ANNEX I - Description of the Action

ENPI/2012/298-255

Mental Health and Psychosocial Support in West Bank & Gaza, Phase II (MHPSS II)

EU CONTRIBUTION AGREEMENT WITH WHO
Contents

1. Context pertinent to the project................................................................. 4  
   1) Mental health morbidity in the oPt .................................................... 4  
   2) WHO contribution to development of mental health services in the oPt ...... 5  

2. Rationale for implementing the project .................................................. 6  
   1) Strategic framework.......................................................................... 6  
   2) Relevance of the current project.......................................................... 8  
   3) Lessons learned.................................................................................. 9  
   4) Coordination....................................................................................... 11  

3. Definition of the project........................................................................... 12  
   1) Project area and beneficiaries............................................................. 12  
   2) Objectives ......................................................................................... 13  
   3) Project results and activities............................................................... 14  
   4) Stakeholders...................................................................................... 14  
   5) Risks and assumptions...................................................................... 27  
   6) Crosscutting issues: gender, human rights and good governance.......... 28  
   7) Project logical framework matrix ...................................................... 28  

4. Implementation Issues ............................................................................. 28  
   1) Project steering committee................................................................. 28  
   2) Project management ......................................................................... 29  
   3) Project staff ....................................................................................... 29  
   4) Consultancy: .................................................................................... 30  
   5) Communication and visibility ............................................................ 30  
   6) Implementation schedule ................................................................. 31  

5. Project Budget......................................................................................... 31  
   1) Procurement and financial arrangements .......................................... 32  
   2) Project accounting and auditing......................................................... 32  

6. Reporting, monitoring and evaluation .................................................... 33  

7. Project sustainability and handover........................................................ 33
Acronyms and Abbreviations:

CMD  Common Mental Disorders
EU   European Union
EUREP European Representative Office for West Bank, Gaza, and UNRWA
GBV  Gender Based Violence
GCMHP Gaza Community Mental Health Program
IMC  International Medical Corps
MDM  Médecins du Monde
MH   Mental Health
MHPSS Mental Health and Psychosocial Support
MoH  Palestinian Ministry of Health
NDP  National Development Plan
NGO  Non-Governmental Organisation
oPt  occupied Palestinian territory
PHC  Primary Health Care
PTSD Post Traumatic Stress Disorder
SOP  Strategic Operational Plan
SMI  Severe Mental Illnesses
TRC  Treatment and Rehabilitation Centre for Victims of Torture
WHO  World Health Organization
1. Context pertinent to the project

1) Mental health morbidity in the oPt
Available evidence indicates a high prevalence of mental health morbidity in the occupied Palestinian territory (oPt). The World Health Organization (WHO) in 2009 estimated that up to 37.8% of people attending primary health care centers (PHCs) in the West Bank and Gaza Strip suffer from psychological problems\(^1\). A study conducted by the Gaza Community Mental Health Programme (GCMHP) in 2010 revealed that 10.03% of children in the Gaza Strip suffer from Post Traumatic Stress Disorder (PTSD)\(^2\). Furthermore, according to the GCMHP, 14.2% of kindergarten children here suffer from emotional problems, with 46% of these having peer relationship problems, 33.8% hyperactivity, and 15.1% multiple-social problems\(^3\).

Occupation of the West Bank, blockade of the Gaza Strip, violence, poverty and unemployment are among the chief reasons for mental health morbidity in the oPt\(^4\). These factors disproportionately affect the most vulnerable population groups: women, children and older people. Each year, an estimated 61% of married and 52.6% of unmarried women in the oPt are subject to psychological violence, 23% of married and 29% of unmarried women experience physical violence, and 10.9% of married women suffer sexual violence. One in ten older people in the oPt is deprived of family support (9.8% in the West Bank and 7.3% in the Gaza Strip); one-third of these reported not receiving any social support services from either State or private organizations\(^5\).

Mental disorders pose a considerable challenge to country development and the alleviation of poverty. Poverty is linked with, and affected by, development of Common Mental Disorders (CMDs) in most low and middle-income countries (LMICs). Recent studies show a distinct association between a range of poverty indicators and CMDs\(^6\). The WHO report on Mental Health and Development (2010) underlined the strong possibility of mentally ill people drifting into poverty as a result of lack of access to employment; this may occur in 70% to 90% of cases, mostly because of employer reluctance to hire people with mental health problems. Furthermore, the report found that people with mental health conditions are excluded from income-generating programmes\(^7\). However, while poverty increases the risk of developing mental disorders, there is evidence that mental health interventions are associated with improved economic outcomes in LMICs: rehabilitating people with severe mental disorders allows them to re-integrate into their societies through taking their places in the labour market again\(^8\).

---

\(^1\) WHO, Prevalence of common mental disorders in the PHC.2009 Unpublished report, Gaza

\(^2\) GCMHP.Trauma, mental health, and coping of Palestinian children after one year of Gaza War May 2010

\(^3\) GCMHP. Evaluation report of project “Capacity Building of Kinder Garden Teachers in the Gaza Strip” July 2010

\(^4\) National Strategic Mental Health Plan 2012-14

\(^5\) National Strategic Mental Health Plan 2012-14


\(^7\) Mental health and development report. - World Health Organization 2010

According to WHO estimates, 5-10% of the general population in a conflict affected area such as the oPt are expected to develop CMDs. Furthermore, WHO estimates that 1-1.5% of people will develop Severe Mental Illness (SMI) at some point in their lives. There is no reliable national data available on the prevalence of mental disorders in the oPt. However, using the WHO figures as a benchmark, it is estimated that 200,000 to 400,000 Palestinians (5-10% of the population) may be in need of mental health care and 40,000 people are expected to experience SMI. Only a fraction of those in need currently accesses health care services: 3,464 new users received mental health services from community mental health centers in the West Bank and Gaza Strip during 2010; there were 1,018 new admissions to psychiatric hospitals in the same year.

In most countries, people suffering from CMDs should be managed at PHC level. In the oPt, mental health services remain insufficiently decentralized; only five out of 453 public PHCs provide mental health services. Furthermore, those who do seek care at primary level may not receive proper diagnosis and treatment: according to a WHO assessment, GPs lack the skills to adequately manage people with mental health care needs. Incorrect diagnosis may result in the prescription of irrelevant and unnecessary medication while failing to treat the true problem. This results in an increasing treatment gap between people suffering from CMD and those that receive proper care.

This project will promote a re-shaping of the traditional model of care for people with SMI: they will receive primary assessment and ongoing care in the PHC center, specialized and community care in the CMHC, and hospitalization and rehabilitation care in acute care units and general hospitals.

2) WHO contribution to development of mental health services in the oPt

WHO has supported the oPt Ministry of Health (MoH) in the development of mental health and psychosocial services since 2002. At that time, the first situation analysis undertaken by WHO in the West Bank and Gaza Strip highlighted the lack of a mental health policy and of public mental health services. Despite the existence of community mental health clinics, the MoH’s mental health resources were concentrated in tertiary psychiatric care at the Bethlehem and Gaza Psychiatric Hospitals. Primary health care workers had little or no training in diagnosing and treating mental disorders.

WHO worked with the MoH and other partners to develop the first Strategic Operational Plan (SOP) adopted by the MoH in 2004. This plan provided a detailed situation analysis and response strategy based on the recommendations of the World Health Report 2001. In 2004/5, WHO developed a proposal for a long term mental health program aimed at reorganising, improving and expanding mental health services using a community mental health approach at primary, secondary and tertiary levels of health care. A Contribution Agreement was signed with the EU in December 2005 for € 3.4 million with an implementation period of 3 years. Due to the political situation in 2006, the project started only in December 2007. A no-cost extension of 6 months was later agreed and the project ended on 31 May 2011. An independent project evaluation commissioned by the EU was undertaken later in 2011.

The term "users" refers to individuals accessing mental health services.

Annual Health Statistics – Palestinian MoH 2010

WHO, Prevalence of common mental disorders in the PHC. 2009 Unpublished report, Gaza
Substantial progress has been made over the past 3 years in implementing the mental health reform project. Mental health directorates have been established to provide leadership and policy direction in the MoH in the West Bank and Gaza Strip. With on-going capacity building support from WHO, the directorates have played a key role in the development of services. Extensive training of mental health professionals has been carried out, including the training of primary care staff to provide first level diagnosis and care, of community mental health staff to provide specialized services (e.g. psychological assessment, psychotherapeutic interventions and psycho-education) and of psychiatric hospital staff on the recovery approach. Postgraduate programs in mental health nursing and psychological therapies have been developed in partnership with local universities and MoH. International links with mental health providers in Italy and the United Kingdom have been established. Mental health users and families associations have been set up as independent Non-Governmental Organizations (NGOs). Psychiatric hospitals have started to promote the recovery approach and Bethlehem Hospital has started to implement a services diversification strategy. In addition, an updated and revised strategy for mental health and psychosocial services has been developed and approved by the MoH, in addition to a strategy for integration of services into primary care.

