worth mentioning that, the current salaries of the NECC staff are in line with the salaries of most NGOs. However, if budget increases, NECC would prefer to increase the staff salaries. The medical expenses portion is appropriates as it covers the cost of drugs, and other medical equipments.

User fee and drug copayments

Adult beneficiaries of general clinic in Shajaia and Daraj centres pay 7 NiS as user fee and a copayment of 2 NiS for each prescribed drug. In Rafah centre, there is no copayment and user fee, all services are provided free of charge. As shown in table (9), the collected revenues are small amount that cover about 1% of total centre expenses, while revenue collected from drug copayments is higher. In 2011, collected revenue from drug copayments constituted 8% and 4%of medical expenses in Shajaia and Daraj centres, respectively. In 2012, drug copayments constituted 4% and 3% of medical expenses in Shajaia and Daraj, respectively.

Table (9): Operating income from fee for service and drug copayments

Year	Item	Shajaia center			Daraj center		
		Operating income	Total expenses "audit report"	%	Operating income	Total expenses "audit report"	%
2011	Drugs-copayments	3,535	46,045	8%	2,013	45,916	4%
2011	User fee	4,817	244,732	2%	3,219	252,954	1%
2012	Drugs-copayments	3,356	75,163	4%	2,272	74,695	3%
2012	User fee	3,938	300,462	1%	3,487	334,775	1%

In health financing, imposing user fees has been highly debated issue. On one hand, proponents of user fees argue that user fees could supplement inadequate financing, help contain costs, and help improve equity through allocating revenues to address the health needs of poor people. On the other hand, opponents of user fees argue that user fees might deprive poor people of health services, and that fees require further administrative work. In-depth interviews with a key informant from Rafah area and staff of the centre revealed the importance of imposing user fees or copayment for cost containments purposes and to help people to utilize services wisely. As residents of Rafah area are poor, imposing user fees may deprive poor people of medical treatment. However, imposing drug copayment is very important to cut down medical expenses

and reduce waste from medical expenses. Additionally, imposing symbolic co-payment on all pregnant women, like a copayment of 1 NiS for each prescribed drug, might help to contain the cost and improve medication compliance among pregnant women.

Evidence from other health providers showed that, providing free of charge services encourages people to over utilize health services. UNRWA provides a wide range of health services free of charge to all Palestinian refugees. The provided free of charge services include primary, secondary, and tertiary health services. In 2012, about 4,000,000 visits to UNRWA-PHCs were reported. According to the chief of UNRWA's health program in the Gaza Strip, one of the main reasons behind this large number of visits is the provision of free of charge service, including the free prescription of drugs. Currently, UNRWA is in the process of transforming from paper-based health records to electronic health records. Among the main motives of this transformation are to closely monitor visits and regulate drug prescription, and improving the quality of the provided services. The chief of UNRWA's health program in the Gaza Strip stated, "*A woman can visit a health center to immunize her baby; the service is free. She can stop by a general clinic to seek medical treatment without having any health issue. Offering free of charge services encourages people to overutilization services, thus, reducing the quality of the service*." According to the chief of UNRWA's health program in the Gaza Strip, the decision of offering free of charge services is a political decision that was adopted by UNRWA's headquarters and the regional officers such as Gaza Strip cannot change it.

In contrary to UNRWA, the MoH offers health services to only insured Palestinians, and it offers free of charge MCH services and well-baby clinics for children up to age three years. In 2012, the about 1,900,000 visits to PHCs were reported. According to the General Director of PHC Directorate, in addition to health insurance, the main reason of having lower utilization, as measured by number of annual PHC visits, rate than UNRWA PHCs is the copayment on drug prescription. The General Director of PHC directorate stated, "*Offering free of charge services could destroy any healthcare system. Beneficiaries should pay for services; even if the payment is symbolic, it helps in regulating the utilization of services and improving the quality of service through reducing the demand*." Additionally, from the general director's point of view, free of charge services increases the irrational use of drugs, motivates people to fill drug prescription even if they have same medicine at home, and encourages people to store medicine.

