Technical Evaluation for AFD Mental Health Project

FINAL REPORT

Prepared by Olivier Appaix and Dr Abdelhamid Afana

CONSEIL SANTÉ

92, boulevard Victor Hugo
92110 Clichy - France
Tel: +33 1 55 46 92 60
Fax: +33 1 55 46 92 79
E-mail: health@conseilsante.com

SOFRECO

92-98, boulevard Victor Hugo
92115 Clichy Cedex - France
Tel: +33 1 41 27 95 95
Fax: +33 1 55 46 92 79
E-mail: health@sofreco.com

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LIST OF ACRONYMS AND ABBREVIATIONS

AFD	Agence Française de Développement
CCE	Centre for Continuing Education (at BirZeit University)
CMHC	Community Mental Health Centres / Care
DC	Al Bireh / Mohamed Said Kamal Documentation Centre
DGCI	Direction Générale de la Coopération Internationale
DSM	Diagnosis and Statistical Manual of mental disorders
EVT	Exposure to Violence and Trauma
FCI	France Coopération Internationale
FTPs	Financial and Technical Partners
GCMHP	Gaza Community Mental Health Programme
GP	General Practitioner
ICD	International Classification of Diseases
IT	Information Technology
MDM-F	Médecins du Monde – France
MDM-S	Médecins du Monde – Switzerland
M&E	Monitoring and Evaluation
MH	Mental Health
MHD	Mental Health Directorate (at the MoH in Gaza)
MHFFS	Mental Health Families & Friends Society
MHU	Mental Health Unit (at the MoH in Ramallah)
MoH	Ministry of Health
MSK DC	Mohamed Said Kamal Documentation centre
oPT	Occupied Palestinian Territory
PA	Palestinian Authority
PAPP	Programme of Assistance to the Palestinian People
PCC	Palestinian Counselling Centre
PHC	Primary Health Care
PMU	Project Management Unit
PTSD	Post-Traumatic Stress Disorder
SCAC	Services de Coopération et d'Action Culturelle
SOP	Strategic Organization Plan
ToR	Terms of Reference
UNDP	United Nations Development Programme
UNRWA	United Nation Relief and Work Agency
WHO	World Health Organization
SC	Steering Committee

EXECUTIVE SUMMARY

Project context

As a substantial body of scientific literature has shown in recent years, needs for mental health services are immense in the occupied Palestinian Territory (oPT) where the population, of now about 4.1 million (2.5 million in the West bank and 1.6 million in the Gaza Strip), is growing rapidly in a very challenging social, political and economic context and in a highly fragmented territory. Mental health or psychological disorders are extremely varied, and the burden of disease is large, especially with the impact of the ongoing and long-lasting conflict that has affected the region. Around 44% of the total population is made up of internally displaced people. Post-traumatic syndrome disorder (PTSD) is highly prevalent, along with more regular conditions such as depression and anxiety.

The oPT, however, lacks a solid web of qualified mental health institutions and professionals from various professional backgrounds. It has only two psychiatric hospitals (one in Gaza and one in Bethlehem) and a few mental health centres, most of which have been recently developed with the support of the World Health Organization (WHO) and funding from the European Union, and with the support of the Agence Française de Développement (AFD) through the United Nations' Development Program (UNDP), which is the object of the present evaluation. In the public sector, mental health services are currently provided through fifteen communities mental health centres (CMHCs), five of them located in the Gaza Strip. There are also some mental health services provided by Primary healthcare (PHC) centres. The oPT also has a number of private providers and of non-governmental organizations (NGOs) working in social and psychological relief, some of which have decades of experience in psycho-social work with populations that have been subject to many stressful events. The United Nations' Relief and Work Agency (UNRWA) also offers some level of services through a psychosocial school service program, but in UNRWA schools only. At the Ministry of Health (MoH), the department in charge of mental health is the Mental Health Unit (MHU), based in Ramallah.

Overall, funding for mental health services is scarce and its visibility in health policy and at the institutional level is very limited. Moreover, mental healthcare suffers from stigma in a society that puts the individual second to the collective organization, and particularly to the family. Many mental disorders are hidden. Coming out to look for help is difficult if not out of the question for many.

Project design and set up

Following up on efforts undertaken previously by the French Cooperation and other partners, such as the WHO, the Agence Française de Développement (AFD) picked up a project earlier prepared by the French cooperation and partnered with the UNDP to fund and implement a 3-year project (2008-2010). Implementers had already been selected when the AFD and the UNDP took over.

The overall objective of the project was to "improve male and female Palestinian mental health condition through improving the access to mental health facilities, developing capacity of mental health care staff and improving quality of the services through action oriented research."[1] The project was to cover both the West Bank and the Gaza strip. The strategy was based on the community mental approach by establishing community mental health centres that work collaboratively with primary health care and other mental health services.

Specifically, the project intended to:

- establish 3 new CMHCs in the West Bank, conceived as referral centres, through the construction or rehabilitation and equipment of CMHCs in Halhul (north of Hebron), Nablus and Jenin, with the one in Halhul serving as a pilot for paediatric interventions;
- to establish one specialized documentation centre (DC) (in Al Bireh / Ramallah);

[1] Project document of AFD mental health project.

- to recruit and train personnel for the 3 CMHCs and the DC (18 people in all),
- to ensure better integration of mental health services with primary health care (PHC) services through training of PHC personnel to improve their capacity to screen, diagnose and refer patients to the CMHCs, and through the conception and implementation of a referral system;
- and to perform action-oriented research studies.

The project's Financial Agreement was signed on April 18, 2007, between the UNDP (the implementer) and the AFD (the donor)[2]. The initial duration was set at 48 months. However, due to the reluctance of donors to work with a government where Hamas would have a representation, the actual implementation did not initiate until March 2008. The duration of the project had to be extended twice, including an "Exit Strategy" endorsed in June 2010 to ensure a proper conclusion to the project by June 2011 and then again from June 2011 until June 2012. The project's budget was set at 2,74 million Euros.

The original third component of the project (applied research) was not initiated, partly because its original design was deemed not suitable.

Implementers selected were:

- the MoH's Mental Health Unit (MHU), based in Al Bireh / Ramallah;
- Médecins du Monde France (MDM-F) and Switzerland (MDM-S) for training and supervision, respectively, at Nablus and Jenin CMHCs, and at Halhul CMHC;
- the Juzoor Foundation for Health and Social Development (Juzoor), and the Gaza Community Mental Health Programme (GCMHP) for training of PHC personnel in the West Bank and in Gaza, respectively;
- Bir Zeit University, as a contributor to training (of the Documentation centre's staff) and as developer of E-Learning modules in cooperation with Juzoor.
- Later on, the Palestinian Counselling Centre (PCC) was recruited to perform supervisory work with the Nablus and Jenin centres, once the contract with MDM-F was terminated.

The project was implemented by the UNDP/PAPP through a Project Management Unit (PMU), established in March 2008, based next to the MHU. A Steering Committee was set-up, comprised of representatives from the MoH, AFD, and UNDP/PAPP. The UNDP's office in Gaza provided help to monitor training activities with the local implementer (GCMHP). The PMU had one director (Feletcia Saleh), one technical advisor (Dr Sylvie Mansour) and one secretary (Nour Salous). A deputy project manager was also recruited (Hani Indiyeh). Mrs Saleh left the project in mid-2009 and was not replaced. Sylvie Mansour had been associated early on, when working with the French Cooperation, to the design of the project (back in 2004-5). She was responsible for designing the training modules and conducting supervision. To a large extent, until her departure of the project in March 2010, she served as co-project manager. She was not paid by the project's funds, as she was by the France Coopération Internationale (FCI) organization.

Objectives and methodology of the technical evaluation

As per the terms of reference the objectives of the present technical evaluation were:

- provide the project's main stakeholders (MoH, UNDP/PAPP, AFD) with sufficient information to make a knowledgeable judgment about the performance of the project;
- document the lessons learned by the main actors throughout the project;
- provide practical recommendations and baselines to the stakeholders for future interventions.

The team, made up of two persons – one socio-economist in health and development and evaluation specialist (Olivier Appaix), and one psychiatrist and community mental health specialist (Dr Abdelhamid Afana) – first drafted an inception report containing a context analysis (reproduced in the

[2] Third-party cost-sharing agreement between the Agence Française de Développement (AFD) (the donor) and the United Nations' Development Programme (UNDP). Signed on April 18, 2007.

present report), a brief description of the project and a review of documentation already collected from the PMU. It also submitted there a methodological framework, as well as two questionnaires to be sent to personnel that had benefitted from training at both the CMHCs and the PHC sector.

The consultants then spent 2 weeks in the oPT in February-March 2012. Logistical limitations associated with the difficulties to obtain permits and to travel around the territory limited the capacity of the team to visit sites more than once. However, they were all visited and their personnel interviewed. The same was done with all implementers and major stakeholders. Further documentation was collected during the field visit. A total of 4 focus groups were organized with PHC trainees and with personnel of all three CMHCs. Questionnaires were also collected from 17 staff of the CMHCs, 13 out of 54 PHC trainees in the West Bank and 9 out of 15 PHC trainees in Gaza. Complementary phone interviews were conducted with CMHC directors, and with trainees.

Analysis of the project's relevance:

The project has correctly inserted itself in the overall effort to develop a Palestinian mental health system to address the high and growing prevalence of psychological disorders and mental health problems in the Palestinian population. In particular, it has aligned with the National Health plan's focus on the needs of the Mental Health programs with a shift from institution to community base care and the integration of mental health services with primary health care services. Such integration is highly needed for various factors related to stigma, limited mental health professionals, and the need to improve the capacity of PHC personnel to better detect and deal with psychological disorders, including the building of a referral / counter-referral system, which lacks. The project has also addressed the need to increase the number and the qualification of mental health professionals in Palestine, leading to the recruitment and training of 19 mental health professionals at the four centres created, who have been eventually transferred to the MoH's payroll thanks to the project's intervention with Palestinian authorities.

The attention given to children's and adolescents' mental health was a very welcome initiative, given the lack of pediatric capabilities in the oPT in that sector, while half of the population is under 18 years of age.

The development of the community-based approach is very relevant to ensure a more holistic approach to mental health. However, training designed for this project, both to CMHC staff and to PHC personnel, did not provide with sufficient coverage of the community-based approaches. Still, there were introductory sessions to the community mental health approach and mental health promotion. Yet, the social determinants of mental health such as unemployment, poverty, violence, human rights abuse, restriction of movements, education, etc, emphasizing the interpersonal aspects of the person's functioning, were not well covered.

Similarly, there has been a lack of psychotherapy skills in the training curriculum, while the methodology used to deliver some of the training modules to the mental health professionals recruited to the CMHCs was not well adapted to the local context. The non-implementation of the research component was unfortunate as it could have been a good opportunity for the MH sector, and the MoH in particular, to better understand and document the ethnographic and socio-cultural tenets as well as the epidemiological profile of mental or psychological disorders in Palestine, and, therefore, better understand the population's needs in terms of services. The lack of research has also limited the capacity of the project to establish a baseline.

Even if the choice of implementing partners had been conducted prior to the involvement of both the AFD and the UNDP in the project, it was still appropriate given the lack of internal capacities at the MoH at the moment of the project's design, even if the MoH was not satisfied with the process, which is a legitimate concern.

Aspects of Coherence / Coordination / Complementarity:

Altogether, there was good complementarity between the UNDP/AFD project and those of other partners of the MoH, essentially as all these partners initially worked with the MoH to develop a common approach to the development of the MH public sector. The 3 new CMHCs in the West Bank complement a small but growing network of CMHCs. The objective of the Palestinian Authority is to have one CMHC at least in each of the administrative districts. Currently, 6 of the 11 districts are

covered with at least one adult CMHC, with one more for children and adolescents in Halhul. The documentation centre is also a welcome addition to a field where the building of data bases and of knowledge is instrumental to improve the relevance and the quality of the response.

However, there is still a lot to do to develop the collaboration and complementarity between the various actors of the sector and the institutional relevance of the MoH, and particularly of the MHU, which still needs to be strengthened, something that the project could not really contribute to.

Analysis of the project's efficiency:

The choice of the project's implementing agencies (UNDP and its partners) was probably judicious given the oPTs' particular and challenging context. The location of the PMU next to the MHU's office was also a rational choice. However, the UNDP's Jerusalem office was not fully equipped to administer a project with soft components of that kind since it had mostly experience and competence in infrastructures. The good pace of realization of the infrastructure and the capacity to solve problems met along the way of these activities has demonstrated that competence.

The absence of a PMU presence in Gaza and the extreme difficulties for staff, even UNDP Palestinian staff, to travel from one part of the territory to another, made it more difficult to follow on the activities planned there. The PMU staff only visited Gaza in a couple of occasions, and belatedly. Even with UNDP Gaza office's support in the following up of activities there, this was not enough to ensure proper implementation and the component allocated to the GCMHP, very unfortunately, had to be terminated before its completion.

The project lacked a solid monitoring and evaluation framework as part of its design. Planning was also weak. Annual work plans were not elaborated, presented and discussed with the Steering Committee that should have approved them. All of this was detrimental to the efficient implementation of the project. Moreover, the institutional set up of monitoring, involving reports issued by a variety of partners, added to the confusion and was not consistently implemented. The Steering Committee only met 5 times in all, between September 2008 and January 2010. The UNDP, which was in charge of supervising the project's implementation, had its own internal financial monitoring system, but this was not equivalent to a comprehensive monitoring and evaluation (M&E) set up, shared with all stakeholders, discussed in Steering Committee meetings and used for decision making. A tentative (retro-active) logical framework was produced by the evaluation team and made available to the UNDP for possible use in future projects in mental health (see Annex 7).

Evaluation of the project's effectiveness:

The project has led to the creation of three well established Community Mental Health centres, in Jenin, Nablus and in Halhoul where 30 professionals, 17 of whom recruited by the project, and now fully part of the MoH, are effectively delivering a wider range of services. They now serve as specialized referral centres. The Halhoul centre is the first of its kind in the West Bank as it serves only children and adolescents. Following the MoH's policies, those centres deliver mostly free services for psychotic patients, but charge for neurological cases that they still have to deal with, including epilepsy.

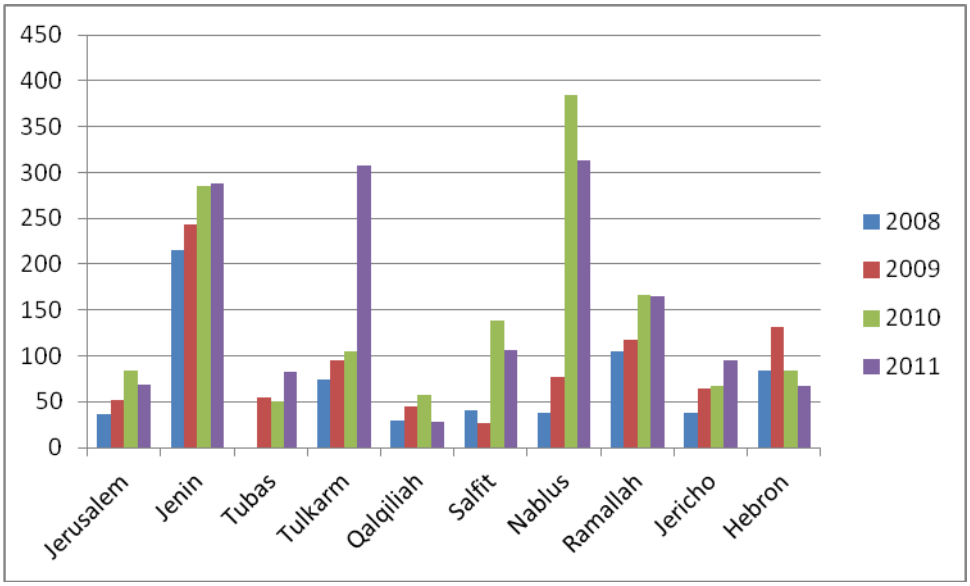
The centres are welcoming and modern structures, rather well constructed and equipped, with some limitations as to accessibility (distance to city centres and lack of elevators) and lay out (Jenin). They are opened from 8 am till 3 pm, only.

The number of patients dealt with increased very rapidly, especially in 2010, following their opening in the spring of 2009. It is not as fast now (2011 vs 2010). In 2011 they combined to attend a total of 950 new cases, a 13% increase over the previous year, all of it recorded at Halhul (+50%), as shown in the table below.

New cases referred to the centres		**2009**	**2010**	**2011**
Nablus CMHC	opened in May, 2009	77	312	316
Jenin CMHC	opened in April, 2009	243	296	284
Halhoul CMHC	opened in June, 2009	53	232	350
Total		**373**	**840**	**950**

Source: AFD/UNDP Project Management Unit

2008-2011 total detection of new mental health cases (plus epilepsy) in CMHCs of the West Bank

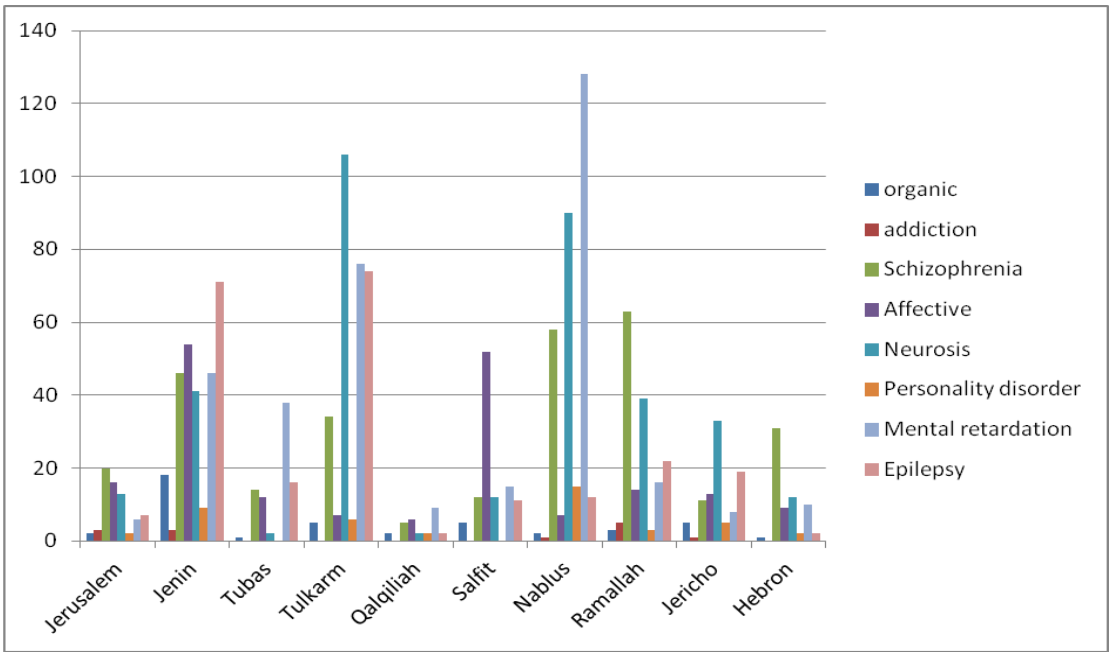


Source: Ministry of Health

The increase in the total number of cases being detected and dealt with in districts where the CMHCs have been completed thanks to the project is significant, particularly so in Nablus as shown by the graph above. Jenin, Nablus and Tulkarem rank first, by far, in the number of cases detected.

The most common conditions diagnosed and treated by the centres are neurosis and mental retardation (see breakdown of conditions in 2011 in the West Bank).

Detection of new mental health cases in all CMCHs of the West Bank in 2011 (Halhul excluded)



Source: data from MoH (based on statistics from CMHCs)

54 Primary Health Care professionals (nurses and doctors essentially) across the West Bank were trained in mental health issues. In the Gaza strip, the project failed to achieve its objectives. It was involving only 20 PHC personnel, for the same purpose as in the West Bank. But the activity there faced an irretrievable breakdown for reasons not well clarified, even in spite of the reduction by one third of the number of hours dedicated to the training modules (from 48 to 32 hours).

Professionals working at the CMHCs were given the opportunity to participate in advanced training workshops, visits to regional and international institutions to gain knowledge and experience. Some professionals working at CMHCs are now involved in training other professionals.

If understanding of psychological disorders, their variety, their complexity and of the variety of responses available to meet them, has increased, the training has not been able to provide all the tools to effectively detect some of the most common psychological disorders, such as depression and anxiety, which are highly prevalent. Most subjects have been covered superficially, therefore limiting the capacity for professionals to build strong therapeutic competences. In particular, psychotherapeutic techniques were not sufficiently covered and full services are currently not available, apart from "fast-track psychotherapy". The lack of time and resources does also play a limiting role in this situation. Halhul is now able, however, to offer 50 mn psychotherapeutic sessions to its patients. Yet, some additional insights and more practical case management capacity have been introduced, especially through family and group therapy techniques, with more practical features delivered through the training modules and ad-hoc workshops.

Due to a lack of transportation means, CMHCs are limited in their capacity to work in the community (in the patients' daily environment), though they do reach out to the community as much as they possibly can.

In terms of treatment protocols, it appears that the prescription of drugs still remains rather systematic, especially for chronic cases. In part, a reason for this is the fact that psychiatrists remain too heavily burdened with an average of 30-70 patients a day, whom they cannot see for more than a few minutes each. They are tiring up and there is a risk to see them leave their positions if their burden is not relieved soon. The implementation of an appointing system, however, a first in the public health sector in the oPT, has allowed to reduce the burden on care providers at Halhul. It has started to produce some effects in Jenin but is absent in Nablus. The case loads increase, anyway, also because the centres have established a reputation that attracts new cases (20% are self-reffered at Halhul and 30% at Jenin CMHC).

Apart from the overall design of the training component, which experienced delays, other issues limites the capacity of the component to deliver its full outcome. Some of the training provided by MDM-F suffered from inappropriate logical sequencing of the modules, from language and translation limitations and from a lack of cultural sensitivity and of preparation in a few cases. Corrective measures were taken, with the support of the project's technical advisor, but the involvement of the NGO was terminated in July of 2010, after the completion of training, and it was replaced by the Palestinian Counselling Centre (PCC), which conducted supervisory activities.

Integration of mental health services into the PHC sector has been an important focus of the training delivered and some aspects have been effectively delivered, particularly as regards an apparently improved capacity to diagnose and refer, especially children's conditions (half of the modules were about children in fact). However, there is still quite a bit of ground to cover regarding referrals, despite attempts to unify the system. Each centre, and even each organization in the oPT, has its own referral system. In Jenin, the centre has been able to build a more integrated system with a nearby PHC centre and a referral booklet now in use in Jenin and Salfit was produced with MDM-F's support.

Supervision activities were conducted, during the project's implementation, by Sylvie Mansour, Julia Granville, Souha Shehadeh (at Halhul) and the PCC. If it is now being conducted internally by CMHC psychiatrists themselves, there is, however, no formal external supervision and related MoH policy since the completion of training.

The Documentation Centre is a rather well equipped facility, staffed by a librarian and an IT specialist, who have been trained at Bir Zeit's Main Library and IT department respectively. Until recently it was unable to reach out to the community of potential users for the lack of an IP address. This was solved recently, which should help the DC expand towards a more complete scope of services.. Interviews showed that mental health professionals still do not know well the benefits they could draw from using the centre's services, when they know about it, which is not the case for many of them still. The lack of decentralized smaller libraries or inventories of basic publications that the DC could administrate may also explain the lack of interest or knowledge. Medical students from nearby universities do use

the centre, however. Also, the DC offers its space once monthly for mental health professionals' gathering, where cases are discussed, materials and pharmaceuticals presented.

An anti-stigma campaign was also conducted by the project, which involved the creation of a series of radio programmes for one local station, community work, including the distribution of leaflets, and school visits. This was performed rather belatedly, mostly at the beginning of 2011, with the help of PCC, the CMHCs' staff and the MHU.

Asssessment of the project's impact

Overall, the establishment of the three CMHCs and the recruitment of their staff, have allowed significant positive developments of the mental health sector in the West Bank. In particular, they have increased the qualification and the number of mental health professionals who are able to provide reasonably diversified and more qualitative mental health services. This can be seen, for example, in the reported improvement in the quality of referrals from the PHC level and in the uptake in attendance at the centres. Patients are even referred from the private sector, but this is also due to the fact that services for psychological disorders are provided for free at the CMHCs.

This positive impact can also be seen through the confidence and satisfaction of the CMHC staff, who feels empowered and capable of delivering a wider range of services and to self-supervise its own work. CMHC staff has taken initiatives to reach out to the community, despite their lack of transportation and communication means, and to the PHC level as well, particularly in Jenin.

On the other hand, counter-referrals of patients coming from PHC setting to these centres back to where they came from is not frequent, except at the Jenin CMHC.

The awareness about the importance of dealing with mental health issues has increased, including among the population apparently, though this could not be measured, and the level of stigma has decreased, at least within neighbourhoods and communities where the CMHCs operate, as reported by CMHC staff. The sizable share of self-referrals is an indication of the fact that the word spreads and that fear about mental health is receding.

To some extent the centres are victims of their success. The increase in the volume of activity puts a lot of pressure on the psychiatrists who have to deal with way too many patients per day, especially in Nablus, and even in Jenin despite its appointment system. There, psychiatrists cannot see patients long enough and grow frustrated.

There have been a few unintended effects of the project:

- the CMHCs have received many medical students who come to learn about mental health care in their midst, which is not easy to absorb for a very busy staff;
- the staff now self-supervises (the centres' directors organize weekly supervisory sessions with their staff) and even self-educates new skills by conducting its own research of material, which tells a lot about their willingness to do things right and to improve, as well as about their understanding of the importance of supervision;
- local NGOs involved in the project, namely Juzoor and PCC, have learned from the project themselves, have developed their capacity, particularly in paediatric mental health care.

Evaluation of sustainability of the project's outcomes

The most important aspects of sustainability of this project is the upbringing of human resource, the building-up of human capital through training, particularly crucial and difficult in such a politically unstable environment where the trend towards an increasing number of cases of psychological disorders is worrying.

The inclusion of the CMHC and DC staff into the MoH's own staff is a key positive element of the sustainability of the products delivered by the project. The increase in volume of activity, resulting from the apparent increase in the diversity and quality of services, is another factor that should enhance the sustainability of those products. However, a higher volume of activity also results in more pressure on quality, which, in turn, puts stress on the centres and could jeopardize their future. The absence of formal supervision and follow up systems has negative impact on the long-term sustainability, quality level of services delivered and on putting mental health professionals at risk of burnout syndrome.

The lack of funding, compounded by a lack of institutional footing at the MoH, which results in a lack of capacity to exert leadership for the MHU, could also be detrimental to the long-term operationality of the centres and, beyond, of the status of MH services within the public health sector. This is true also of the documentation centre, where the lack of a documentation budget is threatening its medium and long-term relevance.

Conclusions:

The AFD/UNDP Mental Health Project has relevantly introduced the philosophy of community mental health services, which was by and large absent in the oPT until then, though training provided both to the newly recruited staff of the three CMHCs and to the PHC personnel, was not able to provide with all the necessary tools and competences needed to fully implement this particular approach.

In particular, the project has allowed the development of capacity in mental health care for children and adolescents, which was virtually non-existent in the public sector before, even when half of the population is under 18 years of age and is particularly exposed to many factors of mental or psychological disorders. In a very difficult context, both socio-politically and institutionally, the project has led to the creation or re-creation of three functional, well equipped and welcoming community mental health centres that are reasonably accessible in economic terms as services to neurotic and psychotic patients are free of charge. A mental health-dedicated documentation centre has also opened.

The project has allowed the expansion of a more qualified and motivated mental health workforce and of more capacity to deal with mental disorders at the primary care level, in the public sector, and, globally, of that sector's ability to better detect, screen and respond to mental disorders. Even the non-governmental sector, which has implemented some of the project's most important activities, has benefited from the project. In all, the project has helped develop a more holistic and integrated response, using an approach that is closer to the community and its reality.

The CMHCs have become an important part of the psychological support provided to communities that are under a lot of stress. They have also become an important fixture of the overall healthcare system. And to some extent, they are victims of their own success with growing workloads that put pressure on their resources and may jeopardize the achievements made in quantity and quality of service. This also tells about the large volume of still unmet mental health treatment and care needs in the territory. These risks are compounded by those inherent to the overall healthcare system and by the political and territorial situation. The context, in which two portions of the territory are not only separated physically but also politically, makes it very difficult to conduct harmonized policies and coherent activities.

The weakness and confusion of the institutional set up of MH at the MoH also limits the capacity of the project's outputs to perform their effects as fully as desirable. This applies, for example, to supervision and to the integration of community services with PHC settings. This also reflects on the lack of an efficient and unified referral / counter-referral system, despite useful work undertaken by the project in that area.

There have been some shortcomings in the project's implementation, both in terms of processes and of outcomes. The abandonment of the research component, the abrupt termination of activities in Gaza as well as difficulties met by MDM-France has contributed to limit the scope and the impact of the project. The lack of planning and of a well-structured comprehensive and opened M&E system has also undermined the efficiency of implementation and, as a consequence, the capacity of the project to fully perform its activities, reach its objectives and produce its impact.

On the other hand, the project has demonstrated flexibility, has expanded on its original scope in the training component and has eventually managed to achieve most of its main goals.

The project has already had a measurable or perceivable impact on the mental health services and on their users, with a reduced sense of marginalization, improved service conditions, a higher sense of purpose and achievement, a more involved community, or a better integration of services with the primary care level.

However, the quality of some of the deliverables, particularly training, has limited the scope and the depth of the impact. The training received provided relatively few practical tools for professionals to use in their practice, both at the CMHC and PHC levels, especially as regards psychotherapeutic services. Yet, training delivered has developed the ability to approach someone's health more holistically, to understand the person's background and context.

Looking forward, there still are many challenges ahead for the mental health sector and services in the oPT, some serious, including the lack of funding and the weak and confusing institutional set up of mental health at the MoH and beyond. Collaboration between all partners, public and not, Palestinian and from outside is probably still necessary and even more needed in order to ensure the sustainability and the expansion of services established and provided.

Recommendations:

Regarding the CMHCs:

- CMHCs should open for more hours than they do today (8 am – 3 pm) with more staff (particularly psychiatrists and clinical psychologists, psycho-analysts)
- Even the type of services offered in all centres
- Even the number of staff working in all centres
- Complete the coverage of the territory in CMHC services
- Develop psycho-therapeutic services, particularly through structured short psychotherapy courses such as cognitive behaviour therapy, short term psychodynamic therapy, etc.,
- Develop preventive and promotion interventions
- 5 more centres would need to be established, at least in Jerusalem, Tulkarem, Jericho and Qalqilya (the CMHC that the Italian Cooperation had started to support there is not completed and is severely under-staffed and equipped). Bethlehem does not have a separate CMHC, since those services are provided at the psychiatric hospital. Therefore, Bethlehem should probably also benefit from a dedicated centre with specialized services. This does not invalidate the existence of services currently offered at the hospital, provided they are delivered to patients residing at the hospital.
- Develop an unified referral system
- Keep creating and enforcing appointment systems
- Establish advisory boards for each CMHC in order to monitor their work and help them achieve their goals. These boards should associate district PHC directorates, self-help groups or family associations (such as the MHFFS), together with the head of each centre.
- Maintain and reinforce the community mental health approach in order to avoid that centres created become mini-hospitals or overly specialized psychiatric or mental health institutions, with some being specialized in a certain disorders like a centre for depression, or anorexia, etc.
- Conduct health promotion activities in order to raise awareness by conducting health promotion activities for the general population, especially targeting rural communities, to inform community members of the importance of mental health, the value of complying with healthcare providers' referrals, free-of-charge healthcare services. Parallelly, promoting and advocating client's rights for services, rehabilitation, education, including emergency MCH referrals, should be actively pursued.
- Improve the newly established CMHCs by recruiting well-qualified professionals, developing more specialized psychotherapeutic courses for different disciplines, which also means to provide these professionals with better salaries, within the administration's scale, so as to attract well qualified individuals;
- The MoH should adopt a collaborative integration approach where both mental health professionals and healthcare professionals work together in the same clinic/centre to assess those in need of health care, working to address both physical and mental health needs of the patients/clients.

Regarding Training:

- Include primary care professionals from private sector and NGOs in the next round of training,

- Next rounds of training should also be more focused on specific aspects of mental disorders, such as anxiety, depression, PTSD, ADHD/ADDD, etc.
- There is a need for special courses in counseling skills for PHC workers of various levels. The lack of child psychiatric services is particularly acute. There is, therefore, a specific need there that should be taken into account in future activities supported by development partners, in agreement with the AP and its mental health strategy.
- Ensure follow-up of the training once it has been delivered. This should actually be part of an overall supervision policy that is definitely needed in MH. A strategy and plan in that regard will need to be drafted, and should be allocated sufficient resources for their implementation.
- A training policy and strategic training plan should also be drafted that should create coherence with the overall SOP and the supervision strategy. It should, equally, be granted sufficient attention and resources.
- Identify and establish a pool of qualified local and regional trainers (mental health professionals) who can give lectures, spread awareness about mental health.
- International trainers have to be selected based upon identified needs, with ToRs approved by stakeholders.

Documentation Centre:

- Develop online services, now that an IP address has been granted.
- Branch out to CMHCs for the creation of mini-libraries of essential publications
- A communication campaign is needed to enhance the DC's visibility, added value, and funding
- Secure a recurrent documentation budget.

Other recommendations to the Ministry of Health:

<u>The Bethlehem psychiatric hospital:</u>

- Shutting down the Bethlehem hospital is not an option in the near future.
- Ensure rehabilitation and modernization of the departments still not renovated is an emergency.
- The psychiatric hospital's role in training should be expanded so that it becomes a university-based hospital for all mental health professionals.
- Parallely, a solution needs to be found to better serve the population territorially in emergency and severe cases care, particularly for acute cases and short-term internment needs, since the West Bank only has one mental health hospital, as does the Gaza strip.

<u>Self help groups:</u>

- There is no clear recognition in the governmental policies, even in the mental health plan, of the role that self help groups can play in mental health prevention and promotion, help to patients and their families, and to the community development at large. This needs to be corrected.
- MHFFS-like associations and groups should be created – or chapters of the MHFFS – in all districts of the Palestinian territories, and supported.
- They should be part of an advisory board that the team also recommends should be set up to govern the CMHCs.
- Support to the creation and empowerment of family associations and self-help groups seems an important step to undertake in order to both de-stigmatise further MH and to bolster the participation of the community in the community approach now promoted in the oPT.

<u>Organization and Management of the mental health system:</u>

The evaluation team has seen high willingness from the MoH and the Mental Health Unit to improve the management system. However, the team recommends the following steps to be considered:
Re-structuring the mental health services at the national level taking into consideration:

- The mental health services at both primary and tertiary levels have to be restructured and consolidated under one independent Mental Health body within the framework of the health and social services and to be linked with the executive management and committee at the national level;
- Establish a Mental Heath Commission responsible for the mental health services delivered in the oPT in all settings.
- A strategy should be developed to avoid the brain drain and encourage Palestinian nationals in the Diaspora to contribute in building strong mental health services;
- The managerial skills of current management have to be developed;
- Strengthen the relationship with other local academic institutions, NGOs, and patients and families associations in order to create a more integrated MH sector where cooperation and better use of resources are enhanced;
- Build a management information system (MIS) for better reporting and provision of data;
- Clearer mandate of the mental health unit with full authority over mental health services including human and financial resources;
- A unified records system that links facilities and tracks client care is necessary for a functional referral system.
- Enhance research studies, particularly in areas related to clients' rights, access to mental health services, effectiveness of community mental health services, etc.
- The MoH should help mental health professionals establish professionals' association that would provide accreditation and licensure.
- A supervision strategy needs to be drafted.
- Help professionals to establish their professional associations,
- Help patients' families to establish their help support groups,
- Support the development of professionals' standards and code of ethics.

The evaluation team strongly recommends that the Mental Health Unit endorse supervision as a professional policy for mental health practitioners. It recommends that the group self- or internal supervision modalities now in place ("institutional supervision") be maintained and that it start Interpersonal Recall Supervision (IRP) to increase the therapists' awareness of the covert thoughts and feelings of the client and self and blind spots.

Recommendations to the UNDP:

- Maintain commitment to the collective efforts towards the implementation of the National Mental Health care policy and plan (the SOP), and more particularly, support the efforts to expand the CMH program to the entire Palestinian population.
- The UNDP should keep supporting the mental health sector in the oPT. To sustain this support it should recruit a mental health specialist with substantial competence in community approaches. This person should also have a strong research experience. This person should be employed by the UNDP and should be advisor / consultant to the UNDP-managed projects.
- In future projects and programs, the UNDP should encourage the implementation of a strong M&E and piloting system (including annual work/activity plans sanctioned by the Steering Committee), including a set of indicators to be used to monitor advancement towards targets and objectives (both output and process indicators), establish a baseline (using the same indicators), ensure the

regularity of SC meetings, and plan for exit strategies. Logical frameworks and scorecards should, therefore, be systematically part of any program and project design, and strategic and operational planning a mandatory managerial activity. A mid-term review should also be planned as part of the original project plan and budget, not only a final review.

- Selecting local or international training institutions has to be based on tendering. Selection criteria must be identified according to the training objectives, with terms of reference that should include the respect and promotion of the rights of candidates (provision of certificates for example), the consideration of the particular cultural and socio-political context, of all which should be strongly emphasized in the intervention's terms of reference.

Recommendations to the AFD:

- In line with the AFD/UNDP mental health project, and to ensure complementarity with other donors' involvement in the health sector, the team recommends that the AFD continue funding the mental health sector due to its high priority needs, and more particularly the area of community mental health services. Among the main areas that should receive specific attentions are: developing clear models of integrating mental health into PHC services, consolidating mental health management, designing mental health policy based on the needs with inputs from various sectors, establishing professional standards, and expanding the network of community mental health services, are all areas to be emphasized in the next project cycle. Work closely with the MoH to improve working relationship and integration of services for a better implementation of the mental health services and provide a more prominent place for mental health services in the overall health system in the oPTs.