The impact on attitudes and services is apparent. The integration of mental health into primary care is on-going, with PHC facilities becoming the first level of service provision and referral. Community Mental Health (CMH) centres are playing an increased role as first level provider of more specialized care – the number of patients managed by CMH centres has approximately doubled since 2007. The reform of the psychiatric hospitals in Gaza and Bethlehem is also underway, although there remains much to do. There is wider acceptance among health staff about the importance of providing better care for people suffering from mental disorders. There are also some indications of a shift in public attitudes, reflected in increased attendance of patients to CMH centres, increasing acceptance of the role of family and users associations among the community, and increased health staff cooperation in integrating mental health into PHC.

Despite this progress, the view of the evaluators, and of WHO and other partners involved in the previous mental psychosocial project, is that the reforms remain fragile and in need of consolidation. There is a risk that the improvements may not endure unless reinforced by further project support. Also, various elements of the reform require further input and development to complete the work started in the previous project, e.g. the integration of mental health into primary care and the establishment of the Family NGO concept as a self-sustaining model.

2. Rationale for implementing the project

1) Strategic framework
Palestinian National Authority National Development Plan (NDP) 2011-2013. The plan summarizes the Palestinian government policy agenda and accountability framework for sustainable socioeconomic development and state building. It is a product of the second comprehensive tri-annual national planning process following on from the Palestinian Reform and Development Plan (PDRP) 2008-10. The NDP 2011-2013 sets out a number of ambitious objectives for the
governance, social, economy and infrastructure sectors to establish a stable and prosperous society and strong economy in Palestine. Promoting and sustaining a healthy society by ensuring equitable access to comprehensive preventative and curative health care is one of the important strategies of the NDP 2011-13.

**Palestinian National Authority National Strategic Mental Health Plan 2012-2014.** Mental health has long been recognized as public health priority in the oPt. The first plan on the Organization of Mental Health Services in Palestine was adopted in February 2004. This plan was informed by the work of a steering committee including representatives of the MoH, key local and international NGOs, WHO and the Italian and French governments. The objectives of the plan were to overcome the fragmentation of services and to improve the organization and collaboration between the mental health service sectors. Seven years later, the Mental Health Thematic Group comprising stakeholders from the MoH, United Nations (UN), NGOs and donor community reviewed the plan and developed a strategy streamlined to the evolved context as well as new evidence and recommendations regarding mental health care policy and practice. The resulting National Strategic Mental Health Plan 2012-2014 developed by the Thematic Group sets forth the following priorities that will determine the focus of efforts by the PA and the international community towards improving mental health in the oPt in the coming years:

- Provide comprehensive and integrated mental health services for the Palestinians
- Regulate community mental health services in Palestine in such a way that the MoH is the major regulator of community mental health services
- Develop and improve the capacity of community mental health professionals
- Promote community development and awareness raising about the importance of mental health towards fighting stigma
- Integrate mental health services into general hospitals.

**Palestinian National Health Strategy 2011-2013.** This is the main health sector planning document that links the NDP 2011-2013 with the sector specific policies and plans. It provides guidance for harmonious development of the health sector in the West Bank and the Gaza Strip to achieve the country’s overall development goals. The main objectives of the strategy are:

- Access to quality health services
- Sustainable health financing
- Public-private partnerships
- Healthy behaviours and disease prevention
- Governance and institutional development
- Aid effectiveness
- Human resource development
- Cross-sectorial collaboration and cooperation.
2) Relevance of the current project

According to WHO estimates, one in every four people will develop one or more mental disorders at some stage in life. Today, 450 million people in developed and developing countries suffer from mental disorders, contributing substantially to the burden of disability worldwide. Five of the 10 leading causes of disability result from mental health conditions. It was estimated that in 1990 mental and neurological disorders accounted for 10% of the total Disability Adjusted Life Years (DALYs) lost due to all diseases and injuries. By 2000, this figure was 12%. By 2020, the burden of these disorders is projected to increase to 15%\textsuperscript{12}, taking an enormous toll in terms of suffering, disability and economic loss.

During 2001, WHO highlighted the issue of mental health to the general public, government officials and the public health community. Through the 2001 World Health Day, World Health Assembly and World Health Report, WHO and its Member States have pledged their full and unrestricted commitment to this public health area. The main recommendations of WHO 2001 reports include: provide treatment at PHC level, make psychotropic drugs available, give care in the community, educate the public, involve families and consumers, establish national policy and legislation, develop human resources, link with other sectors, monitor community mental health and promote research.

The WHO Mental Health Global Action Programme (mhGAP) follows from the events of 2001 to provide a clear strategy for closing the gap between what is urgently needed, and what is currently available to reduce the burden of mental disorders worldwide. The mhGAP initiative calls for enhancing the ability of countries to address the burden of mental disorders and related stigma.

In 2012 the Sixty-fifth World Health Assembly adopted a resolution on the global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at country level. The resolution urges member states to allocate appropriate resources to mental health.

This project will serve as a primary mechanism for provision of technical support to implementation of oPt National Strategic Mental Health Plan 2012-2014. Its objectives are fully aligned with the goal and objectives of the NDP 2011-2013 and the National Health Strategy. The project activities have been discussed and agreed with the MHU/MHD in the West Bank and Gaza Strip.

As described previously, mental health has far-reaching implications for poverty levels and country development. This project will build on the achievements and the lessons learned in the previous EU funded mental health initiative. The project will continue the work to strengthen provision of decentralized mental health services and thus contribute to a reduction in the mental health burden in the oPt and ultimately to the achievement of the targets of the NDP.

The project aims to consolidate the reform of public mental health services through support to reorganization and decentralization of mental health services, thus promoting improved access and cost effectiveness. In the new structure, PHC clinics will become the first point of contact for people requiring mental health care and the main source for referrals to the CMHCs. The CMHCs,

\textsuperscript{12} World Health Report 2001
in addition to being the frontline health facilities for management of moderate and severe mental disorders, will also play an important role in the clinical supervision and training of service providers in PHC clinics.

The reform will also modify the roles of general and psychiatric hospitals in the provision of mental health services. As the treatment of the most common mental disorders will shift to PHC clinics and CMHCs, the role of psychiatric hospitals will have an increased focus on the provision of mental health rehabilitation services. Acute psychiatric units will be established at two general hospitals in the West Bank and Gaza Strip in an effort to de-stigmatize inpatient mental health care through integration within general hospital care. The components of mental health services described here will form a continuum of care, providing appropriate mental health services as close to Palestinian communities as possible.

Significantly, the reform also aims to promote cost effectiveness and efficiency of public health services in the West Bank and Gaza. WHO will support the MoH to ensure optimal organization of mental health services to reduce redundancies and waste throughout the continuum of mental health care. Packages for strengthening case management of mental health services at each level of care will be developed, along with mechanisms for improved supply of medical commodities and improved planning of the numbers, distribution and training of mental health staff. Geographically accessible and improved service provision at PHC level will help to reduce the per capita treatment cost of mental disorders.

3) Lessons learned
Implementation of the previous project resulted in important lessons learned regarding the role of the MoH in mental health system strengthening and capacity building of mental health staff. Experience was also gained concerning the use of local expertise and the need to strengthen civil society organizations’ leadership in fighting stigma as well as their role in shaping mental health related policies. The lessons learned were utilized in the development of this project to enable sustainable outcomes and a successful handover to the MoH.

These lessons can be divided into two categories: 1) those documented through the evaluation of the previous EU–WHO mental health project and 2) other lessons learned by the WHO team through implementation of mental health programs as well as knowledge gained from mental health projects implemented by other agencies:

1. Lessons documented in the previous EU-WHO mental health project evaluation:

1) The previous project had aimed to achieve a broader scope of objectives than the resources it possessed allowed to achieve and thus was overly ambitious.
This project contains more prudently selected interventions tailored to the local technical and operational capacities and the project budget.

2) The implementation of the previous project was often delayed because the MoH was slow to adopt technical materials developed through the project.
The WHO oPt team closely coordinated with the MoH in the West Bank and Gaza Strip and with other stakeholders throughout development of this project to ensure their commitment to achieving
the key project outputs. The MoH and WHO will sign a Memorandum of Understanding (MoU) outlining the roles and responsibilities of both parties within the scope of the project. The MoU will include a number of milestones indicating priority MoH inputs and deadlines that are critical for successful implementation of the project.

3) The PHC staff training conducted within the scope of the former project was not followed by proper supervision and was not well monitored and evaluated by the MoH. The current project will focus on strengthening clinical supervision and on-the-job training at the community mental health centers and PHC clinics as a means to build knowledge and clinical skills of mental health staff.