4. 7. Coordination with other Providers and Involvement of Community Leaders

Within the context of the Palestinian healthcare system, as it has four main providers: the MoH, UNRWA, non-governmental organizations, and private for-profit providers. Coordination is extremely important as it improves the efficiency of operations by avoiding overlapping efforts and duplication of work. Also, coordination among health service providers increases the quality of services, patient satisfaction, and prevents wastage of resources. Thus, it is substantially important that NECC fully coordinate services with other providers, in particular the two main providers: MoH and UNRWA.

With regard to coordination with the MoH, NECC coordinates at different level including decision-making level and service provision level. Examples of coordination between MoH and NECC include:

- NECC involves MoH in its strategic planning and determining the scope of its work, and working areas. Also, NECC participates in the strategic planning of the MoH.
- NECC shares its annual and periodic reports with MoH and UNRWA.
- The NECC health program coordinator regularly attends the health cluster meeting, hosted by the WHO.
- NECC is active member in the Health Information System reform committee.
- The NECC is a member of the reforming MoH mammogram-screening program policies and regulations.
- NECC is active member in the MoH family planning committee.
- The Clinical Consultant of the NECC health program presented the Electronic Health Record system to policy makers including the Minster of Health and General Director of PHC.
- The Clinical Consultant of the NECC health program also presented main achievement of the NECC nutrition to the main actors including MoH, UNRWA, and WHO.

As mentioned earlier, the NECC centres refer cases to MoH hospital and PHC centres. The level of coordination is good and efficient in Gaza governorate. Where Daraj and Shajaia centres refer cases depends on the cases. For instance, malnourished children are referred to the Al Dora Paediatric hospital and Ard Al-Insan. High-risk pregnancies are referred to the Al-Rimal PHC and Al-Shifa hospital. However, coordination with the MoH hospital in Rafah area is very limited. Children with only nutritional problems can get a referral to the European Gaza Hospital and high-risk pregnancies can get a referral to the MoH-PHC. There is a need for more coordination to refer cases other than the nutritional problems. Given the fact that European Gaza Hospital does not have an obstetrics department, there is a need to start referring high-risk pregnancy cases to Al-Emarati hospital. Also, there is a need to develop referral forms, track the referred cases, and continue to follow up the cases.

The coordination with UNRWA needs to be further strengthened. Consistent with the views expressed by the NECC staff, the Chief of UNRWA's health program in the Gaza Strip indicated the level of coordination between UNRWA and NECC needs to be strengthened and there should be an administrative well to do so. Strengthening the coordination with UNRWA would enable NECC delivering more effective and efficient health services. Areas that need to be strengthened include: planning, referral, and exchange of knowledge.

With regard to building capacity of the centres staff, NECC participates in most of MoH relevant trainings such as ANC, family planning, and postnatal care. Additionally, NECC has in-service training program. Every year, NECC conducts several trainings, with participation of internal and external experts. During the data collection, two employees from the NECC were attended training on postnatal care.

With regard to coordination with international organizations such as the WHO and UNICEF, currently, the NECC Health Program Coordinator attends the cluster meetings, which are hosted by the UNICEF and WHO and namely, the Child Protection Working Group and Mental Health and Psychosocial Working Group. As most of the international and national organizations attend these meetings in order to share knowledge and lessons learned by others, presenting the NECC health program achievement—particularly on malnutrition and psychosocial support—would be a great opportunity to do so.

With regard to involvement of community leaders, the NECC involves community leaders greatly. The NECC Executive Director and Health Program Coordinator conduct regular meetings with community members. The meetings serve different purposes, mainly to assess the local community needs and involve community leaders in the decision making process. For instance, decision to include family planning services to the NECC bundle of services was a response to a need that was expressed by community leaders. The community leaders demanded more of such meetings, particularly with the NECC Executive Director.

4.8. Transparency

The level of transparency maintained throughout the program is very high. Financial documents didn't reveal any inconsistencies. Written financial systems, auditing reports, and procedures are available. Another aspect of transparency was demonstrated in the transparent auditable procurement procedures. The examined procurement documents revealed that all the steps were documented and performed according to the financial system of the NECC. Regarding the procurement documents, the examined procurement documents revealed that all the steps were documented and performed according to the financial system of the NECC. Offers solicited, tendering process performed, bids analysis and procurement decisions were made. In order to grantee transparency, the NECC applies the procurement guidelines proposed by the Ministry of Interior in which any purchase request between 2,000 Nis and 10,000 NiS, three quotations are required, and for any purchase request which exceeds the 10,000 NiS, national tender is required. The awarding committee should have the Executive Director of the NECC, the NECC Chairman, accountant, treasurer, logistician, and technical expert. Also, the NECC has a good follow up system to monitor the petty cash in the three centres.