Other recommendations:

- With the Palestinian Authority in charge of implementing the National Mental Health Strategy and plan, it is important that all efforts, from all partners, including international NGOs and other related organizations, be associated with the strategy and integrated within its programs.

1. INTRODUCTION

Mental health has been under-funded and under-addressed from a systemic point of view in the occupied Palestinian Territory (oPT) until recently. The needs, however, are immense, in a context of continuous and prolonged strife and stress for most of a rapidly growing population confined in small and fragmented territories, where movement is heavily constrained, the economy is extremely fragile and nationhood a very difficult enterprise.

The project, whose final and only evaluation is presented in this report, has been part of a more global effort to strengthen the mental health system in the oPT, including the development of a national mental health strategy and framework and of a comprehensive and more holistic response to the vast and complex psychological and mental health challenges and needs faced by the Palestinian population. This led the World Health Organization (WHO), the AFD, the UNDP and the Ministry of Health (MoH) to work together to develop a community-based approach to tackling treatment and care while ensuring a more integrated response involving all levels of care.

The AFD Mental Health Project was one of several main projects undertaken under the MoH's leadership, including a project conceived by WHO and funded by the European Union and work conducted by Médecins du Monde (MDM) Spain at the CMHC in Salfit.

The main objectives of the AFD-funded project were to establish three new community-based mental health centres (CMHCs), one specialized documentation centre, to recruit and train personnel for the three CMHCs, ensure better integration of mental health services with primary health care services through training, the conception and implementation of a referral system, and the performance of research studies. The CMHCs were conceived as specialized referral centres, while training was provided to staff recruited to work in those centres and to selected primary health care (PHC) staff in order to strengthen their capacity to better screen, diagnose, treat and refer cases.

The AFD project was assigned to the UNDP for implementation. Project's operators had already been selected when the project was first designed with the French Cooperation's help in 2004-2005. That project had to be put on hold because of changes in the French Cooperation's organization and due the political context stemming from the election of Hamas to power in 2007.

The project's objectives and design stemmed from previous activities performed with the help of the French cooperation and from a first project draft introduced in 2004-2005. Activities performed by the UNDP partners in the West Bank and the Gaza strip started in March 2008. They were supposed to be completed by June 2010, but due to various delays the duration of the project had to be extended twice, including an "Exit Strategy", endorsed in June 2010 to ensure a proper conclusion to the project by June 2011, and then again from June 2011 until June 2012, mainly to complete the extension of the Halhoul Centre as well as the present evaluation, the last activity of the project.

This report presents the findings of the evaluation team based on a variety of data collection methods as well as lessons learned and recommendations based on those findings.

The report first reviews the context in which the project has been implemented, the evaluation objectives and methodology. Findings and analysis are subsequently presented using criteria commonly used in such exercises: relevance, efficiency, effectiveness, impact, sustainability. In order to address more in depth certain aspects of the analysis, a few criteria have been added, including coordination, complementarity and coherence (the "three Cs"), the added value of the project and of its donor and implementer, as well as the analysis of cross-cutting issues such as gender and the attention paid to vulnerable sections of the oPTs' population.

Throughout our interviews the term "clients" has been regularly used by interlocutors to define the persons who benefit from the services delivered by the CMHCs. The term was chosen over "patient" by the project in order to distinguish people requesting general services from the CMHCs from those receiving treatment. It was also seen as more appropriate for cultural reasons where seeking mental health care is considered "taboo". The evaluation team acknowledges those valid reasons. However, we prefer using the more traditional term of "patients" at least for those who come to the CMHCs, which are the keystone of the present project, as they go there to actually get specialized support, or "treatment", and also because "clients" encompasses a broader spectrum of situations, which are more commercial in nature. Mental health services are no "commercial" activities and even though the term "client" is being used to underline the fact that "patients" in fact actively participate in their

treatment, we think it is not appropriate. “User” is probably a better term for those who come to CMHCs for services. The term ”participants” is also used for personnel that attended training courses, along with the term “trainees”.

Dr Sylvie Ozon-Mansour, technical advisor to the project, is also known to her colleagues as Dr Sylvie or Dr Sylvie Mansour. We will use this latter name throughout the report.

1.1. General context analysis

The total population of Palestinians in the occupied Palestinian territory (oPT) is approximately 4.1 million people; 2.5 million of whom (62%) live in the West bank and 1.6 million (38%) live in the Gaza Strip. Around 44% of the total population is made up of internally displaced people. As indicated in a recent Ministry of Health report[3], the total health expenditure was 1.233 billion Israeli New Shekels (INS); around 43% of the total expenditure were salaries (PMoH, 2010). Key indicators of health status in opt for 2010 are introduced in table 1.

After the signing of the Oslo Accord in September 1993, the oPT (West Bank, the Gaza Strip and East Jerusalem) were divided into three areas; area A, under the Palestinian control, Area B, Palestinian civil control and joint Israeli-Palestinian security control and area C, Full Israeli civil and security control, except over Palestinian civilians. The Territories were arranged into 16 governorates under the jurisdiction of the Palestinian National Authority. The West bank includes eleven (11) governorates while the Gaza strip comprises five (5) governorates.

The socio-political context in the Palestinian territory is very peculiar, and one of the most complex, volatile and difficult in the world today. Following the 1948 war and the creation of the state of Israel, around 900,000 Palestinians were forced to flee from their cities, towns and villages. The majority was displaced to the Gaza Strip and the West Bank and many others found refuge in neighbouring countries. As a result of the second war between Israeli and Arab armies in 1967, thousands of Palestinians were displaced, half of them for the second time, as Israel took control of territory that came to be known as the Occupied Palestinian Territory (Gaza, West Bank and East Jerusalem). It is hard to estimate the number of Palestinian refugees in the world, however, the number of registered refugees by the United Nation Relief and Work Agency (UNRWA) is 4 million. They are living in Jordan, Lebanon, Syria, Gaza and West Bank (UNRWA 2005)[4]. No accurate figures are available for Europe, the United States, Canada, and Scandinavian countries, Australia, Latin America, and Africa. Since 1948, Palestinians have experienced oppression, multiple, repetitive and continuous traumatic experiences, social exclusion and related socioeconomic and political problems. Palestinians describe the 1948 events as `Al Nakbah` (catastrophe). It represents the loss of the homeland, the livelihood, and political power. It also represents the disintegration of society, the frustration of national aspiration and the beginning of a rapid process of destruction of Palestinian culture.

Occupation, social and economic control, and general restricted movements resulted in feelings of frustration, hopelessness and a long period of victimization and dramatization that led to the outbreak of the first Intifada -Palestinian Uprising against the Israeli Occupation- in December 1987. The cost of the Intifada has proved to be high and has affected all sectors of the Palestinian community. Thousands have been killed or left handicapped; Palestine Monitor (1993)[5] reported that 1.162 Palestinians were killed and around 23,600 to 29,900 children required medical treatment for their beating injuries in the first two years of the intifada, one third of who were children under the age of ten years old[6]. Many thousands have also been jailed, including women and children (Afana, 2010)[7]. Moving between Palestinian towns in the West bank means crossing tens of checkpoints dividing the West bank into clusters, which requires permits that are often denied. Treatment at the checkpoints by Israeli soldiers is often “cruel and degrading”. These checkpoints have resulted in hundreds of Palestinians dying because they have not been allowed to pass through to access medical care. There have been 52 cases of women giving birth at checkpoints, resulting in the death of 17 newborns. Together with closures and checkpoints, curfews have imprisoned more than two million

[3] Palestinian Ministry of Health (2010) Annual Health Report, Ramallah, oPT.
[4] http://www.unrwa.org/
[5] Palestine Monitor ; http://www.palestinehistory.com/issues/intifada/intifada1.htm
[6] Are children of Palestine less worthy? Al-Jazeera English News, http://www.aljazeera.com/indepth/opinion/2011/05/201152911579533291.html
[7] Afana, A. (2009). Weeping in silence: the secret sham of torture among Palestinian children. *Torture Journal, 19*(2), 167-176.

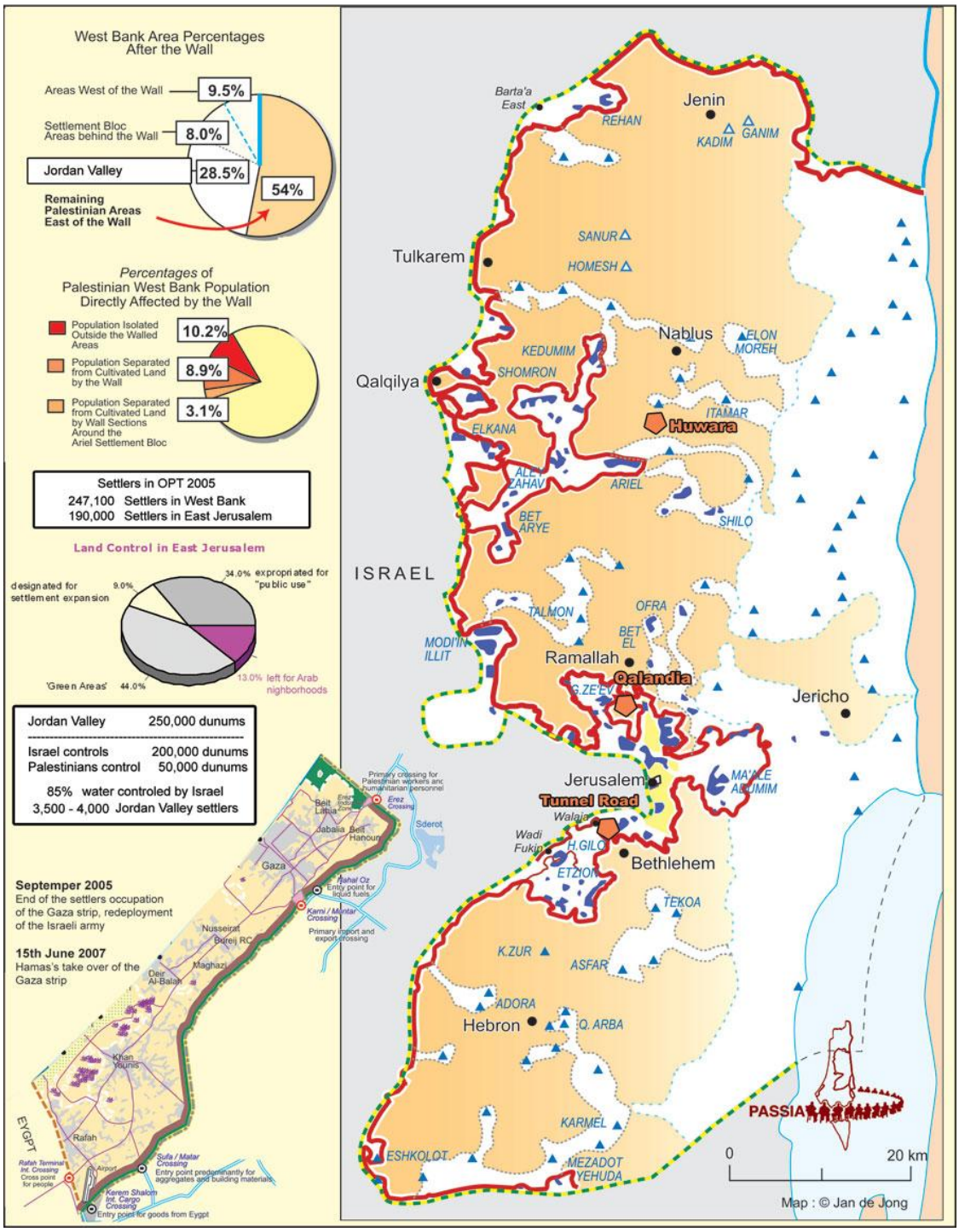
people in their homes (The Palestine Monitor, 2003). Further, the closing of borders between Gaza and the West bank has caused serious consequences for Palestinians in the Gaza Strip.

The maps of Palestinian Territories shown below (figure 1) give an idea of how difficult it is for Palestinians to feel as a nation. Moreover, crossing the oPTs' borders and travelling from one part to another of these territories is very difficult for their citizens. Until very recently, the Gaza strip, which has no actual jurisdiction over the waters it borders, was completely locked up as even the border with Egypt was closed, making it a virtual open-air prison.

Figure 1. Maps of Palestinian Territories

Source: United Nations Office for the Coordination of Humanitarian Affairs - Report 2004 & 2007

West Bank Wall - Map 2006



A multi-stage cluster sample to assess the quality of life of Palestinians living in the oPT, Awad et al (2008) 7 showed that 48% of respondents reported never needing to cross checkpoints. Just fewer than 30% of respondents reported having experienced the death or imprisonment of a family member by the Israeli army, 26% felt that life quality was poor or very poor, 14% reported being ‘‘dissatisfied’’ or ‘‘very dissatisfied’’ with their health[8].

[8] Awad Mataria, R. G., Angelo Stefanini,Nirmala Naidoo,Paul Kowal,Somnath Chatterji. (2008). The quality of life of Palestinians living in chronic conflict:assessment and determinants. *Eur J Health Econ, 10*, 93–101.

Table 1. Key Indicators of Health Status in Palestinian Territories for 2010

Key general indicators	
Life expectancy (males)	70.8 years
Life expectancy (females)	73.6 years
Infant Mortality Rate	14 / 1000 in the West Bank
Birth Rate	31 / 1000 (26/ 1000 In West Bank and 39/ 1000 in Gaza
Crude Mortality Rate	2.7 / 1000 (2.7 in the West Bank and 2.6 in Gaza)
Population increase	2.9% annually overall (2.7% in the West Bank and 3.3% in the Gaza Strip)
Maternal mortality rate	32 / 100.000
Distribution of newly born, 010	52% in the West Bank and 48% in Gaza
Leading causes of death	
Heart problems CVA Cancer Respiratory problems	25.5% of the total deaths 12.1% of the total deaths 10.8% of the total deaths 10.8 % of the total death
Prevalence of some health conditions and risk factors	
Hepatitis B Virus (B)	26.5 / 100.000; Gaza and 38 /100.000; West bank
Anemia among pregnant women	29%
Anemia among children less 3 y	42.2%
Diabetes in the West Bank	13.4% increase compared with 2009 (44% among males and 56% females)

Sources: MoH report, 2010.

1.2. Mental Health situation and sector in Palestine

1.2.1. Mental health situation in the oPT

In the oPT, responding to mental health needs of people is an absolute necessity. Mental disorders constitute one of the biggest challenges to the Palestinian community. Years of political-military occupation, conflict, and violence have had and continue to have substantial public mental health implications, especially in resource-stretched oPT.

With the geographical and political separation as well as the physical confinement that characterize the portions of the territories, the Palestinian territory and polity can be described as fragmented, and even torn apart. The constant political and social tensions, with the immediate surrounding environment and from within, the economic and mobility restrictions and constraints, the permanent possibility of armed confrontations and conflicts and recurrent occurrences of such events, the resulting mourning about the past and present, and the pervasive uncertainty about the future, combine to create a very fertile terrain for mental disorders, both at the collective and the individual levels. The demographic pressure, which, to a large extent, results from politics (a race to numbers)[9] adds to the socio-economic tensions and uncertainties, as well as to the difficulties experienced from a living condition point of view.

Due to the very high level of conflict situation and mass violence experienced in Palestine over a long period both in terms of degree and duration, the level of suffering associated with that situation has remained very high over the years. The mental health impact of the ongoing conflict in the oPT is very significant. During the last 10 years, a number of studies have reported high levels of psychosocial problems among children, adolescents, men and women. They point out very high levels of prevalence of mental disorders, particularly those associated with stress, violence and trauma.

[9] Youseef Courbage. L'étonnant renversement des démographies israélienne et palestinienne (1948-2048). In *Palestine, Israël: un Etat, deux Etats ?* Sous la direction de Dominique Vidal. Etudes Palestiniennes. Actes Sud. 2011.

For example, Baker (1991)[10] showed that Palestinian children living in the West Bank suffer from psychosomatic and pathological symptoms, where the psychosomatic symptoms include headaches, stomach-aches, difficulty in awakening, difficulty in sleeping, nightmares and loss of appetite. Pathological symptoms include auditory hallucinations, delusions, and depression, loss of memory, fear of leaving the house and fear of soldiers.

A study conducted by Punamaki (2005)[11] measuring the life time traumatic events among Palestinians showed that prevalence of traumatic events was higher among men than women. 86% of the men and 44% of the women had experienced at least one traumatic event during their lifetime. Women show higher levels of psychiatric distress than men, except for posttraumatic stress disorder (PTSD). The study also showed that exposure to life trauma was associated with anxiety and mood disorders among women and significant association was found between trauma and somatoform disorder among women too. By contrast, children exposed to other events, mainly through the media and adults, reported more anticipatory anxiety and cognitive expressions of distress than children who were directly exposed.

De Jong, Komproe and Van Ommeren (2003)[12] assessed 3,048 respondents from post-conflict communities in Algeria, Cambodia, Ethiopia, and Palestine with the aim of establishing the prevalence of mood disorder, somatoform disorder, PTSD, and other anxiety disorders. PTSD and other anxiety disorders were the most frequent problems. In three countries, PTSD was the most likely disorder in individuals exposed to violence associated with armed conflict, but such violence was a common risk factor for various disorders and co morbidity combinations in different settings. In three countries, anxiety disorder was reported most in people who had not been exposed to such violence. Experience of violence associated with armed conflict was associated with higher rates of disorders that ranged from a risk ratio of 2.10 for anxiety in Algeria to 10.03 for PTSD in Palestine.

In his study among children aged 10–16 years living in the Gaza Strip, Quota et al (2005)[13] reported that 33% of the children were having acute levels of Posttraumatic stress disorder, 49% from moderate levels and 16% low levels. In “hot” (close to Israeli settlements) areas, 55% of the children suffered from acute levels of posttraumatic stress disorder, 35% from moderate levels, and 9% low levels.

In their study about the level of exposure to political violence among Children and Adolescents in Ramallah district, Giacaman et al (2007)[14] reported high level of Exposure to Violence and Trauma (EVT): exposure to tear gas and sound bombs, having seen shooting and explosions, and having seen strangers being arrested and humiliated were the most frequently reported events. Males reported higher level of exposure compared to females. Individual EVT and other Israeli military related events were higher among males compared with females (45% of boys stated they had had body search, 9% of females; 9% males reported torture compared with 6%females. Overall, 80% had seen shooting, 28% had seen a stranger killed, and 11% had seen a friend or neighbor killed. Students living in camps and in cities reported higher mean levels of EVT compared with those living in villages.

In their series of studies of the prevalence of mental health problems in primary health and the ability of General Practitioners (GPs) to identify these problems, Afana et al. (2003, 2004)[15,16] found that the prevalence of PTSD symptoms in primary health care patients was 29% overall, and significantly

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[8] Baker, A. M. (1991). Psychological Response of Palestinian Children to Environmental Stress Associated With Military Occupation. *Journal of Rcfuget Studies Vol. 4. No. 3 1991, 4*(3), 237-247.

[11] Punamaki, R.-l., Komproe, I. H., Quota, S., Elmasri, M., & Jong, J. d. (2005). The role of Peritraumatic dissociation and gender in the association between trauma and mental health in a Palestinian community sample. *The American Journal of Psychiatric March 162*(3).

[12] De Jong, J., Komproe, I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., et al. (2001). Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings. *Journal of American Medical Association, 28*(5), 555-562.

[13] Qouta Samir, J. O. The Impact of Conflict on Children: The Palestinian Experience. Journal of Ambulatory Care Management, 28(1 January/February/March),

[14] Giacaman, R., Shannon, H., Saab, H., Arya, N., & Boyce, W. (2007). Children and Adolescents individual and collective exposure to political violence: Palestinian adolescents coping with conflicts. *European Journal of Public Health, 17*(4), 361-368.

[15] Afana, A.-h., Dalgard, O. S., Bjertness, E., & Grunfeld, B. (2003). The Assessment of Mental Disorders in Primary Health Care Clinics in the Gaza Strip. *Primary Health Care Research and Development 4*.

[16] Afana, A.-h., Lawler, J., & Sarraj, E. E. (2004). Gender and Other Predictors of Anxiety and Depression in a Sample of People Visiting Primary Care Clinics in an area of political conflict: Gaza Strip. *RAHAT Medical Journal, 2*(1 February).

higher among females than in males. Prevalence of Posttraumatic stress disorders PTSD among those exposed to traumatic events overall was 36%. Highly educated patients were more often exposed to traumatic events, but the prevalence of PTSD was lower than among less educated patients. Males exposed to traumatic events reported a lower prevalence of PTSD than traumatized females. The studies also showed that the GPs detected only 11.6% of patients with mental health problems at Hopkins Symptom Checklist (HSCL-25) score >1.75 and that the GP's assessment was not significantly associated with the HSCL-25 scores. GPs with postgraduate psychiatric training performed better in detecting mental health problems, likewise with female GPs and with those who were more than 40 years old. The results also revealed that the GPs were more able to detect mental health problems among patients older than 25 years, and in female patients. In conclusion, the GPs' poor detection rates of mental disorders point to the importance of mental health training for GPs working in primary health care clinics.

In their recent ethnographical study in the Gaza Strip, Afana et al (2010)17 suggest that social representations and meaning of trauma can be classified there into three main types according to the level and nature of the symptoms associated with the experience, severity, patterns of resort to treatment, and long-term effects: sadma (trauma as a sudden blow with immediate impact), faji'ah (tragedy), and musiba (calamity). Sadma is used metaphorically to refer to painful events that happen suddenly. Faji'ah is used to describe the reaction to an extraordinary event, mainly the loss of a loved one. Musiba is used when traumatic events are persistent and have long-term consequences. Popular descriptions and relationships among these terms and their meanings and relationships to common idioms of distress are illustrated. Examining cultural variations in the understanding and expression of trauma-related distress has implications for the definition of trauma-related disorders in psychiatric nosology, as well as for the design and delivery of culturally appropriate clinical and community interventions.

In Palestine, the extended family helps to cope with the effects of trauma and mental disorders as it provides social support, enhance community network and help to build trust among family members. The cultural capital invested by the family on their members is considered as one of the potential resources that would keep family cohesion and strengthen its extra-family network. Traditionally the family unit is the most important social group and is more important than the individual in terms of identity, status and inter-personal relationships.

1.2.2. Mental health services in the oPT

Health and mental health services are provided by four main sources, namely the Governmental Sector, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), Non-Governmental Organizations (NGOs) and the private sector.

Government services are the main source of services for health care in general and mental health care in particular, in the oPT. They provide primary, secondary and tertiary care through hundreds of primary health care (PHC) centres, hospitals and community mental health centres. More specifically, mental health services are provided through fifteen (15) community mental health centres, five (5) of them located in the Gaza Strip. Also there are some mental health services provided by PHC centres.

According to the Ministry of Health (MoH)'s statistics[18], around 51,505 visits were registered in community mental health centres and primary health care facilities in the oPT in the West Bank in 2010. Mental retardation had the highest incidence rate (19.1 / 100.000), accounting for 22.4 % of the total registered cases in the oPTs (26.5 % in the Gaza Strip and 16.8 % in the West Bank). Addiction accounted for 1.9 % of the case load (2.7% in the Gaza Strip and 0.8% in the West bank). The reported incidence of Epilepsy was 13.3/ 100,000; Schizophrenia 14 / 100,000; affective disorders 10.9 / 100,000; neurosis 16.1 / 100,000; personality disorders 3.5 / 100,000 and organic disorders 4 / 100,000.

According to the Ministry of Health report, the number of new cases registered in 2010 was 3,464. 1,471 of those were registered at the community mental health (CMH) centres in the West Bank and 1,993 in the Gaza Strip. Rafah, in the Gaza strip, registered the highest incidence rate of mental

[17] Afana, A.-H., Pedersen, D., Rønsbo, H., & Kirmayer, L. J. (2010). Endurance Is to Be Shown at the First Blow: Social Representations and Reactions to Traumatic Experiences in the Gaza Strip. *Traumatology, 16* (2), 43-54.

[18] Ibid.

health problems in the whole oPT (235.8 / 100,000) followed by Salfit in the West bank 226.5 / 100,000.

Tertiary care for mental health patients is provided through two main hospitals: one in the West Bank (Bethlehem Hospital, 180 beds) and one in the Gaza Strip, 39 beds. The MoH also provides mental health services and mental health education in schools. During the school year in 2009-2010, 356 schools were visited by mental health professionals in Hebron, Tulkarem and Taybas areas. 29,223 students were screened. The number of cases detected was 736 cases, 33.3% of the detected cases were referred mental health services.

At the Ministry of Health (MoH), the department in charge of mental health is the Mental Health Unit (MHU), based in Ramallah.

UNRWA: Following the 1948 Arab-Israeli conflict, UNRWA was established by the United Nations General Assembly in 1949 to carry out direct relief and works programs for Palestinian refugees. Through more than a hundred primary health care and rehab centres and women programs, UNRWA currently offers comprehensive primary care to registered Palestinian refugees in the oPT. UNRWA runs only one hospital located in Qalqilya, with 63 beds. In addition to the health services UNRWA runs a psychosocial school service program in UNRWA schools only. It is worth mentioning that UNRWA provides other services in the areas of education, relief, human rights as well as other infrastructure activities.

NGOs: the non-governmental sector provides health and mental health care mainly through hundreds of community health centres managed by the NGO sector in both Gaza and the West Bank. Some NGOs provide mental health and psychosocial services in the oPT such as counseling services, mental health care, community interventions, etc. These include organizations such as the Palestinian Counseling centre (PCC) and Juzoor ("roots"). In the Gaza Strip, there are several nongovernmental organizations that provide mental health services to Gaza people. One of the largest nongovernmental organizations in the Gaza Strip is the Gaza Community Mental Health Programme that was established in 1990 and provides mental health services for people in the Gaza Strip.

The **private sector** mainly provides tertiary medical care. The private sector provides both health and mental health managed by medical and psychiatrists. The cost of the private care is expensive and is only accessible to people who can afford it.

1.3. Programme description

Given the lack of appropriate mental services in the Palestinian Territory (oPT), and the close relationship established between the French Cooperation and mental health institutions in France and their counterparts in Palestine[19], in 2003-4 the French Cooperation together with the Palestinian Authority, the WHO and the Italian Cooperation, started to work on the development of the mental health sector in the oPT. This led to the design of a project[20] to support the development of training policy, the creation of three Community Mental Health centres (CMHCs), including one for children and adolescents serving as a pilot for pedo-psychiatry, and to conduct research.

The original budget was set at 2 million euros. The project was then transferred to the Agence Française de Développement (AFD) as part of the reform of the State's development aid apparatus in France. Its budget expanded to 2,74 million euros. It included the construction and equipment of a Documentation centre (DC) and the recruitment and training of its staff.

The overall objective of the project was set as to "improve male and female Palestinian mental health condition through improving the access to mental health facilities, developing capacity of mental health care staff and improving quality of the services through action oriented research."[21] The project was supposed to cover both the West Bank (through three CMHCs and DC) and the Gaza strip (through training of PHC staff).

Its specific objectives were set as to:

[19] For example, the Ste Anne Psychiatric Hospital in Paris has had a twinning relationship with the Bethlehem Psychiatric Hospital, while many mental health professionals have benefited from grants from the French international cooperation to study in France over the years.

[20] Ministère des Affaires Etrangères ; Direction Générale de la Coopération Internationale et du Développement ; Fonds de Solidarité Prioritaire. Rapport de présentation: Aide à la mise en place d'une nouvelle politique de santé mentale dans les Territoires Palestiniens. Non dated.

[21] Project document of AFD mental health project.

- support the MoH in order to develop an institutional framework able to deal with mental health issues; issues;
- create three dedicated mental health centres implementing a community-based approach;
- develop knowledge through research activities and create a mental health documentation centre.

These components were translated into three practical sets of activities:

- Building or rehabilitating and equipment of three CMHCs in Halhoul (north of Hebron), Nablus and Jenin, as well as a Documentation centre.
- Training of the personnel to be recruited for these four centres (originally estimated at 18 persons in all), as well as personnel from the general health system – general practitioners and nurses. The newly recruited personnel were supposed to be integrated into the Palestinian public health sector.
- Action-oriented research studies. Two studies were supposed to be conducted by CEDRATE (France), one regarding children's severe psychiatric disorders and another regarding family violence exerted towards children.

Gender was an important cross-cutting issue identified in the project document.

The project, funded by the AFD, was implemented by the UNDP/PAPP through a Project Management Unit (PMU) based in Ramallah at the Ministry of Health. A Steering Committee was set-up, comprised of representatives from the MoH, AFD, and UNDP/PAPP.

The project's Financial Agreement was signed on April 18, 2007, between the UNDP (the implementer) and the AFD (the donor)[22]. However, due to the reluctance of donors to work with a government where Hamas would have a representation, the actual implementation did not initiate until March 2008. It had originally been scheduled to start in 2007 and last 48 months. It's original end date had been set for December 2010 but was delayed by 6 months through an addendum in order to complement some of the activities undertaken (training in particular) and accommodate some requests from the government (rehabilitation of floors in the CMHCs, garden, etc.). The original third component of the project (applied research) was dropped at the very beginning of the project's implementation. In the more recent documents introducing the project (such as the AFD Factsheet updated as of October 2011), the three components now stand as:

- Construction and equipment of three Community Mental Health Centres (CMHC) in Nablus, Jenin and Halhoul districts and one Documentation Centre in Ramallah city;
- Recruitment and training of staff for the four centres. Integration of recruited staff into the Ministry of Health staffing system;
- Training for general practitioners and nurses in the West Bank and Gaza Strip to identify underlying mental health issues.

Complementary to these areas of intervention, an anti-stigma campaign has been conducted, including radio programs.

The strategy is based on the community mental approach by establishing community mental health centres that work collaboratively with primary health care and other mental health services. The strategy was approved by the project's main stakeholders in April 2010 but was not by the MoH until the end of that year.

An extension of the project's implementation period (at no cost) was granted in 2010 for an additional 6 months, mainly to implement an Exit Strategy approved in June, 2010.

The main activities performed by the project were to be:

- Construction of three community mental health centres (Jenin, Nablus and Halhoul).
- Construction of the Ramallah Documentation centre.

[22] Third-party cost-sharing agreement between the Agence Française de Développement (AFD) (the donor) and the United Nations' Development Programme (UNDP). Signed on April 18, 2007.

- Equipping the constructed centres of Jenin, Nablus, Halhoul and Ramallah with the necessary furnishings and equipments to ensure that centres are functional.
- Recruitment of 18 new mental health professionals to be employed in the centres.
- Theoretical and practical training of the existing and newly recruited mental health professionals working in Jenin, Nablus and Halhoul. The purpose of the training is to improve the staffs qualifications, knowledge and skills in mental health.
- Training of general practitioners and nurses in Gaza and the West Bank, focusing on practical skills to respond to a wide range of mental health needs at the Primary Health Care level.
- Training of the staff to be employed at the Ramallah documentation centre.
- Enhancing referral system
- The organization of short term training courses abroad and the involvement of the staff in different workshops, including internships inside and outside the country.

The original number of personnel to be recruited and trained for the three CMHCs and the Documentation Centre was 18, but was brought to 19, as stated in the 2010 activity report: "during the project implementation it was decided to recruit an additional staff to serve as pharmacist at Jenin's CMHC." Staff recruited was selected on the basis of criteria set by MDM France and Switzerland and approved by the MoH, the UNDP/PAPP and the PMU's technical advisor (Sylvie Mansour). Tests were conducted and interviews led by a panel composed of members of the above-mentioned organizations plus some from other Palestinian mental health institutions.

Training and supervision were implemented by MDM (France and Switzerland), Juzoor and PCC. MDM-France was active in two of the CMHCs (Jenin and Nablus) until June 2010. MDM-Swiss covered the Halhoul centre, a pilot CMHC dedicated to children and adolescents. After July 10, the Palestinian Counseling centre (PCC), a local NGO, took over from MDM-France, until the end of the project's implementation. MDM-France was still involved in an important 2-day workshop in October 2010, which brought together 40 organizations and institutions involved in mental health, including service providers, in the Nablus governorate in order to enhance referral services, standardize referral protocols and tools and to facilitate access to mental health services of the governorate's population.

Altogether, angular stones of the project have been:

- the French Cooperation services (DGCI) as original designer of the project;
- the AFD, which replaced the SCAC becoming the funding agency because of re-organization within the French cooperation apparatus;
- Sylvie Mansour, as technical advisor, and to a large extent, as co-project manager, even if she did not have the title;
- The Ministry of Health, as responsible for the provision of MH services throughout the territories, particularly the Mental Health Unit (MHU);
- Palestinian and international NGOs active in the sector (for a long time for some of them), particularly Juzoor (Juzoor Foundation for Health and Social Development), the Palestinian Counselling centre (PCC), the Gaza Community Mental Health Programme (GCMHP), Médecins du Monde (MDM) France and Switzerland;
- the mental health staff and the CMHCs;
- Bir Zeit University, as a contributor to training (of the DC's staff) and as developer of E-Learning modules in cooperation with Juzoor.

A Project Management Unit (PMU) was established in March 2008, which was set at the Al Bireh centre where the MHU is also located. It is right next to the MHU director's office allowing for continuous work relationships with the head of the MoH's mental health department. Other important MoH directorates, and more particularly that of primary health care (PHC), and many of the project's main stakeholders are located in Ramallah, next to Al Bireh. This includes Juzoor and PCC. MDM France and Switzerland's headquarters for Palestine are in East Jerusalem and so is UNDP's office for the West Bank. However, it was much more difficult for the PMU to monitor the activities scheduled to take place in the Gaza strip. There was no branch of the PMU in Gaza, because of the political situation, leaving or entering the Gaza strip is extremely difficult, even for UNDP personnel. The Acting Project Manager was not able to get into Gaza until December 2011 only. The UNDP's office in Gaza provided help, and coordinated the training activities with GCMHP. However, the person who was responsible for the project in Gaza left the UNDP.

It is important to note that the implementers were in fact selected before the actual start of the project because it was designed earlier through a separate process. Both the AFD and UNDP normally do not pick partners. They use international and national tendering processes, as any bilateral or multilateral aid and funding agency does. The original design of the project, was a process that involved the French Cooperation (the Ministry of Foreign Affairs' cooperation services and more particularly the SCAC services), in cooperation with the Italian Cooperation, the WHO and the MoH. Sylvie Mansour, a clinician psychologist, who has extensive experience in mental health in the region (Lebanon and Palestine), was the Technical Assistant to the French Cooperation in Palestine. She provided inputs in that early design, and subsequently, in the implementation and management of the actual project. This led to the selection of a number of Non-Governmental Organizations (NGOs) with experience in mental health services to populations in crisis, both international (MDM) and national (the Juzoor Foundation and later the Palestinian Counselling Centre or PCC).

The UNDP was neither involved in the design of the project nor in the selection of selection of implementation partners. The MoH had apparently little involvement in the partners' selection process. Sylvie Mansour ended up working as the formal Technical Assistant to the project from 2008 until March 2010. It is important to point out that she was not paid by the project's funds, as she was by the France Coopération Internationale (FCI) organization.

1.4. Objectives and methodology of the technical evaluation

1.4.1. Objectives of the evaluation

As per the terms of reference (Annex 9) the objectives of the present technical evaluation of the UNDP/PAPP/AFD Mental Health Project are:

- provide the project's main stakeholders (MoH, UNDP/PAPP, AFD) with sufficient information to make a knowledgeable judgment about the performance of the project;
- document the lessons learned by the main actors throughout the project;
- provide practical recommendations and baselines to the stakeholders for future interventions.

The ToRs also mentioned the need to identify the priorities and needs specifically related to mental health, "serve as a baseline on which to measure the impact of the project's activities over the past three years" as well as provide an "analysis of other stakeholders working in the mental health field in terms of strengths and weaknesses to be taken into consideration by the MoH on future interventions".

Finally the ToRs indicated that the analysis should be carried out following the common set of evaluation indicators (as set by the OECD's DAC: relevance, effectiveness, efficiency, impact and sustainability). This is further précised by a set of indications, which are as follows:

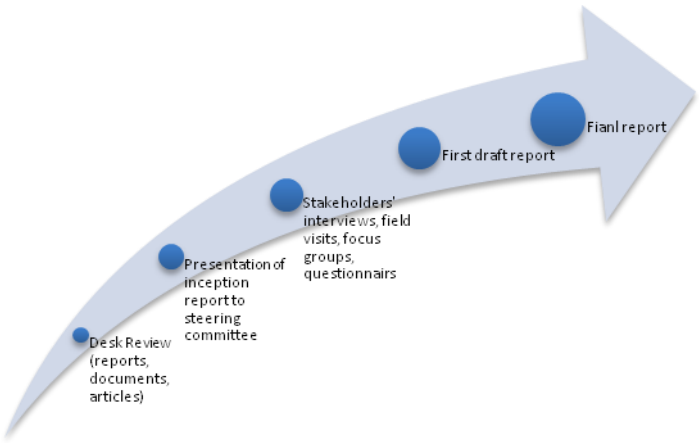
- identify to which extent the objectives of the project were in line with beneficiaries' requirements and sector needs;
- determine if the project results were attained and the specific objectives achieved;
- build a new logical framework with indicators relevant to the objectives of the project like, i.e., increased of frequentation, number case referrals, the quality of services delivered, reduction of stigma, etc., with special attention to the number of clinical sessions delivered (group therapy, individual therapy, occupational work sessions, etc.);
- evaluate whether the implementation procedures, the management and coordination arrangements were adequate to achieve the project's objectives;
- evaluate the effectiveness of the hard components (constructed/rehabilitated buildings) and its contribution to facilitating the access to mental health services from a technical (mental health professional) and user's perspective;
- assess the impact of the project at national level – this should include the contribution of the project to the national policy and system for mental health in the oPT, the role of the project activities in reducing the stigma and in raising awareness of the general public regarding mental health in general and people with psychological disorders in specific;

- identify the outputs delivered by the project partners and its quality as a good reference for future mental health professionals – this should include an in-depth revision of the training manuals and other resources placed in the community mental health centres;
- evaluate the sustainability of the centres' services technically and operationally;
- evaluate the gaps and risk factors that should be taken into consideration for future similar interventions.