4) There were insufficient training opportunities for psychiatrists. Through this project WHO will train 20 psychiatrists in the West Bank and Gaza Strip in child and adolescent psychiatry, emergency psychiatry and the management of psychiatric problems at general hospitals.

5) The many residential trainings provided through the project often disrupted the provision of health services. Most of the trainings to be provided through this project will be on the job, which is least disruptive to the provision of health services.

6) There was a lack of reliable data to monitor and evaluate mental health services and plans in the West Bank and Gaza Strip. This project will help to improve monitoring and evaluation and will promote evidence based planning and management through establishment of an electronic patient record system and development of monitoring and evaluation tools for the new strategic plan.

7) There was excessive use of international consultants for short term services. WHO will make better use of its regional and HQ based expertise to ensure quality and timeliness of the critical outputs of the project. In order to maximize benefits of using external expertise, more rigorous procedures will be applied to the selection and management of consultants, including development of detailed terms of reference with clear descriptions of deliverables and reporting requirements; checking of references; and establishment of performance/outcome based payment procedures.

2) Other lessons learned

1) As a result of limited exposure to competition and cooperation with other organizations working in health, the Family NGOs failed to produce high quality results. Informed by the experience of the previous project, WHO will modify its approaches to strengthening civil society’s involvement in addressing mental health issues and the associated stigma and discrimination. The project will introduce competitive, performance based funding for Family NGO mental health activities and encourage partnerships between the Family NGO and other civil society groups, such as GCMHP in Gaza. WHO will also continue to invest in developing Family NGO capacities in key programmatic areas such as advocacy, community education and human rights.
2) Political discord between the West Bank and Gaza Strip has posed considerable challenges to development and application of common mental health care standards, as well as planning and implementation of mental health services across the oPt.

WHO in the oPt acts as a convener, liaison and advocate for health system strengthening and for harmonizing approaches across the West Bank and Gaza Strip. Through establishing and actively facilitating communication between the Mental Health Unit (MHU) in the West Bank and the Mental Health Directorate (MHD) in Gaza and other relevant stakeholders, the project team will ensure development and application of harmonized mental health policies and standards across the oPt.

3) The mental health rehabilitation program remains weakly defined and integrated within community.

By means of this project WHO will help the MoH to develop a clearly defined, community based rehabilitation strategy for both psychiatric hospitals and community centers. The development of the rehabilitation program in Bethlehem Hospital will be evaluated and the strategy modified where necessary.

4) Over the past years, several other projects have been implemented to develop and strengthen mental health services in the West Bank and Gaza.

The main projects include an EU funded IMC project in Gaza and an MDM France project in the West Bank funded by Agence Française de Dévelopement. WHO has reviewed the outputs and the lessons learned from those projects and utilized them in the design of this project. In particular, WHO will use the mental health referral system developed by MDM France. WHO will promote application of the system in the West Bank and will use it as a basis for developing a similar mechanism in Gaza. Similarly, WHO will use the materials produced by the IMC for occupational therapy and rehabilitation, for monitoring of PHC progress in implementing mental health services, and for awareness raising on mental health related stigma.

4) Coordination

Coordination of mental health activities in the West Bank and Gaza Strip: There are two main mechanisms for planning and coordination of mental health activities in the West Bank and Gaza: 1) the Mental Health and Psychosocial Support (MHPSS) sub-cluster and 2) the mental health thematic group.

Humanitarian mental health activities are coordinated through the MHPSS sub-cluster, co-chaired by WHO and UNICEF. The MHPSS is a cross cutting sub-cluster reporting to both health and protection clusters. The sub-cluster is a coordination and information sharing forum that includes the MoH and other concerned ministries, local and international NGOs, UN agencies and donors. As co-chair, WHO has a central role in leading and coordinating the design, monitoring and evaluation of the humanitarian mental health strategies and standards. WHO has currently scaled down its support to the MHPSS sub-cluster as a result of funding constraints and in preparation for a transition from the cluster system to a less resource intensive mechanism for coordination of humanitarian health and nutrition activities.
In 2009, a mental health thematic group was established in the West Bank and Gaza at the request of the MoH to help coordinate the development of the Mental Health Strategic Plan and to monitor and oversee mental health services and projects. The thematic group included representatives of various ministries, UN agencies, local universities, and international and local NGOs. WHO supports the MHU in coordination and provision of technical advice. The thematic group will be re-activated under this project by the MoH to support the development of technical materials (policies, strategies, guidelines) to enable reform and decentralization of mental health services.

**Project Coordination:** Day to day coordination of the project will be carried out by the WHO team in the West Bank and Gaza. Close coordination with the MoH will be needed to facilitate a smooth transfer of knowledge and information. Therefore, the WHO team members will increase the proportion of their time spent with the MoH to at least 50%. A steering committee will be set up to oversee and validate the overall direction of the project. The steering committee will consist of: 1) a representative of the MoH; 2) a representative of WHO; and 3) a representative of the Head of the EU Delegation as observer.

### 3. Definition of the project

#### 1) Project area and beneficiaries

The project will be implemented in both the West Bank and Gaza and will include all 16 existing MoH CMHCs (10 in the West Bank and 6 in Gaza) as well as all 28 existing level 4 PHC clinics (12 in the West Bank and 16 in Gaza). The only two existing psychiatric hospitals and two general hospitals will also be involved. In addition, two Family NGOs will be included. The project will therefore promote access to primary, secondary and tertiary mental health care services for the entire population of the West Bank and Gaza.

The direct beneficiaries of the project include the MHU in the West Bank and the MHD in Gaza, as well as mental health care providers and civil society groups working to ensure equitable access to mental health services throughout the oPt.

Through this project 380 (200 from the West Bank and 180 from Gaza) primary mental health care professionals from the 28 level 4 PHC clinics will be trained in mental health. Training will also target the 16 CMHCs: 90 staff (60 in the West Bank and 30 in Gaza) will be trained in occupational therapy, inter-sectorial community rehabilitation and life skills, child and adolescent mental health, community based treatment (CBT) and family therapy.

The following staff categories will also benefit from training: psychiatrists (11 in the West Bank and 15 in Gaza), psychologists (20 in the West Bank and 10 in Gaza), social workers (23 in the West Bank and 5 in Gaza), 4 occupational therapists in the West Bank and 10 nurses in Gaza.

Furthermore the project will train 24 staff from psychiatric hospitals in Gaza and Bethlehem on occupational therapy, inter-sectorial community rehabilitation and life skills, child and adolescent mental health, CBT and family therapy. Twenty psychiatrists will be trained in child and adolescent psychiatry, emergency psychiatry and management of psychiatric problems in general hospitals to support provision of inpatient mental health care at Gaza general hospitals.
Twenty members of Family NGOs will be trained in leadership, advocacy, community education, and human rights. The Family NGO in West Bank currently serves 900 users and family members; it is expected that the new established Family NGO in Gaza will serve 800 users and their families.

WHO expects that, as a result of increasing accessibility, quality and acceptability of mental health services in oPt, the number of people using CMHC services will increase by 15%. By the end of the project, approximately 25,000 people with CMDs will have received mental health care at PHC clinics. In addition, 4,600 beneficiaries suffering from SMI will have received treatment: 4,000 in CMHCs and 600 in general hospitals (as a result of shifting inpatient mental health care to the general hospitals in Gaza). The expected long term beneficiaries according to global estimates will be 40,000 with SMIs (1-1.5% of the general population) and 200,000-400,000 with CMDs (5-10% of the general population).

2) Objectives
This project will consolidate advances achieved over the past eight years in the provision of integrated, cost effective community-based mental health services in the oPt. In supporting the Palestinian MoH to increase accessibility, quality and acceptability of mental health services in the West Bank and Gaza, this project will contribute to the NDP objectives of reduced morbidity and mortality, increased life expectancy and poverty reduction.

The overall objective of the project is therefore to contribute to poverty alleviation and strengthened protection of vulnerable groups in Palestine.

The project’s two specific objectives were informed by a problem analysis carried out by the WHO team in the West Bank and Gaza (Annex I, Supplement C). The first objective aims at improving the availability and quality of mental health services in the oPt, while the second seeks to strengthen Palestinian civil society involvement in mental health services and in fighting stigma and discrimination.

SO1: Improved availability and quality of mental health services at primary and secondary care levels in the West Bank and Gaza

The availability and quality of mental health services is recognized by the MoH as one of the key determinants of mental health in the oPt. In its new mental health strategy, the MoH sets out an ambitious plan for improving access to quality mental health care by scaling up services at the community and primary health care levels, and ensuring that more patients with mental disorders are treated at the general hospitals rather than inpatient psychiatric units.