The NECC has trusted transparent environment that helps the team perform in efficient way. As the evaluation team conducted series of in-depth interviews and focus groups with women and community leaders, the staff of the three NECC centres did not try to influence people by asking them to say good things about the program. With regard to documents, as mentioned earlier, the electronic health record system plays a significant role in maintaining on-the-spot accurate documentations. In each centre, all staff can access the centre databases through logging into the system by their usernames, but they cannot access the database of the other two centres. Finally, all documented measurements, such as weight and height, are accurate and reliable measurement. Thus, the database produces accurate indicators.

4.9. Management and Institutional Capacity

Monitoring and evaluation are very important to follow implementation and outputs systematically, measure the effectiveness, and identify the most valuable and efficient use of resources. The NECC enjoys a very committed, dedicated and effective management; each centre has a supervisor, and the three supervisors are well-trained have good managerial skills. At the main office level, the NECC Executive Director and the Health Program Coordinator monitor and supervise the implementation of the health program closely. The three supervisors hold monthly meetings with centres' staff, and the Health Program Coordinator holds regular meetings with the centres supervisors other employees. It is important to mention that, the accurate reliable documentation, and success of achieving most of the expected outcomes clearly reflects great managerial capacity. The NECC health program enjoys good level of monitoring and supervision, but this needs to be further strengthened. The Health Program Coordinator visits Daraj and Shajaia centres regularly, but not Rafah centre. Employees of Rafah centre express need for more monitoring visits from the Health Program Coordinator. They demanded a visit every month.

Since its establishment in 1952, the NECC is committed to improve the health status of Palestine people in the Gaza Strip. This is clearly reflected on the mission of NECC and the strategic goals. The strategic plan 2011-2015 incorporated health intervention as a key component of intervention. The organizational capacitates supported implementing this program included the availability of qualified staff, well-established centres, good procurement, financing, auditing, and logistics departments. To summarize, the health program is very responsive to the NECC capacities, and it is consistent with the work themes, mission, and strategic goals of the NECC.

4.10. Effects, Sustainability, and Exit Strategy

Sustainability has a unique meaning in areas characterized by high degree of uncertainty such as the Gaza Strip. Therefore, we refer in this context to the relative sustainability. Given the fact that the program has different components, each component has a different degree of sustainability. This program is contributing to the long-term development of the Gaza Strip; the relationship between health and development is well known; improving health of a population is a means to the end of development. Given the fact that the NECC health program provides a wide range of services including maternal and child services, care of communicable diseases, and other preventive and curative services, the program will have positive long-term impacts on the beneficiaries of the NECC centres and the whole community as well. Areas that will have positive improvement include reducing mortality rate among infant and under five children, improving access to reproductive health, and preventing the spread and control of many diseases, and reducing the burden from nutritional problems. Clients will keep utilizing health services of the NECC centres, eventually; this will improve the overall level of health. This overall improvement will be sustainable.

Health education is an investment that has long-term positive impacts. The effect of health education is generally positive and sustainable. Through health education, community people including women and children become more aware of healthy nutritional habits and practices. The impact of adopting appropriate nutritional behaviours is long-term sustainable investment that will have long positive impacts. Families who maintain healthy nutritional behaviours will have a better chance to have healthy and productive life. The change in knowledge and practices will sustain long and can be transferred across generations. Awareness is an important component of health promotions and contributes to strengthening communities' abilities to demand and support appropriate practices. Enabling communities to discover and seek appropriate care is a sustainable approach. With regard to human resources, this program has a very sustainable impact through strengthening the capacity of the NECC staff. Currently, the NECC staff members have important technical skills; they are capable and have the ability to offer high quality services. This component of the program will have positive long-term impacts on the whole community.