1.4.2. Evaluation methodology

Based upon the Terms of Reference (ToRs), the evaluation team developed an initial evaluation methodology, presented in the inception report. That report also included a context analysis (which is summarized in the present report's part 1.1), a literature (desk) review, a discussion of the tools to be used for data collection, and two questionnaires to be used with beneficiaries of training conducted by the project. The evaluation was initially planned to begin in the first week of February 2012. The main steps of the evaluation process are depicted in the Figure below.

Figure 2. Data collection and reporting



In the inception report the evaluation team has set out to precise the methodological approach to tackling the above mentioned requirements through the elaboration of an evaluation grid or matrix (see Annex 6). The matrix uses a set of evaluation questions for each of the criteria covered as well as a set of indicators, in order to guide its work. The matrix covers all criteria identified by the ToRs, but also a couple more entries, including "coherence" and "cross-cutting issues", as is usual in evaluation exercises, and also to remain faithful to the project's original design documents. This, particularly, refers to the inclusion of the attention paid to specific sub-sets of the Palestinian population potentially affected by mental disorders, such as women, children, adolescents and the various socio-economic situations.

Given its importance in the sector analysis and in the design of recommendations, aspects of coordination and complementarity (among stakeholders, between donors) are also incorporated in the analysis of the "coherence" criterium. The analysis of the added value of the project to the mental health sector and its needs, and the added value of the AFD as a donor and the UNDP as an implementer or vehicle for the implementation has also been incorporated.

A multi-method informative evaluation design was employed to analyze both processes and outcomes of the project. The evaluation process started with a review of the project documents, reports, training materials and modules available at the time, followed by field work, which involved focus group discussions, interviews, questionnaires and observational site-visits undertaken by the two evaluators.

Interviews were conducted with key sector stakeholders, organizational leaders and directors of the newly established community mental health centres. Questionnaires were distributed to mental health

and primary health care professionals who participated in the training courses. Questions requested participants to mark their reactions on the gained knowledge and skills and record their expectations of the planned training courses. Questionnaires are presented in Annex 8.

To explore the longer-term impact and sustainability of the project, focus group discussions and interviews were held with each collaborating partner. Some of the focus groups and interviews were tape-recorded with the permission of the participants.

We attempted to organize a focus group or interviews with users of the centres. The Mental Health Families & Friends Society (MHFFS) was willing to organize a focus group with some of their members in Ramallah. However, due to scheduling and time constraints this was, eventually, not possible. At the CMHCs, it was not possible to meet both the staff and patients in the same visit. Staff leaves the premises at 2-3 pm and patients cannot stay after 2-3 for interview. With the logistical constraints inherent to the transportation difficulties in the West Bank, it was impossible to come back to the community mental health centres for further activities, despite our attempts.

	Questionnaires to CMHC staff	Questionnaires to PHC personnel in the West Bank	Questionnaires to PHC personnel in Gaza
Distributed	19	54	15
Collected and used for the analysis	17 + 3 interviews	13 + 10 telephone interviews	9 + 3 telephone interviews

Sources : Conseil Santé

Focus group	Halhul CMHC staff	Jenin CMHC staff	Nablus CMCH staff	GAZA Training participants
Nb of participants	4	6	10	6

Sources : Conseil Santé

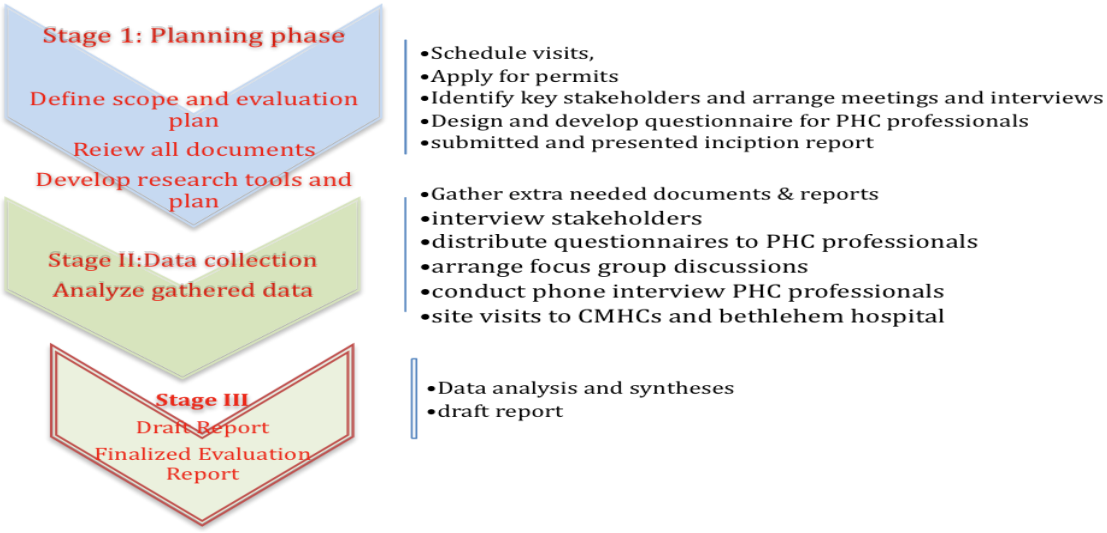
The evaluation was undertaken in accordance with ethical guidelines for health services research. The nature and purpose of the evaluation were explained on each data collection occasion. It was stressed to all participants that their involvement in this study was voluntary, yet, important for being a stakeholder. Plans for dissemination were discussed with some stakeholders. Care has been taken with confidential information, and appropriate measures have been taken to ensure anonymity.

1.4.3. Evaluation process

During the inception phase a number of documents were reviewed, which were complemented by a number of documents further collected before, during and after field work. This was, in part, possible through to a database opened by the Project's Management Unit (PMU) to that effect and made accessible to evaluators. Other documents were collected on the ground, from a variety of stakeholders. The bibliographical list is presented in Annex 1.

The evaluation was conducted in three stages. They are illustrated in the figure below.

Figure 3. Evaluation stages



With the literature review the evaluation team reviewed internal and external sources of information including macro needs analysis data, situational reports, project plans, previous evaluations, thematic reports from other humanitarian agencies, and implementation reports.

Due to time and movement constraints, the primary source of data collection focused on information gathered from UNDP partners and their staff as well as participants involved in training through semi-structured interviews and the questionnaire. In total the evaluators interviewed by telephone 10 PHC professionals in the Westbank, and 3 PHC professionals in the Gaza Strip. In addition, evaluators interviewed the directors of all three CMHCs, leaders of local and international training organizations conducted training activities, the director of the Mental Health Unit, staff of the documentation centre, the director and some staff of the Bethlehem psychiatric hospital; the WHO national coordinator, UNDP project supervisors, the director of the Mental Health Families & Friends Society, and other officials from the MoH, including the Director of PHC services. Focus group discussions were organized with staff of all three CMHCs, as well as a focus group discussion in Gaza with 6 PHC professionals, and another one in the West Bank gathering the staff of the MHU. Annex 2 shows the list of persons and institutions met and interviewed.

Limitations and Challenges

A number of limitations and challenges have arisen in the course of conducting the evaluation of which merit discussion given their impact on the evaluation team‘s ability to collect quality data and undertake fully-informed analysis.

It was not possible to obtain the training modules used by the GCMHP despite our efforts and those of the UNDP office in Ramallah, which did not have them. The GCMHP justified their inability to provide the needed information by lack of Internet connexion and electricity. With the help of the UNDP office in the Gaza Strip, the mental health expert was able to conduct a focus group discussion with 6 participants in addition to 3 telephone interviews. The focus group was taped with the permission of the participants who were assured of the confidentiality and anonymity.

The 2011 activity report was not ready yet when the evaluation work was conducted (February-April 2012).

Evaluators completed a field visit, during the months of February and March 2012. Each of the two experts spent 2 weeks in the West Bank and East Jerusalem, and Dr Afana covered the Gaza strip. Due to logistical difficulties (it is difficult to accommodate more than 3 interviews per day due to logistical complications typical of travel from one point to another in this part of the world) and permit issuance delays (even with UNDP’s help in that matter), the evaluation process in the West Bank was somewhat delayed, therefore limiting the capacity of the two experts to work together there.

Yet, with the help of the UNDP and the Project's PMU, who combined to organize encounters and to provide with transportation, the two experts were, overall, able to conduct all necessary activities and visits, even if mostly separately. All stakeholders and CMHCs were visited, as well as the Mohamed Said Kamal Documentation Centre in Al Bireh. In order to complement the analysis of the Mental Health sector in the WB, visits were also conducted to the Ramallah CMHC, which was supported by the WHO Mental Health Project, and to the Bethlehem Psychiatric Hospital, which is the ultimate referral level as well as where psychiatrists are trained in the WB. In all three CMHCs supported or created by the UNDP/AFD project, the visits included an interview with their director, and a focus group with the whole staff. Questionnaires, which had been developed as part of the inception phase, were also distributed in hand at each site, and later collected with the help of the PMU. Questionnaires were also prepared for the PHC staff trained by the project (through the Juzoor organization). The team requested the help of Juzoor for their dispatching to trainees. Juzoor did send an email to all trainees. The official acceptance of the querying of the PHC staff was also requested from the MoH's PHC directorate. No answer was received. A number of the trainees were unreachable as their email addresses had changed. The evaluators received 20 questionnaires in all from the CMHCs' trained staff (7 from Halhul, 8 from Nablus and 5 from Jenin), as well as 13 questionnaires from the PHC trainees.

On February 27, 2012, a debriefing meeting was held at the MHU in which Dr Afana was part, even if still in Gaza, through a telephone conference. The AFD and the UNDP were present at that meeting, along with the project's manager and the MHU's director. Annex 2 presents the list of people and institutions met and interviewed.

Dr Afana stayed in the WB until March 9 to complete data collection work and interviews with informants and stakeholders. However, due to logistical constraints, he could not get all the transportation help that had been provided by the UNDP to the Team Leader before. Neither could he get it from the MoH. This limited his capacity to visit sites where he could have complemented interviews and meetings already conducted by the TL and by himself over the phone. With all the limitations due to the known complications for a Palestinian to move around in the West Bank and the change of weather, heavy rains and snow, leading to the early closing or even vacation of some institutions, he conducted meetings with Juzoor, PCC, the centre for Continuous Education at Bir Zeit University, the Association of Psychiatric Patients and their families, as well as the Bethlehem Hospital.

2. ANALYSIS BY EVALUATION CRITERION

2.1. Relevance

Through the "Relevance" criterion the evaluation examines whether the project has been in line with the identified needs and priorities of the population (mental health situation). It also observes to which extent the Mental Health Project implemented by UNDP/PAPP and funded by the AFD matched priorities and policies of the MoH and its staff, i.e. the direct beneficiaries of the project.

The general context and epidemiological situation analyzed in sections 1.1. and 1.2 underline the overall relevance of responding to the growing psychosocial and mental health needs of the Palestinian population, which the project sought to address from its early onset.

2.1.1. Alignment with the mental health sector's strategic framework

The project has been part of a general effort to develop a Palestinian strategy to address the mental health needs of the Palestinian population. It has fallen in line with the national mental health strategic plan, developed first in 2004[23] with WHO's support, a plan was designed to develop community mental health care services and to integrate mental health services into primary health care services. There now is a second plan (2012-2014), though it has not yet been officially approved by the MoH. The plan reasserts the goal to develop a community based approach to mental health problems and to integrate mental health services into PHC settings. As stated in the plan, "The mental health strategy focuses on the importance on shifting the trend towards community based mental health services instead of providing treatment in the psychiatric hospitals." And: "One of the most important factors to have a comprehensive mental health service is the integration of mental health into primary health care especially in treatment and prevention for service users who suffer from common mental health problems such as depression and anxiety."

Therefore, the development of Community Mental Health centres (CMHCs), is a crucial component of the UNDP/AFD project, inserts itself into the overall mental health sector strategy. The 2012-2014 national strategic mental health plan states that "the goal is to have a community mental health centre in every district".

Integration of mental health services with Primary Health Care (PHC) services is a major objective of the national mental health strategy. It relies on the capacity of PHC personnel to be able to correctly detect, identify and refer cases of mental disorders. Cases referred should then be taken care of by specialised care facilities and providers, which, in the public sector, are represented by the CMHCs.

The national mental health plan

The National Strategic Mental Health Plan 2012-2014 is based on the organization of mental health services plan adopted in 2004. The previous plan was based on developing mental health services rather than focusing on the expressed needs of people; it was more a community-based project than a community development program. The plan was designed around needs defined normatively. There was a lack of an identification process that would have involved a more in-depth analysis of needs expressed by the various community groups and members in need to identify their concerns and necessities, taking into consideration the local sociocultural and spiritual context, as well as the human resources available and needed.

The national mental health plan was not able to translate operationally both the need for integration of mental health into PHC services and the objective of "deinstitutionalization" into clear measurable mechanisms. The plan also puts a lot of emphasis on theoretically short or quick courses for PHC professionals such as "Step Care Model" and "Music therapy" or general training modules, assuming that these courses will enable them to indentify and detect mental health problems without highlighting the institutional problems that General Physicians (GPs) face such as time, privacy, follow up, supervision, facilities. These short courses are suitable for professionals who already have a good

[23] Plan on the organization of mental health services in the occupied Palestinian Territory. by the Steering Committee on Mental Health. Final report. February 2004.

mental health background. Moreover, the policy did not provide with financial provisions for the undertaking of the process of integration. The diagnosis and treatment of mental health disorders in the Palestinian population had been characterized in the past by a lack of a vision and appropriate strategies. Many reasons were responsible for this situation, including: the stigma associated with mental disorders and the lack of training and appropriate tools – and interest to some extent – of the health personnel and authorities. This has led to a number of patterns associated with diagnosing and dealing with mental health disorders:

- Because of stigma, families hide their mentally ill and refer them to health centres only when they become severe or aggressive and families cannot deal with them any more;
- Cases have to be "stabilized" and are done so fairly systematically through medication only;
- Many cases are ill-diagnosed (autism, somatoform disorders, epilepsy – which is not a mental health issue – in lieu of actual mental disorders) and therefore are ill-treated;
- There is no or little attention to prevention or mitigation strategies;
- Training is inadequate (including in psychology and clinical attention);
- The primary care sector is not equipped to identify and triage cases adequately, and is not interested either (case of general hospitals refusing to accommodate dedicated emergency care services for mental disorders).

In order to address the weaknesses of the detection and diagnosis components of dealing with mental health disorders, the project included a large component of training to both primary health care staff (in order to improve their capacity to detect and refer cases) and to staff recruited for the newly created three centres.

This approach certainly made sense to address some of the main issues identified earlier. However, the relevance of this approach was limited. The philosophy of community mental health is to move mental health problems away from the exclusive territory of psychiatric care to more community-oriented interventions and holistic care. It views mental health in its wider perspective that emphasizes the relationship between mental health and social determinants of mental health such as unemployment, poverty, violence, human rights abuse, restriction of movements, education, etc. This shows that the intra-psychic determinants are recognized, but greater stress is laid on the interpersonal aspects of the person's functioning. This philosophy was not explicitly emphasized in the training modules for both the primary health care and community mental health centres. In MDM-F training to the CMHC personnel of Jenin and Nablus and in the Juzoor training to PHC personnel in the West Bank, there is introductory material about the philosophy of community-based approach, and in training conducted by Juzoor, there is also a module about mental health promotion. But, overall, this is still too limited to really cover the community-based approach in a comprehensive fashion.

2.1.2. Project design

The project represents a unique and comprehensive approach to the extensive problem of mental health within oPT. Each centre has its own multidisciplinary team that consists mostly of nurses, a trained psychiatrist, psychologists, and social workers. In one case there is also a speech therapist. The project has aimed at meeting the increasing and overwhelming mental health needs of Palestinians by establishing community mental health centres that are geographically accessible to beneficiaries. The project has also tried to integrate mental health into PHC services in order to increase the capacity of those to detect and correctly diagnose and refer cases, and provided mental health training to PHC personnel.

The task at hand was particularly challenging, since there are only about 35 psychiatrists in the whole of the oPT – 17 of whom in the WB and 18 in Gaza according to the 2012-2014 National Mental Health Strategic Plan for a total population of over 4 million people suffering from a large range of disorders, while psychologists in the public health sector, who number only about 15 in the WB and 30 in Gaza, do not have all the necessary qualifications to be able to tackle all the types of issues faced by their patients.

There are only 2-3 child psychiatrists, which certainly is insufficient given the fact that half of the population is under the age of 18, and is very exposed to a large array of stressful situations. In that regard, the pilot project in Halhoul was, indeed, a breakthrough in the West Bank, one that has

brought a new set of services in an area, pedo-psychiatry, which was un-developed until then. The 2012-2014 National Mental Health Strategy actually cites the opening of the Halhoul CMHC, dedicated to children and adolescents, as a "remarkable effort to develop children mental health services". It is very noteworthy to mention that the Bethlehem psychiatric hospital has no admission unit for children, which raises major concerns about the type and quality of attention for children with mental disorders.

The project has also attempted to tackle one of the serious social aspects of mental ill-health conditions – stigma attached to mental disorders – through the "anti-stigma campaign training" and leaflets distributed by the centres. In many communities, including Palestine, mental disorders are often a source of fear, and their causes are commonly thought to be supernatural possessions by "evils and devils" and sufferers and their families feel stigmatized to approach psychiatric services that are usually seen as custodial institution in which troublesome and frightening people are segregated[24]. Therefore people seek the help of primary care providers as the main gate of entrance, presenting their mental sufferings in physical terms.

The anti-stigma campaign using leaflets and mass media to convey the message about mental health and mental disorders addressed key issues in prevention. What is noticeable, however, is the lack of cooperation with two important institutions: religious orders and police forces. These institutions play an important role that should be explored and used in future plans.

The CMHCs attempt to utilize the family as a resource to help in follow up and support of their mentally disordered. In the Palestinian community collectivism prevails over individualism. Traditionally the family unit is the most important social group and is more important than the individual in terms of identity, status and inter-personal relationships, which makes community interventions more relevant than dyadic ones. When individuals suffer from mental health problems, it is the family who takes the responsibility of care, which is not always upbeat very positive kind of support. The evaluation team was told that some families hide psychiatric cases and even that some keep them behind locked doors.. Although utilizing families in providing care, such as in dealing with medication's side effects, anger, and other issues is not well documented by CMHCs, it has been introduced and is now practiced as an incidental part of the social norms.

The project set up, inherited from the initial involvement of the Cooperation services (SCAC) and also from the political situation in Palestinian territories (both in the West Bank and Gaza), has led to the recruitment without competitive bidding and without coordination with Palestinian national authorities of implementers, including Médecins du Monde's (MDM) France and Switzerland chapters, the Juzoor ("roots") Foundation for Health and Social Development, the Gaza Community Mental Health Programme (GCMHP), the Palestinian Counselling centre (PCC), and Bir Zeit University. Another two institutions were supposed to work on the project (the Guidance and Training centre or GTC from Bethlehem) and the CEDRATE from France. GTC dropped out because of the departure of its head (a pedo-psychiatrist). It was supposed to work in Hebron and was replaced by MDM Switzerland. CEDRATE, which was going to implement the research component, did not operate either since that component was abandoned[25].

The MoH has expressed resentment over the fact that the project picked a number of NGOs, international and national, for its implementation. The number of independent organizations that, eventually, participated in the project was four (4), five if MDM is considered for its two chapters or sister organizations, plus the Bir Zeit University (Library and Continuous Education Department). Some of the MoH officials interviewed thought that this number was much higher. Those same officials have expressed their dislike of the fact that independent organizations were primarily involved. MDM France's failures certainly did not help (see analysis of "effectiveness" and "efficiency" further down). The MoH officials don't perceive "logical" reasons for involving all these organizations in the implementation, rather than doing it directly through the Ministry. As legitimate as this critique is, it is also noteworthy that the MoH had, until then, little internal capacity to conduct a project of that nature and scale. Mental Health was given little regard the MoH and the public sector probably did not have enough resources, back when the project was designed. Although the project's implementation with different stakeholders and sub-stakeholders could be seen as confusing (MDM-F covering Jenin and Nablus while MDM-S was covering Halhul), the accumulated collaborative experiences with international and national organizations made it relevant to mobilize them to contribute to the

[24] Afana (200*6)* mental health situation for Palestinians, in Judy Kuriansky (etd) Terror in the Holy Land: inside the anguish of the Israeli-Palestinian conflict Praeger Publishers USA ISBN 0-275-99041-9.

[25] Sylvie Mansour, Assistante technique. *Rapport de fin de mission*. Not dated.

objectives of this project. Organizations of that sort usually bring different experiences and ideas as well as creative perspectives to the field. They also have flexibility to adapt to difficult socio-political circumstances, even if that is not always possible or well done as, indeed, has happened to MDM-F.

In order to develop the knowledge base, which is necessary to better understand the situation, the needs and to better plan, a research component had also been included in the project's original design. However, it was omitted, just as what happened with the WHO/EU mental health project. The problem with giving up this component, which was a relevant one in fact, even if ill planned, is that the opportunity was foregone to increase knowledge about the epidemiological profile and ethnographic and sociological dimensions of mental disorders in Palestine. The component could also have focused on more practical or operational research to help the mental health sector devise better approaches to tackling specific conditions, highly prevalent among the Palestinian population, such as depression, anxiety, PTSD.

The actual implementation of the project has, at times not addressed appropriately the socio-cultural context. This was, however, not a major issue. It was essentially limited to MDM France. The sequence of training sessions organized by MDM France and the approach used by some of the international instructors were not well received and created some frustration among participants. Language barriers were also a problem, sometimes, with some of the French instructors unable to fully communicate with the trainees for lack of a good translator between French and Arabic. Therefore, MDM-F was replaced by PCC, which is a local organization. The training was also deemed too general and theoretical by some (as reported by the 2010 activity report and by interviews with PHC professionals). In addition, the introduction of some modules was not conducted in the most culturally appropriate way, especially those related to adolescents' development, sexual development, family and mother relations, collective trauma, social and cultural representation of trauma and how trauma is expressed locally, the cultural relevance of PTSD in the Palestinian community, resilience and coping and local idioms of distress. Geriatric psychiatry is not perceived as a problem in the Palestinian community as expressed by some who were interviewed, and Ministry of Health reports in 2007, 2008, 2009 do not highlight geriatric psychiatry as one of the significant mental health problems. It is also worth mentioning that language barriers (the majority of handouts were in English), the fact that some of the international trainers were not aware of the socio-political context, that some of trainees professionals' preparation and skills were not up to level expected, and that days and time of training were often difficult to accommodate for trainees and their institutions, did contribute to technical limitations of training sessions and to limitations in their impact. There also was a lack of clear mechanisms of follow-up and supervision of those who completed training, no step by step guidelines for PHC professionals.

Main findings on Relevance:

The project has been an important part of the overall effort to develop a Palestinian mental health system to address the high and growing prevalence of psychological disorders and mental health problems in the Palestinian population.

In particular, the project has aligned itself with the National Health plan's focus on the needs of the Mental Health programs with a shift from institution to community base care and the integration of mental health services with primary health care services.

The project has also addressed the need to increase the number and the qualification of mental health professionals in Palestine. This was particularly the case for services to children and adolescents, an area where little had been done until then, even when half of the population is under 18 years of age.

The project addressed integration of mental health into primary health care. Such integration is highly needed for various factors related to stigma, limited mental health professionals; patients usually visit primary care providers as the main gate of entrance into the health care system.

The development of the community-based approach is very relevant and needed to ensure a more holistic approach to mental health. However, training designed for this project, both to CMHC staff and to PHC personnel, did not provide with sufficient coverage of the community-based approaches. The social determinants of mental health such as unemployment, poverty, violence, human rights abuse, restriction of movements, education, etc, emphasizing the interpersonal aspects of the

person's functioning, were not well covered. There were introductory sessions to the community mental health approach and mental health promotion. But, overall, this was too limited to really cover the community-based approach in a comprehensive fashion.

The choice of implementing partners, which has been done in an unusual manner, was still appropriate given the lack of internal capacities at the MoH at the moment of the project's design, even if the MoH was not satisfied with the process, which is a legitimate concern.

Some aspects of the project, however, have not adequately responded to the needs, in particular in regard to the lack of psychotherapy skills in the training curriculum, or the methodology used to deliver some of the training modules to the mental health professionals recruited to the CMHCs.

The non implementation of the research component was unfortunate as it could have been a good opportunity for the MH sector, and the MoH in particular, to better understand and document the ethnographic and socio-cultural tenets as well as epidemiological profile of mental or psychological disorders in Palestine, and, therefore, better understand the population's needs in terms of services. The lack of research has also limited the capacity of the project to establish a baseline.

2.2. Coherence / Coordination / Complementarity

With the "three Cs" (Coherence, Coordination, Complementarity), in the spirit of the 2005 Paris Declaration of Aid Effectiveness, the evaluation measures to which extent the design and the implementation of the project have been in line with the sector's and donors' other policies and interventions. This allows the assessment of whether the project has contradicted other efforts, whether it has set a different direction to the overall policies and why.

The WHO, together with the MoH, the Italian Cooperation and the French Cooperation, had started to work on developing support to the mental health sector in Palestine back in 2004, including the 2004 Strategic Organization Plan (SOP)[26]. This translated into an early programme, which focused on the development of new CMHCs, in Hebron, Al Bireh/Ramallah and Gaza, and training, while the Italian Cooperation, together with MDM Spain, supported the CMHC in Salfit. In particular, Sylvie Mansour, who has played an important role in the design and implementation of the UNDP/AFD project, was part of the working group that designed the national policy and its strategic plan. WHO's support was in line with its mandate in mental health, which is detailed in a "global mental health program to assist countries in establishing national mental health strategies, which support the development of local, community based, comprehensive mental health services."[27] WHO bases its interventions on its "Mental Health Global Action Plan" (2008).

The approach promoted by WHO in its support to the development of the mental health system in Palestine is called the "step-care model". It aims at developing a capacity for PHC personnel to better screen, identify and refer cases of mental disorders. To that aim, the UNDP/AFD project has contributed by including a training component directed to the PHC personnel.

The WHO/EU project started in December 2007, shortly before the UNDP/PAPP/AFD project, with a budget of 3.4 million euros. It helped establish the MHU in the West Bank and the Mental Health Directorate (MHD) in Gaza, supported the development of the Mental Health Families & Friends Society (MHFFS), trained mental health care personnel and supported the creation of three CMHCs in Al Bireh, Hebron and Gaza. It was deemed relevant to the needs of the mental health sector in the oPTs and was credited as having positively contributed to the development of the mental health sector's policies and overall responsiveness capacity by an external evaluation conducted in 2011[28]. The WHO approach to training for PHC staff was, however, very different to that of the UNDP/AFD project, with one-time 5-day training sessions for PHC GPs and nurses focusing on the "Step-care model", as well as to trainers (ToT) on the integration of mental health care into PHC.

[26] Plan on the organization of mental health services in the occupied Palestinian Territory. by the Steering Committee on Mental Health. Final report. February 2004.

[27] Office of the European Union Representative West Bank and Gaza Strip. Draft Report. *End of Project Evaluation "Mental Health and Psychosocial Services Support Project" In West Bank and Gaza strip*. Prepared By: Dr. Ahmed Heshmat Mohamed, Dr. Fahmy Bahgat Hanna. Rotterdam, July 27, 2011.

[28] Ibid.

The institutional positioning of the Mental Health Unit, which is unclear, especially as regards its relationship to the PHC directorate, slows the coordination process between the two authorities. The PHC professionals who are trained to identify and detect mental health problems in their settings are left without any follow-up, and the coordination between the PHC directorate and the MHU after training is not clear. In the same line, the MHU is sometimes not aware or even consulted when changes take place at CMHCs that are located in PHC premises. This lack of clarity of rules has led some mental health professionals to express their fears and concerns about the future of these centres. They are afraid that when the project ends the PHC directorate will take the over the centres and professionals will be reallocated to PHC centres.

As commented in 1.3, the original project design called for "support" to the MoH "in order to develop an institutional framework able to deal with mental health issues." The creation of 3 CMHCs, training to recruited staff and PHC personnel, and research were the three sets of activities to be performed, which did not address a number of important institutional aspects of the mental health sector's infrastructure, including the strengthening of the MHU's role and position within the MoH; the development of the collaboration between the MHU and international and local organizations to design professional standards, design therapeutic guidelines for depression, or anxiety for example, legislation regarding mal-practice, a supervision system, or risk allowances to encourage professionals to work in the mental health field. A team of local and international professionals was established to review and design a referral system, which is still work in progress.

The documentation centre is a complementary asset to CMHCs and PHC professionals. However, the centre was not able to coordinate and collaborate with local partners such as schools, religious institutions, and even with the Ministry of health. MoH's publications and reports are not even included in the Documentation centre. Intra-sectorial and inter-sectoral collaborations and cooperation are necessary.

Support provided by the WHO to the MHU included the recruitment of 3 staff, who were paid at international organizations' rates, way above the MoH's salary scale. They, therefore, left the MHU before or at the end of the project. This was avoided by the AFD/UNDP project, which managed to recruit staff for CMHCs at government rates and later to have them included in the MoH's payroll.

Some of the interlocutors met during the present evaluation have, actually, mentioned an impression of "confusion" between the two projects. Together, still, they have worked towards the development of a more coherent strategic framework and of the capacity of the mental health's sector capacity to meet the needs of the population, even if a lot remains to be done.

Parallely, the Italian Cooperation, with MDM Spain, supported the creation of the CMHC in Salfit, where the referral manual developed by MDM France in Nablus for the UNDP/AFD project is now also in use.

Finally, the financial support provided by the AFD for this project has been coherent with the overall support provided by the French cooperation to the development of the mental health sector over the years, as mentioned in 1.3.

Main findings on Coherence / Coordination / Complementarity:

Altogether, there was good complementarity between the UNDP/AFD project and those of other partners of the MoH, essentially as all these partners initially worked with the MoH to develop a common approach to the development of the MH public sector.. The 3 new CMHCs in the West Bank complement a small but growing network of CMHCs. The documentation centre is also a welcome addition to a field where the building of data bases and of knowledge is instrumental to improve the relevance and the quality of the response. The integration of MH services with PHC is also a very needed strategy to that end.

However, there is still a lot to do to develop the collaboration and complementarity between the various actors of the sector and the institutional relevance of the MoH, and particularly of the MHU, which still needs to be strengthened, something that the project could not really contribute to.

2.3. Efficiency

The "Efficiency" criterion measures the adequacy of the project's implementation procedures, management and coordination arrangements to deliver the expected outcomes. In particular, the evaluation reviews how UNDP/PAPP, the PMU and their implementing partners managed the provision of services associated with the activities planned, particularly in terms of timeframe, of quickness of response, and whether management procedures and processes, and the use of resources, were adequate and cost-effective. It also assesses the mechanisms used to plan, steer, and correct course when needed.

The initial phase of the project experienced delays due to the transfer of the project from the Cooperation services of the French Ministry of Foreign Affairs (and the SCAC at the French Embassy) to the AFD. This was not specific to this particular project as the transfer of competences from one administration to another, after the reform of the French public development aid apparatus was decided in 2003-2004, was extremely contentious and complicated, delaying many programmes and projects. The project was supposed to start in 2005, but did not until 2008. The arrival of Hamas in power, along the Fatah, in the summer of 2007, also led to further delays, as donors withheld their activities until after Hamas' departure in the West Bank. Subsequently, there were two addenda to expand the time-period allocated to the project's execution, at no further cost.

The UNDP was selected for the implementation of the project for various reasons including solid financial procedures, and also because of the very peculiar political and territorial context and its logistical consequences. A UN agency has more leeway, though by no means freeway, to move around in the oPT and between the oPT and Israel. However, UNDP's Jerusalem office has no experience in mental health and in the type of project proposed by AFD. But it has a lot of experience in infrastructural projects, which was relevant for the construction and rehabilitation component. The UNDP office in East Jerusalem has a solid organization to deal with procurement and management for engineering and construction. The high turnover of supervisors at the UNDP headquarters in Jerusalem (there have been four over the implementation period of the 3-year project and none with mental health background), and the general lack of community mental health expertise have undernourished the process and outcome.

The PMU was located next to the MHU's offices at the Al Bireh building that also hosts a PHC centre, a CMH centre and the MSK Documentation centre. This certainly is an appropriate location as to the daily work relations with the MHU. The UNDP headquarters in Jerusalem are a relatively short distance from the MHU, even with the longer routes imposed by the check points between Jerusalem and Ramallah. Many of the stakeholders are in Ramallah, next to Al Bireh, in Bir Zeit and East Jerusalem (MDM). UNDP's capacity to expeditiously cross those check points does facilitate the mobility of the personnel involved in the project, as the evaluation team has been able to witness.

Training performed by MDM France in Jenin and Nablus, which covered 14 sessions over a period of 1,5 year in all (see Annex 4), met with a number of problems, particularly the fact that the delivery of sessions did not follow the originally agreed logical sequence and that some of the sessions were conducted in an untimely and culturally inappropriate fashion. This was the case, more particularly, of the session covering sexual abuse. The modification in the logical sequence of sessions' delivery affected the efficiency of the programme in building up capacity. There also were a few gaps in time in the sequence of sessions, particularly between sessions 1 and 2 (4 months), 8 and 9 (three months), 10 and 11 (2,5 months) and 13 and 14 (2 months), while some of the sessions were delivered over short periods of time (sessions 4 to 8 over 1,5 month and 11-13 in one month). The actual sequence of the training programme was the following:

Trainers from France were voluntaries, unprepared, had no pedagogical material, could not speak either Arabic or English, some of them were not aware of the professional level of the trainees or the general context of the mental health provision in Palestine; printed materials and handouts in Arabic were very limited and the English handouts were distributed later. In her reports to the French Cooperation, Sylvie Mansour qualifies their intervention as a « fiasco »[29].

Problems with the involvement of MDM France led the project's Technical Assistant to accurately advise MDM to take action in June 2009, 6 months from the first session and 3 months after the second module[30]. She pointed at all the shortcomings, some of them judged very serious, and advised on ways to address them and correct course. This led to a better implementation process,

[29] Sylvie Mansour. *Rapport de fin de mission*. Not dated.
[30] Sylvie Mansour. Letter to MDM France. Ramallah, 23/06/09

particularly as regards the appropriateness of the delivery of sensitive materials. Among the correcting measures implemented was the recruitment of an experienced technical person who helped reorganize activities and who performed quality supervision. But she soon left the project and supervision work was then covered by local personnel with insufficient capacity.

As a result of the difficulties met with the MDM-F portion of the project, supervision and support work at Nablus and Jenin by MDM-F was terminated in July 2010 and handed over to the Palestinian Counselling centre (PCC), a local organization. However, PCC did not start working there until the end of 2010. PCC had been working in Halhoul CMHC in the past and was also familiar with the project's approach and activities.

3. PROJECT MANAGEMENT

Monitoring and evaluation set up

There was no logical framework used in the monitoring and evaluation process of this project. Such a framework existed, though, as part of the Program Document. However, no process or output indicator had been selected, diminishing its relevance for monitoring. A proposal for what could have been an operational logical framework (a synthetic version) is displayed in Annex 7.

Contrary to what is usually done in development projects, no multi-annual or annual action plans were established. There was a so-called "project results and resources framework" in the Project Document[31], with annualized main activities allocated to each implementing partner and indicative budgets. However, this document was never revised and adapted to the actual situation. Standard procedure would have seen the PMU design and submit an initial multi-annual plan and, subsequently, annual plans to the Steering Committee for approval. They would have served as the road map for implementation and as the reference for monitoring and evaluation. There was no baseline either, which makes it all the more complicated to measure achievements and impact. This, globally, was, in part, the result of the implementers' selection process, which had been done prior to the transfer of the project to the AFD for funding. This was unusual from a Development Aid standpoint, particularly for an aid agency like AFD.

As a result, project monitoring and coordination of stakeholders have not followed very clear procedures. It was left to the Steering Committee (SC) to review the advancement of activities, based on presentations made by the project's manager or acting manager, not on quarterly or half-yearly reports following a pre-determined framework.

The Steering Committee (SC), formally headed by the Director General of PHC and of Public Health at the MoH, which included representatives of the MoH, the UNDP and the AFD, did not meet as often as planned in the Project Document. This was supposed to take place at the end of each quarter. Its first meeting took place 6 months after the start of the project. It then did meet quaterly (3 times between September 2008 and April 2009), but there was then a gap of 5 months. Its final meeting was in 2010, at the very beginning of the year. According to the 2010 Activity Report, this was due to the difficulties to summon participants from the MoH, despite efforts from both the UNDP and the AFD to help convene the meetings. After Sylvie Mansour's departure from the project (March 2010), no SC meeting took place. This contributed to a late endorsement of the project's exit strategy and to delays in the implementation of certain activities such as the construction of an additional floor at Halhoul's CMHC.

- 1st SC meeting: 4th September, 2008
- 2nd SC meeting: 29th January, 2009
- 3rd SC meeting: 29th April, 2009
- 4th CS meeting: 17th September, 2009
- 5th SC meeting: 21st January, 2010

[31] UNDP / PAPP. *Project document for AFD Mental Health Project*. Undated.

The minutes and presentations made available to the evaluation team of these SC meetings only report on what is being achieved, and limited in depth of analysis. There are no mentions of the serious issues met by MDM-F and of the measures that were taken to correct course. The 4th meeting states that "*all the components of the program are now on the right track*" when in fact the GCMHP was not delivering what it was supposed to do.

Similar comments apply to a large extent to the two activity reports made available to the evaluation team (for 2009 and 2010), where fairly little is said and analysed about the problems faced, and some of the analysis of 2009 is repeated into 2010, with little added value. It is noted for example that one operator (MDM-F) is replaced by another (PCC), but in a very brief manner with no contextualization and real explanation as to why. On that aspect, the 2009 report was a bit more specific, but did not provide with the depth of information that was available in reports by Sylvie Mansour and that was provided to the evaluators during their field work.

Parallely, the reporting system has not been implemented in a clear fashion, which has probably been detrimental to a more efficient management of the project. Even if of good quality, activity reports have been produced only annually, twice: in 2009 and 2010, while the 2011 report was not yet available at the time of the evaluators' work (February-March 2012). Meanwhile the AFD conducted its own supervision visits in various occasions and irregular schedule. The Technical Assistant sent her own reports, in French, to the SCAC. With the early departure of the project's managing director, who was not replaced, this further weakened the monitoring process and effectiveness of the project.