Achieving the objectives of the strategy will require development of an appropriate mix of qualified health staff, design of operational strategies and guidelines, and strengthening of MoH capacity to monitor service provision as well as progress of the new mental health strategy. It will also require addressing stigma and discrimination, still common among the Palestinian health care workers, toward mental health care users.
SO2: People in the West Bank and Gaza seek diagnosis and treatment for their MH conditions

Raising public awareness on mental health issues and service users’ rights and needs is a key activity for combating stigma and improving mental health service utilization. It is one of the priorities of the MoH mental health strategy for 2012-2014; it is also one of the specific objectives for scaling up mental health services in the oPt. The stigma attached to mental health users and the misconceptions that the population have developed toward mental health issues and mentally-ill people are considered among the main barriers to seeking mental health care in low and middle income countries. The 2010 WHO Report on Mental Health and Development emphasizes the fact that people with mental health problems have been marginalised and largely ignored; and that communities, families and consumers should be included in the development of policies and services. Collaboration with community resources is key to carrying out a successful community based intervention and public education is crucial in order to mobilize the community toward supporting mental health users.

3) Project results and activities

RESULT 1.1: SUFFICIENT NUMBERS OF SKILLED MENTAL HEALTH STAFF ARE AVAILABLE AT PRIMARY AND SECONDARY CARE LEVELS

In every health system, the workforce is central to advancing health. It is impossible to establish and run effective and efficient health services without motivated, well-trained and adequately distributed health staff. Quality improvements in health care are best initiated by workers themselves because they are in the unique position of identifying opportunities for innovation.

The MoH in its new mental health strategy has recognized that a shortage of well trained staff, particularly psychiatrists, mental health nurses, clinical psychologists, social workers and occupational therapists, is a significant impediment to improving accessibility of mental health services. The MoH staffing needed to scale up mental health services at the primary and secondary care levels and in general hospitals is estimated at 380, 90 and 10 mental health specialists respectively.

In order to ensure that the limited resources at the disposal of the MoH are utilized efficiently, this project will support the MHU/MHD to develop a human resource development plan. The plan will help the MoH to identify the number and mix of mental health specialists required to implement the strategy, as well as their long term training needs. The required specialist staffing will mainly be achieved through training of existing MoH staff in mental health.

Several training opportunities were created for mental health professionals in the previous EC funded project: two long-term skill-based training courses on psychological interventions were organized for psychologists and social workers in the West Bank and Gaza; several short-term training courses were organized on recovery approach, supervision and CBT; two masters programs for mental health nursing were developed in the West Bank and Gaza; a psychological therapies diploma program was created in Gaza.
These opportunities resulted in significant upgrading of professional skills especially for nurses and psychologists. However, adopting a community mental health approach requires further investment in the mental health workforce, in terms of improving the skills of the CMHC staff and also in creating continuing education opportunities. The skills acquired by nurses and psychologists need to be developed and sustained; furthermore, training opportunities need to be created for other staff cadres such as psychiatrists and occupational therapists.

The methods of capacity building to be employed by this project differ from the approaches of the previous EU project. This time, residential training is limited and emphasis is given to on-the-job training and clinical supervision, which are more efficient and less disruptive to service provision compared with residential training. This change was informed by lessons learned in the previous project and paves the way for developing a sustainable capacity building system for continued professional development.

Materials addressing stigma and discrimination will be mainstreamed in the training to ensure that community mental health services are capable of identifying and properly addressing some of the most common factors affecting mental health, including gender issues and care for victims of gender based violence.

The project aims to provide on-the-job training and strengthened clinical supervision for all categories of mental health staff. Gender parity will be observed during the process of training enrolment to ensure that both male and female service providers have equal opportunities to receive training.

Clinical supervision is a critical component in the professional development of mental health professionals. It is a process that promotes personal and professional development within a supportive relationship, formed in order to promote high clinical standards and to develop expertise by supporting staff and helping them to avoid problems in busy practice settings. WHO will help the MoH to establish a sustainable, supportive clinical supervision system that will help to strengthen the quality of mental health services at PHC clinics and CMHCs throughout the implementation of the project and beyond. The clinical supervision model will include case conferences, role-plays, seminars (to discuss scientific materials relating to the mental health), review of patient records and observation of clinical practice. The model will facilitate development of needs-based, clinical supervision schedules linked to individual performance and experience of the mental health professionals (e.g. new graduates will be supervised more frequently than more experienced staff members).

Within the scope of this activity WHO will hire local consultants to provide clinical supervision to 90 CMHC staff and in parallel train 20 CMHC staff as clinical supervisors. The trained supervisors will provide regular clinical supervision to CMHC and PHC staff. The CMHC staff will be supervised according to individually developed schedules while PHC staff will be supervised bimonthly. This is expected to help establish a culture of good clinical practice and to promote high quality mental health services.

While on-the-job training and supervision are critical for continuing education and for ensuring the quality of services, formal training programs, such as the postgraduate courses established in the
scope of the former EU project, are important for preparing new specialists. In the scope of the new project, WHO will build the capacity of the university course tutors in key technical areas such as the recovery approach, contemporary community mental health nursing approaches, supportive supervision and community based treatment of mental health conditions.

Through the above interventions, the project will contribute to the continuous development of the technical capacity of mental health professionals in the oPt and ensure the sustainability of investments made in the previous mental health project.

**Main activities under result 1.1:**

1.1.1 Support the MoH to develop a human resources (HR) plan for mental health
1.1.2 Build capacity of 60 MH staff in WB and 30 MH staff in Gaza to engage in service provision at CMHCs
1.1.3 Support training of 380 PHC general practitioners and nurses on mental health
1.1.4 Support training of 24 staff from two psychiatric hospitals on selected key mental health topics
1.1.5 Support training of 20 psychiatrists on selected key mental health topics
1.1.6 Enable clinical supervision for 60 CMHC staff in WB and 30 CMHC staff in Gaza and 200 MH staff at PHC-s in WB and 180 MH staff at PHC-s in Gaza
1.1.7 Support 8 mental health staff (4 from WB and 4 from Gaza) to participate in 2 conferences and 2 study tours
1.1.8 Facilitate capacity building of 10 mental health post graduate course tutors in community based treatment of mental illness

**The main outputs of result 1.1 are:**

- Mental health service human resource plan is developed by the MHU/ MHD
- 60 MH staff working in 10 CMHC in WB and 30 MH staff working in 6 CMHC in Gaza are trained on occupational therapy, child and adolescent mental health, CBT and family therapy for 3 months for each subject.
- 380 PHC staff (200 in West Bank and 180 in Gaza) are trained for 4 days on the management of common mental disorders in 28 level 4 PHC clinics (12 in West Bank and 16 in Gaza)
- 24 staff from Bethlehem and Gaza psychiatric hospitals are trained for 3 months on occupational therapy, inter-sectorial community rehabilitation and life skills, child and adolescent mental health, CBT and family therapy
- 10 psychiatrists from WB are trained on child and adolescent psychiatry and emergency psychiatry; 10 psychiatrist from Gaza are trained on the above mentioned topics and on management of psychiatric problems in general hospitals to enable them to run inpatient mental health services in Shifa and Naser general hospitals
- 90 CMHC staff (60 in WB and 30 in Gaza) are provided with clinical supervision; a sustainable system of supervision is established and handed over to the MoH
- 20 MoH staff are trained on clinical supervision
- 380 PHC staff are provided with bimonthly supervision in their PHC clinics
- 8 mental health staff (4 from WB and 4 from Gaza) participate in 2 conferences and 2 study tours
- 10 post-graduate tutors are trained on CBT, recovery approach and contemporary mental health nursing methods in the Islamic University in Gaza and An Najah University in WB.

**RESULT 1.2: MENTAL HEALTH SERVICES ARE INTEGRATED AT PRIMARY HEALTH CARE LEVEL IN THE WEST BANK AND GAZA**

The previous EU mental health project helped to shift the attitudes of health practitioners towards support for integrating mental health into general health services. Mental health is now accepted as one of the public health programs provided through PHC clinics. The MoH in the West Bank and Gaza has started to integrate mental health at different levels of health service provision. In the previous project, WHO supported the MoH to develop a PHC intervention package in Gaza that included guidelines, case recording forms and other materials for management of CMDs. Currently five level 4 clinics in Gaza provide integrated management of CMDs using this package.

In order to improve accessibility of mental health care, particularly for CMDs, the MoH is determined to scale up mental health services in PHC clinics in the West Bank and Gaza. While the MoH vision is to eventually provide these services at all level 2, 3 and 4 PHC clinics, current resources limitations have resulted in an appropriate strategy that pursues decentralization to 28 level 4 PHC clinics only.

In order to build on the achievements attained so far and to facilitate decentralization of mental health services in the oPt, WHO will help the MoH to refine its mental health intervention package and adapt it for use in the West Bank. To enable referrals between service levels, referral guidelines designed with the support of MDM France will be operationalized in the West Bank and adapted for use in Gaza. The project will also streamline and operationalize a tool developed by IMC to determine progress of PHC facilities in providing mental health services. Finally, WHO will facilitate the establishment of a system for monitoring utilization and quality of mental health services at the primary health care level.