With regard to exit strategy, within the context of this evaluation, the evaluation team assessed two kinds of exit strategies: First, exit strategy of any service delivery such as treatment of anaemia and follow up in the well baby clinic. Second, exit strategy in case of donors decided to cut the financial support. With regard to service delivery, NECC health program has very clear exit strategy for most of the provided services. For instance: (1). The exit strategy for well-baby clinic is linked to age and it is precisely reaching the age of six years. (2). The exit strategy for anaemic children after recovery consists of prophylactic administration of iron treatment for three-months, then referring cases to well-baby clinic for hemoglobin follow-up for six-month and then the regular follow up as any case in the well-baby clinic. Periodically, NECC randomly selects 5% of recovered closed cases for check up. Interestingly, NECC has full information about all the anaemia children including children who recovered, improved, are still anaemic or have deteriorated.

With regard to exit strategy in case if a particular donor decided to cut its financial support, within such humanitarian situations and the good outcome of the NECC health program, it is not feasible that NECC stops providing health services to such vulnerable population. As a solution to such scenario, NECC always looks for diversity in funding to contain any potential cut of financial support from certain donors. Additionally, as a mean to cover or compensate any financial cut, NECC could increase the user fee and drug copayments.

In case if NECC decided to stop providing health services, hypothetically, the exit strategy could be to hand over the three family centres to other providers, namely: MoH, UNRWA, and local NGO. In the last two decades, the MoH has been facing financial problems to a degree that the MoH is experiencing frequent drug shortages. The idea of handover the three NECC family centres to the MoH is not feasible. Currently, the Palestinian Ministry of Health is in the process of drafting a major reform of the current healthcare system. The core of health reform will be to separate the financing function of healthcare system from the provision of services function through restructuring the health insurance to be a private or a semi-automatous body. This body will be responsible for collecting, pooling and allocating financial resources to healthcare

service provision. NECC is part of the reforming committee. A window opportunity for NECC to secure funding could be to be part of this system and link the provision of services with the enrollment in the Social Health Insurance system.

UNRWA has its network of PHCs and the decisions come from the Headquarter in Amman. Any change in UNRWA system should be reflected in the UNRWA's five working places: Gaza, West Bank, Amman, Syria and Lebanon.

Finally, the handover of the NECC three family care centres to a local organization is not possible as most local organizations suffer from financial problems and securing the required funding is very hard.

5. Lessons Learned

The lessons learned are listed below as follows:

1. The relevancy of the NECC health program is very high as it focused on promoting the overall health of Palestinians. Promoting health will have positive long-term impacts on the beneficiaries of the NECC centres and the whole community as well. Thus, it is very important to continue implementing such activities.
2. Nutritional problems remain prevalent in the Gaza Strip, as the NECC health program is contributing to reducing the prevalence of nutritional problems among Palestinians particularly children. The NECC health program emphasis on nutrition is very relevant and appropriate, thus, it is very important to continue implementing such program in the future.
3. The relevancy of the psychosocial component of the NECC health program is very high as it focused on the promoting mental health and increasing psychological wellbeing of Palestinians, NECC should continue implementing such activities in the future.
4. The NECC health program incorporates health education as a core component of the health program. Health education has long-term positive impacts. Additionally, awareness is an important component of health promotions and contributes to strengthening communities' abilities to demand and support appropriate practices.

6. Recommendations

Recommendations are listed below as follows:

1. More efforts are needed to share knowledge and lessons learned with other national and international organizations, particularly the success of the NECC in reducing the prevalence rate of anaemia among children less than 6 years of age and the postnatal care.
2. With regard to Rafah centre, family planning services are not provided. There is a need to speed the process of introducing this service in the centre.

3. The prevalence rate of IDA among lactating women is very high. It is recommended that the NECC scan for anaemia among lactating women and provide anemic women with the needed medical treatment. Given the fact that the interval between pregnancies is short, tackling the issue of anaemia during lactation might reduce the burden of anaemia during pregnancy and shortly after delivery.

4. The decision of offering free of charge services in Rafah centre needs to be reassessed; imposing user fees or drug co-payment helps people utilize services wisely, cutting down on medical expenses and reducing waste from medical expenses. This issue needs further research.

5. Although the current level of monitoring is good, there is a need to strengthen it. More supervision should be provided to the implementation teams of the three centres.

6. NECC needs to conduct a national awareness campaign to educate people about healthy behaviours, particularly on nutritional behaviour.

7. Currently, the NECC prescribes iron supplementation only to anaemic pregnant women. Given the high prevalence rate of anaemia among pregnant women, it might be appropriate to prescribe iron to also non-anaemic pregnant women as prophylactic after 13 weeks of gestation.