The monitoring process was not clearly established, even though a monitoring system was apparently in place at UNDP. Only annual activity reports were prepared, which did not mention that M&E set up anyway. The 2011 activity report was not yet finalized at the time of the final evaluation process (February-March 2012) and still is not available as of June 2012, which is quite unusual in project management terms. The AFD, on its own, did conduct regular monitoring or so-called "supervision" visits (see list of monitoring reports in Annex 1). These took place, during the lifetime of the project, in September 2007, May 2009, September 2009, March 2010, and January 2011.

The AFD's direct involvement in supervising the project led to the design of the "Exit Strategy". This was due to the fact that the project management was not, until then, really planning forward (there were no plans for that matter), and, more particularly, not preparing for the end of the project, as if assuming that the project would keep on going, with continuous funding. The design and implementation of this exit strategy was a very relevant initiative, which is in line with standard procedures for project and program design nowadays.

Procurement and cost-effectiveness

Procurement was, overall, fairly smooth, through the UNDP's procurement department. Most materials were procured nationally, except for sand (Israel), steel tubes (imported from outside), and some other items such as the folding separation at Halhoul, which was imported from the United States. Imported items have to go through Israeli customs, which can be cumbersome but was, generally, not a problem. The UNDP's procurement office and the Engineering department seem to have been able to solve issues that arouse. This included electrical power in Halhoul, which was going to cost way more than budgeted as the specifications changed (from 24 Amps single phase to 32 Amps triphase). The Engineering department managed to rework the budget negotiating with the mayor of Hebron to lower the costs of electrical fixtures that were to be set up by that municipality.

Construction projects were first elaborated by the Engineering Department (with contractors but under their supervision). The Department's staff ensured supervision. Cement could not be poured without their approval. The Halhoul CMHC created some challenge because the addition of a new floor (in 2008-2009) meant the strengthening of the building's foundations and supportive structure. Yet, it posed no serious challenge to the project's schedule. Another floor was actually added in 2011 to that same building in order to expand the centre's floor space in order to accommodate group work.

Working with Birzeit University was not a very smooth process, apparently, especially with the Main Library. Three addendas (one more than for the overall project) had to be agreed upon and the request for funds from the university was very significantly higher than originally budgeted. One of the extensions was at no cost, though. Strikes at both the MoH and BZU, in separate occasions, did

contribute to the delays recorded. Training that BirZeit University's Main Library provided was mainly related to classifications and cataloguing, which is definitely important for a library setup.

Table 2. Costs of centres built and equipped

Costs in €	Surface area (m²)	Total construction cost	Cost / m²	Equipment cost	Total cost	Total cost / m²
Jenin Community Mental Health centre	**360**	**106 300.00**	**295.28**	**49 276.30**	**155 576.30**	**432.16**
Nablus Community Mental Health centre	**558**	**194 221.14**	**348.07**	**47 641.80**	**241 862.94**	**433.45**
Halhoul Community Mental Health centre	**130**	**86 123.80**	**662.49**	**20 033.02**	**106 156.82**	**816.59**
Al Bireh Documentation centre	**140**	**54 000.00**	**385.71**	**43 960.29**	**97 960.29**	**699.72**
Total	**1 188**	**440 644.94**	**370.91**	**160 911.41**	**601 556.35**	**506.36**

Note: The average cost at Halhoul is higher because consolidation work had to be undertaken on the building in order to be able to add new floors to it.Source: 2009 and 2010 Activity reports

Due to delays at the start of the project and in the delivery of training activities, two extensions of the project were decided, one from June 2010 until June 2011 and then from June 2011 until June 2012, mainly to complete the extension of the Halhoul Centre as well as the present evaluation, the last activity of the project. Both extensions were decided with no further cost.

The present evaluation has apparently been one of the most complicated of all activities to procure and set up. The selection process was launched several times (the only time in the whole project). The first time it was nationally, as per the UNDP procurement rules (budget is within the 2.500 – 100.000 USD threshold), but due to the failure of the three initial bids to match the quality criteria, the tender was launched again, at the international level internationally, repeatedly until a decision was made. This alone explains the extension of the execution period until June 2012. However, there were still construction works underway at Halhoul centre where the second floor's fixtures were still being completed at the time of evaluators' visit. It will be used for group work. The MHU was, according to the UNDP's rules and regulations, solicited to provide feedback on the evaluation's ToRs, but did not provide any. It was not involved in the selection process of the contractor for the final evaluation.

The Exit Strategy

As mentioned earlier, under the request of the AFD, an "Exit Strategy" was designed to help bring the project to its forestalled conclusion. It set a course for the final 6 months of operation (June 2010 – December 2010). A very large number of activities were supposed to be undertaken and of results to be achieved, including an additional floor at Halhoul, the installation of elevators in CMHCs deprived of them, the rehabilitation of another CMHC in the West Bank, and many completion and capitalization reports by partners. The MoH was supposed to perform also a large number of tasks and produce numerous outputs. These included:

- A standardized referral system exists and it is replicated in other CMHCs;
- One-year training plan for future trainers;
- Training manuals included in the MoH's learning pgrmes and uploaded on MoH's website;
- These training modules have become standard for delivery before recuiting MH staff;
- Develop a role playing video ;
- 3-year O&M plan by MoH for the 4 centres;
- 4-year recruitment plan ;
- Community Outreach Plan built by the MoH from those built by the operators.

Very significant savings (of up to 809 358 euros) had been recorded as of mid-2010, which were to be used for the Exit Strategy's implementation. This was mainly due to delays in the implementation of some of the project's activities, in the availability of funds and lower costs accounted for by the UNDP

services to the project and because there was a need to beef up supervision of mental health professionals working at the centres. Staff's salaries and operational expenses at the Documentation centre and the Halhoul CMCH were also to be covered by this remaining budget.

This was an overly ambitious plan and it is apparent that many of the activities and outputs envisaged have not been achieved. However, the strategy was instrumental to secure the inclusion of the CMHCs' and Documentation centre's staff into the MoH's personnel with regular employee contracts. This was obtained through a negotiation, which included the acceptance by the UNDP/AFD to pay for the staff's salaries for another year (2010). The cost to the programme of paying those salaries was 102,000 USD a year.

In order to manage the implementation of the Exit Strategy, a work plan was to be designed and monthly meetings were to take place between UNDP, AFD and the MoH to monitor progress. We have not seen either the work plan or minutes of those meetings, confirming the appreciation of a lack of a solid monitoring and evaluation system, overall.

Despite the fact that several amendments were applied to the project and that AFD brought forward the idea of an Exit Strategy for the reasons expressed above, no mid-term or intermediate evaluation was conducted. An external review would have been helpful to design that exit strategy, in particular.

Main findings on Efficiency:

The choice of the project's implementing agencies (UNDP and its partners) was probably judicious given the oPTs' particular and challenging context. The location of the PMU next to the MHU's office in Al Bireh was also a rational choice. However, the UNDP's Jerusalem office was not prepared to administer a project with soft components of that kind since it had mostly experience and competence in infrastructures. The good pace of realization of the infrastructure and the capacity to solve problems met along the way of these activities has demonstrated that competence.

The absence of a PMU presence in Gaza and the extreme difficulties for staff, even UNDP staff, to travel from one part of the territory to another due to the political situation affecting this part of the world, made it more difficult to follow on the activities planned there.

The weak planning, the absence of annual action plans approved by the Steering Committee in particular, of a clear monitoring tool and procedure and of a baseline, were detrimental to the efficient implementation of the project. It did lack a tool for measurement of efficiency, effectiveness and impact. Moreover, the institutional set up of monitoring, where the Steering Committee met only 5 times in the course of almost 4 years, and involving reports issued by a variety of partners, added to the confusion and was not consistently implemented. This contributed to a lack of clear leadership, to the need to extend the project twice. Responding to these steering issues, an Exit Strategy was designed belatedly in order to help bring the project to its end. It had too many objectives and activities, and its own M&E system was not implemented.

The implementation of the project itself also faced a few several serious challenges, including the incompletion of activities in the Gaza strip and damaging difficulties in the delivery of the training component entrusted to MDM France for the CMHC staff in Nablus and Jenin.

3.1. Effectiveness

With the "Effectiveness" criterion, the evaluation assesses the level of execution of the project, the level of fulfilment of its objectives, and the results that this has allowed to achieve.

The Project had an original budget of 2.740.000 Euros, or approximately 4.2 million USD at the time of the start of the project (March 2008). Of these 3.2 million USD have actually been spent as of the end of 2011 (see table 3).

Table 3. Summary of project expenses

Data in US Dollars	2008	2009	2010	2011	2008-2012
Activity 1: Construction of Jenin, Nablus, Halhoul and Ramallah centres.	247 219,84	413 135,04	45 795,79	111 133,73	**817 284,40**
Activity 2: Furnishing and Equiping Jenin, Nablus, Halhoul and Ramallah	0,00	105 278,97	51 378,35	40 289,62	**196 946,94**
Activity 3: Capacity development of Mental Health & Primary Health care staff	206 909,32	573 015,57	601 434,84	538 594,30	**1 919 954,03**
Activity 4: PMU management	63 333,22	93 990,57	34 899,00	90 714,37	**282 937,16**
Activity 5: CMHC Salaries and Running cost		101 802,12	102 014,78	7 660,47	**211 477,37**
Total	**517 462,38**	**1 287 222,27**	**835 522,76**	**788 392,49**	**3 217 122,53**

Source: PMU

As noted in the relevance section (2.1), the last of the three components of the project (research) was not performed. This was due to several factors, among which: the apparent inadequacy of the research planned as compared to the MoH's needs, the fact that the French researchers who were going to conduct the research had no counterparts in Palestine (when this should have involved Palestinian researchers first and foremost), that there were some language barriers (none of them could speak either English or Arabic), and the fact that Palestinian students who were going to perform research activities under this component had no research experience.

It is not clear why research was budgeted again as part of the Exit Strategy, given the fact that it had already been abandoned at the start of the project. Research is not a straightforward activity to organize and manage. It requires a lot of preparation, very specific skills and fairly long time-lines, unadapted to the type of project that was conducted and especially to a one-year "exit strategy". No research activity was performed, indeed.

3.1.1. Achievements

Component 1: Construction and rehabilitation of 3 CMHCs and of a Documentation centre

The project has led to the opening, in the spring of 2009, of three modern and well equipped Community Mental Health centres (see table 4), located in three of the four main Palestinian urban centres of the West Bank (Hebron-Halhoul, Nablus, Jenin) and of a documentation centre dedicated to mental health in Al Bireh / Ramallah. The CMHC in Halhoul is dedicated to children and adolescents. There now are 6 CMHCs in the West Bank in all, including those opened recently in Al Bireh and Hebron (with the support of the WHO/EU project) and in Salfit (with the support of the Italian Cooperation and MDM Spain). There also are 7 CMHCs in the Gaza strip (Jabalya, East of Gaza City, West of Gaza City, Middle area, Khan Younes, Rafah, and one dedicated to children).

CMHCs seem to be provided with enough space to accommodate all activities planned to be performed there. The Halhoul CMHC is being expanded at the time of this writing, with a second added floor that will be used for group activities in order to meet the growing demand for services. The Halhoul centre was built up from an existing one-floor old building, formerly used as a PHC centre during the Jordanian times. One floor was added there in 2008-2009. The addition of the second floor was decided as part of the exit strategy and commissioned in 2011. The ground floor is being used as a storage space by the Hebron MoH.

In Jenin, the space floor is probably not as well organized as it could have, with a stair case leading into a large open space in the middle of the first floor, which serves mainly as a waiting area. The space dedicated to occupational therapy is too small and seriously limits the ability of that department to operate, as reported by the staff.

The Nablus CMHC is located on the top floor of a fairly large building where a PHC centre is also located (similarly to the CMHC's situation in Al Bireh/Ramallah). It seems well equipped. The centre is

located in an area that is fairly difficult to reach (far up on the hills even if close to an important hospital).

CMHCs are opened from 8 in the morning until 3 in the afternoon, five days a week Sunday to Thursday.

Documentation centre

The project has allowed the creation and the equipment of a mental health Documentation centre (DC), named "Mohamed Said Kamal" (MSK DC). It is located on a new floor (third) added to the Al Bireh Directorate of Health building. That building also hosts Al Bireh PHC and CMH centres, as well as the MoH's Mental Health Unit. The centre is staffed by a librarian and an Information Technology (IT) specialist.

The UNDP/AFD project funded the acquisition of books and the subscription to periodicals, up until 2011. There currently are a total of 576 references, 346 of which in English, 214 in Arabic and 16 in French. Subscriptions to scientific journals include the British Journal of Psychiatry and the American Journal of Psychiatry. These subscriptions run up till the end of 2012. There are no plans to renew them for now. MoH reports and publications are not included, leaflets and other anti-stigma materials published by the CMHCs and other local institutions are also missing; local research studies and articles are not part of the list contents.

As a complementary activity, the centre hosts monthly meetings and workshops for the CMHCs. The evaluators did not have a chance to attend one such meeting but these have been confirmed by CMHC psychiatrists. Pictures of those meetings have been placed in Annex 5. The centre's nature, it seems, is oriented more towards a traditional library, where the vision and mission of a veritable and modern resource centre is probably still missing. Moreover, the DC has no website despite attempts and preparatory work to open online services. An IP address has finally been secured in the fall of 2012.

The centre is being used by students from local universities' medical schools who come to research for papers they need to write as part of their curriculum.

The DC is located on the third floor of the Al Bireh Health Directorate, where there is no elevator and no access for disabled people who are interested in using the resource centre.

Table 4. Construction and opening schedule for the four centres

	Construction time-line	Operational in
Jenin Community Mental Health centre	**Sept 08 - Oct 09**	**April 2009**
Nablus Community Mental Health centre	**August 08 - March 09**	**May 2009**
Halhoul Community Mental Health centre	**Nov 08 - March 09** (1)	**June 2009**
Al Bireh Documentation centre	**July 09 - January 10**	**Oct. 2010**

(1) A second floor was added to the Halhul centre as a result of the Exit Strategy. It is to be used for group work. This was completed between July 2011 and March 2012.

Source: Interviews with UNDP's Engineering Department, PMU, activity reports, visits to the centres.

Component 2: Recruitment and training of staff for the 4 centres. Integration of recruited staff into the Ministry of Health staffing system

The project had planned to recruit 18 professionals to staff the 3 CMHCs and the Documentation centre. 19 were actually recruited and incorporated into the 4 centres, two of whom for the DC. Since then, employment in the centres has increased and there currently are 30 positions opened for a total of 28.5 equivalent full time employees, 3.5 of whom are psychiatrists (see table 5). Recruitment started when the construction of all centres was completed. Job descriptions were prepared by MDM-F and MDM-S, with the MoH and the PMU's supervision.

Table 5. Current employment levels in centres created by the project

Centre	Personnel (Qualification / Positions)	Number
Halhoul CMHC	Psychiatrist Psychologist Nurse Occupational Therapist Other specialties (Speech Therapist) Social Worker Pharmacist Clerk / Receptionist *TOTAL (Equivalent full time / Employed)*	1 3 1 0 1 0 0 1 ***7 / 7***
Jenin CMHC	Psychiatrist Psychologist Nurse Occupational Therapist Social Worker Pharmacist Clerk / Receptionist *TOTAL (Equivalent full time / Employed)*	1,5 (1 full time + 1 ½ time) 2 1 1 1 1 1 ***8,5 / 9***
Nablus CMHC	Psychiatrist Psychologist Nurse Occupational Therapist Social Worker Pharmacist Clerk / Receptionist *TOTAL (Equivalent full time / Employed)*	1 4 1 (2 part time) 1 2 1 1 ***11 / 12***
MSK Documentation centre	Librarian IT Specialist *TOTAL (Equivalent full time / Employed)*	1 1 ***2 / 2***
TOTAL	**Psychiatrist** **Psychologist** **Nurse** **Occupational Therapist** **Other specialties (Speech Therapist)** **Social Worker** **Pharmacist** **Clerk / Receptionist** **Librarian** **IT Specialist** ***TOTAL (Equivalent FTE)***	**3,5 / 4** **9** **3 / 4** **2** **1** **3** **2** **3** **1** **1** **28,5 / 30**

A problem with recruitment at government health facilities in the oPTs is that salary scales are very low and, therefore, unattractive.

Training was organized for both primary health care professionals to enable them to identify mental health problems in their clinical settings and for mental health professionals at the CMHCs to enhance their skills and improve service delivery. It has benefited to all personnel newly recruited or already in place in the 3 CMHCs (20 persons in all) and the Documentation centre (2 persons), as well as to additional personnel recruited for the CMHCs but not paid by the project, as explained above.

Personnel recruited at the 3 CMHCs was trained by MDM France (MDM-F) for the Jenin and Nablus staff and MDM Switzerland (MDM-S) for Halhoul's, over a 1,5 year period and 14 modules, as shown in Annex 4.

Despite the MHU's opposition to bring in foreign trainers, and its wish to use psychiatrists from the MoH, MDM-F and –S's involvement in the project were maintained. MoH psychiatrists did not have, at the time, the necessary training in certain areas and were mostly driven by an experience from severe cases essentially treated with medication. The MHU director and its "training and education officer"

were both involved in the training sessions and acquired experience in "selecting trainers, preparing pedagogical material, training approaches, and training evaluation techniques."[32]

In general, training touched on many different subjects related with mental health (see Annex 4 for a complete list of training modules used by the organizations involved in the project). The time dedicated to each of these subjects was generally insufficient to provide with an in-depth education about each of the topics. They did provide with a good overview of many important subjects to know about in mental health care. But in terms of practical skills, the training sessions organized by MDM-France and Switzerland, were not able to provide real applicable tools.

Training conducted by MDM-France:

The MDM-F provided services for teams in both Nablus and Jenin, after a needs assessment targeted the two teams. The needs assessment showed the need for shifting the paradigm of training from individual to community-based approach focusing on a positive mental health approach, emphasizing community resilience, prevention of mental health problems, promoting mental health aspects and provides care for pathological reactions MDM-F trained both newly recruited staff as well the MOH already existing staff. Also, MDM-F provided supervision of the staff in both Nablus and Jenin, in the form of group and individual supervision.

As indicated by the UNDP Final Report-MDM 22-03-2011, MDM-F was not able to meet the needs for the development of psychotherapy skills training because it "requires long term training that involves not only analysis but also (…) self reflection (…) and requires a common basis on wellbeing and psychopathology that should be part of the University curricula of post graduation studies". Training provided was approved by the MoH and the Mental Health Unit.

MDM France's involvement in the project was not as effective as it should have been, in part because the selection of experts recruited for training was not always adequate. This was particularly the case with some of the international trainers, volunteers who came unprepared. Trainers did not have the handouts needed and some of the trainers were not familiar with the Palestinian mental health context. Another problem faced by MDM-F was the language barrier; French instructors used French as the language of instruction. As indicated in section 2.1.2, the lack of good translation hindered the transmission of technical and conceptual material. Other challenges related to the time and venue of the training as well as the fact that some of the trainees did not receive their wages on time.

There was also inadequacy in the way some of the material was delivered by international trainers, in a few cases, which were not appreciated by the trainees[33]. In some cases also, the material delivered was different from what had been announced in the session's title. All this led Sylvie Mansour to react strongly and ask for adjustments early on[34]. Adjustments were provided. However, the involvement of MDM-F was terminated upon the completion of the training component, in July 2010. The PCC was brought in to perform supervision in Nablus and Jenin.

MDM-France was still involved in a 2-day workshop in October 2010, on the standardization of referral protocols and tools and to facilitate access to mental health services of the Nablus governorate's population.

During the year 2009 MDM-F national and international trainers taught 14 training modules described in tables 4.1 and 4.2 of Annex 4 (with dates, hours and time), conducted in 43 full training days.

Training conducted by MDM-Swiss:

MDM-S provided five days introductory training about community mental health, about services provided by a CMHC centre, team members and definition of Community mental health centre, organization and difficulties faced by the team. However, the training was not able to convey the philosophy of community mental health services and Supports Standards that cover a wide variety of

[32] Sylvie Mansour. *Rapport de fin de mission*. Not dated.
[33] Communication by Sylvie Mansour.
[34] Letter of Sylvie Mansour to MDM-F on 23 June 2009.

services including mental health promotion and education, early intervention services, crisis intervention, counselling and therapy, peer and self-help programs, diversion and court support, and social rehabilitation and recreation.

Various of the training and supervision sessions were conducted by local and international trainers that varied between child development, parenting skills, law and ethics, child psychopharmacology, and interventions such as expressive art therapy, play therapy and psychometric evaluation of children and adolescents. Handouts were distributed, some of them in Arabic. Annex 4, table 4.3, presents the list and content of the training modules used by MDM-S.

Training for the Documentation centre's staff:

The Librarian recruited for the MSK Documentation centre was trained at the Bir Zeit University's Main Library in traditional library cataloguing and classification of textbooks and periodicals, while the IT specialist received training at the university's IT Department.

Component 3: Training for PHC personnel

Training was organized for primary health care professionals to improve their capacity to screen / detect cases and refer them more appropriately. Training was designed to a large extent by Sylvie Mansour, with contributions from psychiatrists involved, with her, in the preparation of the original FSP project, and delivered by Juzoor in 12 modules (see table 4.4 in Annex 4). Modules were developed from training modules already developed and used by Sylvie Mansour in the past in the oPT. They were adapted to fit the project's objectives, as well as to fit the format intended for delivery, including face-to-face sessions and, later, distance learning.

The PHC training was conducted in the West Bank and the Gaza Strip. The main purpose of PHC training was to integrate mental health into PHC and make mental health services more accessible to service users.

The training modules are rather general in scope and theory based with less emphasis on skill-based training, something that participants to the focus groups and interviews conducted by the evaluation team expressed as highly needed. The philosophy of Community mental health is missing in all training and major part of the implementation. Community mental health services and Supports Standards that cover a wide variety of services including mental health promotion and education, early intervention services, crisis intervention, counselling and therapy, peer and self-help programs, diversion and court support, and social rehabilitation and recreation.

Training modules are very general and not focused on the main mental health problems prevalent in PHC settings such as anxiety, depression and stress related disorders. The modules are good in raising PHC professionals' awareness about mental health, but come short to really enable GPs to detect and identify mental health problems. The modules allow a good exposure to mental health and mental disorders, but they don't enable GPs to intervene effectively on mental disorders because the modules are mainly theoretical and cover a wide range of themes. In all, 110 topics were covered by 13 different trainers. The modules were not able to provide PHC professionals with skills needed to enable them to detect and identify common mental disorders such as anxiety and depression. The modules also were not able to give GPs and PHC professionals a picture of available community resources that enhance recovery and social support. Half of the training modules are about children, only one about disorders. There is not one module about ways of identifying anxiety and depression, tools that would enable GPs and other health professionals to identify and detect these disorders, such as short list screening tools. Modules do enable GPs, however, to provide some support to patients and their families such as reassurance, understanding patients' sufferings and becoming more sensitive to mental ill-health conditions.

PHC staff training In the West Bank:

The Juzoor ("roots" in Arabic) Foundation for Health and Social Development, an NGO that has been active in the Palestinian Territory since 1996, was identified to train primary health centre providers (primarily medical doctors and nurses) from the MoH, the UNRWA and local NGOs. Juzoor was also recruited to provide supervision and anti-stigma campaign training. However, interestingly, persons responsible for the program at Juzoor, that we met, have no training in mental health. They are trained in management and public health. Juzoor has contracted mental health professionals such as PCC to provide training.

Training was organized in 12 modules, covering a variety of general topics (see tables 4.5 and 4.6 in Annex 4). Half of the modules (1-5) are about child, adolescent and post-partum disorders, while anxiety and depression disorders, which are the most common mental disorders in PHC are given less attention. Palestinians are exposed to multiple and repetitive traumatic events and live in constant stressful situations that have great impact on their life. These important topics were given little time and were discussed quickly and briefly. The field visits and case presentations described in module 11 and 12 are observational visits to CMHCs to raise participants' awareness about existing facilities and possible ways of cooperation through referrals in the future. However, this does not provide skills based clinical training. Case presentations were discussed as part of OSCE final evaluation day (see below the list of modules).

Bir Zeit University's centre for Continuous Education (CCE), in collaboration with Juzoor, arranged an E-learning training and developed educational materials available electronically. The department provided the design of training materials and a multi-media specialist. The Department designed a platform of 9 educational modules available at the Continuous Education Website. Participants were given access to these modules by providing each of them with a user name and a password. It is important to mention that for the last year, nobody accessed the web-materials and there is no mechanism to develop or modify the materials on-line. When participants were asked about the last time they had accessed the on-line materials all of them responded they had not done so since they had completed training because they do not have access to emails, or because the materials remain the same and they already have them. The involvement of Bir Zeit University's CCE allowed the course to be validated by a university certificate.

Training involved "face to face" sessions only for the first two groups, and a blend of "face-to-face" and online teaching for the third group. The first two groups were trained over a period of 12 months, 3 days per month, in Ramallah, while the third group was trained in 5 months only as part of the exit strategy. The list of modules is presented in Annex 4.

Before training and throughout the courses, questionnaires indicated that most participants reported a cooperative atmosphere within the training institutions but also that there was some ambivalence about roles, equity and resolving conflict within the team. Participants were well disposed towards more comprehensive training. Some fears were expressed about taking time out from work with patients.

Feedback from trainees was collected by the evaluators from 9 telephone interviews conducted with some randomly selected professionals, in addition to the collection of 13 questionnaires from the PHC trainees. Informants communicated that the training modules were delivered in a relaxed atmosphere, with good rapport between participants and the facilitators. There were high levels of participation and positive, focused interaction. Modules helped participants to understand mental health clients / patients and ways to deal with them; how to listen to their patients and talk to them; participants were introduced to the use of psychiatric medication such as antidepressants, mood stabilizers and antipsychotics, especially regarding their side effects, indications and classifications.

The aim of the training was clarified for the participants by the delivering institution at the beginning of training. The PHC directorate, which endorsed the training, circulated written announcements to all PHC centres to participate in the training.

Post-training evaluations, interviews, and questionnaires indicated that collaboration within trainees' working facilities remained largely unchanged. There was, however, some improvement in clarity about roles and individual authority within their team. Follow-up interviews confirmed earlier responses and revealed that no follow-up from the training institutions or from the PHC directorate or even the mental health unit was conducted. Most trainees interviewed expressed their unhappiness because they felt ignored after training and felt that they are not utilized as they should. Some said, that "nobody asked us about the training we completed, you are the first one to ask us about our opinion, we were sent by the PHC directorate, we left our work for training and no one bothered to ask us". Main points rose by the trainees in the interviews and questionnaires collected were the following:

- Some of the training modules need to be designed in a way that is more appropriate to the cultural and political context; this regards, more particularly, modules about mother child relations, adolescent mental health, ADHD and complex trauma; PTSD and its relation to culture and social meaning of trauma;
- Training was too theoretical, lacking systematic practical skills such as interview skills, how to identify cases in PHC settings etc. Role-play, lecturing on signs and symptoms of psychiatric disorders are not skills; it is giving information and knowledge.
- Although participants were officially approved by the PHC Directorate, there was no follow up from the mental health unit in Ramallah and or from the PHC directorate;
- Specific course in a specified psychotherapeutic approach and comprehensive skills based counselling techniques are needed;
- Theory based training have contributed to the frustration because when participants are back after the course no change in the system and no proper placement to employ the knowledge gained throughout the courses: no privacy, no private room to conduct interviews with patients;
- No protocols for PHC and no clear vision and plan of what is going to happen after the training courses.
- Training topics were general and scattered ("training topics were like picked from different areas").
- No encouragement or incentives for mental health professionals associated with training;
- After training, there is no communication and or clinical consultations with mental health specialists.

Three groups of PHC staff were trained in the West Bank. The first two groups were composed, respectively, of 17 and 18 people. A third group was added, as part of the Exit Strategy. This group's training ended in December 2010. 60 persons in all were selected to participate, with the PHC Department's help (Dr Ramlawi, the PHC Director, even participated in interviews). Sylvie Mansour also contributed to the selection of trainees. Among the criteria retained was training already received (they tended to select persons who had not yet been trained in other programs), age (tending to recruit younger persons), some proficiency in English (tests were conducted), direct contact with patients, level of commitment. 7 trainees did not complete the course, so 53 PHC staff received a certificate. 35 staff from the MoH's PHC sector and 18 more from other departments of the MoH, from the UNWRA and one from Juzoor participated in the training sessions (table 6). Contrary to what was stated in the 2009 report – that 25% of the personnel trained that year were from local NGOs –, only one person trained actually worked in the NGO sector.

Table 6. Number of PHC professionals trained by the UNDP/AFD project in the West Bank

	Qualification of trainee			
	GP/Doctor	Nurse	Other	Totals
MoH/District				
Bethlehem	*2*	*-*	*-*	*2*
Hebron	*6*	*6*	*-*	*12*
Jenin	*3*	*1*	*-*	*4*
Jericho	*-*	*1*	*-*	*1*
Jerusalem	*1*	*1*	*1*	*3*
Kufr Naameh	*-*	*1*	*-*	*1*
Nablus	*3*	*6*	*-*	*9*
Qalqilya	*1*	*-*	*-*	*1*
Ramallah	*4*	*4*	*-*	*8*

	Qualification of trainee			
	GP/Doctor	**Nurse**	**Other**	**Totals**
Tubas	*1*	-	-	*1*
Tulkarem	*1*	-	-	*1*
Salfit	*1*	-	-	*1*
Sub-Total	23	20	1	44
MHU	-	-	1	1
UNRWA	1	4	3	8
NGOs	-	-	1	1
Total	**24**	**24**	**6**	**54**

Source: Lists of trainees provided by the PMU

PHC staff training in the Gaza Strip

Training to the PHC staff in the Gaza strip was to be conducted by the Gaza Community Mental Health Programme (GCMHP), an ONG created in 1990. There were many difficulties faced by the organization of this activity. An agreement was signed between the UNDP/PAPP and the GCMHP in August 2009. 20 PHC professionals were to be trained from the MoH (14 personnel) and various institutions (Medical Relief, Medical Services, Patient's Friends, Medical Services Hospital and GCMHP itself).

Juzoor sent teaching material to the GCMHP as well as all the details concerning the procedures they use to evaluate the training program, the trainers, the trainees and the impact of the training[35].

Despite the discussion of issues and efforts made towards their resolution, as attested by the minutes of the SC meetings, the programme never really performed as expected. For example, one third of the training time was cut: from 48 to 32 hours. UNDP Project management was not satisfied with the GCMHP training performance and interrupted their contract. Only part of the full amount was transferred. The project's financial liquidation report for GCMHP shows that out of 81,623 USD allocated by the project to the activities to be performed by GCMHP, 57,064 USD had been spent, leaving with a balance of 24,658 USD. It is also worth reminding that travelling to Gaza is very difficult, even for UNDP employees. A Permit is needed to pass the Eretz check point, which limited very significantly the ability of the PMU and even of UNDP to monitor the advancement of activities in the Gaza strip, despite the involvement of the UNDP Gaza office. Sylvie Mansour was able to visit Gaza and review the progress of the GCMHP component[36]. Video conferences also took place at times between the various stakeholders involved in the project; during Steering Committee meetings particularly, that also included the GCMHP and UNDP Gaza. The project's acting manager was not able to visit Gaza until December 2011.

The program tried to get the Islamic University in Gaza to get involved and to deliver a certificate to the trainees, but the university requested a sum of money for this that was deemed inappropriate and that idea was eventually not pursued.

The document obtained from the UNDP in Gaza is ambiguous and not clear. The title of the activity as written in the document is "one year training of doctors and nurses working in PHC in Gaza in community mental health", while the second page of the document describes a postgraduate Diploma in community mental Health. In addition the document also mentioned a "clinical year" described as: "training year will be divided into three semesters of 16 weeks each, and four core modules (48hrs) will be given each semester, (three semesters, 16 weeks each) and 12 teaching modules".

However, the GCMHP's progress report[37] indicates that the total number of hours of training was reduced by 1/3, from 48 to 32, due to the fact that "trainees were allowed to attend the training twice weekly (Tuesdays & Thursdays) with only 4 hours each time (11.00-15.00)." The report further notes

[35] Minutes of the 3rd Steering Committee, April 29, 2009.
[36] As mentioned by: Gaza Community Mental Health Pogramme. *Training of doctors and nurses working in primary health care centres in Gaza. Progress report. July 2009 – May 2010.* Not dated.
[37] Gaza Community Mental Health Pogramme. *Training of doctors and nurses working in primary health care centres in Gaza. Progress report. July 2009 – May 2010.* Not dated.

that “the ministry of health is understaffed and they could not (as they say) exempt the trainees from work for two full days a week.” According to information provided by the focus group discussion, the course was stopped without notice. Trainees pointed to weak managerial steps taken by the GCMHP and were not able to tell where the challenge laid.

The document lists 5 broad aims and objectives of the postgraduate diploma that are not related to the 12 training modules listed. Those objectives are:

- Explore theoretical concepts in community mental health and human rights in addition to their practical application. Wide exposure to clinical experience enables them to discover their particular interest in mental health, while learning…integrate them in clinical practice and research;
- Shift interventions away from concentration on the individual and his unconscious motivational conflicts to move closer towards an emphasis on social interpersonal care and the role of a person’s environment;
- Understand the change in the role of mental health professionals from being providers of mental health care to facilitators of care, thus enabling individuals to solve their problems using the resources of the family and community institutions such as schools, etc;
- Analyze the links between health and human rights in addition to the role, which they play within the community;
- Gain professional skills, which help the transition from theoretical classical-based study to skilled and practical application with the community;

It looks that the document described a two-year postgraduate diploma in community mental health that is not related to PHC training. The training modules are listed in Annex 4.

Of the total initial number of 20 PHC professionals who participated in training, two dropped at the beginning of the course (first 2 sessions) for personal reasons. The evaluation team’s mental health expert held a focus group discussion with 6 PHC participants in Gaza in addition to phone interviews with 3 more trainees.

Those who work in the governmental sector heard about the course from the PHC directorate while others who work at NGOs section were approached by the GCMHP. The candidates indicated that they applied for a diploma in mental health recognized by educational institution, but it was not the case. The focus group discussion showed that, in fact, the aim of the training was not clear to participants and that the GCMHP provided them with conflicting messages as to the nature of the course: first an accredited diploma in community mental health certified by a local university, then a course in community mental health. The participants did not receive any forms of certification for their participation. But the fact is that the course was not completed, even though it had been shrunk from 48 to 32 hours. Moreover, according the GCMHP’s progress report, the fees required by local universities for the accreditation of the course were too high and were not accepted by the project (the report says “by the donor”). This had been discussed with the UNDP representative visiting Gaza and with Mrs Mansour, but it could not be solved.The participants reported that, in the beginning, training was delayed for around two months as the GCMHP’s training department was not ready to start. Trainers were not punctual and participants felt that some trainers were not qualified. At the beginning was scheduled in the morning; then it moved to the afternoon, which was not convenient to participants. Training was not consistent and always interrupted by the GCMHP. Participants used to come two times a month, sometimes three times and then the training stopped suddenly without any notice. As indicated by the participants around one third of the planned training sessions were missed.

They also reported that the GCMHP stopped the training without informing the participants. They also indicated that no pre or post assessment was conducted and they kept asking for practical training or even some skills development to be incorporated into training, but the training department did not listen to their demands. The participants reported the following weak points of the training received.

- Training environment was tense and not relaxing;
- Training was confusing, no specific goals or objectives were explained by anyone, including trainers;
- Trainers were not updated, not punctual and regularly postponed their lectures;
- Trainers were not aware of why training is organized;
- Training was based on lectures, which participants described as “useless and boring” information;
- Participants needs were not respected;
- Some of the training modules did not match the cultural context and reality such as child and adolescent disorders, communication;
- There was no course in a specified psychotherapeutic approach;
- No protocols for PHC and no clear vision and plan of what is supposed to happen after training’s completion;
- Training topics were scattered (“training topics were like picked from different areas”).
- Participants were not given any handout materials, no reading materials and no references;
- No certificates were provided to participants;
- Participants were officially approved by PHC Directorate. However, there was no follow up form the PHC directorate nor from the GCMHP;
- No guidance after the training courses;

Complementary training

In order to strengthen the capacity of MH professionals to better diagnose and serve their patients, a number of complementary training sessions were organized. Needs were identified by the PMU, mostly Dr Mansour.

Training in psychological tests: A one-week workshop on Psychological tests was conducted by Dr Claire Deacon for 8 psychologists (3 from Nablus, 2 from Jenin, 2 from Ramallah, 1 from the Bethlehem psychiatric hospital) in October 2009. It was about conducting an assessment using the Wechsler Intelligence Scale for Children. During 2009, Sylvie Mansour delivered complementary training to psychologists from the 3 CMHCs set up by the project as well as from other mental health institutions (the Ramallah Health Directorate and the Bethlehem Psychiatric Hospital). According to the 2009 activity report, “this training concentrate on the skills needed to use psychological tests for evaluation and other skills psychologists need in order to conduct an assessment or evaluation of the client.”

Professional training Workshops: Seven Mental Health Professionals from Jenin, Nablus and Halhoul participated in the training that was organized by a team from Sainte-Anne Hospital, Paris (23 – 26 March 2009). The training sessions took place in the Bethlehem Mental Health Hospital.

Workshops and visits abroad: Two psychiatrists, one of whom is director of the Halhoul CMHC, received a few days of training abroad (in England and Switzerland in July 2009) on Adolescents Mental Health Care.

Staff from the Nablus CMHC was also sent abroad for on-site training and observation: one group in Jordan and one in Egypt. Trainees reported to the evaluators that they did not greatly benefit from those experiences as they thought that did not learn anything particularly new there. But they certainly appreciated the possibility to get out of the West Bank.

Other complementary training activities included the support provided by the project to the logistics involved in the participation of mental health professionals from the Jenin, Nablus and Halhoul CMHCs in a session organized by the Ste Anne Hospital in Paris at the Bethlehem Psychiatric Hospital in March 2009. At that time the two hospitals had a twinning relationship. This was terminated when the person who led it at the Ste Anne hospital later retired.