In bringing services closer to the beneficiaries, the integration of mental health at the primary health care level will improve case finding and management, particularly of CMDs. By the end of the three year implementation period, WHO expects that 28 PHC clinics will provide mental health services, delivering correct case management to at least 70% of patients, and that around 25,000 people will have received treatment for their mental health conditions at the primary care level.

The role of PHC clinics will include identifying and managing people with CMD at the primary care level, and referring people with moderate and severe mental illnesses to CMHCs in their catchment areas. Moreover, PHC clinics will play a major role in providing routine care for people with SMI that are referred to the PHC clinic by the CMHC and psychiatric hospitals for routine assessment and distribution of medication.

**Main activities under result 1.2:**

1.2.1 Develop and disseminate protocols and intervention guidance for PHC practitioners
The main outputs of result 1.2 are:

- Mental health referral guidelines developed by MDM France and the MoH are adapted for use in Gaza
- Referral guidelines and protocols on the use of psycho-tropics at the PHC facilities in the West Bank and Gaza are printed and disseminated and their implementation is monitored
- A recording and reporting system for monitoring mental health services at PHC clinics is developed
- A PHC readiness checklist is used in the process of scaling up mental health services to the PHC clinics

**RESULT 1.3: SERVICE PROVISION AT THE COMMUNITY MENTAL HEALTH CENTRES IS STRENGTHENED**

CMHCs have been functioning in both the West Bank and Gaza since 2004 but no operational policy for running the centres is yet in place. Attempts were made to establish operational policies in the centres but these were not adopted by all mental health service providers because of lack of an effective mental health management body to organize and standardise the service at that time.

Therefore, this project will support the MHU/MHD to develop a standardised operational policy for running CMHCs and furnish the necessary tools and procedures for organizing day-to-day functioning. It will address issues such as case management, development of a patient care plan and supervision. It will also define the roles and responsibilities of different staff cadres involved in the provision of mental health care at CMHCs.

The development of the operational policy will build on the previous work of the WHO, IMC and other organisations, in accordance with the existing policies and regulations adapted by the MoH for organizing mental health services and in line with evidence based knowledge and practice for community mental health care. Development of the policy will involve organizing various workshops for mental health professionals from CMHCs, with WHO providing technical support.

The CMHCs will play a major role in promoting primary care services for CMDs by supervising and providing continuous technical support for the PHC staff that will primarily manage people with CMDs. Additionally, moderate and severe cases of CMD will be referred to CMHCs for advanced intervention. The majority of people with SMI will be managed in the CMHC; only severe cases in need of hospitalization will be referred to acute care units in general hospitals or to psychiatric hospitals.

By setting common standards and defining the requirements for establishment of and daily operations at the CMHCs, the project will promote uniform and coordinated service provision at the centres, which will enhance their quality as well as cost effectiveness.

**Main activities under result 1.3 are:**

1.3.1 Develop operational policy and tools for CMHCs
The main outputs of result 1.3 are:

- CMHC operational policy and tools are developed
- 4 workshops are organised in both WB and Gaza to discuss the CMHC operational policy
- The CMHC operational policy is operationalized at all CMHCs in the West Bank and Gaza

RESULT 1.4: INPATIENT MENTAL HEALTH CARE IS INTEGRATED IN SHIFA AND NASER HOSPITALS IN GAZA

Historically, in-patient mental health services in the oPt were provided by two psychiatric hospitals, one in West Bank and the other in Gaza. These hospitals drain the limited human and financial resources dedicated to mental health by the MoH. Neither residential long-stay services nor acute in-patient units in general hospitals have been established, to complement tertiary psychiatric services. The distribution of mental health budget and human resources is unequal with more resources allocated to the psychiatric hospitals compared to the CMHCs. Both psychiatric hospitals function in a custodial, institution-oriented manner. This approach leads to many patients with mental disorders staying in psychiatric hospitals for years, depriving them of basic human rights and obstructing their integration into society. It has also contributed to stigmatization of mental health services and people with mental disorders.

Integration of mental health services into general hospitals is one of the objectives for the oPt National Strategic Mental Health Plan 2012-2014 and the Gaza Mental Health Action Plan 2012-2014.

Mental health services can be provided in general hospitals through the establishment of psychiatric inpatient wards or psychiatric beds in general wards. In the previous EU funded project, an agreement was reached with the MoH in Gaza on the importance of integrating mental health into two general hospitals in Gaza (Shifa and Nasser) as part of the planned re-shaping of mental health services. To this end, the MoH has taken preparatory steps by training 20 doctors and nurses working at Shifa hospital on the management of acute mental disorders and developing intervention protocols for inpatient management of acute mental disorders. The MoH in Gaza has committed to provide sufficient space and appropriate equipment at Shifa and Naser hospitals to accommodate the inpatient mental health. However the process of establishing the units has not yet started.

In the West Bank, several discussion were held with the MoH on establishing an acute inpatient unit in the Tulkarem or Nablus general hospital, but the hospital directors have so far rejected the idea. Interventions at general hospitals in the West Bank were therefore not included in the strategy of this project. WHO will provide technical support to the MoH to develop an operational policy for organization of the inpatient mental health care and to conduct workshops to sensitize the staff at the Shifa and Naser hospitals on the importance of the integration of mental health services. Staffing of the two acute units will be managed by the MHD through re-allocation of staff from the psychiatric hospital and community centres.

Establishing acute psychiatric care at general hospitals will contribute to deinstitutionalizing and destigmatizing mental health services and to a gradual scaling down of psychiatric hospitals. At the
same time, the existing psychiatric hospitals will increasingly focus on the provision of rehabilitation services.

**Main activities under result 1.4:**

1.4.1 Support the MoH in Gaza to develop an operational policy, including case management protocols, for integration of inpatient mental health care at general hospitals

1.4.2 Conduct workshops to sensitise staff on the importance of the integration of mental health care into general hospital services

**The main outputs of result 1.4 are:**

- Operational policy for the integration of inpatient mental health care at general hospital in Gaza is developed
- One day workshop is organised to finalise the operational policy
- The operational policy is adopted by MoH
- Workshops are organised to sensitise the staff at the Shifa and Naser hospitals on the importance of the integration of mental health care into general hospital services

**RESULT 1.5: SOCIAL INCLUSION PROGRAMS ARE INTEGRATED IN THE WEST BANK AND GAZA PSYCHIATRIC HOSPITALS**

Social inclusion of people with SMI requires, in most cases, a phase of rehabilitation and development of certain physical and mental skills to help them reintegrate in their societies. This involves training, and various sports and occupational programs that empower people, thus facilitating their reintegration into the community. Occupational therapy is an important component of a social inclusion program as it helps patients build certain skill and also helps them to become more self-reliant socially and often financially.

A social inclusion program was started in Bethlehem psychiatric hospital through the previous EU funded project, and with support from specialists of Trieste hospital. The programme currently includes horticultural and sports components; both components were chosen by the Bethlehem psychiatric hospital taskforce based on their expected added value for patient care, the availability of infrastructure, ease of implementation and feasibility. The horticulture program is functioning well, providing the participants with occupation and income, while the sports program, that was added later, requires further development. The sport program progressed slowly because many of its components were not implemented as a result of many delays from the MoH side. However, applying a lesson learned from the previous project, the replication of the rehabilitation program in Gaza will focus only on horticulture because the MoH lacks the capacity to run several rehabilitation programs at the same time.

In Gaza, the MoH has established a rehabilitation unit in a general hospital. Establishment of this unit was not supported by the previous project. The unit manages to function with very few available resources, providing basic rehabilitation activities. Also in Gaza, the GCMHP, with assistance from IMC, has upgraded a rehabilitation centre specialised to assist mentally ill persons. The centre has good facilities and a modern operational policy that regulates intake, rehabilitation
path, referrals, etc. Lessons learned from the GCMHP/IMC intervention will be utilised in this project.

The project will provide logistic and technical support for the existing project in Bethlehem to assess the program so far and to assist with the further development of the rehabilitation strategy. It will build MoH staff capacity to develop rehabilitation and social inclusion pathways for individual patients with mental disorders and will support establishment of additional occupational training programs at the psychiatric hospital rehabilitation units. Materials on the occupational therapy developed and tested by IMC in Gaza will be used in this process. These units will then support the establishment of the community rehabilitation program at CMHCs. Further, this model will be replicated in the Gaza psychiatric hospital.

Equipment to be procured through this project will include horticultural and sport equipment in West Bank and horticultural equipment in Gaza. The WHO sub-office in Gaza will manage procurement of the equipment from Gaza according to WHO procurement policy.

The expected outcome of this project component will be that an increasing number of persons affected by SMI can be rehabilitated and reintegrated in their family and community.