8. Giving the importance and relevance of the psychosocial component of the NECC health program, there is a need to implement more proactive approaches to increase the number of beneficiaries.

9. The coordination with the MoH, UNRWA and local community organizations needs to be strengthened. In particular, the NECC needs to coordinate with more providers from Rafah area.

10. Although the psychosocial component of the NECC health program is achieving its outcomes, counselors are in need for professional supervision and training. Training could include the following topics: psychological counseling, case management, dealing with behavioral problems among children, and dealing with trauma.

11. The NECC decision to include breast examination to its bundle of services is a very necessary and appropriate decision. The NECC needs to start implementing this service as soon as possible. Before starting to offer the services, the NECC needs to address the following critical points:
    - Determine time and age to conduct breast examination and mammography screening, if needed.
    - Identify proactive measures to reach women and encourage them to utilize this service.
    - Set clear criteria for referral mechanism for mammography screening.
    - Identify facilities to referral cases for mammography screening.
    - Identify who is going to pay the cost of mammography screening.
    - Set clear referral mechanisms for further diagnostic tests, if any abnormalities were detected in the mammography screening.

12. A comprehensive need assessment need to be done to assess the need for increasing the number of NECC family health care centres and the operational capacity of NECC to do so.

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8. Annexes

Annex 1: Schedule and Tools of Qualitative Data Collection

No	Tasks	Purpose	Involved person	Place	date
1. Desk Review and Field Visits					
1.	Desk review of program documents, reports, and other relevant program data	To fully understand the components of the program To review the program reports and compare the outcomes with the objective To check financial and administrative records To identify key informants and stakeholders and To finalize the work plan	Khitam	NECC-office Gaza	12,July Friday
2.	Field visits and review of PHCC records	To observe the interaction between clients and providers and the interaction among health providers To observe the implementation of program activities	Khitam	Kherbet Al Adas PHCC	12,July Friday
3.	Field visits and review of PHCC records		Khitam	Shijaia PHCC	16, July Tuesday
4.	Field visits and review of PHCC records		Khitam	Daraj PHCC	16, July Tuesday
2. In-depth Interviews with Key Informants, Key Program Staff, and Community Leaders					
1.	Dr. Issa Tarazi- Executive Director of NECC-Gaza	General discussion To identify the main objectives of the Community Health Program To assess the value add and the complementarily nature of the Community Health Program To assess the relevance and appropriateness of the program design and specific activities to meet the program's stated objectives	Khitam	NECC-office Gaza	17, July Wednesday
2.	Dr. Wafa Kanan- Health Field Coordinator		Khitam	NECC-office Gaza	16, July Tuesday
3.	Dr. Bassam Abu Hamad		Khitam	NECC-office Gaza	September, 19 Thursday
4.	NECC Administrative and Financial Manager		Khitam	NECC-office Gaza	TBD

5.	Director/ Manager of Daraj PHCC	To assess the link between the program theme and the long term activities and strategic plan of the NECC To assess the degree in which the program achieved its objectives and outcomes To determine the main strengths and benefits of the program, in particular the quality of the provided services To assess the program's outcomes at different levels, including beneficiaries, community members, and health providers To assess the longer-term sustainability and impact of the project To assess the program efficiency in relation to the use of resources and outcomes achieved To assess the level of coordination between MoH and the health main providers: MoH and UNRWA	Khitam Heba	Daraj PHCC	TBD
6.	Director/ Manager of Shijaia PHCC		Khitam	Shijaia PHCC	16, July Tuesday
7.	Medical doctor, Shijaia PHCC nutritionist		Khitam	Shijaia PHCC	17, July Wednesday
8.	Medical doctor, family planning specialists- Shijaia PHCC		Khitam	Shijaia PHCC	18, July Thursday
9.	Director/ Manager of Kherbet Al Adas PHCC		Khitam	Kherbet Al Adas PHCC	12,July Friday & 15, July Monday
10.	Medical doctor, Daraj PHCC, general practitioner		Khitam	Daraj PHCC	19, July Friday
11.	Registered nurse from Daraj PHCC		Khitam	Daraj PHCC	18, July Thursday
12.	Lab Technician or a Pharmacist from Shijaia PHCC		Khitam	Shijaia PHCC	17, July Wednesday
13.	Psychologist/ Animator Kherbet Al Adas PHCC: Suha Zo'rab		Osama Heba	Kherbet Al Adas PHCC	15, July Monday
14.	Psychologist/ Animator: Shijaia PHCC		Osama Heba	Shijaia PHCC	18, July Thursday
15.	Psychologist/ Animator: Shijaia PHCC		Osama Heba	Daraj PHCC	18, July Thursday
16.	Community leader from Kherbet Al Adas Area : Abed –Al-Hamed Al-Shaer		Khitam	Kherbet Al Adas PHCC	13,July Saturday
17.	Community Leader from Shijaia Area		Khitam	Shijaia PHCC	17, July Wednesday
18.	Community Leader from Daraj area		Khitam	Daraj PHCC	18, July Thursday
19.	Chief of UNRWA's Health Programin the Gaza Strip		Khitam	UNRWA Health department	15, September Sunday
20.	General Director of PHC Directorates- MoH		Khitam	PHC directorate	18, September Tuesday