Other activities had been planned, which involved a participation of professionals at a conference in Geneva and training in Al-Riad, but could not be performed for visas were issued either too late (Geneva) or not at all (Al-Riad). The administrative hurdles faced by the project, including difficulty to obtain visas, has actually hindered the capacity of the project to perform some of the complementary training that had been envisaged for CMHC staff.

A specific module on parental skills was set up at the request of both the MHU and Sylvie Mansour and was delivered in March of 2010 through a full 7-day session. 17 psychologists and social workers attended the session, from all three CMHCs but also from the Bethlehem Arab Society for Rehabilitation.

As part of the Exit Strategy, MDM France, after the termination of its activities at the Nablus and Jenin CMHCs in July 2010, organized a workshop in Nablus in October 2010, in order to help harmonize the referral system there. This brought representatives from a variety of organizations and institutions involved in mental health, including the MoH and the PHC level, and led to the production of a referral booklet[38]. This booklet is now in use in Jenin and Salfit.

Supervision

Supervision was conducted during the project by MDM-F in Nablus and Jenin through Norani Khalafan, who was competent but left the project early. She was replaced by a local psychologist who did not have the competence to perform this activity. Professionals were brought in by MDM-F for training (Julia Granville for example) who also contributed to more quality supervision. After the end of the MDM-F involvement in the project in July 2010, PCC took over and performed supervision, but for only about 6 months and not until the end of 2010. Supervision was also conducted by Sylvie Mansour.

However, supervision conducted during the project's implementation was task-oriented, emphasizing case discussion and conceptualization, where supervisors provide with instructions to clinicians on how to deal with the case and information about appropriate diagnostic and therapeutic interventions. This supervision is of the "integrated model" type; the focus is on process and conceptualization. "Process" issues examine how communication is conveyed. For example: is the supervisee reflecting the client's emotion, did the supervisee reframe the situation, could the use of paradox help the client be less resistant? Conceptualization issues include how well supervisees can explain their application of a specific theory to a particular case--how well they see the big picture.

Supervision practiced at Halhul CMHC was part of the training activities. However, It seems that clinical supervision was constructed around individualized learning plans for practitioners working with clients. It seems that supervision has not been endorsed as key professionals' development.

MDM Switzerland implemented "clinical supervision" for counselors at Halhul community mental health centre as well as training courses. Supervision was provided once every 2 weeks for 3 hours each session. The supervision was provided in the form of case discussion by a psychologist and psychotherapist. Another "clinical supervision for psychiatrist" was provided for the child psychiatrist. Another form of supervision ("institutional supervision") was provided for all team members where they can discuss their feelings and challenges faces during their work. This form of supervision was provided once every 4 weeks, three hours a session.

Anti-stigma activities

As intended by the project design, work was also conducted specifically towards the reduction of stigma associated with mental disorders in the oPTs. This was performed rather belatedly, mostly at the beginning of 2011, with the help of PCC, the CMHCs' staff and the MHU. This campaign included leaflets and a series of radio programmes on one local radio station, in addition to some community activities and school visits.

[38] Ministry of Health ; Mental Health Unit. Mental Health Referral System. Booklet on referral protocols and tools. 2011.

The anti-stigma activities were conducted in the form of producing leaflets about mental health problems, radio spots related to mental health issues, in addition to school visits. The effectiveness of these activities was not researched in the framework of the present evaluation. Moreover, it takes time to measure the effectiveness of combating stigma and the impact of stigma activities. Yet, the community (and family)-based approach does pay off as far as reducing stigma is concerned, as underlined by Martin and Johnston (2007): "the importance of engaging clients and their families at all levels of decision-making and service delivery based on their unique understanding and direct experience of stigma contribute positively to combating stigma efforts."[39].

3.1.2. Outcomes achieved

Clinical practice

In the following section, the evaluators refer to training modules conducted in the West Bank only. Training in the Gaza strip is not included here. The main reason for this is that training was not completed.

The program included international and local trainers who have long experience in clinical practice, medicine and training. The evaluation team managed to interview some of the local trainers only. Feedback from the trainees, local trainers and the mental health project management was used to assess the international trainers' contribution. The main findings of this assessment are summarized as follows:

- All are very positive as they thought that International trainers used high standards for delivering training and had strong clinical experience;
- Trainees appreciated the variety of professionals' profiles and experiences provided by the project, as this provided them also with a variety of perspectives;
- Sometimes, the literature provided was too much to absorb, especially in a short period of three days a week;
- Follow-up after training was finished, by either local training institutions or the PHC, or the MHU (which has a training department), was very weak; as one of the trainees commented: "what is the value of our training if there is no follow up and monitoring".

In the West Bank, staff interviewed in all three CMHCs indicated that training modules on family and group therapy, and on parenting skills (delivered by a clinical psychologist - Julia Granville), had been the most effective on their learning process and their capacity to perform. Interestingly this included more particularly the last two sessions. In particular, psychologists mentioned repeatedly the benefits they draw from the training on psychological and IQ tests. This included the "Wechsler Preschool and Primary Scale of Intelligence" (version IV) for kids and adults.

The overall length of time over which the sessions were delivered (1,5 year) probably also affected the efficiency of the learning curve. But the fact, also, is that the person who delivered the last module on Family Therapy (Dr Julia Granville) stayed for a total of three months to work with the personnel she had trained. She conducted supervision and was there to support the staff in their daily work and to implement new skills practically. This has certainly played a major role in the development of capacity and, as a consequence, has had a positive impact on the staff's appreciation of the training delivered in this particular case.

There is a sense, from all interviews and focus groups with practitioners, that if understanding of psychological disorders, their variety, their complexity and of the variety of responses available to meet them, has increased, the training has only superficially grazed the depth of each subject and, therefore, has not been sufficient to build strong therapeutic competences. "People know the chapters' title" as one interviewee put it, "but they don't really know their good details".

There still are no real psychotherapy services offered at the centres. This is an effect of both lack of training in those skills but also of constraints inherent to the situation of the CMHCs and of the public MH sector in general. Psychotherapy requires long and patient processes that may last years as well

[39] Neasa Martin & Valerie Johnston (2007) A Time For Action: Tackling Stigma and Discrimination - MHCC Report to the Mental Health Commission of Canada.

as specific training not offered in the oPT. Such services are not currently possible in the Jenin and Nablus CMHCs. Psychiatrists offer "fast-track psychotherapy" (about 3-4 sessions) in the best of cases. This was seen at the Al Bireh/Ramallah CMHC as well. They just don't have the time to dedicate 45-50 mn sessions to their patients on a regular basis, except at Halhoul and psychologists don't have the appropriate qualification. With 30-70 patients a day that is impossible for psychiatrists. And the number of patients is increasing. The Halhoul CMHC definitely has more space as the psychiatrist there does not see more than a dozen patients a day. The psychologists who work in the CMHC are not clinicians, and there are no psycho-analysts or clinician psychologists, contrary to what can be found at PCC for example.

The lack of psychotherapeutic services at the CMHCs is due to the lack of time and of qualification, but also to the fact that training provided did not really cover techniques and procedures covered by psychotherapy. Psychologists or psychiatrists have not received training to that end during the project. It is true that the background of psychologists does not predispose them to be able to become psychotherapists just after a few sessions of training. Even the training provided by WHO emphasized that adults suffering from depression and stress should be taken care of in primary care settings using, to a large extent, anti-depressants. Sylvie Mansour noted that recent work conducted in France blamed the over-prescription of anti-depressants by GPs and the "medicalization of social suffering".[40]

As a consequence, in the public sector at least, treatment relies on prescribing psychiatric medication by psychiatrists, and of a mixed bag of supportive interventions (games, income-generating activities including weaving and basket making, field trips, etc.). Psychiatrists deal with the more psychotic patients, many of whom were referred from the psychiatric hospital where they had been stabilized with drugs, and keep them on the psychotropic medications, only varying the dosage. Mental health patients usually come late in the development of their troubles, at advanced stages of psychological or mental health disorders, leading almost systematically to medication. In the private and non-governmental sector there are many organizations that do psycho-social work. However, only a handful (Juzoor and PCC) do have some competence in psychiatry and psychology/clinical work. PCC for example has clinical psychologists and psycho-analysts trained in France, the USA and elsewhere. PCC has an active line of 500 patients or so. The public sector apparently dealt with about 800 a couple of years ago. The current figure is probably a bit higher now as shown in table 7.

Regarding training for therapy, Sylvie Mansour noted that "training for therapeutic care has been dealt with through several training and supervisory sessions. Progress here can only be relative when one wants to introduce the concept of dynamic psychotherapy, taking into account the intra- and inter-psychic conflicts. Psychologists do not have the theoretical basis and cannot, therefore, easily deepen the therapeutic interventions. They are frustrated by the psychotherapy training because they are looking for practical solutions, "recipes", that they could use systematically."[41] She was pointing at the training provided by Julia Granville in family therapy as a potential vector to help transform the way therapy is approached.

The evaluation team, based on the interviews and focus groups with trainees, understands, in fact, that the participants are looking for structured therapeutic skills training that would enable them to interview and help their clients.

The treatment patterns seem very similar to what happens in the United States where psychiatrists' time dedicated to each patient has progressively been squeezed, to a point where psychotherapy is not part of the treatment any more, in many cases, and their work ends up checking patients every now and then to pretty much just refill the prescription[42]. A large number of patients actually come to the CMHCs, referred by private doctors (about 1/3 of the patient load in Jenin for example according to the centre's staff) because drugs prescribed there are free of charge. In fact, according to the information gathered, psychotic or neurotic patients do not have to pay for either consultation services or prescriptions. Only neurological cases, including epilepsy, have to. And it is arguable that these patients should not be taken care of in CMHCs. In the CMHCs, however, psychiatrists say that those patients still come to them because the treatment they receive in the PCH centres or from neurologists is not appropriate.

Staff interviewed in all three CMHCs indicated that sessions on family and group therapy, and on parenting skills, had been the most effective as to the development of their capacity to perform. In

[40] Sylvie Mansour, Assistante technique. *Rapport de fin de mission*. Not dated.
[41] Ibid
[42] See for example : Daniel Carlat. *Unhinged: The Trouble with Psychiatry — A Doctor's Revelations about a Profession in Crisis.* Free Press. 2010.

particular, psychologists mentioned the use of IQ tests, which they did not have before. IQ tests are used to estimate a child's intellectual functioning through performance of various tasks designed to assess different types of reasoning.

Despite the lack of transportation means, the staff indicated that they now can work with the community, the families, in a much more effective way. In Jenin they even organize workshops with the community, with schools.

In all three centres the focus groups with the staff did show the fact that there is a lot of enthusiasm among them, and that they work as teams. They also pointed at many needs, including better equipment for occupational therapy, more specialized training, transportation, a speech therapist (in Jenin), and for leasure activities that would benefit them, personally, including field trips. They need to "get out there", to see the world, "go to the beach".

Administration and logistics

There now is an appointment system in place in Halhoul and Jenin, which is a novelty in the West Bank. This was not easy to implement. Patients, at first, did not understand or accept the new system. In the Palestinian health care system, people are attended on a first come first served basis; so they cram the waiting rooms early in the morning, putting pressure on health care personnel to deliver services as fast as they can. MDM France (in Jenin and Nablus) and Switzerland (in Halhoul) provided support in the implementation of the appointment system. Because of a lack of interest in the training and the support to the centre in general from the director in place in Nablus at the beginning of the project's implementation, the appointment system was not set up and has not been able to work there ever since. It is a pity, because in both Halhoul and Jenin, where it has been set up, it works well and to the satisfaction of everyone, care takers and beneficiaries alike. Patients and their families have got used to it and, actually, adjusted well. As reported by staff interviewed in Halhoul, nowadays families coming with their children to the CMHC apologize over the phone when they cannot come. Centres do not have phone lines that can reach to cellphones so staff members use their own phones at times to reach out to people for appointments when needed.

The project had procured a car to the Nablus and Jenin centres through MDM France, which used it in the two centres alternatively to enable their staff to do community work. No car was provided to the Halhoul centre through MDM Switzerland. As agreed, at the end of the involvement of MDM France, the car was turned to the Nablus MoH. It was supposed to be still used by both centres. However, the car was then transferred to the MoH's logistical department in Ramallah, and was subsequently made available to the MoH Nablus, but used by the PHC Department. Therefore, contrary to the original agreement, the means of transportation that had been planned for the two CMHCs in Nablus and Jenin did not materialize in the long run.

Activity volume at the CMHCs

As a result of better work conditions and overall environment at the CMHCs, for both staff and their patients/clients the number of cases referred to the centres and the overall workload have been increasing, especially at the Halhul CMHC (see table 7). In the first half of 2012, Halhul has registered 193 new cases, which, if extrapolated, would indicate a trend towards 386 new cases in 2012, or another 10% increase, after 50% in 2011.

Table 7. Uptake in new cases at the three CMHCs

New cases referred to the centres		2009	2010	2011
Nablus CMHC	opened in May, 2009	77	312	316
Jenin CMHC	opened in April, 2009	243	296	284
Halhoul CMHC	opened in June, 2009	53	232	350
Total		**373**	**840**	**950**

Source: PMU, MoH, CMH centres

With the 3 centres opening in the spring of 2009, the increase was essentially recorded in 2010. In Nablus and Jenin the number of new cases has remained stable in 2011 as compared to the previous year, according to data provided by the project's PMU. According to data from the Ministry of Health, the increase in the total number of cases being detected and dealt with in districts where the CMHCs have been completed thanks to the project is indeed significant, particularly so in Nablus. Overall, Jenin, Nablus and Tulkarem rank first, by far, in the number of cases detected (see figure 4).

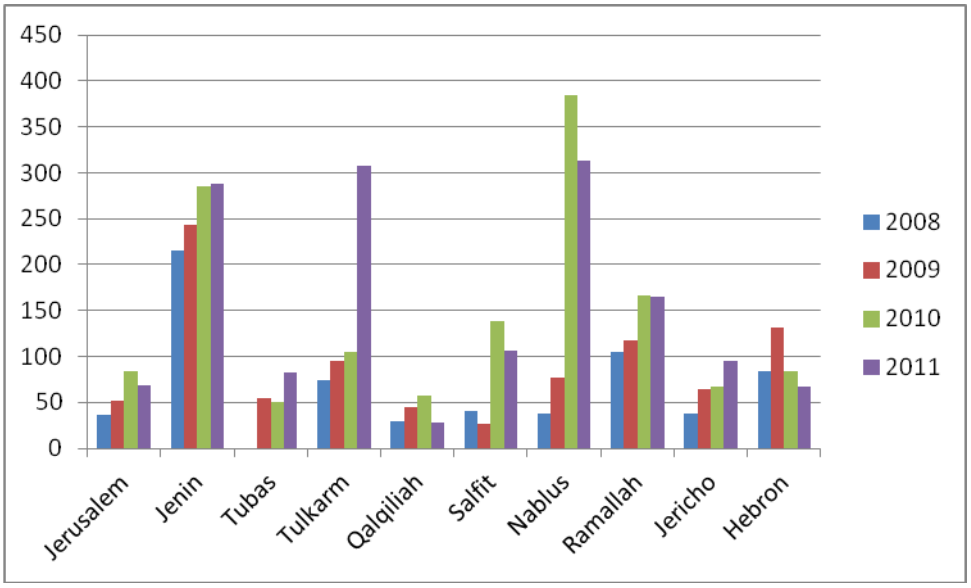
A portion of these cases are referred back to where they came from, especially those that regard confirmation of diagnosis (for example the degree of IQ, of mental capacity) or for establishing a therapeutic plan and a referral to specialized establishments (for rehabilitation for example). But some are not referred back. In Halhul, for example, 20% of referrals are self-referrals, and 30% in Jenin[43]. Those are taken care of at the centres. In Halhul, 40% of new cases are referred by the MoH, 20% by private doctors, 20% by the Ministry of Education (schools). With services provided for free at the centres, there is no or little incentive for patients and their families to be sent back to private practices, for example. The accumulation of cases has created a situation in which the psychiatrists, more particularly, are overloaded. In Nablus, the psychiatrist sees up to 70-120 patients a day. It is about 30-40 a day in Jenin and a dozen a day in Halhoul. Nablus does not have an appointment system in place, which puts extra pressure on the psychiatrist, who has to check on all the chronic and new patients, others being taken care of by psychologists, social workers and other therapists according to the treatment plan established by the psychiatrist and the team for supporting activities (family therapy, games, occupational therapy, field trips, etc.). Patients seen by the psychiatrist can only be interviewed briefly to review their status and, most of the time, to prescribe drugs. Prescribing, as a result, is still used on a pretty systematic basis ("we are doctors after all, we have to prescribe" says one psychiatrist). With the proportion of the persons coming to the centres being referred by their own families, particularly because they have heard positively about the centres, these are a little bit victims of their own success. And it is clear that there is still a very large margin of increase in the number of cases that are still in the community without appropriate detection and treatment, despite the advances in screening, diagnosing and treating that have been allowed by the project. But, evidently, the centres are, at this point in time, reaching their absorption full capacity. They are opened only until 3 pm and do not record much activity after 2 pm.

Overall, in the West Bank, the uptake in MH new cases has been sharp between 2008 and 2011, particularly for neurosis and mental retardation (see Annex 3 for the data base and figure 5 below for 2011 data). Apart from Nablus, already mentioned, this was particularly true for Salfit, and Tulkarem (figures 4 and 5). In Jenin, one of the centres developed by the project, the uptake has been much slower. There, the statistics show that the progression of the number of new cases has been on the upward trend mostly for affective disorders, a bit less for neurosis and epilepsy (figure 6). In Nablus, schizophrenia, neurosis and mental retardation explain the sharp increase (figure 7).

With data constructed as they are, it is difficult to draw clear overall indications and conclusions. With the same training applied to both Jenin and Nablus, the numbers and the trends do not match. Other factors need then to be identified.

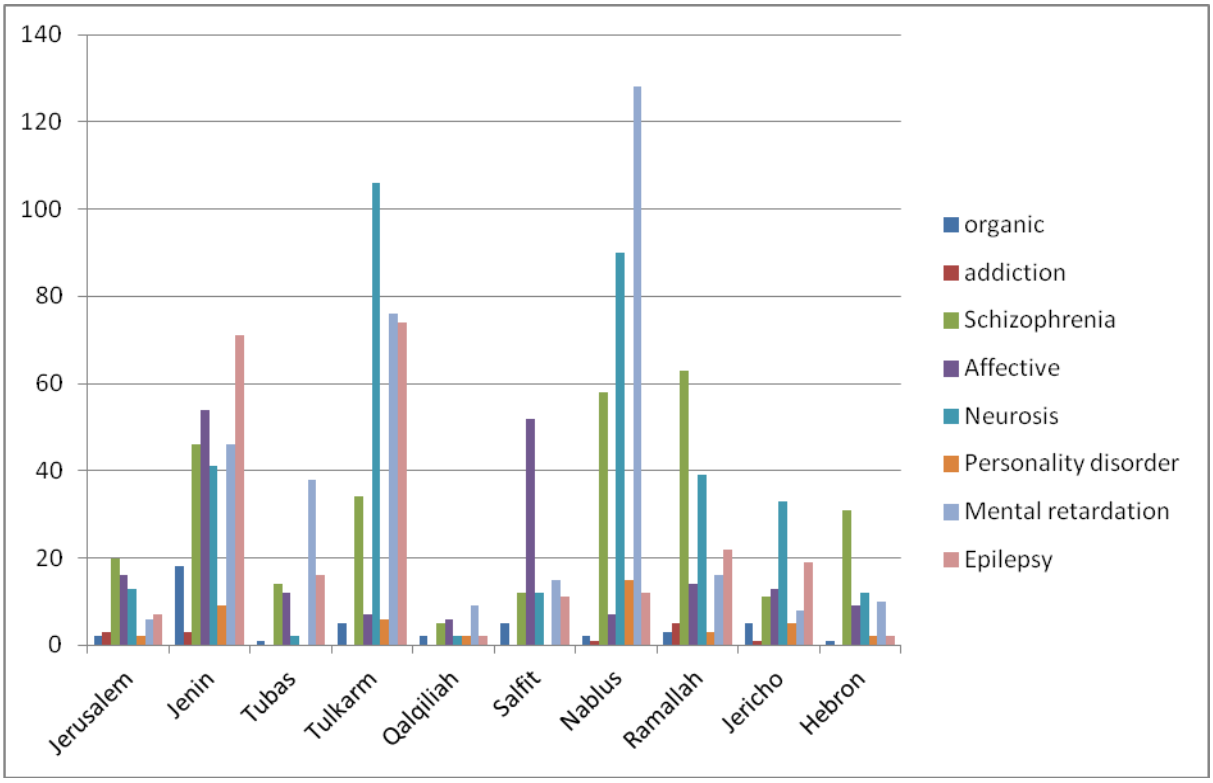
[43] Communication from the centres' directors.

Figure 4. 2008-2011 total detection of new mental health cases (plus epilepsy) in CMHCs of the West Bank



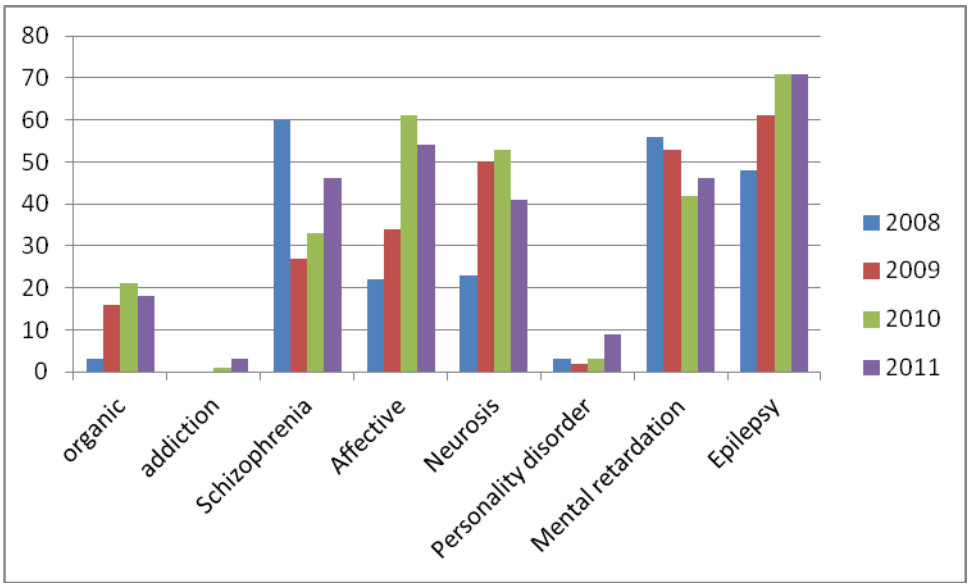
Source: data from MoH (based on statistics from CMHCs)

Figure 5. Detection of new mental health cases in all CMCHs of the West Bank in 2011 (Halhul excluded)



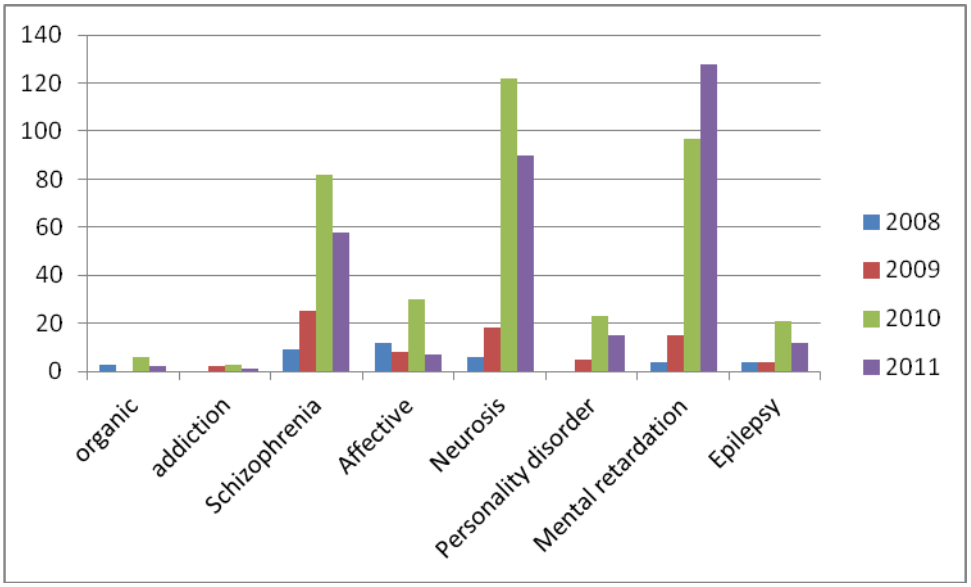
Source: data from MoH (based on statistics from CMHCs)

Figure 6. 2008-2011 detection of new mental health cases at the Jenin CMHC



Source: data from MoH (based on statistics from CMHCs)

Figure 7. 2008-2011 detection of new mental health cases at the Nablus CMHC



Source: data from MoH (based on statistics from CMHCs)

Activity at the Documentation centre

Despite its promises and the apparent dynamism of its staff, the Documentation centre is barely used. Staff members interviewed in all three CMHCs supported by the project declared that they had never used it, neither had they ordered books or other publications from it. On the contrary, the Al Bireh / Ramallah CMHC, located in the same building as the DC, does use it. Clearly, the distance, logistical obstacles and, maybe, a lack of communication between centres and the DC may explain this surprising fact. Despite its repeated requests to the MoH, the DC had not been granted an IP address and was therefore unable to open a website and on-line services. Fortunately, this issue has been resolved and an IP address was granted in the fall of 2012. The IT technician has been trained and recruited precisely for that purpose and the maintenance of such services.

In the meantime, the DC staff has been printing lists of all the documents held in the centre and distributed it to all public mental health institutions. However, there still are staff members in the CMHCs who do not know about the very existence of the MSK DC. The absence of an electronic platform, where potential users could check on line the list of documents available, order them, download those digitalized, and search for further information from links made available by the website (after review of their relevance by a MHU review or a panel), does limit the capacity of the centre to fully perform its function. The idea of opening decentralized small libraries in each of the CMHC, where basic publications would be shelved, is being discussed. Some of the publications available at the DC have multiple copies that could be spread around. However, after more than a year of operation, nothing has been undertaken to that end yet. There seems to be a lack of leadership in that regard.

Still, the centre seems to have established itself as a good reference for universities. Students do come to the centre in order to search for information that might be useful for their academic duties, particularly when they have to write papers. However, as it is the only one centre of its kind in the oPT, and maybe even in the region (Israel excepted – but because of the restrictions on movement the existence of other documentation centres in Israel and the region would probably not make much of a difference for students and other users).

Integration of mental health into PHC settings

The integration of mental health services into PHC was stated in almost all documents reviewed as a goal to be achieved. However, the National Strategic Mental Health Plan (2012-2014) and the Plan of mental health services in Palestine 2004 do not describe clear mechanisms to achieve this integration. Interviews with key mental health interlocutors showed that the concept has been understood differently by different people. At the Bethlehem psychiatric hospital, for example, integration is seen as making mental health services for chronic patients more geographically accessible by using the PHC settings to dispense psychotropic medication instead of making it hard to chronic patients to travel for hours to get the medication from the out-patient clinic of the hospital. As described in the project document, integration is (only) about training of PHC professionals, mainly GPs and nurses, in mental health. The aim is to provide PHC professionals with basic knowledge and certain skills to enable them better identifying mental disorders in their settings. Work was also conducted between by a team made up of representatives from WHO, MDM-S, MDM-F, MDM Spain and the PMU to review and modify referral forms, among other documents used to follow up on patient care.

The WHO document called “Manual for Health Counselors Draft 1: program for integration of mental health care for common mental disorders in PHC”, clearly states that “the manual is for health counselors working in PHC in OPTs”. The manual gives a clearer idea of how to identify the most common disorders, namely anxiety and depression. The manual describes thoroughly the bio-psychosocial reactions to stress; defines mental health and vulnerability and risk factors to the anxiety and depressions; and describes methods of screening depression in the clinic and how to use General Health Questionnaire. It gives substantial knowledge about certain skills that the counselor can use in very clear and simple language.

The manual is not known by all those who were interviewed and was not mentioned by the key stakeholders except the WHO national mental health coordinator in the oPT.

However, that same manual has its own limitations. It presumes that a health counselor is available in PHC setting, which is not the case in the oPT. The manual was designed and applied to an Indian context. It is not culturally appropriate because it misses the metaphors, local expressions, local idioms of distress people use when they are stressed such as “*sadma*”, “*my chest is tight*”, etc.

I think we have talked about integration above, it is enough we do not need the box and in the recommendation section we also give them a recommendation

There still are limitations to the actual integration of community mental health care services with the PHC level. In particular, there is no unified referral system at the national level: each centre or district (Nablus has a more integrated system thanks to the workshop held with MDM France’s support in October 2010) has its own referral system, developed with the support of partners (MDM France in Jenin and Nablus for example), and so do NGOs (such as Juzoor and PCC). There are also still many

epileptic cases referred to the CMHCs, when they should actually be taken care of by neurologists (69 in Jenin alone in 2011 out of a total of 284 new cases, or about ¼ of those cases).

The institutional "integration" of mental health services into the primary care sector is a very contentious issue at the MoH. The centres are designed as specialized care facilities, first level of referral. In the health system sense they, therefore, belong to the secondary level of care, between the PHC level (including family doctors) and the tertiary care level represented by the two psychiatric hospitals in Gaza and Bethlehem. In Gaza, however, the CMHCs report to the primary care department. In the West Bank, centres report functionally to each District MoH where they are located, and, operationally, to the MHU. The MHU, itself, reports the Vice-Minister of Health. Administratively, it is a very complex proposition. For example, if the MHU wants to invite CMHC personnel to a conference, it has to ask the approval of the PHC department. This institutional confusion does hamper the capacity of the MHU to truly be the MH public sector's leader that it was supposed to be. At the ground level, CMHC do not have all the means that they should, as the case of the car donated by MDM France to the Nablus and Jenin CMHCs illustrates: it was diverted to the PHC departments of the those health districts and has since then been unavailable to those centres. The MHU is not in a position to solve the kind of practical issues that CMHCs face and it is weak, institutionally.

Supervision

Activities have been conducted to implement supervision, during the project, with the project's resources, which was a relevant and needed thing to do. Supervision was mostly conducted by Sylvie Mansour, Norani Khalafan, from MDM France, who first designed and implemented a supervision framework for the Jenin and Nablus centres, Julia Granville, Souha Shehadeh (a paediatric psychiatrist of the Bethlehem Arab Society for Rehabilitation, at Halhul) and the PCC.

However, the MH public sector still lacks a supervision policy and resources to perform this very important activity. There currently is no external supervision performed at the centres, apart from voluntary services provided by Sylvie Mansour. This limits the effectiveness and the impact of supervisory activities. The project, however, has been able to instil the idea of supervision as a routine activity. Centres self-organize internally in order to review case management: once a week, on a specific day that varies from centre to centre, psychiatrists review and discuss cases with their staff. There also are monthly discussions organized at the documentation centre where cases and practice are also discussed. Specialists are sometimes brought in at those meetings to share knowledge. External donors, such as pharmaceutical companies, have, at times, paid for transportation and other expenses, and used those meetings to introduce participants to their products. This still relatively informal system would need to be upgraded by supervision performed at the centres by experts coming from outside. However, it is apparent that the MHU in particular and the MoH in general, do not have the resources in personnel and in transportation to conduct such activities. The difficulties met by Palestinians to move around their territory makes it all the more so difficult.

Main findings on Effectiveness:

The project has led to the creation of three well established Community Mental Health centres, in Jenin, Nablus and in Halhoul (a centre dedicated to children and adolescents) where 30 recruited personnel, now fully part of the MoH, are effectively delivering a wider range of services. They serve as specialized referral centres since their opening in the spring of 2009. The Halhoul centre is the first of its kind in the West Bank as it serves only children and adolescents. Following the MoH's policies, those centres deliver mostly free services for psychotic patients, but charge for neurological cases that they still have to deal with, including epilepsy.

The number of patients dealt with increased very rapidly, especially in 2010, following their opening the previous year. It is not as fast now (2011 vs 2010). In 2011 they combined to attend a total of 950 new cases, a 13% increase over the previous year, all of it recorded at Halhul (+50%).

Two of the centres are self standing (in Jenin and Halhoul), while the other is set in a larger building also hosting a PHC centre. They are not conspicuous and therefore allow patients and their caretakers to come to them fairly anonymously. They are welcoming and modern structures, rather

well constructed and equipped, with some limitations as to accessibility (distance to city centres and lack of elevators) and lay out (Jenin). They are opened from 8 am till 3 pm, only. A total of 17 mental health professionals were recruited and trained to work in the 3 CMHCs.

54 Primary Health Care professionals (nurses and doctors essentially) across the West Bank were trained in mental health issues and become more aware of the mental health problems.

Professionals working at the CMHC were given the opportunity to participate in advanced training workshops, visits to regional and international institutions to gain knowledge and experience.

Some professionals working at CMHCs, are now involved in training other professionals.

In the Gaza strip, the project failed to achieve its objectives, even though they were only focusing on training 20 PHC personnel, for the same purpose as in the West Bank. The activity there faced an irretrievable breakdown for reasons not well clarified and despite the reduction by one third of the number of hours dedicated to the training modules (from 48 to 32 hours).

Training remained fairly general and introductory in nature, covering many subjects, but few in details. A few exceptions include psychological tests, as well as family and group therapy, with more practical features delivered through the training modules and ad-hoc workshops.

If understanding of psychological disorders, their variety, their complexity and of the variety of responses available to meet them, has increased, the training has not been able to provide tools to effectively detect some of the most common psychological disorders, such as depression and anxiety, which are highly prevalent. Most subjects have been covered superficially, therefore limiting the capacity for professionals to build strong therapeutic competences. Complementary training has been able to provide some additional insights and build more practical case management capacity.

The issues laid mostly with the design of the training modules. But there were also a few missteps with the delivering modality. Some of the training provided by MDM-F was not delivered effectively due to inappropriate logical sequencing of the modules, to language / translation limitations and to a lack of cultural sensitivity in a few cases. Some of the instructors, even if nominally competent in the subjects, were not well prepared. Corrective measures were taken, but the involvement of the NGO was terminated in July of 2010, after the completion of training, and it was replaced by the Palestinian Counseling centre (PCC), which conducted supervisory activities.

There are still important areas of mental health care that are not well dealt with in the MH sector, even in the West Bank, despite the completion of the project. This includes psychotherapy services and, to some extent, work in the community (in the patients' daily environment). The lack of their own means of transportation, despite the delivery of one car to Jenin and Nablus CMHCs by MDM-F, hampers the CMHCs' capacity to perform this latter activity. Prescription of drugs still remains rather systematic, especially for chronic cases. Psychiatrists remain too heavily burdened with an average of 30-70 patients a day, whom they cannot see for more than a few minutes each. They are tiring up and there is a risk to see them leave their positions if their burden is not relieved soon. The implementation of an appointing system, however, a first in the public health sector in the* oPT, has allowed to reduce the burden on the care providers at Halhul. It has started to produce some effects in Jenin but is absent in Nablus. The case loads increase, anyway, also because the centres have established a reputation that attracts new cases (20% are self-referred at Halhul and 30% at Jenin CMHC).

Integration of mental health services into the PHC sector has been an important focus of the training delivered and some aspects have been effectively delivered, particularly as regards an apparently improved capacity to diagnose and refer especially children's conditions (half of the modules were about children in fact). However, there is still quite a bit of ground to cover as regards referral, despite attempts to unify the system. Each centre, and even each organization, has its own referral system. In Jenin, the centre has been able to build a more integrated system with a nearby PHC centre.

If supervision, which was mostly conducted by Sylvie Mansour, Julia Granville, Souha Shehadeh (at Halhul) and the PCC, is now being conducted internally by CMHC psychiatrists themselves, there is no formal external supervision since the completion of training.

The Documentation centre is a rather well equipped facility, staffed by a librarian and an IT specialist, who have been trained at Bir Zeit's Main Library and IT department respectively. However, it lacks the full scope of a documentation centre, and particularly, lacks the full outreach to the mental health and psycho-social professional community, for the lack of a website and of an electronic data base reachable from outside, the relative lack of knowledge of these professionals about the benefits they

could draw from using the centre's services, and the lack of decentralized smaller libraries or inventories of basic publications that the DC could administrate.

3.2. Impact

The assessment of "Impact" looks into the effects that the project has had on the functionalities of the sector it has operated into, on the outcomes produced by the services provided by that sector, and their results on the final beneficiaries, the users of the mental health services provided to them. The absence of a baseline and the limitations of the evaluation process, as mentioned in part 1.4.3, make it difficult, however, to conduct the full scale of that assessment, particularly in terms of quality, so proxy indicators are used, such as those measuring the volume of service and the perceived quality of certain aspects of the services, such as referral.

The creation and staffing of the three CMHCs with support from the UNDP/PAPP/AFD project has increased the availability of more diversified, effective and efficient services. With the presence of multi-functional and multi-skilled teams that work in the same place, it is now possible to implement real treatment plans for patients affected by mental disorders. This has helped growing trust between the patients and the families on the one hand and their care takers in CMHCs on the other. The fact that centres are modern, well equipped and staffed, has, actually, bedazzled some families who still expect to pay because premises look more like a private practice, or even a "bank" as reported by some of the personnel interviewed.

The staff of these newly created facilities, which seem to be well constructed and equipped, looks and sounds quite happy to be working there. They even say it. In that regard, the inclusion of the staff to the MoH's payroll was instrumental to create a sense of satisfaction and security for the personnel. And a happy staff is certainly an important and positive factor for the quality of the services delivered to the patients. Though we do not have patients' take on their experience in those centres, there also seems to be a good level of satisfaction among them. An indicator of this is the fact that a significant number of referrals (about one third at Jenin CMHC and 20% at Halhul according to staff interviewed and centres' statistics communicated to the evaluation team) are self-referrals based on mouth-to-ear information spreading around in the communities, from families of patients receiving services in those centres. This, in turn, also seems to be working positively towards the lowering of stigma attached to mental disorders because families and patients who have a positive experience at the CMHCs now spread the word around them. In Halhoul, the neighbouring population was unhappy, initially, to see the erection of a dedicated mental health centre in its midst. They used to call it the "house of the crazy". But, with time, the attitude has changed dramatically, and that stigmatization has declined. The stigma campaign may also have played a role but that is difficult to measure in the absence of specific studies to that end, which would need to be conducted specifically.