**Main activities under result 1.5:**

1.5.1 Support the MoH to integrate occupational therapy and social inclusion programs in Gaza and Bethlehem psychiatric hospitals

**The main outputs of result 1.5 are:**

- Detailed objectives for the social inclusion program for both Bethlehem and Gaza psychiatric hospitals are developed
- Bethlehem and Gaza psychiatric hospitals offer rehabilitation interventions, including horticulture and sports, tailored to the needs of individual patients.
- Equipment and materials for development of an occupational programme in Gaza and West Bank are provided
- 20 service users in Gaza hospital are trained in horticulture
- By the end of the project, the number of new patients receiving rehabilitation services has increased from 72 per year to 90 per year in the West Bank and from zero to 20 per year in Gaza.

**RESULT 1.6: THE CAPACITY OF MoH FOR COLLECTION AND ANALYSIS OF MENTAL HEALTH DATA AND ITS USE FOR SERVICE PLANNING, MANAGEMENT AND RESEARCH IS STRENGTHENED**

Developing a monitoring and evaluation plan for mental health services provided by the MoH was one of the main recommendations of the end of project evaluation report. It is the responsibility of the MHU/MHD to monitor and evaluate the quality of mental health services, the impact of project activities and the progress made in reforming the mental health system. This project will provide technical support for the MHU/MHD in helping them to develop a monitoring and evaluation
framework, plan and tools to track the progress of the new mental health strategy. Such support will be provided by the project team and through international consultancy as needed.

The MoH operational plan for 2012-2014 emphasizes the establishment of a mental health information system as one of the priorities for obtaining accurate information for better evaluation and planning. Under the previous EU funded project, a comprehensive assessment of the infrastructure of the information system in the CMHCs and the psychiatric hospital was carried out in the West Bank. A computerised patient file was developed, a database established, staff trained to use it and pilot utilization of the database was carried out in six CMHCs in the West Bank.

The lesson learned from the previous project is that accelerating the establishment of an electronic information system in mental health facilities is crucial for proper monitoring and planning processes. To date the electronic patient file has not been made operational and the CMHCs in the West Bank and Gaza use the old paper based system to gather, store and analyse data on their patients. Therefore, this project will take the pilot process forward and will accelerate the establishment of electronic patient files in all mental health facilities in the West Bank and Gaza.

The database will be centralized in mental health facilities and a network will be established among mental health facilities with the assistance of the information department at the MoH. The activities to finalize the system will include installing the electronic software and training all mental health professionals on utilizing the software and producing monthly reports. The MoH National Mental Health Strategic Plan monitoring and evaluation framework will be linked with this and other systems that collect data on mental health. The result will be improved quality of mental health patient data, improved patient management and improved ability of the MoH to analyse and use data for evaluation and management of mental health services across the oPt.

Operational research is essential for evaluating tools and strategies and to guide their effective implementation in programmatic settings. In the scope of the project two small grants will be provided through the MoH on the basis of competitive selection to facilitate application of operational research in key areas of mental health care service delivery in the West Bank and Gaza.

A joint committee consisting of MoH and WHO representatives will set the research topics and develop the grant documentation. The grants will be awarded to graduates of the mental health postgraduate program established in the scope of the former project who will develop proposals to addressing the research priorities set by the committee. The funding will be disbursed through consultancy agreements between the WHO and the students who won the grants.

The outcome of this project component will be that the MoH will be able to systematically monitor and evaluate progress on the National Mental Health Strategic Plan. Furthermore, the MoH will obtain computerized patient data which can be used for evidence based planning and improvement of services.

Main activities under result 1.6:

1.6.1 Support the MoH to develop a monitoring and evaluation system to track the progress of the national mental health strategic plan 2012-14
1.6.2 Support the MoH to establish a mental health computerized patient file and data base in 16 CMHCs and 2 psychiatric hospitals in the oPt
1.6.3 Promote mental health research capacities in the West Bank and Gaza

The main outputs of result 1.6 are:

- National Mental Health Strategic plan M&E framework is developed
- Computerised MH patient file functions in 16 CMHCs in West Bank and Gaza and in the 2 psychiatric hospitals
- One day training for 60 MH staff in WB and 100 MH staff in Gaza on use of the MH computerized patient file and data base is conducted
- 2 small grants are provided to postgraduate students and operational MH research relevant to the MoH is completed.

RESULT 1.7: STIGMA AND DISCRIMINATION TOWARD MENTAL HEALTH PATIENTS AMONG THE HEALTH CARE PERSONNEL IS REDUCED

Stigma and discrimination against mental health care users is a major impediment to both accessibility and quality of the mental health care services. Many individuals with mental health conditions and their families are reluctant to seek mental health care services, fearing negative attitudes and bad treatment on the part of health providers.

Some useful work was done in Gaza under the previous project in updating the draft Mental Health Legislation and developing a draft Code of Practice. It includes a set of guidelines and procedures that set standards for mental health practice such as 1) Accreditation System for mental health professionals, 2) Job descriptions 3) Code of ethics for mental health practice and 4) Classification of mental health services for mental health organizations. There has been no equivalent progress in the West Bank.

In Gaza two ministerial decrees were issued to enact the newly developed accreditation system for mental health professionals and the job descriptions. The code of ethics and classification of mental health services has not yet been approved.

This project will support the development of the mental health code of practice for the oPt, utilising the documents drafted in Gaza as a basis and providing necessary technical support for the mental health stakeholders to review and revise them. The aim will be to achieve consensus on a code of practice and to support the MoH to adapt and enact the new code of practice for the benefit of all mental health service providers and users.

The mental health code of practice and messages addressing stigma and discrimination against mental health patients in healthcare settings will be included in the mental health training curricula to ensure that every health care provider is acquainted with the ethical norms and principles of the mental health practice. An existing IMC module on mental health related stigma and discrimination will be utilized in the above process. After its enactment by the ministerial decree, adherence to the
code of practice will become mandatory for all mental health practitioners working in the oPt public health care sector.

**Main activities under result 1.7:**
1.7.1 Support the drafting of the mental health Code of Practice and its approval by the MoH
1.7.2 Integrate modules addressing stigma and discrimination of mental health patients by health staff in all training activities

**The main outputs of result 1.7 are:**
- Mental health code of practice is developed and adopted by MoH
- One consensus workshop is organised in West Bank and one in Gaza
- Modules addressing stigma, gender and human rights are integrated in all training activities for mental health staff and PHC staff

**RESULT 2.1: THE INVOLVEMENT OF PALESTINIAN CIVIL SOCIETY, PATIENTS AND CAREGIVERS IN SHAPING MENTAL HEALTH POLICIES AND ADDRESSING MENTAL DISORDERS IS STRENGTHENED**

Within the scope of the previous EU funded project, WHO established a Family NGO in the West Bank that linked a number of individuals and family associations around the ideas of: protecting the rights of people with mental disorders and their families; facilitating their involvement in the development of mental health policies; advocating for the rights of the mental health service users; and advocating for improving the quality and accessibility of the mental health services in the oPt.

Since the end of the project in May 2011 the Family NGO in the West Bank has continued its activities in collaboration with Juzoor (a Palestinian NGO) and a number of other local NGOs. Relying largely on volunteers, activities have included raising awareness about mental health issues and availability of MH services in the villages in Ramallah governorate and carrying out advocacy with the MoH to ensure uninterrupted supply of psychotropic drugs at CMHCs. Inspired by the progress of the Family NGO in the West Bank a similar NGO was established in Gaza in 2011.

While the Family NGOs and the users and family groups will remain the central mechanism of the project’s strategy for raising awareness about mental health issues and promoting the rights of people with mental health problems in the Palestinian communities, the WHO team will change its approach to supporting those groups to ensure efficiency of their operations and thus increase their independence and sustainability. This change has been induced by the lessons learned from the previous project. The Family NGO will shift to a community grass root organization, gradually depending less on funding over the three year project period and more on community and local resources as well on voluntarily work by the families affected by mental illness. WHO will also provide additional support in administration, human resource management, and methods of awareness raising, fundraising and advocacy. WHO will also facilitate alliances between the Family NGOs and established civil society organizations such as the Gaza Community Mental Health Program (GCMHP) and Treatment and Rehabilitation Center for Victims of Torture (TRC).
The outcome of this activity will be that the rights of people with mental disorders will be better protected. Family NGOs will engage with policy makers and provide input into relevant policies and plans. Through the activities of the family NGOs, the public will be more aware of issues affecting people with mental disorders. Finally, social and recreational activities of the family organisations will positively affect the wellbeing of people with mental disorders.

**Main activities under result 2.1:**

2.1.1 Build capacity of Family NGO and family association groups to advocate for and support mental health patients and caregivers.