<table>
<tr><th colspan="6">3. Focus Groups</th></tr>
<tr><td>1.</td><td>Nine female beneficiaries of Kherbet Al Adas PHCC</td><td rowspan="3"><u>General discussion</u>

To assess the relevance and appropriateness of the Community Health Program in improving the health status of Palestinians, in particular women and children

To assess the impact of the Community Health Program in improving and promoting the health status Palestinian people

To assess the quality of the provided services in the PHCCs</td><td>Khitam</td><td>Kherbet Al Adas PHCC</td><td>13,July Saturday</td></tr>
<tr><td>2.</td><td>Nine female beneficiaries of Shijaia PHCC</td><td>Khitam</td><td>Shijaia PHCC</td><td>17, July Wednesday</td></tr>
<tr><td>3.</td><td>Nine male beneficiaries of Daraj PHCC</td><td>Khitam</td><td>Daraj PHCC</td><td>19, July Friday</td></tr>
<tr><td>4.</td><td>Nine female beneficiaries of Kherbet Al Adas PHCC</td><td rowspan="3"><u>.General discussion</u>

To assess the relevance and appropriateness of the Community Health Program in improving the nutritional status of children under 5 years

To assess the impact of program in improving the nutritional status of children.</td><td>Khitam</td><td>Kherbet Al Adas PHCC</td><td>15, July Monday</td></tr>
<tr><td>5.</td><td>Nine female beneficiaries of Daraj PHCC</td><td>Khitam

Heba</td><td>Daraj PHCC</td><td>18, July Thursday</td></tr>
<tr><td>6.</td><td>Nine female beneficiaries of Shajaia PHCC</td><td>Khitam</td><td>Shajaia PHCC</td><td>17, July Wednesday</td></tr>
<tr><td>7.</td><td>Six children aged 12 years old, beneficiaries of Shijaia PHCC</td><td rowspan="4"><u>General discussion</u>

To assess the relevance and appropriateness of the Community Health Program in improving psychosocial wellbeing of Palestinians

To assess the impact of program in improving the psychological wellbeing of children, women, and families</td><td>Osama Heba</td><td>Shijaia PHCC</td><td>18, July Thursday</td></tr>
<tr><td>8.</td><td>Six children aged 12 years old, beneficiaries of Kherbet Al Adas PHCC</td><td>Osama Heba</td><td>Kherbet Al Adas PHCC</td><td>15, July Monday</td></tr>
<tr><td>9.</td><td>Nine female beneficiaries of Daraj PHCC</td><td>Osama Heba</td><td>Daraj PHCC</td><td>18, July Thursday</td></tr>
<tr><td>10.</td><td>Nine female beneficiaries of Kherbet Al Adas PHCC</td><td>Osama Heba</td><td>Kherbet Al Adas PHCC</td><td>15, July Monday</td></tr>
<tr><td>11.</td><td>Nine female beneficiaries of Daraj PHCC</td><td rowspan="2">To assess the effectiveness and appropriateness of the afternoon activities</td><td>Khitam</td><td>Daraj PHCC</td><td>16, September Monday</td></tr>
<tr><td>12.</td><td>Nine female beneficiaries of Shijaia PHCC</td><td>Khitam</td><td>Shijaia PHCC</td><td>12, September Thursday</td></tr>
</table>