In focus groups, some personnel working in CMHC have indicated that training and the fact of working in those facilities have lowered their own fears and prejudices towards mental disorders. They do not fear mental health patients anymore and feel empowered to carry out their duties and even to spread the good word around. It is hard to know if this change is related to the type of "patients" seen in centres or because of stigma campaigns. However, it is worth to mention that Nablus centre, for instance, used to be a psychiatry clinic affiliated to Bethlehem hospital and most of the patients seen are chronics and in stable conditions.

However, with better services and higher user satisfaction, and mostly free services for neurotic and psychotic patients, has come higher attendance, and centres now are quite solicited. Even the private sector now refers some of its patients to those centres, especially those who are poorer and cannot afford the private sector's rates. The daily case-load in Jenin, for example, used to be a dozen a day, it now stands at around 30. If psychiatrists, who seemed quite frustrated before the project, have better working conditions and a more stimulating environment (just as patients do), they also are getting frustrated by the growing burden. If one said that he had not retired, as he had thought doing, thanks to the project, others have pointed to the fact that their growing frustration has them thinking that they should leave. This would be catastrophic for the centres affected, especially given the very small number of trained psychiatrists, psycho-therapists and clinical psychologists in the oPT.

The implementation of an appointment system in Halhoul and in Jenin has been instrumental in the capacity to a better control of the flow of activity as well as a better case management altogether. With the appointment system the psychiatrist does see more than a dozen patients a day. The case-load of psychiatrist in Jenin is still too high, but it is much better than before.

Despite the lack of transportation means, some care takers manage to visit communities where their patients reside. This is due to the lower case-load per person. However, the fact that centres do not have their own means of transportation does limit their ability to actually work with families and communities directly where patients reside.

Statistics available from the MoH and, and information gathered through interviews and focus groups with the centres' staff, show that the project has had a significant impact on the volume and the quality of referrals to the CMHCs that it has helped establish. In Nablus the case load is 1.200 chronic cases a month, who come mostly for medication and the number of cases receiving care daily is around 70. The number of new cases, as indicated by the centre's director, is above 20 new cases a month. As shown in table 7 and Annex 3, there were a little over 300 new cases in both 2010 and 2011 there. Some of these cases come only for consultations. At the Halhul centre, the number of new cases was 350 cases in 2011 compared to 285 cases in 2010. The number of new cases from January to April 2012 was 73 cases, which is on the trend of 2010 rather than 2011.

Psychiatrists, in particular, are quite burdened, with over 30-40 patients per day. This number even balloons up to 120 a day in some cases, as reported in Nablus. It is worth mentioning that the Nablus CMHC is located in the third floor of a PHC building, which used to be one of Bethlehem hospital's clinics. It used to provide services - mainly medication - for chronic cases such as schizophrenia, epilepsy, or manic depression, which form the majority of the registered cases by the centre. This is obviously way too much for anyone to handle. Whereas the staff seems pretty happy and relaxed, psychiatrists working at the centres seem stressed and far less satisfied by their work. Moreover, they have another assignment in private practice after the centres shut their doors, at around 3 pm each day of the working week, which obviously burdens them further. They do not have enough time to review cases. Most of these cases are follow ups, and, to a large extent, their duties are limited to prescribing varying doses of drugs for those patients. This was also seen at the Al Bireh / Ramallah CMHC, which had received the support of the EU/WHO project.

As regards the integration of mental health services with PHC services, psychiatrists interviewed at CMH centres have indicated a marked improvement in the quality of referrals. For example, whereas, before, a large proportion of autism cases were actually referred to mental health services as "mental retardation". The Jenin CMHC has developed an interesting and apparently good system of collaboration with the nearby PHC centre where they meet on a weekly basis to discuss cases and coordinate care. This is, partly, an effect of training of both CMHC and PHC staff and MDM-Swiss efforts to develop referral system.

On the other hand, there are few counter-referrals of patients back to the PHC. The CMHC in Jenin, however, does work with the nearby PHC centre to develop better care protocols for patients which cases they review together. Also, some counter-referral does take place back to private services (psychiatrists at the CMHCs also have their own practice and in some cases they refer their own patients back to themselves). The development of the referral system is still a work in progress, being led by MDM-Swiss through series of workshops.

The impact of the Documentation centre has been minimal for now. It is not as well-known as it should be, and it is underused. The lack of a website and of on-line services minimizes the potential of this important tool.

Unintended effects

An unintended effect of the project is the fact that CMHCs have now a created links with local universities, such as the American University in Jenin. Students come for observational visits to the centre to get an idea of the type and nature of work provided to clients: they spend time with the staff. However, the staff itself is pretty busy (centres are only opened from 8 am to 3 pm - 7 hours in all and there is apparently not much activity after 2 pm). The centres' staff complains about the fact that they are not really geared to be receiving students or become teaching institutions. But they don't reject the idea of it.

Another “unintended” effect is the fact that personnel in the CMHCs organize themselves, with their own means, to increase their knowledge, to work as teams, to exchange on their cases to stay in touch with their patients. In Jenin, for example, the staff meets to continue the training that they have received, particularly that provided by Sylvie Mansour. All personnel displayed a lot of motivation, and self- and collective motivation in particular. Being unable to make phone calls to the families or patients’ cellphones from the centre’s land lines, team members use their own cellphones most of the time to call families, which is not cheap and costly for team members.

Finally, the involvement of local NGOs in the project, particularly Juzoor in training, and PCC (only on supervision), has allowed them to develop their own capacities. Juzoor in particular reports that they have been exposed “for the first time” (according to our interlocutors there) to the mental health of children and adolescents. This was a bit odd to hear. Juzoor indicates that they have now incorporated paediatric MH in their strategic plan. The UNRWA is now also incorporating or developing those aspects in their clinical services, with Juzoor’s support.

Main findings on Impact:

The establishment of the three CMHCs and the recruitment of their staff, has allowed significant positive developments of the mental health sector in the West Bank. In particular, it has increased the qualification and the number of mental health professionals who are able to provide reasonably diversified and more qualitative mental health services. This can be seen, for example, in the reported improvement in the quality of referrals from the PHC level and in the uptake in attendance at the centres. Patients are even referred from the private sector, but this is also due to the fact that services for psychological disorders are provided for free at the CMHCs.

This positive impact can also be seen through the confidence and satisfaction of the CMHC staff, who feels empowered and capable of delivering a wider range of services and to self-supervise its own work. CMHC staff has taken initiatives to reach out to the community, despite their lack of transportation and communication means, and to the PHC level as well, particularly in Jenin.

On the other hand, counter-referrals of patients coming from PHC setting to these centres back to where they came from is not frequent, except at the Jenin CMHC.

The awareness about the importance of dealing with mental health issues has increased, and the level of stigma has decreased, at least within neighbourhoods and communities where the CMHCs operate. The sizable share of self-referrals is an indication of the fact that the word spreads and that fear about mental health is receding.

To some extent the centres are victims of their success. The increase in the volume of activity puts a lot of pressure on the psychiatrists who have to deal with way too many patients per day, especially in Nablus, and even in Jenin despite its appointment system. There, psychiatrists cannot see patients long enough and grow frustrated.

There have been a few unintended effects of the project:

- the CMHCs have received many medical students who come to learn about mental health care in their midst, which is not easy to absorb for a very busy staff;
- the staff now self-supervises (the centres’ directors organize weekly supervisory sessions with their staff) and even self-educates new skills by conducting its own research of material, which tells a lot about their willingness to do things right and to improve, as well as about their understanding of the importance of supervision; but with no external supervision, this has its own limitations;
- local NGOs involved in the project, namely Juzoor and PCC, have learned from the project themselves, have developed their capacity, particularly in paediatric mental health care.

3.3. Sustainability

Sustainability of a project in the oPT is rather difficult to attain and sometimes the concept is detached from the Palestinian reality where the whole future of Palestinians is not certain and sustained. The political situation in the oPT is not predictable, compounded by the current divide between Gaza and the West Bank, and even the current revolutions and struggles in the Middle East and their unknown

outcome. The facts that the Palestinian economy is very fragile and under siege, and that 2/3 of the Palestinian Authority's salaries are funded by external sources also provide an important insight into the very serious challenges met by the Palestinian public institutions. Palestine, in those conditions, can be seen as a state in life-support mode.

On the other hand, however, the project was able to build concrete premises, and, even more importantly, to train a group of professionals working in PHC settings and at various CMHCs. Training creates human capital, which is a crucial factor for the building-up and sustainability of any endeavour.

Following on the previous criterion's last paragraph, it is clear that the motivation and satisfaction displayed by the personnel working in the CMHCs is high. A satisfied staff can perform its duties better and is motivated to sustain its level of commitment and to improve on its skills. The fact that they self-organize, under the leadership of their directors, to self-supervise, or that they reach out to the PHC level (Jenin) to increase the effectiveness of treatment is a very positive sign in that sense.

The acceptance by the MoH to include the CMHCs' staff into its personnel is, obviously, a momentous decision as regards the sustainability of the infrastructure and of the services created.

The marked increase in frequentation, which is a positive response from the community and the health system to the existence of the new centres, poses challenging questions as to the long-term quality of the services delivered. This can be exemplified today already with the psychiatrists' work load. The low number of psychiatrists and the absence of psycho-analysts and clinical psychologists is a problem in that sense to.

The lack of external supervision of the work performed in the CMHCs is a serious issue for the long-term quality of the services delivered in the centres. Centres have self-organized in order to ensure the best quality possible of services given the resources they have. As noted above, psychiatrists organize weekly reviews of cases with their staff, discuss them. On a monthly basis there are professional meetings of all psychiatrists at the Al Bireh centre. These are hosted by the Documentation centre who provides logistical support. Transportation to the centre is paid for by sponsors, including pharmaceutical companies who use those meetings to introduce practitioners to their drugs, which, obviously, is debatable from an ethical point of view and has proven to be a serious source of problems in countries where this is performed on a large scale, such as in the USA. Indeed, it is a known fact that most of the information on pharmaceuticals received by medical doctors usually comes from medical visitors, who promote drugs by specific companies who pay them to market their products. Therefore, the communication on those drugs is quite biased and the scientific neutrality of the information not ensured, particularly as regards side-effects and long-term effectiveness, as has been proved in too many instances.[44]

Another serious sustainability concern is raised by the fact that the MSK Documentation centre has no budget to purchase more books and publications, and to renew subscriptions to journals. It now relies on what has been purchased with the project's funds. If no new funding is secured, the DC will progressively lose its relevance. With the provision of an IP address, the centre should now be able to open its own website and provide online services, which will help to expand its reach and the use of its resources.

Also, the weakness of the institutional set up of the MH sector within the MoH (with the MHU at one of its centres and the PHC directorate as the other one) makes it very difficult to develop a strong leadership from within. The fact that MHU is administratively placed under the PHC directorate but reports to the vice Minister of health, while CMHCs report to district health directorates and the Bethlehem hospital to the hospital directorate at the MoH, weakens the development of mental health services delivery and undermines MHU decisions. It also raises questions and probably suspicion by CMHC's team leaders, staff, as well as by the NGOs sector, about the seriousness of the MoH to develop mental health services and consider it as a priority. The still apparent suspicion of some of the MoH leaders "vis-à-vis" the non-governmental sector, where valuable resources and field experience exist, compounds the impression of a still poor visibility of MH at the MoH, and in the health sector in general.

Finally, the long-term sustainability of the mental health system is also threatened by the funding situation. 2/3 of the PA's salaries are paid for by the European Union. The structural weakness of the Palestinian economy, strangled by the occupation, and the consequent lack of internal fiscal

[44] Rober Whitaker. *Anatomy of an Epidemic : magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. Crown, 2010.

resources, makes it very challenging for the PA to mobilize funding for its operations, especially those who are not seen as a priority, which, still, the case for mental health services.

Main findings on Sustainability:

The most important aspect of sustainability of this project is the upbringing of human resource, the building-up of human capital through training. This is particularly crucial and difficult in such a politically unstable environment where the trend towards an increasing number of cases of psychological disorders is worrying.

The inclusion of the CMHC and DC staff into the MoH's own staff is a key positive element of the sustainability of the products delivered by the project. The increase in volume of activity, resulting from the apparent increase in the diversity and quality of services, is another factor that should enhance the sustainability of those products. However, a higher volume of activity also results in more pressure on quality, which, in turn, puts stress on the centres and could jeopardize their future. The absence of formal supervision and follow up systems has negative impact on the long-term sustainability, quality level of services delivered and on putting mental health professionals at risk of burnout syndrome.

The lack of funding, compounded by a lack of institutional footing at the MoH, which results in a lack of capacity to exert leadership for the MHU, could also be detrimental to the long-term operationality of the centres and, beyond, of the status of MH services within the public health sector. This is true also of the documentation centre, where the lack of a documentation budget is threatening its medium and long-term relevance.

3.4. Added Value

3.4.1. Overall added value of the project to the sector

Main aspects of the added value to the mental health sector in the oPT have been:

- the creation of a larger pool of mental health professionals;
- the creation of 3 relatively large, welcoming and more modern community mental health centres;
- the integration of a more holistic approach to mental health;
- the introduction of new techniques and tools in the public health sector;
- the undertaking of important steps towards a more integrated mental health system (both with the communities and the general health system);
- the reduction of stigma associated with mental disorders, in various sectors of the population, including health personnel.

3.4.2. Added value of the UNDP

Because of the specificity of the Palestinian territory, and more particularly of the difficulties to move around and to work through a number of political, bureaucratic and sometimes unexpected hurdles, the UNDP, which has accumulated significant experience of working with both Palestinian and Israeli authorities, has proven to be able to work through hurdles of various kinds. However, whereas this has been particularly useful for some aspects of the project, especially when it comes to constructions, it has not proven as useful for the "soft" component of the project, particularly training.

The UNDP's experience and effective organizational engineering management in construction projects have provided an added value to the AFD/UNDP project in building the centres. This has not been as effective in the case of the "soft" components, where burdensome procurement procedures and inadequate planning and M&E, have limited the efficiency of the project as proven by the need for the late drafting of a so-called "exit strategy".

The lack of an experienced mental health consultant paid by the UNDP, and more particularly, with an experience in community mental health, the various changes in leadership (departure of the project manager, changes of the UNDP's project supervisor, intervention of the AFD to correct course), the passive involvement of the UNDP management on the selection of international partners, have combined to limit the extent of the benefits of implementing the project despite of the great efforts invested by the project's instrumental acting manager. He was able to sustain good communication between all stakeholders (NGOs, MoH, CMHCs, international organizations) to implement the project activities.

3.4.3. Added value of AFD

The French cooperation has played an instrumental role in initiating a general movement towards the establishment of a more developed and integrated mental health system in the oPT. The AFD has inherited the project, and with its experience in development aid and approaches, has been able to insert more accountability and to help redirect the project's course when needed.

This has led to the development of an Exit Strategy which role has been instrumental to finalize the project and develop key factors of sustainability for the results achieved.

3.5. Cross-cutting issues

Among the main objectives of the 2004 National Mental Health Policy (NMHP) is "to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population". The project has created 3 CMHCs that are relatively easy to access for most inhabitants of the three urban centres where they are established. Their catchment area actually includes surrounding villages from which patients also come to the centres. The centres' staff also manages, to a certain extent, for lack of their own transportation means, to reach out to the communities from which patients come. Costs to patients are minimal when it comes to psychotic disorders, whereas they are not for neurotic disorders. Those, however, should probably not be dealt with in those centres; but they are because they seem to be better taken care of, still, in there.

The private sector, which charges for services, refers some of its patients to the CMHCs, knowing that those who cannot afford private services will be able to receive services in the public sector and be taken care of for free.

The 2012-2014 National Mental Health Strategy cites the opening of the Halhoul CMHC, dedicated to children and adolescents, as "remarkable effort to develop children mental health services". The pilot centre is the first one of its kind in the West Bank and paediatric care in mental health was virtually non-existent in the public sector before the project. This has even helped develop capacity in this area among organizations that had been active in the psycho-social and mental health sectors for several decades, such as in the case of Juzoor and PCC.

Main findings on Cross-cutting Issues:

The three CMHCs are reasonably accessible to fairly large catchment areas which include rural areas surrounding the urban centres they are part of. Services are reasonably accessible in economic terms as neurotic and psychotic disorders are taken care of for free. The private sector now refers to the CMHCs their poorer patients. Neurological cases are charged.

The project has allowed the development of capacity in mental health care for children and adolescents, which was virtually non-existent in the public sector before. This has even had effects in the non-governmental sector.

4. LESSONS LEARNED

Training delivered on specific practical subjects and skills, in a more intensive fashion, such as multiple-day workshops, tend to be more effective and to bear more immediate fruits and trigger more tangible satisfaction from trainees. This was, in particular, the case of parenting skills and the use of psychological and IQ tests, although these trainings were short, but were structured and benefited from them.

Training has to be culturally appropriate to the context, and not all successful programs can be applied to different contexts. The external evaluation of the WHO/EU project noted a similar point: "programs implemented including training and rehabilitation programs, need always to check with the local communities and to be adapted to the cultural context."

The fragmentation of training, with relatively short sessions grazing over a great deal of complex subjects over a long period of time (4 to 12 months) and with few practical skills, may have to be reconsidered in future projects.

Different experts from abroad brought with them different ideas and concepts. While this was very good for personal growth and development, however, gave different messages and philosophies and understanding about community mental health, community psychiatry and psychosocial interventions. in order to develop capacity building plan, clear objectives and goals have to be on hand.

In political unstable environments, like Palestine, where people feel disrespected and ignored, the training institution has to give a clear model of respect of their trainees. They have the right to express their needs freely and openly and they have the right to get certificates at the end of their training course. To avoid what happened in Gaza, with the GCMHP, these values have to be well highlighted in the contract.

In planning for mental health services, over-estimation of public tolerance and acceptance of the mentally health services in their catchment areas has to be avoided. Evaluation of public tolerance and attitudes towards mental health has to be considered in the planning process for any successful CMHC. Therefore, research on the attitude and knowledge of PHC professionals towards mental health is an important first step to understand how professionals see mental health. Also, research on the social and cultural aspect of mental health where CMHCs are to be opened is a concrete step towards access and acceptance of the mental health services.

4.1. Risks and opportunities

The risks may be divided into two major risk assumptions; first related to the general political situation and the current political division between Gaza and West Bank, second to the organization, funding and management of the mental health system and services.

As shown by the AFD/UNDP project, it is very difficult to conduct activities in the Gaza strip if piloted from Jerusalem and Ramallah, and even with a more local presence. Gaza is a very peculiar setting where operations are difficult to organize and monitor. In both case, transportation is a major source of risk or headaches and makes it complicated to operate as well. Tensions resulting from the territorial and political unique situation flare up now and then, which, also, complicates operations.

As regards risks and opportunities associated with the mental health system and services themselves, there is clearly a momentum created by the project and other efforts (including the WHO/EU project), which has helped change the mental health response's landscape in the oPTs. This has opened the gates towards a more integrated and effective system offering more diversified and specialized care and support to the population in need. Stigma has been fought and seems to be receding. All this creates a better context for further interventions that could help solidify and expand upon what has already been achieved. However, there also are risks associated with the outcomes identified earlier. In particular, the stark increase in patients' flow at CMHCs puts a lot of pressure on them. The quality of their services is at stake. Also, training has created or further increased the demand for more qualification from the

The low salaries offered to public servants is in sharp contrast to what is offered elsewhere, especially as the project has helped increase the qualification of health personnel in the PCH an MH sectors. The lack of acknowledgment or recognition pointed to by several interlocutors is also a risk for the

future. Some of the staff trained could now be looking for other opportunities, more lucrative, or more rewarding.

Finally, the weakness of the institutional set up of the MH sector within the MoH hinders its future development, as well as the very fragile political, social and economic situation of the Territory.

5. CONCLUSIONS

In a very difficult context, both socio-politically and institutionally, the AFD/UNDP Mental Health Project has allowed the creation or re-creation (in Jenin) of three functional, well equipped and welcoming community mental health centres and of a documentation centre which, altogether, contribute to improving the capacity of the mental health sector to face its daunting challenges in a very difficult context where resources are scarce but needs are enormous. It has allowed the expansion of a more qualified and motivated mental health workforce and of more capacity to deal with mental disorders at the primary care level, in the public sector, and, globally, of that sector's ability to better detect, screen and respond to mental disorders. Even the non-governmental sector, which has implemented some of the project's most important activities, has benefited from the project. In all, the project has helped develop a more holistic and integrated response, using an approach that is closer to the community and its reality. The creation of a centre dedicated to children and adolescents, in a country where they make up half of the population and are particularly exposed to many factors of mental or psychological disorders, was particularly appropriate, even though a lot remains to be done in child psychiatry and other specialized mental health services for that population. As a consequence, more diversified services are offered in three new community mental health centres, staffed with motivated personnel.

Yet, there have been some shortcomings in the project's implementation, both in terms of processes and of outcomes. The abandonment of the research component, the abrupt termination of activities in Gaza as well as difficulties met by MDM-France, have all contributed to limit the scope and the impact of the project. The poor planning and lack of a well-structured monitoring system have also undermined the efficiency of implementation and, as a consequence, the capacity of the project to fully perform its activities, reach its objectives and produce its impact. Despite of these challenges, as well as the turn over at the UNDP project management leadership, the UNDP managerial team was able to sustain the project activities and handle differences between various local and international stakeholders.

The CMHCs in particular have become an important part of the psychological support provided to communities that are under a lot of stress. They have also become an important fixture of the overall healthcare system. And to some extent, they are victims of their own success with growing workloads that put pressure on their resources and may jeopardize the achievements made in quantity and quality of service. These risks are compounded by those inherent to the overall healthcare system, and are independent from the project's own effectiveness, where resources are few in a context of dependency from external funding, where logistics are highly complex and difficult to sort out, and where two portions of the territory are not only separated physically but also politically, making it very difficult to conduct harmonized policies and coherent activities.

The weakness of the institutional set up of MH at the MoH also limits de capacity of the project's outputs to perform their effects as fully as desirable. This applies, for example, to supervision and to the integration of community services with PHC settings.

On the other hand, the project has demonstrated flexibility, has expanded on its original scope in the training component and has eventually managed to achieve most of its principal goals.

The project has already had a measurable or perceivable impact on the mental health services and on their users, with a reduced sense of marginalization, much better service conditions, a higher sense of purpose and achievement, a more involved community, or a better integration of services with the primary care level.

However, the quality of some of the deliverables, particularly training, has contributed to the limitation of the scope and the depth of the impact. The training received was probably too general in nature, at both the CMHC and PHC levels, for beneficiaries to really be fully applicable practically on a daily basis. Apart, maybe, for group therapy, family therapy and parenting skills, as it was more pointed and specific. On the other hand, given the fact that there was an important lack of qualification in the

public mental health sector until recently, the project has allowed an increase in awareness and capacity that opens the door for more qualified and specific training, which is, actually, requested from the staff. Training delivered has developed the ability to approach someone's health more holistically, to understand the person's background and context. Now would be the time to build and expand on this capacity in order to provide with more pointed and robust responses to the immense and complex mental health situation and needs of the oPTs' population.

The project has also attempted to tackle one of the serious social aspects of mental ill-health conditions – stigma attached to mental disorders – through the "anti-stigma campaign training" and leaflets distributed by the centres, mass media and school visits.

The confusing institutional set up of mental health within the MoH has slowed down the implementation process of the project and has influenced its outcome. Moreover, it is making it more difficult to expand services, and integrate them, in general. There is still confusion as to the exact role of the CMHCs and even as to their future in the overall health sector development. This is sensed by the CMHCs' staff.

Looking forward, there still are many challenges, some serious, ahead for the mental health sector and services in the oPT, as in the case of child psychiatry, but also opportunities. Collaboration between all partners, public and not, Palestinian and from outside is probably still necessary and even more needed in order to ensure the sustainability and the expansion of services established and provided.

6. RECOMMENDATIONS

The following recommendations address the Palestinian Mental Health System in general (including the MHU and its partners). Specific recommendations to the AFD and the UNDP are also provided afterwards.

6.1. Regarding the CMHCs

With growing needs and, more visibly, a growing demand for services, the time of operation of the newly created centres (from 8 am to 3 pm) seems un-adapted. These centres should be opening at least a couple of hours more. Also, the number of staff members should be equated between the centres (at least between general centres – Jenin has 8,5 equivalent full-time jobs while Nablus has 11), with more specialties being made available, including psychiatrists and/or psycho-analysts. Longer hours of operation and more specialties should therefore lead to more staff being hired. We understand that this is not an easy proposition given the limited financial resources of the PA. But it is needed to both increase services and their quality, but also to reduce the workload on psychiatrists and their staff, which, in turn, will also lead to improved service delivery.

According to the 2012-2014 National Strategic Mental Health Plan, the goal is to have one CMHC in each district (and even one per 100,000 population). There are 11 districts in all and only 6 general CMHCs and one dedicated to children and adolescents. Therefore, 5 more centres would need to be established, at least in Jerusalem, Tulkarem, Jericho and Qalqilya (the CMHC that the Italian Cooperation had started to support there is not completed and is severely under-staffed and equipped). Bethlehem does not have a separate CMHC, since those services are provided at the psychiatric hospital, which is probably not the best location for community mental health services. Therefore, Bethlehem should probably also benefit from a dedicated centre with specialized services. This does not invalidate the existence of services currently offered at the hospital, provided they are delivered to patients residing at the hospital.

CMHCs should to be able to offer real psychotherapy services parallel to preventive and promotion services. These are not provided for now, and psychiatrists, psychologists and other mental health professionals are not in a position to provide such services basically for lack of psychotherapy training and for the lack of time they can allocate to each of their patients. To create space for that type of activity, structured short psychotherapy courses such as cognitive behaviour therapy, short term psychodynamic therapy, etc., are highly needed for mental health professionals including psychiatrists. Complementary well qualified personnel should also be recruited, with better salaries so as to attract qualified personnel.

Clearly, expanding the range and depth of services means more resources. To address this, a range of solutions should probably be applied. This could include the addition of at least a second psychiatrist (with psycho-analytical skills), working full time, in each of the centres, while further training should be provided to the existing mental health teams.

Referral and counter-referral system should be incorporated at CMHC's functions including the private and non-governmental sectors. The implementation / enforcement of an appointment system, which was introduced for the first time in the public health sector by the UNDP/AFD project, is another element of the solution, as shown by what happens in Halhoul, and to a lesser extent, in Jenin.

Advisory boards should be established for each CMHC in order to monitor their work and help them achieve their goals. These boards should associate district PHC directorates, self-help groups or family associations (such as the MHFFS), together with the head of each centre.

The philosophy of community mental health is to move mental health problems away from the exclusive territory of psychiatric care to more community-oriented interventions and holistic care. It is recommended that the philosophy of community based approach be maintained and reinforced in order to avoid that centres created become mini-hospitals or overly specialized psychiatric or mental health institutions, with some being specialized in a certain disorder like a centre for depression, anorexia, etc.

It is necessary to improve the level of community awareness about mental health related issues by conducting health promotion activities for the general population, especially targeting rural communities, to inform community members of the importance of mental health, the value of complying with healthcare providers' referrals, free-of-charge healthcare services. Parallelly, promoting and advocating client's rights for services, rehabilitation, education, including emergency MCH referrals, should be actively pursued.

The integration of mental health services into PHC services was stated in almost all documents reviewed as a goal to be achieved. However, there are different understandings of integration; from the Bethlehem's psychiatric hospital perspective integration is perceived as making mental health services for chronic patients more accessible through PHC settings where medication can be dispensed instead of patients coming to the out-patient clinic of the hospital, while the MHU understands integration by providing comprehensive mental health training for PHC professionals enabling them to intervene at the PHC level. The evaluation team visualizes integration as both mental health specialists and GPs working together to address both physical and mental health needs of their clients/patients. Therefore, the team's recommendation is that the MoH should adopt a collaborative integration approach where both mental health professionals and healthcare professionals work together in the same clinic/centre to assess those in need of health care.

6.2. Training

It is important to include the primary care professionals from private sector and NGOs in the next round of training, whoever organizes and funds it. Indeed, referrals from those sectors still suffer from the weaknesses identified in the public sector prior to the project. Also, the PHC level still tends to indicate to patients that they will need medication, so patients ask for them when they come to mental health services, even though only a portion of them might already benefit from certain drug regimens.

Next rounds of training should also be more specific and pointed, technically. They should be able to focus more on specific aspects of mental disorders, such as anxiety, depression, PTSD, ADHD/ADDD, etc. There is a need for special courses in counseling skills for PHC workers of various levels. The lack of child psychiatric services is particularly acute, still, in the oPT, despite the fact that so many children and adolescents are affected by the socio-economic and political situation, which put a further strain on their family and social environments. There is, therefore, a specific need there that should be taken into account in future activities supported by development partners, in agreement with the AP and its mental health strategy.

It is also important to ensure follow-up of the training once it has been delivered. This should actually be part of an overall supervision policy that is definitely needed in MH. A strategy and plan in that regard will need to be drafted, and should be allocated sufficient resources for their implementation. A training policy should also be drafted that should create coherence with the overall SOP and the supervision strategy.

Education and training are not only about lecturing and providing information, they are about empowerment, dialogue and developing culturally appropriate mental health tools and manuals. Therefore, helping professionals to establish their professional associations, and patients' families to establish their help support groups, contributes to the development of professionals' standards and code of ethics, which are necessary and sustainable endeavours.

Many international consultants have conducted trainings in the project; some more effectively integrated in the project than others. None of the international consultants were directly selected by a joint agreement with CMHCs, MoH, and UNDP. The selection of international consultants should be demand-driven and based on written requests specifying types of competences required. To ensure that the seconded consultant is integrated into the project/program, TOR should be developed and monitored.

Relying on international consultants for capacity building, supervision and follow-up delayed and slowed down the project implementation. Identifying local and regional trainers and capacities for training the CMHCs and PHC staff. Establish a pool of qualified local trainers (mental health professionals) who can give lectures, spread awareness about mental health. If expertise is not available locally the project managers should then request internationals and be able to select them based on CVs.

Documentation centre

Now that the Documentation centre has been granted an IP address, it should be able to open its services on line. This is an urgent necessity in order to expand its reach and provide resources to those who have not been able to use them yet. It should also be able to branch out to various parts of the oPTs, particularly at the CMHCs where small libraries should be set up, with a number of manuals and key publications should be disseminated and therefore made readily available to practitioners there. A communication campaign would also be needed in order to enhance the centre's visibility, funding and added value to MH personnel, students, and other stakeholders (family associations, self-help groups, NGOs, etc.).

6.3. Other sectoral issues

The Bethlehem psychiatric hospital

The future of the Bethlehem hospital is currently being debated. Some of its wards are currently being renovated, but some other wards are in very poor conditions (male rehabilitation, male forensic, both male and female acute cases) and do not offer appropriate services. It is very difficult to envisage that patients taken care of in those conditions get any better. The contrary would rather be expected. The idea promoted by the SOP 2004 was to reduce the number of beds at the Bethlehem hospital and to open acute care beds in general hospitals. Both the department of hospitals at the MoH and general hospitals themselves have expressed their opposition to that idea. Shutting down the Bethlehem hospital is obviously not an option for the near future. On the contrary, and in line with the hospital's own plans to better use the facilities and premises that it has (including the land around the buildings), rehabilitation and modernization of the remaining departments seems to be an emergency. Parallely, there are no psychiatric beds in parts of the territories that would need them, especially in the northern part (Jenin). A solution probably needs to be found there in order to better serve the population, particularly for acute cases and short-term internment needs.

The psychiatric hospital's role in training should be expanded so that it becomes a university-based hospital for all mental health professionals.

Self help groups

Health professionals can, sometimes, contribute to the victimization of mentally disordered people through their attitude and exercise of power over their clients/patients. Self-help group can be empowering and supportive to health systems, clients/patients and their families. However, there is no clear recognition in the governmental policies, even in the mental health plan, of the role that such

groups can play in mental health prevention and promotion, help to patients and their families, and to the community development at large. The Mental Health Families & Friends Society (MHFFS), established in 2008 with support from the WHO/EU project, remains relatively weak and marginalized. The Society used to have a room it could use at the MHU, but not anymore. MHFFS-like associations and groups should be created – or chapters of the MHFFS – in all districts of the Palestinian territories. They should be part of an advisory board that the team also recommends should be set up to govern the CMHCs. Support to the creation and empowerment of family associations and self-help groups seems an important step to undertake in order to both de-stigmatise further MH and to bolster the participation of the community in the community approach now promoted in the oPT.

Organization and Management of the mental health system

The evaluation team has seen high willingness from the MoH and the Mental Health Unit to improve the management system; however, the team recommends the following steps to be considered:

Re-structuring the mental health services at the national level taking into consideration:

- The mental health services at both primary and tertiary levels have to be restructured and consolidated under one independent Mental Health body within the framework of the health and social services and to be linked with the executive management and committee at the national level;
- Mental health is not entirely equivalent to mental disorders and is not only the sole responsiblitity of the MoH. The Ministry of social Affairs has a role to play when comprehensive mental health services are to be provided. Therefore, the evaluation team's recommendation is to establish a Mental Heath Commission as a national body that should be established to be responsible for the mental health services delivered in the oPT at PHC settings, CMHCs and at psychiatric hospitals or general hospitals if psychiatric beds can be opened there, and in other settings. It would provide policy advice to the government, including the Ministry of health. The commissions' chairperson should not necessarily be a psychiatrist. Members of the commission should have strong mental health background, solid research experience, strong administrative and managerial skills and substantial years of experience in the field of mental health with a clear vision and expertise. Self-help groups and family association representatives should be represented in the commission. An example of such commission is the Mental Health Commission of Canada.
- A strategy should be developed to avoid the brain drain and encourage Palestinian nationals in the Diaspora to contribute in building strong mental health services;
- The managerial skills of current management have to be developed;
- Strengthen the relationship with other local academic institutions, NGOs, and patients and families associations in order to create a more integrated MH sector where cooperation and better use of resources are enhanced;
- Build a management information system (MIS) for better reporting and provision of data; that system also needs to be opened so that its findings can be shared with the entire MH sector in the oPT and beyond;
- Clearer mandate of the mental health unit with full authority over mental health services including human and financial resources;
- A unified records system that links facilities and tracks client care is necessary for a functional referral system. Records should collect appropriate data for making decisions regarding referral patterns and continuity of patient care. Records enable providers continued learning opportunities and link facilities together in the continuum of care.
- There is a serious lack of research studies and rigorous evidence-based data linked to the work of community mental health centres, especially at the Ministry of Health level. Research/solid evidence should form the basis for further programming. It would be recommendable to conduct at least one study annually, either jointly or individually, in areas related to client rights, access to mental health services, effectiveness of community mental health services, etc.

- The MoH should help mental health professionals to establish professionals' association that would provide accreditation and licensure. Professional associations play a key complementary role to both national regulation authorities (MoH in the oPT) and can help and should be associated with designing professional criteria and standards, including protocols and guidelines. This is now being conducted at the PHC department (for PHC settings). It is unfortunate that the MHU and MH professionals are not associated with those important undertakings.

The evaluation team strongly recommends that the Mental Health Unit endorse supervision as a professional policy for mental health practitioners. It recommends that the group self- or internal supervision modalities now in place ("institutional supervision") be maintained and that it start Interpersonal Recall Supervision (IRP) to increase the therapists' awareness of the covert thoughts and feelings of the client and self and blind spots.

6.4. Recommendations to the UNDP

Generally speaking, with the experience it has accumulated through the present project, the UNDP should maintain its commitment to the collective efforts towards the implementation of the National Mental Health care policy and plan (the SOP), and more particularly, support the efforts to expand the CMH program to the entire Palestinian population.

The UNDP should keep supporting the mental health sector in the oPT. To sustain this support it should recruit a mental health specialist with substantial competence in community approaches. This person should also have a strong research experience. This person should be employed by the UNDP and should be advisor / consultant to the UNDP-managed projects.

In future projects and programs, the UNDP should encourage the implementation of a strong M&E and piloting system (including annual work/activity plans sanctioned by the Steering Committee), including a set of indicators to be used to monitor advancement towards targets and objectives (both output and process indicators), establish a baseline (using the same indicators), ensure the regularity of SC meetings, and plan for exit strategies from the very beginning (as part of the overall project / program plan). Logical frameworks and scorecards should, therefore, be systematically part of any program and project design, and strategic and operational planning a mandatory managerial activity. A mid-term review should also be planned as part of the original project plan and budget, not only a final review.

Selecting local or international training institutions has to be based on tendering. Selection criteria must be identified according to the training objectives, with terms of reference that should include the respect and promotion of the rights of candidates (provision of certificates for example), the consideration of the particular cultural and socio-political context, of all which should be strongly emphasized in the intervention's terms of reference.

6.5. Recommendations to the AFD

There is a high need for mental health services in the oPT. Clear models of integrating mental health into PHC services, consolidating mental health management, designing mental health policy based on the needs with inputs from various sectors, establishing professional standards, and expanding the network of community mental health services, are all areas to be emphasized in the next project cycle. In line with the AFD/UNDP mental health project, and to ensure complementarity with other donors' involvement in the health sector, the team recommends that the AFD continue funding the mental health sector due to its high priority needs, and more particularly the area of community mental health services.

Work closely with the MoH to improve working relationship and integration of services for a better implementation of the mental health services and provide a more prominent place for mental health services in the overall health system in the oPTs.

6.6. Other recommendations

With the Palestinian Authority in charge of implementing the National Mental Health Strategy and plan, it is important that all efforts, from all partners, including international NGOs and other related organizations, be associated with the strategy and integrated within its programs.