**The main outputs of result 2.1 are:**

- Provide seed funds to the family NGOs in the West Bank and Gaza over the three years of the project implementation to cover basic running costs (utilities, communication, office stationaries)
- Facilitate partnership between the Family NGOs in the West Bank and Gaza and other organizations with established administrative, human resources and fundraising systems
- Implementation of one week training for the 20 Family NGO volunteers in leadership, advocacy and human rights

**RESULT 2.2: KNOWLEDGE IS IMPROVED IN THE TARGET COMMUNITIES IN THE WEST BANK AND GAZA ABOUT AVAILABLE MENTAL HEALTH SERVICES AND THE IMPORTANCE OF SEEKING CARE FOR MENTAL DISORDERS**

Lack of awareness of the availability of health services and the importance of seeking care is one of the most significant barriers that hinders access to appropriate health care. The Palestinian public knows little about mental health and where to seek mental health services. Their perception of mental health issues is dominated by myths and misconceptions that create a fertile ground for stigma and discrimination against the people with mental disorders and their families.

Some work was done in the scope of the previous project and by the Family NGO in the West Bank to address misconceptions and increase awareness of the Palestinian public on mental health issues (for more details refer to Result 2.3).

WHO will support the MHU/MHD to produce materials informing communities about the availability of the mental health services and promoting their utilization. The materials will be disseminated through printed and electronic media and through the public health care network: PHC clinics, CMHCs and general hospitals. Several awareness-raising materials have been developed in the scope of previous EC funded project in both West Bank and Gaza; these will be utilized in this project as well. It is expected that with sufficient effort the awareness raising activities will gradually address the prevalent misconceptions about mental health in the oPT.

**Main activities under result 2.2:**

2.2.1 Disseminate information about the importance of seeking treatment for MH disorders and available MH services in the oPt communities
The main outputs of result 2.2 are:

- Two types of brochures are developed addressing public misconceptions about mental health and informing the Palestinian public about the availability of mental health services (1,000 copies of each type of brochure)
- Two posters addressing public misconceptions are produced and distributed in all PHC clinics (1000 copies each)
- 2 radio spots addressing public misconceptions relating to mental health and informing the Palestinian public about the availability of mental health service are produced (each radio sport will be broadcasted 50 times)

RESULT 2.3: STIGMA AND DISCRIMINATION AGAINST PEOPLE WITH MENTAL DISORDERS IS REDUCED

Stigma is one of the main barriers to seeking health care. Reducing stigma and discrimination against mental disorders is accompanied by improved access to mental health care in most countries\textsuperscript{13}. A comprehensive anti-stigma campaign was conducted in Gaza in the scope of the previous project. However, the campaign was not able to mobilize and involve the communities in the work against stigma. Presently there are no anti-stigma activities taking place in Gaza.

In the West Bank, the Family NGO has spearheaded awareness raising and anti-stigma activities. It conducted several meetings on mental health issues in communities in Ramallah, Hebron and Bethlehem districts. The NGO produced an annual magazine with materials on mental health issues, and advocated for the rights of the people with mental disorders with policy makers and the Palestinian public through meetings and the media.

The MoH will provide technical and advisory support to develop the content of all messages to be disseminated to the community through the family NGO. Also, they will disseminate all information related to public raising awareness and combating stigma through their communication routes (as mentioned in result 2.2).

WHO will support the Family NGOs in the West Bank and Gaza to develop evidence based messages, and to design and implement activities which can effectively reduce stigma and discrimination against people with mental disorders. Family NGOs will engage with community leaders: religious leaders, mayors, village councils and other power groups to facilitate integration of the people with mental disorders in their communities. They will also engage with the Ministry of Social Affairs and Ministry of Labour to advocate for the rights of the people affected by mental disorders.

Main activities under result 2.3:

2.3.1 Support the development and implementation of mental health anti-stigma activities in West Bank and Gaza

The main outputs of result 2.3 are:

- The six most common public misconceptions related to mental health are identified
- Five workshops targeting community leaders in the West Bank and Gaza are conducted
- Three workshops targeting community members in the West Bank and Gaza are conducted
- Advocacy meetings with Ministry of Social Affairs and Ministry of Labour on the rights of people with mental disorders are carried out
- Materials targeting mental health related stigma published in the local newsletters
- Four meetings take place between 6 CMHC staff and the community members to reduce stigma and misconceptions

4) Stakeholders

The main stakeholders of the project are the Palestinian MoH, represented by Mental Health Unit in the West Bank and Mental Health Directorate in Gaza; PHC and Hospital directorates; support departments such as finance and human resources; WHO and the European Union. They will be closely involved in planning, implementation as well as the monitoring and evaluation of the project. The MoH and WHO will bear the main responsibility for timely implementation of the project and the quality of its deliverables.

However, in order to succeed, the project and consequently the MoH Strategic Mental Health Plan, need the involvement of a broad spectrum of stakeholders: providers of mental health services from the UN (UNRWA, UNICEF), NGOs (IMC, MDM France, MDM Spain, MDM Switzerland, GCMHP, Family NGO-s, TRC, PCC, GUPWD) and the private sector. The MoH and WHO will involve these stakeholders in the development of mental health guidelines, norms, procedures and education materials. Furthermore, the MoH and WHO will ensure coordination of mental health activities through the MHPSS sub-cluster and the Mental Health Thematic Group.

5) Risks and assumptions

One main assumption is the continuation of the Israeli military occupation and associated military operations in the West Bank and Gaza. There is a risk that, if there is a serious escalation of military operations, it could delay or suspend some of the activities, increase the load on mental health professionals and lead to prioritization of the crisis intervention agenda over development.

Another important assumption is the continuation of the current political split between the West Bank and Gaza. This may affect the development of national level legislation, codes of practice and operational plans and is likely to result in project objectives being achieved at different speeds in West Bank and Gaza.

A significant risk is the level of sustained leadership and commitment on the part of the MoH in the West Bank and Gaza to the planned reforms. The existing management structures in the MoH still face major challenges in the effective management of mental health services and the successful
delivery of a reform project. That has been the case for some while now and progress has been made despite this but it remains a risk to the implementation of the project especially as a key aim is to shift the main burden of responsibility for implementation of this project to the MoH.

6) Crosscutting issues: gender, human rights and good governance
The equal rights of women and men are explicit in the human rights documents that form the basis of Human Rights Law. Women and men have the same entitlement to health services, to respect for their human dignity, and to acknowledgement of their equal human capacities including the capacity to make choices. Health services are more effective when they are based on an understanding of the different needs, vulnerabilities, interests, capacities and coping strategies of women and men, and girls and boys of all ages. The understanding of these differences, as well as inequalities in women’s and men’s roles and workloads, access to and control over resources, decision-making power and opportunities for skills development, is achieved through gender analysis.

An extreme but common expression of gender inequality is sexual and domestic violence perpetrated against women. This form of socio-cultural violence contributes to the high prevalence of mental disorders among women. Women with mental disorders face more discrimination and stigma from the community than men, for example, women with mental disorders are less likely to get married compared to men. Moreover, women with mental disorders are more likely to face confinement by their families and thus be forcibly isolated from their relatives and communities.

The project will tackle gender and human rights issues, by raising awareness among mental health professionals and the wider Palestinian public on gender and human rights through the training, awareness raising and behavior change activities. WHO will ensure that gender considerations are appropriately reflected in the guidelines, plans and code of practice to be developed in the scope of the project as well as through the design and organization of gender appropriate mental health services. The project will help the Palestinian MoH to establish data management systems that collect and analyze sex and age disaggregated data and will facilitate the use of this data in design and management of mental health services.

The project will also strengthen good governance of mental health services within the MoH through the development of a code of practice, guidelines and protocols, as well as improvement of information systems, supervision and clinical audit practices.

7) Project logical framework matrix
See Annex I, Supplement A

4. Implementation Issues

1) Project steering committee
WHO will have the overall responsibility for the implementation of the project, in partnership with the MoH. A project steering committee to oversee and validate the overall direction and the policy of the project will be established. The committee will include technical staff from the WHO country office, the MoH and the EU.
Duties of the project steering committee will be as follows:

- To ensure that project deliverables are produced on time and meet defined targets;
- To identify and resolve any obstacles to the achievement of the project objectives and results;
- To maintain partner commitment;
- To make sure that partners agree on common procedures for planning activities, communication, coordination, decision-making and operational procedures for timely and accurate reporting to the EU;
- To ensure appropriate monitoring of the project results and outcomes and that the project data is duly used for learning and project management.

The project committee will convene at least twice a year.

Sub-committees or task forces will be established as required to design and establish frameworks and mechanisms for implementing the various project components.

2) **Project management**

The management of the project will be undertaken by WHO in close coordination with the MHU/MHD at the MoH. This will include: overseeing project activities including securing technical assistance, contracting out arrangements, procurement of equipment and logistics, co-chairing project management and coordination meetings, dissemination of assessment results, visibility and project evaluation activities. The project management team is responsible for keeping records of the activities, financial tracking and reporting back to the EU. The WHO mental health team will work between the WHO office and the MoH, ensuring that adequate time is spent with the MoH to enable proper coordination and transfer of information.