7. ANNEXES

7.1. Annex 1. List of documents reviewed

- Plan on the organization of mental health services in the occupied Palestinian Territory. By the Steering Committee on Mental Health. Final report. February 2004.
- Palestinian National Authority. Ministry of Health. National Strategic Mental Health Plan; Palestine, 2012-2014. Undated.
- UNDP. Technical Evaluation for AFD Mental Health Project. Inception Report. Conseil Santé – SOFRECO. Undated.
- Ministère des Affaires Etrangères ; Direction Générale de la Coopération Internationale et du Développement ; Fonds de Solidarité Prioritaire. Rapport de présentation: Aide à la mise en place d'une nouvelle politique de santé mentale dans les Territoires Palestiniens. Non dated.
- AFD. Pays: Territoires Autonomes Palestiniens. Note de présentation de Projet. Appui aux Services Communautaires de Santé Mentale. Agence de JERUSALEM. 11 juillet 2005. Numéro de projet: CPS 3005.
- Office of the European Union Representative West Bank and Gaza Strip. Draft Report. End of Project Evaluation "Mental Health and Psychosocial Services Support Project" In West Bank and Gaza strip. Implemented by: EPOS Health Management. EUROPEAID/127054/C/SER/Multi Framework contract Beneficiaries – Lot n°8 – Health. Prepared By: Dr. Ahmed Heshmat Mohamed, Dr. Fahmy Bahgat Hanna. Rotterdam, July 27, 2011.
- MDM France. Final Report. February 2008-December 2010. Undated.
- UNDP / PAPP. Request for proposals (RFP). RFP 2011-009. Technical evaluation for AFD Mental Health Project. 29 August 2011.
- UNDP / PAPP. Health care services in the West Bank (EMRI). Tracking sheet. May-June 2008.
- UNDP / PAPP. Project document for AFD Mental Health Project. Undated.
- UNDP / PAPP. Project fact sheet. AFD Mental Health Project. Undated.
- AFD Mental Health Project. Annual Report. Period of the report: January – December 2009. Undated.
- AFD Mental Health Project. Annual Report. Period of the report: January – December 2010. Undated.
- Palestinian National Authority. Ministry of Health, Mental Health Unit. AFD Mental health project, Exit strategy. June 20th, 2010.
- MoH Organigramme. Undated.
- Third-party cost-sharing agreement between the Agence Française de Développement (AFD) (the donor) and the United Nations' Development Programme (UNDP). Signed on April 18, 2007.
- Mental Health Project. Power Point presentation. October 11, 2011.
- Palestinian Ministry of Health. Annual Health Report. Ramallah, oPT, 2010. Undated.
- Ministry of Health ; Mental Health Unit. Mental Health Referral System. Booklet on referral protocols and tools. 2011.
- Gaza Community Mental Health Pogramme. Training of doctors and nurses working in primary health care centres in Gaza. Progress report. July 2009 – May 2010. Not dated.
- Steering Committee meetings minutes and presentations:
  - Steering Committee Meeting. Minutes. September 4th, 2008. Ramallah, UNDP office, Sateh Marhaba.
  - Updates. Steering Committee Meeting. AFD-Mental Health Project. Report submitted to Steering Committee members. Project analyst: Mr Fadi Hidmi; mental health project manager: Mrs Feletcia Saleh. Report covers the period til August 2008. September 4th, 2008.

- Steering Committee Meeting. Minutes. September 4th, 2008. Ramallah, UNDP office, Sateh Marhaba.
- Community Mental Health Project – Empowerment. Project Management Unit – PMU. Project update. Second Steering Committee Meeting. 29/01/2009
- Community Mental Health Project – Empowerment. Project Management Unit – PMU. Project update. Third Steering Committee Meeting. 29/04/2009.
- Steering Committee Meeting. Minutes. April 29th, 2009. Ramallah, UNDP office, Sateh Marhaba.
- Steering Committee Meeting. Minutes. September 17th, 2009. Ramallah, UNDP office, Sateh Marhaba.
- Fifth Steering Committee Meeting. AFD/UNDP Mental Health project. Minutes. January 21st, 2010. Ramallah, MoH Central Laboratory.

- AFD Supervision reports:
  - *Palestinian Territories Mental Health Project supervision– Identification of new project 2008*. AFD mission, November 4th – 9th 2007. Catherine Dauphin-Llorens. AFD/TDH/SAN, December 19th, 2007.
  - *Palestinian Territories Health Projects*. AFD mission. May 4th – 16th 2009. AFD/DTO/SAN, Mai 2009.
  - *AFD Health Sector mission*. 14th - 20th of September 2009. AFD/DTO/SAN, 24-09-2009.
  - *AFD Health Sector Mission*. 28th March – 3rd of April 2010. AFD/DTO/SAN, 21-05-2010.
  - *AFD Health Sector Mission*. 16th – 21st of January 2011. AFD/DTO/SAN, 04-02-2011.
  - *AFD Health Sector Mission*. *Mental Health Project – CPS 3005 & Strengthening Drug Policy and Management of Drugs Project – CPS 1013*. 23 - 28th October 2011. AFD/DDH/SAN/bb November 2011.
- Sylvie Mansour reports and letters (Sylvie Mansour was technical assistant to the project):
  - *Sylvie Mansour, Assistante technique. Rapport de fin de mission. Not dated.*
  - *Sylvie Mansour Assistante technique. Projet « Santé Mentale »: Etat d'avancement au 23 juin 2008. Not dated*
  - *Sylvie Mansour ; Conseillère du Directeur de la santé mentale Ministère de la santé, Palestine. Projet "Santé mentale": Rapport couvrant la période de mars 2008 à mars 2009. Not dated.*
  - *Sylvie Mansour ; Conseillère du directeur de la santé mentale dans le cadre du projet « Santé mentale ». Compte-rendu de prise de fonction. Ramallah, 8 avril 2008.*
  - *Sylvie Mansour. Letter to MDM France. Ramallah, 23/06/09.*

7.2. Annex 2. List of persons and institutions met and interviewed

	Name	Position, Institution	Date
1.	Hani Hindiyeh	Acting project manager ; UNDP/AFD Mental Health Project	15.02.12 & in many more occasions
2.	Dr Hazem Ashour	Chairman ; Mental Health Unit, MoH	16.02.12 27.02.12
3.	Rabab Abdo	Librarian ; Mohamed Said Kamal Documentation centre, Al Bireh	16.02.12
4.	Ahmed Elghwadneh	Information Technology Specialist ; Mohamed Said Kamal Documentation centre, Al Bireh	16.02.12
5.	Nader Atta	Programme Analyst, Infrastructure, Youth and Culture, Poverty Reduction and Economic Development ; UNDP/PAPP	17.02.12
6.	Jacky Amprou	Chargé de Mission ; AFD Palestine	17.02.12 24.02.12 27.02.12
7.	Matthias Themel	Project Manager, Health and Education ; Delegation of the European Union, Palestine	17.02.12
8.	Covadonga Morales Bertrand	Programme Analyst, Social Development ; UNDP/PAPP	18.02.12 22.02.12 27.02.12
9.	Veronica Forin	General Coordinator ; MDM Switzerland – Palestine	19.02.12
10.	Lauriane Whittaker	MDM Switzerland - Palestine	19.02.12
11.	Dr Qazem Maani	Director General ; General Directorate for Planning & Health Policy, MoH	20.20.12
12.	Dr Nour Al-Deen B. Al-Qaqa	Neuropsychiatrist, member of the Palestinian Board; Director ; Nablus CMHC	20.02.12
13.	Amira Ab Wazani Nihaya Jabr Raeda M. Fraitile Salam Masri Fida Sholly Rawda Massad Souma Qneer Falestin Al-Qadie Mohammed Burghal	Psychologist ; Nablus CMHC Psychologist ; “ Psychologist ; “ Psychologist; “ Nurse; “ Nurse; “ Social Worker; “ Social Worker; “ Occupational Therapist; “	20.02.12
14.	Nour Salous	Project Assistant; UNDP/AFD Mental Health Project	21.02.12
15.	Stephanie Hansel	Programme Manager; Juzoor Foundation for Health and Social Development	21.02.12
16.	Fatem Tammous	Project Associate; Juzoor Foundation for Health and Social Development	21.02.12
17.	Diana Sayej Naser	Director; Main Library, Bir Zeit University	21.02.12
18.	Adnan Dagher	Executive Director; Mental Health Families & Friends Society	21.02.12
19.	Dr Issam Bannoura	Director; Dr Kamal Psychiatric Hospital, Bethlehem	22.02.12
20.	Dr Ibrahim Ikhayes	Coordinator; Total Quality Management, Dr Kamal Psychiatric Hospital, Bethlehem	22.02.12
21.	Dr Riyad Zawarah	Psychiatrist; Dr Kamal Psychiatric Hospital, Bethlehem	22.02.12
22.	Dr Iyad El Azzeh	Psychiatrist, Director; Halhoul CMHC	22.02.12

	Name	Position, Institution	Date
23.	Khita Awad Mai Arar Mahdi Hafeth Hamza Mashal	Speech Therapist; Halhoul CMHC Psychologist; “ Psychologist; “ Nurse; “	22.02.12
24.	Sylvie Mansour	Clinician Psychologist; former advisor to the French Cooperation and the UNDP/AFD project; also participated in training and project management.	23.02.12
25.	Mourad Amro	Psycho-clinician; Palestinian Counselling centre	23.02.12
26.	Fahmi Masri	Deputy Field Coordinator ; MDM France – Palestine	23.02.12
27.	Mahmoud Isleem	Program Assistant – Nablus ; MDM France – Palestine	23.02.12
28.	Hervé Conan	Directeur ; AFD Palestine	24.02.12
29.	Bénédicte Brusset	AFD headquarters, Paris	24.02.12
30.	Wahib Adwan	Engineering Analyst ; South Area of West Bank, UNDP/PAPP	24.02.12
31.	Abdallah Jibril	Senior Mechanical Engineering Analyst ; UNDP/PAPP	24.02.12
32.	Nasser Aker	Engineering Analyst ; Nablus, UNDP/PAPP	24.02.12
33.	Shehadeh Habash	Procurement Specialist, Head; Procurement Unit, UNDP/PAPP	24.02.12
34.	Khalil Hjeij	Procurement Assistant ; UNDP/PAPP	24.02.12
35.	Nurjihan Riyad-Bshara	Procurement Analyst ; UNDP/PAPP	24.02.12
36.	Dr Assad Ramlawi	Director General ; PHC and Public Health Directorate, MoH	26.02.12
37.	Dr Malek Hassan	Psychiatrist, Director ; Jenin CMHC	26.02.12
38.	Qamar Nafiz Assaf Muayad Bani Odeh Nayfey Abu Al Hous Sondos T Khalil Safa Jalghoum Moath Zyoud	Social Worker ; Jenin CMHC Psychologist ; “ Psychologist ; “ Clerck ; “ Assistant Pharmacist ; “ Occupational Therapist ; “	26.02.12
39.	Dr Adam Afana	Psychiatrist ; Al Bireh / Ramallah CMHC	27.02.12
40.	Rawieh Haroun	Mental Health Training officer ; MHU, MoH	27.02.12
41.	Rajiah Abu Sway	Mental Health Training & Community Development Officer ; WHO – Palestine	28.02.12
42.	Dr. Khaleel Siam	Director, Surani clinic, Gaza	12.03.12
43.	Dareen Abdel Atti	Staff nurse, Surani clinic Gaza	12.03.12
44.	Manal Ghaith	Staff nurse, PHC clinic, Gaza	12.03.12
45.	Dr. Hatem Al Shawa	Benevolent Medial Association, Gaza	12.03.12
46.	Dr. Alla Abdel Fatah	GP, PHC clinic, Gaza	12.03.12
47.	Dr. Ezo Younis	GP PHC clinic, Gaza	12.03.12
48.	Dr. Sana Snaya	Medical relief, Gaza	14.03.12
49.	Abeer Yasseen	Staff Nurse, PHC, Gaza	14.03.12
50.	Dr. Ezo Younis	GP, PHC, Gaza	14.03.12
51.	Dr. Yousif Tarazi	Medical Relief, Gaza	14.03.12
52.	Rawia Jaber	Training Director, MHU Ramallah	01.03.12
53.	Suheir Hamad	Community development Director, MHU Ramallah	02.03.12
54.	Basem Saleem	Director of Admin and Finance, MHU, Ramallah	02.03.12
55.	Rabab Al Hasana	Documentation Centre, Ramallah	
56.	Lama Tarazi	Palestinian Counseling Centre, Ramallah	03.03.12
57.	Rana Nashashebi	Palestinian Counseling Centre, Ramallah	03.03.12
58.	Dr. Salwa Najjab	Juzoor Foundation, Director, Ramallah	05.03.12

	Name	Position, Institution	Date
59.	Adnan Sabah	Director, Association of Psychiatric Patients and their Families, Ramallah	05.03.12
60.	Asaad AbdelAziz	Birzeit Continuous Education Centre, project coordinator	06.03.12
61.	Busayna Amryne	Birzeit Continuous Education Centre, learning design specialist	06.03.12
62.	Dr. Jamil Sbaih	GP, Jenin PHC centre	06.03.12
63.	Khalid Maitouk	Staff Nurse, Augusta Victoria, Jerusalem	06.03.12
64.	Ranias Kitana	Staff Nurse, PHC clinic, Ramallah	06.03.12
65.	Kariman Heliqawi	Staff Nurse, PHC clinic director, Hebron	07.03.12
66.	Mutaz Badaw	GP, PHC Red Crescent Society, Hebron	07.03.12
67.	Jamal Abu Ghusha	GP, PHC clinic, Qalqelia	07.0312
68.	Ibtessam Katab	Staff Nurse, PHC clinic, Hebron	07.03.12
69.	Suheir Elyan	Staff Nurse, Palestinian Institute of Diabetes	07.03.12
70.	Fida Shouly	Staff nurse, CMH, Nablus	07.03.12
71.	Dr. Najah Manasra	Associated Prof. Alquds University	08.03.12

7.3. Annex 3. Statistical annex

The following are data collected from the MoH on new cases registered at community mental health centres in the West Bank over the 2008-2011 period.

Figure 8. Distribution of new cases of mental health registered at CMHCs in the West Bank, 2008-2011.

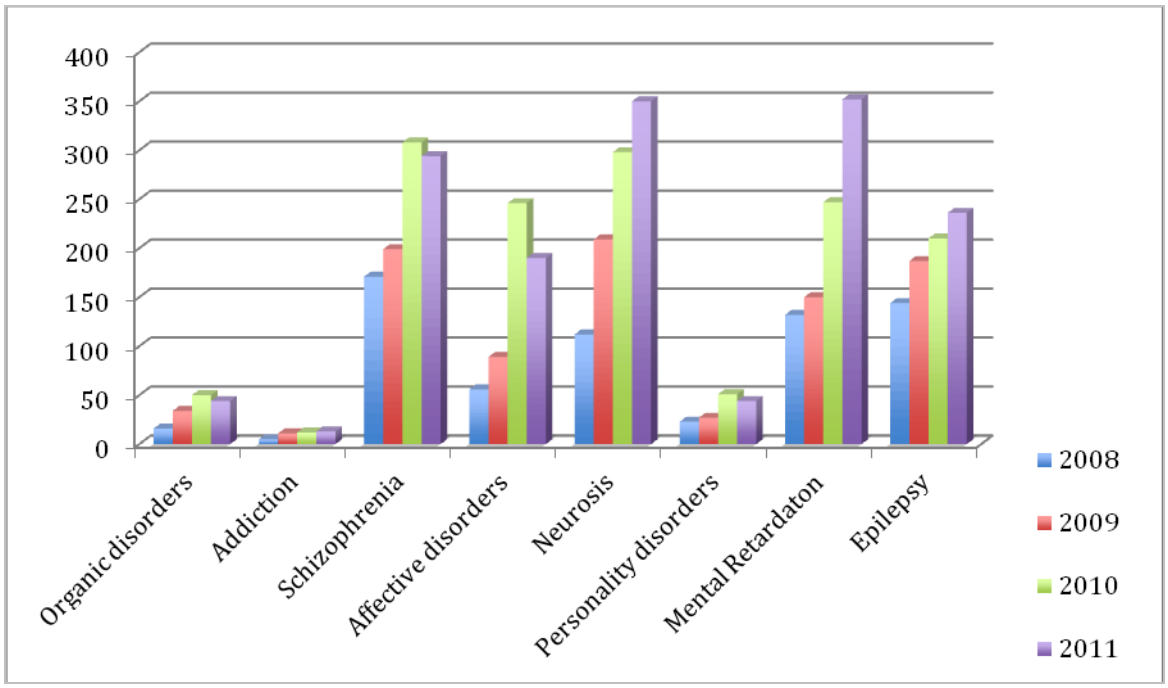


Table 8.1 Distribution of new cases of mental health registered at CMHCs in the West Bank, 2008-2011.

	organic	addiction	Schizophrenia	Affective	Neurosis	Personality disorder	Mental retardation	Epilepsy
Jerusalem	0	1	9	1	8	0	7	10
Jenin	3	0	60	22	23	3	56	48
Tulkarm	2	1	17	0	14	7	11	22
Qalqiliah	1	0	3	0	1	4	7	13
Salfit	0	0	8	11	2	1	4	14
Nablus	3	0	9	12	6	0	4	4
Ramalla	5	0	27	5	26	5	12	25
Jericho	0	0	4	1	15	2	8	8
Hebron	2	3	34	4	17	1	23	0

Table 8.2 Distribution of new cases in Westbank and Jerusalem in 2009

	organic	addiction	Schizophrenia	Affective	Neurosis	Personality disorder	Mental retardation	Epilepsy
Jerusale	8	1	8	5	14	1	7	8
Jenin	16	0	27	34	50	2	53	61
Tubas	0	0	7	10	8	3	5	21
Tulkarm	3	3	32	4	19	0	10	24
Qalqiliah	0	1	5	1	1	2	10	25
Salfit	0	0	4	5	4	0	4	10
Nablus	0	2	25	8	18	5	15	4
Ramalla	2	2	45	8	26	7	14	13
Jericho	3	0	4	2	37	3	6	9
Hebron	2	2	42	12	32	4	26	12

Table 8.3 Distribution of new cases in Westbank and Jerusalem in 2010

	organic	addiction	Schizophrenia	Affective	Neurosis	Personality disorder	Mental retardation	Epilepsy
Jerusale	1	0	30	19	19	2	12	1
Jenin	21	1	33	61	53	3	42	71
Tubas	2	0	13	19	0	0	5	12
Tulkarm	9	0	25	6	18	4	18	25
Qalqiliah	3	1	9	2	5	7	10	20
Salfit	0	0	12	66	0	3	22	36
Nablus	6	3	82	30	122	23	97	21
Ramalla	4	6	64	20	40	5	17	10
Jericho	3	1	10	4	22	2	12	13
Hebron	1	0	30	19	19	2	12	1

Table 8.4 Distribution of new cases in Westbank and Jerusalem in 2011

	organic	addiction	Schizophrenia	Affective	Neurosis	Personality disorder	Mental retardation	Epilepsy
Jerusale	2	3	20	16	13	2	6	7
Jenin	18	3	46	54	41	9	46	71
Tubas	1	0	14	12	2	0	38	16
Tulkarm	5	0	34	7	106	6	76	74
Qalqiliah	2	0	5	6	2	2	9	2
Salfit	5	0	12	52	12	0	15	11
Nablus	2	1	58	7	90	15	128	12
Ramalla	3	5	63	14	39	3	16	22
Jericho	5	1	11	13	33	5	8	19
Hebron	1	0	31	9	12	2	10	2

7.4. Annex 4. Organization of training modules

Training modules delivered by MDM France for CMHC staff (two tables)

Table 9.1. Synthetic presentation (MDM-F)

No.	Date	Module	Facilitator	Location	Brief Description of the content
1	30+31 / 12 / 2008	Awareness Session	Dr. H Ashor + Dr. B. Madi	CMHC - Nablus + Jenin	Integration of the methodology of CMHC in the PHCC system
2	18+19 / 04 / 2009	Introduction to CMHC	Dr. H Ashor + Dr. B. Madi	CMHC-Selfiet	• Provide trainees with an introduction on Community Health and PHC. • Provide the trainees with information about medical ethics and services. • Orienting trainees towards the importance of addressing mental health issues and the role of PHC.
3	27+28 / 05 / 2009	Group Approach	Mr. Bassam Marshod	Rowad School-Nablus	Provide information about group approach with beneficiaries in the psycho-social scope of work through the implementation of group work, practical implications and role playing dynamics.
4	18+20+21 / 06 / 2009	Sexual & Gender Disorders & Couple Approach	Dr. Mary Revillue	CMHC - Nablus	• Overview of Family violence, violence against women and against children, sexual abuses, • Psychological consequences for the victims, Psychology of aggressors and Interventions of professionals
5	1+2 / 07 / 2009	General Psychatry	Dr. Hazem Ashour	CMCH Nablus	Introduction to psychopathology, reasons for hallucination, neuroses, psychosis, Schizophrenia and Mood disorders
6	15+16+17 / 07 / 2009	Therapeutic Link	Dr. George Sarter	CMHC-Nablus	• Introduction to humanization without being vulnerable. • Provide techniques on how to help the patient and his family in a better way, in the simple and difficult situations and avoid any involuntary suffering through communication and • Typology and singularity of relationships
7	1+2 / 08 / 2009	Addictive Behaviour	Dr. Abdallah Tawfiek	CMHC – Jenin	• Overview of drugs and AIDS in the Arab countries, • Drug use/abuse in Palestine, • Harm reduction targeting injecting drug users definitions, rational approaches and applications

No.	Date	Module	Facilitator	Location	Brief Description of the content
8	8+9 / 08 / 2009	Geriatric psychiatry	Dr. Chantal Delmas	CMHC Jenin	• Introduction to normal and pathological ageing, • Psychiatric pathologies such as depressive syndrome, post trauma syndrome, alcoholisms and other addictions, dementia, and Instruments of psychiatric evaluation of old patients
9	4+5+6+7 / 11 / 2009	Law & Ethics	Ms. Zeina Jalald + Police Officer	CMHC - Nablus	Introduction to the legal and practical framework of the psychology profession including the legal, regional and Palestinian standards , the institutional framework, and study cases of procedures, complaints, etc.
10	9+10+12 / 12 / 2009	Child Psychatry	Dr. Suha Shehadeh	CMHC – Jenin	• Early mother-child interactions (bonding and attachment) • Psychopathology of infants and toddlers • Early childhood pathology and how it impacts adult psychopathology
11	22+23 / 02 / 2010	Normal Development of Children	Ms. Luma Tarazi	CMHC Nablus	• Development and behavior theories, • Early child development, physical development, social development, factors affecting development.
12	2+3 / 03 / 2010	Child Development	Dr. Rana Nashashebe	CMHC - Nablus	• Development and behaviour theories, • Early child development, physical development, social development, factors affecting development.
13	23-30 / 03 / 2010	Parenting Skills	Dr. Lucy Draper + Dr. Julia Granville	BASR - Bethlehem	The social learning basis for structured parenting skills trainings whether in groups or for individual families, so that participants would have a thorough grasp of the underlying principles.
14	1/03 - 17/06 / 2010	Family Therapy	Dr. Julia Granville	CMHC - Nablus+ Jenin	• Basic ideas on Family systems Family Life cycles • Beliefs as it relates to mental heal Using Genograms in clinical practice • Impact on children and family relationships • Interviewing/ Questions skills • Working with organizations and networks, positioning and dialogue[45]

Source: MDM France. Final Report. February 2008-December 2010. Undated.

[45] The 4 special training topics were integrated in this training based on revising the relevancy of the topics initially proposed by MDM-F.

Table 9.2. Topics and time dedicated in each module (MDM-F)

Module/time	Themes of the module	Duration	Trainer
Module 1 11-13 May 2009 First day	**Introduction** 1. The current situation in Mental Health in PHC in Palestine 2. Definition of Mental Health 3. Ethics in PHC 4. Primary Health Care and Community Health 5. Integration of Mental Health in PHC 6. Communication skills 7. Getting to know each other 8. The interview in the context of the PHC centre: the stages 9. What makes communication difficult? 10. Communication techniques in interview (Verbal communication) 11. Non-verbal communication 12. How can we improve communication in the PHC centre? 13. From good communication to guidance, counseling and therapy 14. Effective Communication with Children 15. Effective communication with adolescents Handout is in English language	**16.30 Hrs** 1 hr 1 hr 2 hrs 1 hr 1 hr 1 hr 1.45 hrs 1 hr 1 hr 1 hr 1.30 1.30	Dr. H. Ashour Dr. S Mansour Dr. B Madi S. Mansour S. Alami Dr. S. Mansour
Module 2 16-18 June 2009 Three days	**Early Child-Parent Relationship, Bonding and Attachment** 1. Psychological needs and psychological state of the mother to be during pregnancy 2. Ensuring a good start in the relationship through interventions at the primary health care centre during the prenatal visit: Bonding; role of the ultrasound; involvement of the father. 3. What if something goes wrong: psychiatric illness of the mother, abortion, still-born baby 4. Preparation for the delivery Psychological impact of delivery 5. What if something goes wrong: Difficulties on the mother's side: post partum disorders 6. Difficulties on the baby's side: new born with a disability, premature baby 7. What should the PHC centre staff do? 8. Breast feeding Introduction to the concept of attachment	15.45 hrs 1 hr 1 hr 2.45 hrs 1.30 1.30 1 hr 1 hr 1 hr	Dr. S. Shehadeh

3 nd day	9. How to propose a proper accompaniment of parenting skills during early infancy; emphasis on the early interactions between the parents and their infant 10. How to promote an optimum development of the child during the first years through a special focus on practices around weaning and toilet training 11. Discussion around early signs of psychological distress: normal versus abnormal behaviors (crying sleep difficulties, thumb sucking , conflicts around food Handout is in English Language	1.30 1.30 2 hrs	
Module 3 July 14 –16, 2009 Three days 1st day 2nd day 3nd day	**Normal Development of Children, Early Detection of Developmental Problems and Signs of Psychological Distress** 1. What is Mental Health? 2. What problems do children have? 3. History taking and assessment 4. *Normal Development* – activities 5. *Abnormal Development* – activities 6. DVD – 'The Hidden Face of Autism' and discussion 7. *Emotional Problems in Children – Activities* 8. *Behavioral problems in Children*-activities 9. *Assessment of behavioral problems* 10. Management of behavioral problems **Handout: English on child mental health**	**15 hrs** 2 hrs 1.45 1.45 1.30 1.30 1.30 1.45 1.30 1.30 2 hrs	L. Tarazi
Module 4 4-6 august 2009 Three days 2nd day 3rd day	**Violence Against Children** 1. Brain storming to identify the different types of violence 2. Presenting different theories: instinct, sociobiology, behavioral genetics, learning, environmental, etc. 3. Social and situational influences Personal, familial, cultural, gender based predisposition to aggressive behavior 4. Social and political environment effects on Palestinian children and families: how to minimize negative effects and how to handle possible violent acts 5. Identifying 'aggressive models' 6. Basic Definitions: abuse, neglect, maltreatment 7. Sexual Abuse: who is the victim? Identification of mechanisms 8. The cycle of family violence How does it work, and why Predisposition factors to be abusive/ abused 9. Examine values, attitudes and explore models of behavior 10. Discussion on code of ethics 11. Role play and presenting leading questions to facilitate doctors/nurses 'orientation and sensitivity to the identification of possible victims of violence 12. Referral bodies and support systems available within Palestine **Handout; PowerPoint presentation in english**	**17 hrs** 1 hr 1 hr 1.30 1 hr 1.30 1 hr 1 hr 1.30 1.30 0.30 1 hr 1 hr	Yoa'd G. HAkim

Module 5 6-8 October Three days 2nd day 3rd day	**Adolescent health** 1. What is Different about Adolescents that is Relevant to Their Mental Health 2. Confidentiality and Youth Friendly Services Normal Behavior in Adolescents 3. Understanding the bio-psychosocial development of youth, impacts on risky behavior and mental health 4. The Present Political Situation in Palestine that Might Influence the Mental Health of Young People 5. Group work: Mental Health Problems and Concerns of Palestinian Youth and of their parents 6. Presentation by Groups on 'Health Problems and Concerns of Palestinian Youth. 7. The professional dialogue with youth - HEADS Visual analogues scale, etc. Role play in triangles 8. Alcohol, Smoking and Illegal Drugs 9. Sexual Health and Its Importance in Mental Health including Q&A session 10. Suicidal Conducts/ Self Esteem, including Signs and Symptoms 11. Eating Disorders – Anorexia, Bulimia, Obesity 12. Risk, Vulnerability and Resilience in Young People 13. Promoting mental health for YP with a chronic condition 14. Strategies for Helping and Supporting Parents 15. Do Male and Female Adolescents Have The Same Needs and Rights When it Comes to Their Health? 16. Strategies & interventions which promote Healthy Youth Development and protects from Harm – working with the local society in Palestine 17. Methods of Health Promotion in Adolescents in General 18. What mental health services are available for youth in Palestine **Handouts are collection of articles in English**	**19 hrs** 1 hr 0.45 1 hr 1 hr 0.30 0.30 0.50 1 hr 0.40 1 hr 0.50 0.45 0.45 1 hr 0.30 1.30 1 hr 0.45	Dr. Aidan Dr. Krisitina, Dr. Luma Tarazi
Module 6 8-10 December009 2nd day 3rd day	**Introduction to Adult Psychology** 1. Signs and symptoms of mental disorders 2. Etiology of mental disorders 3. Interviewing and history taking 4. Introduction to Diagnosis and Classification of Psychiatric Disorders 5. Psychotic Disorders: major signs, symptoms, assessment, overview of treatments 6. Mood Disorders: major signs, symptoms, screening and assessment & treatment 7. Anxiety Disorders: major signs, symptoms, screening and assessment 8. Other disorders in psychiatry: dissociative disorders, somatoform disorders 9. Review of Psychopharmacology **Handout is Arabic and English**	 1 hr 1 hr 0.45 1 hr 2 hrs 2.45 hrs 2.45 0.40 5 hrs	 Dr. I Banoura Dr. Ashour

Module 7 January 11, 2010	**Common Mental Issues & Disorders in Primary Care** 1. Depression in Primary Care 2. Menopause 3. Anxiety in Primary Care 4. Sleep disorders Handout about elderly in English some in Arabic	**2.15 hrs** 1 hr 2 hrs 0.30	Dr. I Amleh
Module 8 May 05, 2010 2nd day, May 06 Management of Cases at the Primary Health Care centres	**Treatments, apart from Medication** 1. Presentation of counseling intervention and expressive art therapy 2. Discussion and relating to case study 3. Psychosocial intervention in relation to community 4. Case presentation (Palestinian counseling centre experience) – 5. What should be recorded in the patient file? 6. Referral – how to refer, to whom to refer? 7. Role of the PHC team: follow-up and rehabilitation, home visits 8. Bringing support to the family 9. Networking with resources in the community Handouts in English	1.30 0.30 1.45 0.45 1 hr 1 hr 1 hr 1.15 0.45	R. Nashashibi Dr. H Ashour
Module 9 May 25, 2010 2nd day Trauma and PTSD 3rd day May 27, 2010 Psychosocial Needs of Ex-Detainees	**Stress, Emergencies and Crisis interventions** 1. Theoretical presentation and defining the terms: stress, trauma, loss and grief 2. Theory and discussion of individual traumas in children and adults 3. Therapeutic skills grounded on the concept of acknowledgement 4. Concrete applications in the context of PHC 5. Theory and discussion of collective griefs and collective trauma 6. Applications in prevention and health promotion programs in the context of Palestine, collaboration with other professionals 7. Interventions in situations of acute anxiety crisis, panic attack, abuse. Interventions in situations of agitation and acute psychotic states. Interventions in situations of suicidal attempts. Collaboration with other community actors 8. Presenting of complex trauma versus simple trauma in relation to ex-detainees 9. Presentation of neuropsychology behind complex trauma 10. Psychosocial intervention in relation to the specific features of patients and trauma 11. Recovery process Handouts are English	1.45 1.15 1 hr 1 hr 1 hr 1.30 hr 0.45 1.30 1.30 1.15 0.45	Yoa'd Ghanadry Hakim L Tarazi A Srour

Module 10 20-22 April, 2010 2nd day April 21, 2010 3rd day April 22, 2010	**Mental Health Promotion** 1. Health, Public Health, Community And Medicine 2. What Is Health Education and Promotion? 3. Tools of Health Education! How to use it? 4. Organizing groups for the clients of the PHC centre 5. Health Education in Community 6. Mental health education group model 7. Introduction to Group Dynamic 8. The Doctor of the Nurse Facilitators in a Support Group at the PHC Centre 9. How to Manage Groups of Patients (or not) the Same Kind of Problems (Children or Adults) No handouts	 1 hr 2.15 2.15 2 hrs 1.30 1 hr 2hrs 1.15 2.30	Dr. H Jaber

Table 9.3. Description of supervision, trainings and workshops content provided in Halhul-CMHCCA

Sup=supervision / Tr=training / Wk=workshop

Topic	Trainer	Description	Daily hours and frequency
Sup-Clinical supervision for counsellors	Murad Amro - psychologist and psychotherapist	Clinical supervision is a need for professionals in mental health services, and a very good way to get trained on therapeutical processes, skills and techniques. The counsellors meeting regularly with a senior professional can discuss caseworks. In that way they learn from their experience and progress in expertise. All therapist, and especially at the beginning of their practice, are expected to have regular clinical supervision to be able to ensure a good service to the clients.	All year 3 hours/session 1 sess./2 weeks
Sup-Clinical supervision for psychiatrist	Dr. Souha Shehadeh – child psychiatrist	As therapist, the psychiatrist also needs supervision, but given his medical background, supervision by a child psychiatrist will allow considering also the biological aspect of the disorders.	1 hour/session 1 sess./2 weeks
Sup-Institutional supervision	Yoa'd Ghanadry - psychologist and psychotherapist	Dealing with people with mental health disorders on a daily base is a very challenging work that can convey very strong feelings. These feelings need to be analyzed as part of the work process to allow an holistic approach of the patient, and to avoid the development of mechanisms that will impact the ability of the team to receive patients in a proper way. Meeting regularly with a skilled professional in mental health, the team members will be able to discuss the challenges they face in their work with clients, and how they affect the way they work with their colleagues	All year 3 hours/session 1 sess./4 weeks

Sup-Supervision on speech therapy with autistic children	Suha Awwad	As well as any mental health professional, the speech therapist also needs supervision, in this case with the use of **Picture Exchange Communication System (PECS)** that allows children and adults with autism and other communication difficulties to initiate communication	6 months 3 hours/session 1 sess./4 weeks
Sup-Work with children with pervasive development disorders – training and supervision	Dr. Souha Shehadeh	Autism is one of the most acute pervasive pathology in childhood. It impairs a lot the development of the child and affects the family. Offering support to mothers, and a therapeutical space for the child can be very helpful is breaking the isolation of the family and allowing the child to improve. But it's a very challenging and difficult work for professional who need a strong and continuous support to understand the autistic process and hold very disruptive feelings to which they are confronted in their work with the child. A specific setting needs to be implemented to make this work possible.	3 months 2 hours/session 1 sess./2 weeks

Topic	Trainer	Description	Daily hours and frequency
Tr-Art and play therapy	Rana Nashashibi	In their daily work with children and adolescents, mental health professional have to be able to offer their young clients ways to express themselves. In many cases, especially with children but also older patients who have difficulties in communication, play and art have proved to be useful tools to allow the patients to express their difficulties, but also to rebuild themselves through creative means during individual sessions as well as in group settings.	3 months training 6 hours/ session 1 sess/2 weeks 3 months supervision 2 hours/session 1 sess./2 weeks
Tr-Autism Assessment	Network of Institution Working in the Disability Field (Bethlehem)		
Tr-Child and adolescent development	Rana Nashashibi	A proper knowledge of normal development of children and adolescents relative to the different functions (motor development, language, cognition, as well as emotional and social aspects) is essential. This knowledge allows the professional to make a comparison between what is "normal" and what is "abnormal" at each age, and to evaluate delays, and difficulties.	