3) **Project staff**

The WHO team will provide technical support and guidance to the implementation of the project through WHO country office staff and selected technical assistance inputs (compare project organisational chart below). WHO will be responsible for the provision of identified technical expertise and advice under this project. To this effect, the WHO West Bank and Gaza office in Jerusalem will appoint an international project manager on a part time basis (25%) who will have the responsibility for overseeing all aspects of the project’s implementation and financial management. The project manager will be assisted by two full-time technical officers who will undertake day-to-day tasks and ensure on-going communication, as well as by a full-time project finance and administrative assistant. WHO will also provide international consultancy support as detailed in the project description and budget.

Support by staff from the WHO regional and headquarters office will be provided for the financial, administrative, logistics and technical roll-out of the project e.g. through project coordination support, monitoring and evaluation. Technical missions may be required to support country operations.
4) Consultancy:
As a mechanism for ensuring the quality of the project outputs, WHO will contract a number of local and international experts to provide technical support to the MoH (and to the project team). These experts will advise both on the overall project, to ensure that the development is taking place in line with evidence based practice, and on individual components. The part time project manager will not be a specialist in mental health as explained below (section 10). It will therefore be important to utilize an international expert on a periodic basis for monitoring and evaluation of the project and to provide advice and inputs as required. This is over and above the consultancy inputs for specific headings as identified under headings 1-3 of the budget. Most of the deliverables of this activities will consist of providing assessment reports and revision of implementation strategies and plans that will help the WHO team to follow quality standards that can be realistically achieved.

WHO will apply a reporting format that will ensure that all the main outputs of the consultancy mission are included. Moreover, all deliverables from any consultant (e.g, guidelines, operational policies, etc) will be reviewed by WHO experts in the regional and headquarters offices to ensure the quality of the products.

5) Communication and visibility
Implementation of the project activities will be carried out according to the annual visibility plans and will adhere to the Joint Visibility Guidelines for EU-UN actions in the Field. Specifically, all communication and visibility implementation of project activities will be done in close cooperation between WHO and EUREP (Annex II, Article 6 of the General Conditions applicable to EU
contribution agreement with international agencies). The visibility plans will include celebration of the international mental health day.

6) Implementation schedule
See Annex I, Supplement B.

The implementation schedule will be updated at project inception (inception report) and for every project report.

5. Project Budget
The total cost of the project is estimated at 1,500,000 Euro. In adherence to the EU requirements all costing is in Euros. Details of project costs are presented in Annex D, Budget for the Action.

For trainings, workshops and consultancies a standard cost per unit is applied based on the market rates, specified as follows:
- 1 week international consultancy: 3.750 Euro (including travel, fee and per diem)
- 2 week international consultancy: 6.000 Euro (including travel, fee and per diem)
- Local consultancy: 800 Euro per week
- Coffee break: 5 Euro per person per day
- Lunch, coffee break, logistics: 30 Euro per person per day

The budget for the first Specific Objective, “Improved availability and quality of MH services at the primary and secondary levels in the WB and Gaza”, constitutes of 353,181 Euro or approximately 24% of the budget. The main type of expenditure under this objective is training, supervision, MH integration and capacity building. One of the means of achieving the planned results is by facilitating subcontracting a local organization in both WB and Gaza. The total amount involved is estimated at 90,235 Euro (budget line 1.1.2.1).

This objective also includes the procurement of horticulture equipment and materials for the development of the rehabilitation programme in Gaza and WB for 30,120 Euro (budget line 1.5.1.4).

The budget for the second Objective, “People in the WB and Gaza seek diagnosis and treatment for their MH conditions”, constitutes 87,785 Euro or about 6% of the budget. 67% of that amount is planned for support and capacity building of the WB and Gaza Family NGO’s during the three years (result 2.1.1).

The project management costs amounts to 801,109 Euro or 53% of the total budget. The staffing includes a part time project manager (25% FTE), 2 National Professional Officers (one to cover Gaza, one to cover WB), a Project Assistant (80% FTE) and the support of an office shared Driver and Finance Officer for one month per year each. The estimated monthly amounts are based on the standard amounts as given by the WHO Regional Office. This budget line also includes a lump sum of 35,000 Euro for Monitoring & Evaluation consultancies as explained under chapter 4.

The field office costs, visibility and audit of partner organizations amount to 120,306 Euro (8% of the total budget).

WHO, like all UN agencies, adds 7% of the direct eligible costs as indirect costs as per FAFA to all project budgets. There is no room for flexibility on this percentage. These indirect costs do not cover direct project costs related to the action such as field office costs.
WHO’s core funding through assessed contributions from Member States has reduced very substantially over the years. As a result, a larger share of WHO’s operating costs, including at country level, has to be met through voluntary contributions. We have to cover these costs through our projects to continue to function. These costs are direct costs and are considered eligible under article 3.2 of the FAFA. They represent a proportionate share of the operational field costs (rent, transport etc) of the WHO West Bank and Gaza offices. This share has been calculated as the average operational costs per staff member per month times the number of full time staff months as included in heading 3 of the budget. The average operational field office costs per full time staff member per month are 984 Euro while the number of full time months of 113 is calculated as:
- Project manager: 25% * 35 = 9 months
- National Officers: 2 * 35 = 70 months
- Project Assistant: 80% * 35 = 28 months
- Finance Officer & Driver: 2 * 3 = 6 months

The average field office costs per staff member per month of 984 Euro can be specified as follows:
- Office rent/utilities/maintenance: 338 Euro
- Security: 368 Euro
- Transportation: 120 Euro
- ITT: 87 Euro
- Other: 71 Euro

The visibility budget of 3.500 Euro will be used to publicise the fact that the action has received funding from the European Union. There is also an amount budgeted for the external audit of external partner organizations. The decision regarding the performance of an external audit of the partner organizations will be made by WHO in collaboration with the EU.

The budget includes a contingency reserve of 39.488 Euro and a PSC rate of 7% is applied as per FAFA.

1) Procurement and financial arrangements

The procurement of any goods, works or services by the WHO in the context of an Action financed or co-financed by the Commission shall be carried out in accordance with the applicable rules and procedures adopted by WHO (Annex II, Article 10, The General Condition applicable to EU contribution agreement with international agencies). An overview of the anticipated contracts is attached in Annex I, Supplement E.

2) Project accounting and auditing

WHO will keep accurate and regular records and accounts of the implementation of the project. Separate accounts will be kept for each Action and will detail all income and expenditure. At the end of the action, WHO HQ will issue a final financial statement certified by the WHO Chief Accountant.

Expenditure of partner organizations will be closely monitored by the WHO project team. A budget has been made available to perform external audit(s) on the funded activities of these partner organizations.
6. Reporting, monitoring and evaluation
The monitoring and evaluation of the project activities will be the responsibility of WHO and the MHU/MHD of the MoH in both West Bank and Gaza. WHO will produce technical and financial reports every six months to monitor the progress of the project activities toward meeting the project’s objectives. At the end of every 12 months period, an updated detailed work plan will be provided, reflecting any changes in the timing or orientation of activities, in conformity of Article 2.4 of the General Conditions.

A representative of the EU will participate in the steering committee meeting for overseeing and monitoring the progress toward achieving the project objectives.

A final evaluation of the project may be carried out by the European Commission.

7. Project sustainability and handover
As mentioned earlier, this project will serve as a primary mechanism for provision of technical support to implementation of the oPt National Strategic Mental Health Plan 2012-2014. Its key aim will be to reinforce the responsibility, technical capacity and leadership role of the MoH for all elements of the mental health reform in the West Bank and Gaza, which is central to the sustainability of the project outcomes and successful phase out of the project. The Project will ensure that the MoH will take responsibility for the project activities, and will facilitate any necessary support from the WHO team. A situation where WHO staff assumes responsibilities which are clearly with the MoH will be avoided. The project will develop a set of process and outcome indicators to monitor the implementation of all phases. Further, when necessary, WHO will involve its regional and HQ experts and external consultants to ensure the quality of the materials and tools produced with the support of the project.

To guarantee the smooth implementation of the project, the MoH (West Bank and Gaza) and WHO will develop a work plan and an MoU that will outline roles and responsibilities of each party in the project as well as critical milestones and deadlines. The implementation of the MoU and the work plan will be monitored by the project steering committee.

In the scope of this project WHO will not provide mental health services itself, but will support the Palestinian MoH to decentralize and scale up public mental health services in the West Bank and Gaza. The project outputs will be taken over by the MoH upon their development throughout the duration of the project, which makes a dedicated handover process less of a requirement.

Nevertheless, in the final year of the project WHO and the MoH will develop a handover plan to take a stock of the project contributions to the mental health reform and to outline the project phase-out process. This process will culminate in a handover workshop which will mark the end of the project and formal takeover of the project outputs by the Palestinian MoH.