Tr-Child and adolescent psychopathology	Chiara Beguin-Clinical *Dr Iyad ** Khitam Awad	A deep knowledge of children and adolescents psychopathology, and all the signs and symptoms for each disorder is necessary to do a proper diagnosis and propose an appropriate plan of intervention. It covers disorders such as: Stress and PTSD, Neurotic and emotional disorders, Psychosomatic disorders, Conduct disorders, Substance misuse disorders, Psychotic disorders, Autism, Depression, Child abuse*, Epilepsy*, Mental retardation*, Speech and language disorders**, Learning disorders**.	3 weeks 6 hours/session 1 see./day
Tr-Child psychopharmacology	Dr. Pierre Canoui	The general policy in terms of children psychopathology is to reduce as much as possible the use of psychotropic drugs and focus more on psychotherapeutical treatment. Mental health professional thus need to understand about the specificity of child psychopathology and psychopharmacology to make the best use of both kind of treatments,. Psychiatrists and nurses were trained to detect and evaluate psychiatric and psychopathologic disorders of children and adolescent that can be improved and/or cured with the use of psychoactive drugs. The training provided information on: the different categories of psychotropic drugs, the psychoactive drugs that can be used with children and adolescents, the posology, and specially indication and contra-indications.	3 days 6 hours/day

Topic	Trainer	Description	Daily hours and frequency
Tr-Counselling skills	Yoa'd Ghanadry Hakim	Better self awareness, introspection, good communication skills and practical experience in counselling are basic blocks considered a must for any person working in mental health. The training focuses on basic counselling techniques including active listening, body language, tone, asking questions, paraphrasing, summarizing and note taking. In addition it brings introspection regarding underlying processes usually taking place during counselling sessions among which are projection, transference and counter-transference mechanisms. The importance of setting limits between caregiver and patient in mental health has also been cover in this training.	3 days 6 hours/day
Tr-Family therapy	Julia Granville	The child cannot be considered without his family environment and the specific dynamic in the family system. Professional have to understand how the family system can impact the development of the child, and the expression of mental health disorders. A knowledge of different family structure and how to deal with them is a must for therapist dealing with children. The training covers theoretical aspects as well as ways of intervention: main theoretical models and approaches in family structures, life cycles, social constructionist and narrative models, hypothesising, use of genograms/family Trees, enactments with families and sculpting, working with domestic violence	3 months 5 hours/day 1 day/week
Tr-Introduction to psychology and psychopathology (review of signs and symptoms).	Chiara Beguin	General presentation of the topics covered by psychology and psychopathology. The different aspects of human being: behavior, feelings and thoughts. The importance of observing, and looking for, signs and symptoms of mental health disturbances.	3 days 6 hours/day
Tr-Law and ethics	Zeina Jallad	The professional in mental health need to know about the legal, the institutional, and the practical frameworks that administrate their profession, the impact of the legal framework on the daily work of the mental health staff with patients, and more specifically children and adolescents. It will give the team the opportunity to discuss cases.	3 days 6 hours/day 1 day/week
Tr-Mental health in Palestine	Dr. Hazem Ashour	Presentation of the situation of mental health in Palestine: historical development, existing services, strengths and weaknesses, future development.	1 day 6 hours/day

Topic	Trainer	Description	Daily hours and frequency
Tr-Mental health status examination	Chiara Beguin	The mental health status examination is the first step in the assessment of the patient's disorder. It covers getting information on signs and symptoms regarding presentation, behaviour, feelings, language, cognition, social abilities, etc. At the end of this examination the professional should be able to provide hypothesis regarding a possible diagnosis, and make propositions concerning treatment.	5 days 1.30 hours/day 1 day/week
Tr-Outcome measures- ESQ	Julia Granville	The Experience of Service Questionnaire (ESQ) allows the service user to express his/her satisfaction about the services provided in the centre, and gives feed back to the team to improve their work.	2 sessions 2.30 hours/day
Tr-Outcome measures- SDQ	Julia Granville	The Strengths and Difficulties Questionnaire (SDQ) gives information about the child's risk of presenting acute mental health disorders. It's also a monitoring tool to access the improvement of the child during and after treatment.	2 sessions 2.30 hours/day
Tr-Parenting skills	Julia Granville and Lucy Draper	An important part of the work with children needs a deep involvement of the parents. Parental guidance has both a preventive aspect, as it helps universal families to provide an appropriate environment for the development of the child, and a curative aspect, as it has also shown its effectiveness treating children's mental health disorders. It is very helpful to tackle behavior symptoms that are one of the most frequent expressions of disturbances in children (ADHD, mental retardation, etc).	6 days training 7 hours/day 10 sess supervision 2.30 hours/day 1 day/week
Tr-Psychometric evaluation	Jeries Shawhan	To do a proper evaluation of the child it is sometimes needed to use specific psychometric tools, especially to assess intellectual abilities (Ravens Matrices, Token test, etc.). This training defines psychometric testing, provides initial competence in the administration, scoring, interpretation and analysis of various tests, acquire report writing skills based on pertaining assessments.	2 months training 6 hours/session 1 sess./2 weeks 3 months supervision 4 hours/session 1 sess./2 weeks
Tr-The relationship between caregiver and patient in mental health: empathy and beyond	Pernette Steffen	The relationship between caregiver and patient is either the necessary foundation for any intervention or the very means of intervention through which change can occur. The mental health caregiver not only needs to master theoretical knowledge and technical tools, but also needs to know how to "use himself" as his own tool in the relationship with patients. Which means that in order to put his knowledge into practice with a patient - making himself appear to the patient as someone who knows what he is talking about and thus can be trusted - the mental health caregiver has to build bridges between the theory and his own experience.	5 days training 6 hours/day

Topic	Trainer	Description	Daily hours and frequency
Tr-Training of trainers and capitalization on psychometric evaluation	Chiara Beguin Amina Mustapha	The professionals of the centre can be asked to provide trainings to people from other organizations or students. As a consequence, they have to be able not only to use some tools that are essential to their profession, but also to explain and demonstrate how to use them. This TOT processed focused on the use of psychometric tests: Raven matrix, Portage test, etc.	2 months training 2 hours/session 1 sess./week
Tr-Working procedures	Chiara Beguin	To work properly a CMHCCA team has to understand and implement properly working procedures. They are the framework of the activities and services provided by the team, they allow each staff to understand very clearly what has to be done, when and by who: pathway of patient, services provided, duties of each position, patients files, communication, referral,, weekly schedule, etc.	3 weeks training 6 hours/session 6 months supervision 2 hours/ session 1 sess./week
Wk-Establishing a referral system in Hebron district	Virginie Mathieu	A CMHCCA cannot work with a good referral system and network: what are the potential institutional partners (schools, care centres, organizations working in the field of mental health, etc), what kind of activity/service they provide, how to refer to them, who is the key person, what is the communication system, etc.	2 days 6 hours/days 1 day/2 weeks
Wk-Team work and burn out in a CMHCCA	Dr. Pierre Canoui	Working in mental health can be extremely stressful for professional. This workshop sensitized the team to the process of burn out, helped evaluate the actual ability of the team to cope with their working environment, and provided them with some tools to improve their coping mechanism.	1 day 6 hours/day
Wk-Workshop on patient database	Murad Amro	It is essential to keep a database of patients with different information concerning them to: name, contact, age, gender, etc. This is useful in the daily contact with the patient, as well as to follow-up the activity in the centre.	1 day 3 hours/day

Source: MDM-S final report – Annex 1.

Table 9.4. Themes and activities covered by the modules used by Juzoor in the West Bank

Module	Topic
Module 1	Introduction, Communication Skills and Interviewing Techniques.
Module 2	Early Parent- Child Relationship, Bonding and Attachment
Module 3	Normal Development of Children, Early Detection of Developmental Problems and Psychological Distress.
Module 4	Violence Against Children.
Module 5	Adolescent Health.
Module 6	Introduction to Adult Psychology.
Module 7	Specific Psychological Issues During Adulthood.
Module 8	Introduction to Treatment in Psychiatry
Module 9	Stress, emergencies and Crises Interventions.
Module 10	Mental Health Promotion.
Module 11	Sites Visits to referral institutions, case presentations.
Module 12	Case Presentations, topics decided by trainees

Source: AFD Mental Health Project. Annual Report. Period of the report: January – December 2009. Undated.

Table 9.5. Themes and activities covered by the training modules used by GCMHP in Gaza according to the UNDP

Module	Topic
Module 1	Normal and pathological: **life cycle, life crisis and experience of loss/ mourning; perception of mental health (Definitions)**
Module 2	Mental health and physical health redefined**: community health; relationship medical team/patients, basics in communication/counseling.**
Module 3	**Stages in child development:** bonding, psychomotor development, intellectual development, emotional /social /sexual development
Module 4	Child psychopathology: **specifics of the encounter between the child and the medical staff, signs of psychological distress, introduction to child psychopathology (main entities)**
Module 5	Adolescence: **what happens during this stage, specifics of the encounter between the adolescent and the medical team, counseling and support with adolescents, identification of early psychiatric problems.**
Module 6	Adult psychopathology: **Introduction to main pathologies (neuroses, psychoses, epilepsy, psychosomatic disorders); what is expected from the primary health care centre.**
Module 7	Adult psychopathology (continued): **addictions, personality disorders**
Module 8	Adult psychopathology (continued): **specifics of the encounter with the elderly, psychiatric problems and senility.**
Module 9	Introduction to different kinds of therapy**: How to work in close coordination with the community mental health clinic**
Module 10	**Introduction to psychopharmacology**
Module 11	Violence in the families: **battered wives, physical and sexual abuse of children.**
Module 12	**Emergencies and crisis intervention:** psychiatric emergencies, stress and PTSD.

Source: AFD Mental Health Project. Annual Report. Period of the report: January – December 2009. Undated.

Table 9.6. Themes and activities covered by the training modules used by GCMHP in Gaza according to the GCMHP' progress report

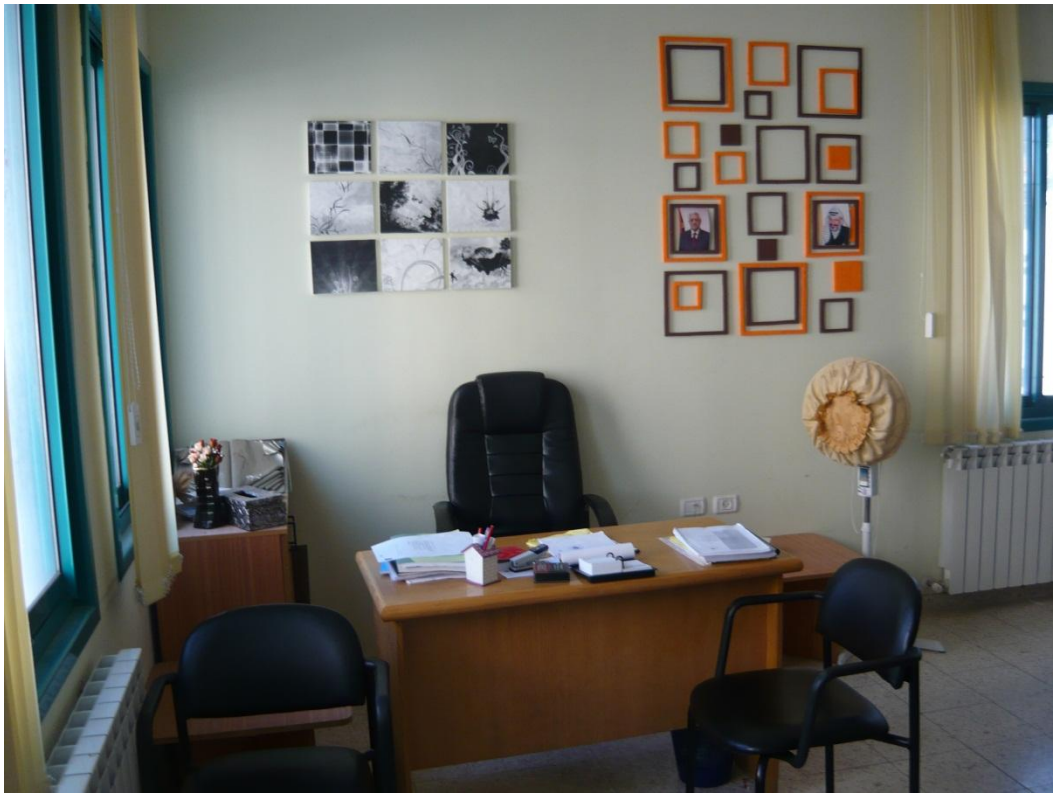
مرفق المنهج التدريبي وأسماء المدربين

الرقم	المساق	مدرس المساق
1	Child Development	محمد الزير
2	Child Psychopathology	د. جمال قنن
3	Adolescence Psychopathology	د. عبد العزيز ثابت
4	Adult psychopathology: main pathologies	د. نمر أبو زرقة
5	Adult psychopathology: addictions, personality disorders	د. عايش سمور
6	Adult psychopathology: psychiatric problems and senility	د. تيسير العمصي
7	Introduction to Psycho therapies	د. فضل أبو هين
8	Emergencies and crisis intervention	د. زياد عوض
9	Violence in the families	د. سمير زقوت
10	Normal and pathological life cycle	د. ياسر أبو جامع
11	Psychopharmacology	د. محمد أبو السبح
12	Mental health and physical health redefined	د. ياسر أبو جامع

Source: Gaza Community Mental Health Programme. Training of doctors and nurses working in primary health care centres in Gaza. Progress report. July 2009 – May 2010. Not dated.

7.5. Annex 5. Photographic annex

1. Nablus CMHC



2. Activities at the Al Bireh MSK Documentation centre (monthly professional meetings)

In the first picture Dr Hazem Ashour, director of the MoH's Mental Health Unit, conducts a presentation.


07/14/2011 10:53 am


07/14/2011 11:13 am

7.6. Annex 6. Evaluation Matrix

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
1. Relevance:		
1.1. To what extent did the project respond to priorities and needs of the mental health epidemiological situation / needs of the population, in the oPT? 1.2. To what extent did the project provide a missing building block of the overall mental health care system in the oPT?	• Incidence & prevalence rates of various mental health conditions / disorders as defined by internationally accepted definitions • Number and level of facilities and of health professionals providing appropriate mental health in the oPT prior to the start of the project • The quality and types of therapeutic interventions health professionals used in providing care prior to the start of the project • Number of published health policies, mental health professional standards and regulations prior to the project • Number of professionals and family networks/associations established prior to the start of the project • Relevance of the training program to the needs of the health sector in PHC, and CMH: personnel selected for recruitment had the right type of profile; the number of persons trained was adequate for the mental health system's needs; the modules elaborated covered the essential needs of mental health care (diagnostic tools, treatment and care / support to patients); training was adequate to the Palestinian culture and specific epidemiological profile.	Documentation: • WHO / UNDP reports on mental health and healthcare in the oPT; WHO health statistics • MoH reports • Scientific reports available • Other relevant published sources Interviews with key informants from MOH and UNDP/PAPP Meetings with civil society organizations or other institutions

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
2. Coherence:		
2.1. To what extent did the project fit into the overall mental health response policy and framework of the Palestinian authorities? 2.2. To what extent did the project fit into the overall support to the health system from development partners (UNDP, AFD and others)? (Is there a coherent approach to their intervention in the overall health sector and more particularly in the mental health sub-sector?)	• Government policy and strategies in the health sector / mental health sub-sector • Financial and Technical Partners' (FTPs') policy and intervention/support framework and projects • Existence of sectoral / sub-sectoral coordinating mechanism / platform • No. of multi-sectoral meetings held • Existence of sectoral reviews involving government and development partners (health sector)	Documentation: • Government policies and strategic frameworks in the area of healthcare and more specifically mental health • FTPs' policy and intervention/support framework and projects documents Interviews with UNDP, AFD and other key FTPs

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
3. Effectiveness:		
3.1. To which extent were the overall and specific objectives assigned to the project achieved (as per the project's Terms of Reference / logical framework)? 3.2. To what extent did the project improve mental health services' infrastructure, and access to mental health facilities? 3.3. Are the three constructed / rehabilitated / equipped Community Mental Health centres in Nablus, Jenin and Halhoul, and the Al Bireh Documentation centre in Ramallah fully staffed, appropriately equipped and operational? 3.4. To what extent did the project improve associated human resource capacities? 3.5. Did the project enable the recruitment and training of as many staff and health professionals as planned?	• Project's indicators of achievement / result • Number of health facilities and of health professionals trained and recruited in mental health services • Level of staffing and of equipment of the CMHCs and of the Ramallah DC (including the quality and variety of the documentation available at the DC) • Level of maintenance and practicality of the CMHCs • Level of confidentiality and understanding ensured to patients and relatives at the CMHCs • Content and delivery process of the training modules • Quality of training program, including materials, trainers, etc • Level of qualification of health professionals involved in mental health services (including a comparison of prior and post-project levels and number of professionals hired and trained as a result of the project's implementation) • Geographical and practical accessibility of the CMHCs and of the DC to the population and to other users • Existence and actual use of protocols of care and of a referral system • Level of functionality and of utilization (volume of activity / frequentation) of each of the 3 CMHCs • Types of services actually delivered at the CMHCs • Level of functionality and utilization (volume of activity / frequentation) of the Ramallah DC • No. of staff trained in finance, MIS, strategic planning,financial planning • Number of managers trained, by type of training	Documentation: • Project's activity reports • MoH and other stakeholders (UNDP, AFD, others)' reports • Review of scientific and grey literature publications • CMHCs' administrative and medical logs Interviews with UNDP/PAPP staff, trained MOH staff, CMHCs' and DC's staff Questionnaires to trained health professionals Field visits to the three CMHCs and to the Documentation centre, and videoconference with key informants in Gaza Focus group with users of the Documentation centre On-the-spot interviews with visitors / patients / relatives at the CMHCs

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
4. Efficiency:		
4.1. To what extent were project resources accurately used to achieve the project's specific objectives? 4.2. To what extent were activities managed in a manner to ensure the delivery of high quality outputs?	• Project's administrative and financial procedures and leadtime for specific procedures (such as approval of reports, of expenses, payments, etc.) • Project's level of financial execution • Respect of bidding processes' procedures • Level of staffing and recruitment of expertise (and cost) used to ensure the implementation of the project • Content and organization of training modules and sessions	Documentation: • Review of project documents (activity reports, financial reports, financial audit reports, partners' reports) • Interviews with the project's staff
5. Impact:		
5.1. Did the project contribute to the improvement of the quality of mental health services provided? 5.2. To what extent did the project help reduce stigma and increase people's awareness regarding mental health? 5.3. Did the project contribute to the improvement of the patients' mental and overall health? 5.4. Were there unintended effects (positive, negative or otherwise) or consequences produced by the project?	• Effective exchange of knowledge and experience has been achieved from the program • Functional health information and communication system (information collected, analyzed, accessed and used) • Functional service delivery systems (i.e.,affordable mental health services are available; professional supervision system is in place, follow up and monitoring) • The number of patients cared for at CMHCs and in the overall health system is increased / increasing • Mental health policies and strategies have evolved towards a more holistic, differentiated approach for care as a direct or indirect result of the project's implementation • Frequency of medication / pharmaceutical prescription vs psycho-therapeutic / more holistic approaches • Overall resources allocated to mental health care have increased / are increasing • Measured / perceived change in patients' mental health outcomes • Access to mental health services, self-referral, level of family involvement in planning • The anti-stigma campaign has reached out to the whole Palestinian community (Palestinians living in the oPTs have a more positive and understanding attitude vis à vis mental disorders and psychiatric ailments) • Level of participation in community health committees	Documentation: • Review of health sector and mental health sub-sector policy and strategy documents • Review of studies / reports produced by various stakeholders and research teams / scientific publications • Review of press articles • Review of radio campaigns material • Review of the content of other anti-stigma communication campaign materials • Field visits to the three CMHCs and to the Documentation centre • Interviews with trained MOH staff, CMHCs' and DC's staff • Questionnaires to trained health professionals • On-the-spot interviews at the CMHCs • Focus groups with trained personnel • Focus groups with patients or patients' representatives

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
6. Sustainability:		
6.1. Was an exit strategy designed as part of the project's implementation framework and implemented? 6.2. Did the project enable the development of an operational referral system? 6.3. Are the three rehabilitated /constructed CMHCs integrated into the Palestinian health system (including in financial terms)? What are their links with the psychiatric departments of the different hospitals? 6.4. What is the nature of the links that have been developed between the Documentation centre in Ramallah and Palestinian Universities and research centres?	• Existence and effectiveness of formal referral documents and organization between the PHC level, the CMHCs and the secondary / tertiary level • Existence of a mental health strategy within sector policy and strategic frameworks • Level and evolution of funding from government going to mental health (CMHCs, DC and other facilities and programmes) • Status of mental health professionals (vs that of other health professionals in the public sector) • The DC in Ramallah has established formal links with academia in the oPTs (and beyond) • Effective exchange of knowledge and experience is now taking place on a regular basis as a result of the project • An effective and strong educational network of supporthas been established at both local and international levels	• Review of health sector / mental health sub-sector policy and strategy documents • Interviews of stakeholders: health and social sectors officials, civil society organizations involved in the mental health sector if any, persons in charge of curriculum design and training at the University, CMHC staff and medical staff of hospital psychiatry departments, social workers • Questionnaires to trainees • Focus groups with health professionals and patients' representatives

Evaluation questions associated to each evaluation criterium	Associated indicators / critical information to be measured / reviewed / assessed	Data collection methods
7. Cross-cutting issues:		
7.1. Did training provided to the recruited staff and the primary health care professionals integrate practical trainings to tackle specific mental health issues focusing on women, children and adolescents and /or family therapy? 7.2. Did the project help the mental health services provided in the oPT serve the poor and most vulnerable strata of the population in those territories (socio-economically deprived, ethnically or culturally/religiously outcast / rejected / marginalized)?	• Training modules / curriculae incorporated specific material regarding the care for sub-sectors of the population / the consideration of specific categories of population (children, youth, women, men, the socially and economically vulnerable or deprived, etc.) • Consideration given to and practical responses designed for the care of sub-sectors of the population through a holistic, differentiated approach (the poor, women, children, adolescents, men, according to various levels of trauma, etc.)	• Review of training modules / curriculae • Possible meeting with trainers • Interviews with mental health professionals • Review of protocols of care

7.7. Annex 7. Possible logical framework for the AFD/UNDP mental health project in the oPT

Overall objective	Improve male and female Palestinian mental health condition through improving the access to mental health facilities, developing capacity of mental health care staff and improving quality of the services through action oriented research.				
Specific Objectives / Components	**Activities**	**Outputs**	**Indicators**	**Source of verification**	**Hypotheses/ Prerequisites Risks/opportunities**
Component 1 – Provision of community mental health (MH) services	**Activity 1.1. Construction / Rehabilitation and equipment of 3 community mental health centres**	• 3 newly constructed / rehabilitated and equipped mental health community / referral centres in Halhul (pediatric), Jenin (general) and Nablus (general)	• Certification of completion of work • Equipment is provided and functional	• UNDP engineering department • MoH department dealing with facilities and equipment	• The MoH provides the project with suitable land / buildings and construction permits. The procurement of material is not hampered by the political / logistical difficulties.
	Activity 1.2. Recruitment of staff	• X professionals are recruited to staff the 3 CMH centres	• X letters of employment	• MoH HR department	• MoH salary scale is sufficiently attractive to recruit personnel with a minimum of education and experience in mental health, health promotion, psycho-social interventions.
	Activity 1.3. Training of CMHC staff recruited	• X staff recruited to work in the 3 CMHCs newly created are able to perform the work that is expected from a community mental health approach	• Curriculae are developed and approved by Steering Committee (including MoH) • Training modules are delivered to X staff • Up-to-date techniques are used to diagnose and treat patients • An appointment system is in place	• Curriculae (training institutions) • Training reports • End of training evaluations • Certificates delivered to trainees • PHC centres' / CMHC logs and referral documents • Patients' medical records	• Facilities are available for training sessions. • A preliminary evaluation of the training needs is conducted. • Curriculae use internationally sanctioned material adapted to the context of the oPT.
	Activity 1.4. Supervision	• Supervisory activities are organized that allow CMHC staff to review its practice and	• Supervisory system is formally organized (guidelines) • Supervisory activities take place on a regular basis	• Supervision guidelines • Supervision reports	• The MoH has a developed supervision policy / strategy and has means to implement it.

		improve on it			
Component 2 – Integration of MH services with primary health care (PHC) services	**Activity 2.1. Training of PHC personnel**	• Y PHC personnel receive training and, as a result, are more able to screen, diagnose, refer, treat psychiatric and psychologically adverse conditions according to internationally sanctioned guidelines	• Curriculae are developed and approved by Steering Committee (including MoH) • Training modules are delivered to Y PHC personnel • Up-to-date techniques are used to diagnose, treat and/or refer patients • Cases are increasingly accurately diagnosed, treated, and referred to CMHCs	• Curriculae (training institutions) • Training reports • End of training evaluations • Certificates delivered to trainees • PHC centres' / CMHC logs and referral documents • Patients' medical records	• Facilities are available for training sessions. • A preliminary evaluation of the training needs is conducted. • Curriculae use internationally sanctioned material adapted to the context of the oPT.
	Activity 2.2. Development of guidelines	• PHC and MH sectors use professional guidelines to standardize practice and integrate the treatment and care provided to mental health patients in the overall healthcare sector	• Referral guidelines are approved by the MoH and used by PHC and MH professionals • Therapeutic guidelines are approved by MoH and used by PHC and MH professionals	• Referral guidelines • Therapeutic guidelines	• An existing committee of the MoH is mobilized or an ad-hoc committee is set up by the MoH on professional guidelines
	Activity 2.3. Supervision	• Supervisory activities are organized that allow PHC personnel to review its practice and improve on it	• Supervisory system is formally organized (guidelines) • Supervisory activities take place on a regular basis	• Supervision guidelines • Supervision reports	• The MoH has a developed supervision policy / strategy and has means to implement it.
Component 3 – Development of knowledge mental health in the oPT / Creation of a MH-dedicated documentation	**Activity 3.1. Construction and equipment of a MH-dedicated documentation centre**	• A functional centre is provided with staff and all the necessary documentation that heathcare professionals need in the oPT to	• Certification of completion of work • Equipment is provided and functional • Documents are procured (including journal subscriptions)	• UNDP engineering department • MoH department dealing with facilities and equipment	• The MoH provides the project with suitable land / buildings and construction permits. The procurement of material is not hampered by the political / logistical difficulties.

centre		update their knowledge in mental health			
	Activity 3.2. Recruitment of staff	• 2 professionals are recruited to staff the documentation centre	• 2 letters of employment	• MoH HR department	• MoH salary scale is sufficiently attractive to recruit personnel with a minimum of education and experience in documentation and information technology.
	Activity 3.3. Training of staff recruited to run the centre	• Staff is capable of running a MH-dedicated documentation centre	• An operational documentation loan system is in place • A functional website is available	• Curriculae (training institutions) • Training reports • End of training evaluations • Certificates delivered to trainees	• BirZeit University will be able to provide training in its premises.

7.8. Annex 8. Questionnaires to mental health and primary health care professionals

Annex 8.a. Graduates questionnaire الاستبيان الخاص بالخريجين

Evaluation of the mental health training program

تقييم لبرنامج التدريب في الصحة النفسية

I. General information: معلومات عامة

1. Professional background الخلفية المهنية	2. Title اللقب المهني	
3. Previous qualification **المؤهل العلمي (الدرجة العلمية)**	4. Additional specific courses in psychotherapy after graduation **هل حصلت علي كورسات تخصصية في العلاج النفسي بعد االمؤهل العلمي و ما هي**	5. other skills courses **اي كورسات مهاراتية النحقت بها**
6. Position before the training **الوضع الوظيفي قبل التدريب**	7. Years of Experience: **عدد سنوات الخبرة**	8. Current position and where **الوضع الوظيفي الحالي و اين**
9. Do you have a job description? If yes, describe the main tasks **هل عندك وصف وظيفي مكتوب؟ اذا كانت الاجابة بنعم ما هي اهم المهام**	10. How long have you been in the current position? **كم سنة لك في هذه الوظيفة**	11. Process of employment (please describe briefly): **الرجاء وصف اليات توظيفك**

Evaluation of Training modules تقييم المساقات التدريبية

1. How did you know about the training program provided by the UNDP/AFD project?
كيف عرفت ببرنامج التدريب المثدم من مشروع UNDP/AFD

2. What training program did you participate in?
ما هي برامج التدريب التي شاركت بها؟

3. How many times have you interviewed to attend the training Program?
كم مرة نم مقابلتك لكي تشارك في برامج التدريب؟

4. What was your evaluation of the criteria of selection to attend the training Program?
ما هو تقييمك لمعايير الاختيار للمشاركة في يامج التدريب؟

5. What training module did you like most? Why?
ما اسم المساق الدي احببت بشكل كبير و لماذا؟

6. Each training module complied with stated goals agree (1) neutral (2) disagree (3)
كل مسافات التدريب امتثلت لاهداف معلنة و محددة **(3) غبر موافق (2) محايد (1) موافق**

7. Training modules were appropriate to my practice agree (1) neutral (2) disagree (3)
المساقات التدريبية كانت مناسبة لعملي **(3) غبر موافق (2) محايد (1) موافق**

8. I acquired knowledge from my participation agree (1) neutral (2) disagree (3)
اكتسبت العلم و المعرفة من خلال مشاركتي بالتدريب **(3) غبر موافق (2) محايد (1) موافق**

9. Training modules met my needs agree (1) neutral (2) disagree (3)
المسافات التدريبية توافت مع احتياجاتي **(3) غبر موافق (2) محايد (1) موافق**

10. training modules helped me to modify my practice agree (1) neutral (2) disagree (3)
المساقات التدريبية ساعدتني في تحسين ادائي العملي **(3) غبر موافق (2) محايد (1) موافق**

11. I was satisfied with the organization of training agree (1) neutral (2) disagree (3)
انا راضي عن المستوي التنظيمي لبرامج التدريب **(3) غبر موافق (2) محايد (1) موافق**

12. The training modules included practical sessions agree (1) neutral (2) disagree (3)
اشتملت مساقات التدريب علي دورات عملية **(3) غبر موافق (2) محايد (1) موافق**

13. I acquired skills needed to provide good quality services agree (1) neutral (2) disagree (3)
لقد اكتسبت المهارات المطلوبة الازمة للتحسين مستوي الخدمة (3) غبر موافق (2) محايد (1) موافق

14. I learnt form the case presentations in some sessions agree (1) neutral (2) disagree (3)
لقد تعلمت من عرض الحالات في بعض المساقات **(3) غبر موافق (2) محايد (1) موافق**

Evaluation of skills gained by the academic training program (Modules)

تقييم المهارات المكتسبة من خلال مساقات التدريب

Please, indicate below the type of skills that you have gained in each of the proposed categories:
الرجاء الاشارة الي نوع المهارات التي تم اكتسابها من الفنات التالية

a) Set up and implementation of a therapeutic plan**:** **اعداد و تنفيذ الخطة العلاجية**
b) Assessment skills: **مهارات التقييم**

c) Mental state exam: فحص الحالة العقلية
d) Diagnostic and analytical skills: مهارات التشخيص و التحليل
e) Interview skills مهارات و المقابلة:
f) Intervention skills: مهارات التدخل
g) Community assessment skills: مهارات التقييم المجتمعي
h) Lecturing in topics related to community and mental health:
عمل محاضرات في موضوعات لها علاقة بالصحة النفسية و المجتمع

a) Capacity for case management (including referral/counter-referral):
المقدرة علي ادارة الحالة و التي تشمل النحويل و اعادة التحوبل

b) Psychotherapeutic skills: مهارات العلاج النفسي
c) Family therapy skills: مهارات العلاج الاسري
d) Parenting courses: دورات تربية الاطفال
e) Group therapy skills: مهارات العلاج الجماعي
f) Other skills: مهارات اخري

IV. Evaluation of trainers (lecturers). Please, provide with your assessment:

نفييم المدربين (المدرسين). من فضلك اعط تقييمك حسب الجدول المدرج

	Strongly agree اوافق بشدة	**Agree** اوافق	**Neutral** محايد	**Disagree** لا اوافق	**Strongly disagree** لا اوافق يشدة
Are Competent and experienced عندهم الكفاءة و الخبرة					
Were well-prepared for the class كانوا مستعدين و محضرين للدرس					
Demonstrated thorough understanding of the subjects اظهروا فهما جيدا للموضوعات					
Willingness to transfer knowledge to trainees عندهم الرغبة في مشاركة معلوماتهم مع المتدربين					
They have update knowledge عندهم المعلومات الحديثة					
Give examples form reality اعطوا امثلة من الواقع					

They were able to recognize the impact of cultural and political variables on psychological differences and response to treatment **كانوا فادربن علي معرفة اهمية العوامل السياسية و الثقافية علي الوضع التفسي و الاستجابة للعلاج**					

V. Application of gained skills into clinical practice:

توظيف المهارات المكتسبة في العمل العيادي الاكلينيكي

1. What are the fields of clinical/community practice that you have performed after training program?
ما هي مجالات العمل العيادي او المجتمعي التي مارستها بعد انهائك للدورة التدريبية؟

2. What is the average number of cases that you see weekly?
كم هي عدد الحالات التي تراها اسبوعيا؟

3. What is the average of number of cases that you see independently every week?
كم هي معدل الحالات التي تراها يشكل مستقل كل اسبوع

4. How many cases are improved/discharged from your case load?
كم هي عدد الحاالات التي تحسنت او تم اخراجها من حالاتك

5. Do you have a professional supervision? If yes, what type
هل عندك اشراف اكلينيكي؟ ادا كان نعم فما هو نوع الاشراف و كيف ينم

6. Do you think the supervision Program was suitable to gain the necessary practical experience? (Why)
هل تعتقد ات الاشراف الاكلينيكي مناسب لاكسابك مهارات عملية؟ لماذا؟

VI. Personnal assessment

النقبيم الشخصي

Describe some good points about the course **صف الاشياء الايجابية للتدريب**

……

……

……

……..

…….

Describe some areas of the course that could be improved **صف بعض الاشياء التي كان نت الممكن ان تكون افضل او يتم تحسينها** …….. …….. …….. ……..
Describe the relevance of training to your current job **الرجاء وصف مدي اهمية التدريب الدي اخدنة علي وظيفتك الحالية** …….. ……. ……..
Could you describe the impact that you see of the program on your patients? **هل ممكن ان تصف أثر التدريب علي المرضي و عائلاتهم** …… …… ……..
Would you say that the referral / counter-referral system in your specialty is adequate in the mental health system, and if not, why? **هل تري ان نظام التحويل و التحويل المضاد كاف؟ و ادا كان الجواب لا. لماذا؟** …… …… ……
Other comments **ملاحظات اخري** …….. ……. ……..

VII. Recommendations / Suggestions that you would like to make:

هل تحب ان تضيف اي اقتراحات او توصيات

Annex 8.b. الاستبيان الخاص بالمؤسساتHealth organizations questionnaire

Evaluation of the mental health training program

تقييم لبرنامج التدريب في الصحة النفسية

II. General information: معلومات عامة

1.1. About the respondant: **معلومات عن المشارك**

1. Your name optional: **الاسم اختياري** Name of the org. **اسم المؤسسة**	2. Your position: **الموقع الوظيفي**	3. Time in that position: **الفترة الزمنية في الموقع الوظيفي**

About the organization / institution: **معلومات عن المؤسسة**

1. Name of organization / institution:**اسم المؤسسة**	2. Address: **العنوان**	3. Phone No.: **رقم التليفون**
4. Date of establishment:	5. Type of organization:	6. Number of employees:

تاريخ التأسيس	نوع المؤسسة	عدد االموظفين
8. Person in charge and title: لقب الشخص المسؤل		

7. Categories of employment and specialties and number of personnel in each of them:
ما هي فئات التوظيف و التخصصات و الاشخاص في كل منهم

-
-
-
-
-
-
-

8. Please, describe the type of professional supervision in place, if available:

الرجاء وصف نوعية الاشراف الفني التي تمارس , ان وجدت

9. Qualifications of supervisors, if available, please indicate the type of supervision training they have received:

مؤهلات المشرفيين الفنيين, ان وجدت, الرجاء توضيح نوعية الندريب الدي تلقاة المشرفين بما يخض الاشراف الفني

I. Fields of work: مجالات العمل

1. Departments and sections in the organization:
ما هي الدوائر و الاقسام في المؤسسة
2. Types of services provided: **أنواع الخدمات المقدمة**
3. Geographical coverage: **ما هي المناطق الجغرافية التي تغطيها المؤسسة**

4. Number of cases currently being dealt with in your organization:
ما هي عدد الحالات التي ننابعها المؤسسة حاليا

5. How many new patients do you see every week on average?
كم عدد الحالات الجديدة التي تتعامل معها المؤسسة في الاسبوع

6. What are the type/s of therapeutic interventions used to help clients and their families?
ما هي نوعية التدخلات اعلاج النفسي التي تستخدم لمساعدة المرضي و اسرهم؟

How many cases do you refer to a more specialized mental health care every week on average?

كم هي عدد الحالات التي يتم تحويلها الي خدمات نفسية متخصصة في الاسبوع تقريبا

7. How many weeks/months a patient stays in therapy, on average (can you specify by main type of diagnosis)? How many therapeutic sessions?
كم اسبوع او شهر يبقي المريض في العلاج النفسي؟ يمكن ان توضح التشخيص و عدد الجلسات العلاجية؟

8. What is the drop-out rate?
ما هو معدل تسرب الحالات ؟

9. What are the activities that organization use in order to combat stigma attached to mental illness?
ما هي الانشطة التي تقوم بها المؤسسة من اجل مكافحة و صمة العار المصاحبة للمرض النفسي؟

10. Did the training program contribute to improving the quality of services offered by the organization, and how?
هل ساهم التدريب الدي تلقاة مقدمي الخدمة في تحسين نوعية الخدمات المقدمة من المؤسسة و كيف؟

II. Organizational development

1. Do you have and implement professional standards
هل يوجد معاييرو توصيفات مهنية تتبعها المؤسسة

2. Do you have therapeutic protocols?
هل يوجد لدي المؤسسة بروتوكولات علاجية

3. Do you have internal bylaws and regulations?
هل يوجد قوانين و لوائح داخلية

4. Does the centre have a strategic plan with clear vision and mission?
هل بوجد للمؤسسة خطة استرتيجية

5. Do you have a job description for each employee?
هل بوجد وصف وظيفي لكل موظف

6. Do you have a therapy manual in one of the psychotherapeutic individual or group psychotherapy intervention?
هل يوجد دليل علاجي لاحدي العلاجات النفسية سواء كان علاج نفسي فردي او جماعي

7. In your opinion, did the training program contribute to the centre's development and if so, in which ways?
في رأيك هل ساهم التدريب في تطوير المؤسسة, اذا كانت الاجابة نعم, كيف؟

III. General evaluation:

تقييم عام

1. In your opinion, what are Gaza's/Westbank's needs in terms of mental health?
   في رأيك, ما هي احتياجات الضفة الغربية و قطاع غزة بما يخص الة النفسية؟

2. Do you think that the training Program has provided a number of community and mental health specialists adequate to the needs of Gaza/Westbank (elaborate if needed)?
   هل تعتقد ان مساقات التدريب فد زودت الخدمات النفسية في كل من غزة و الضفة الغربية بعدد من المتخصصين المدربين و المؤهلين, الرجاء التوضيح؟

3. Would you have some recommendations or suggestions to improve the mental health training?
   هل عندك بعض الاقتراحات او التوصيات التي ممكن ان تساهم في تحسين جودة و نوعبة التدريب في الصحة النفسية؟

7.9. Annex 9. Evaluation's Terms of Reference

United Nations Development Programme

Programme of Assistance to the Palestinian People
برنامج الأمم المتحدة الإنمائي/ برنامج مساعدة الشعب الفلسطيني

RFP-2011-009

Date: 29 August 2011

REQUEST FOR PROPOSAL (RFP)

RFP-2011-009

Technical Evaluation for AFD Mental Health Project

1. UNDP/PAPP is seeking qualified firms to conduct a technical evaluation for the AFD Mental Health Project activities as detailed in this RFP. You are therefore invited to submit a quotation in accordance with the terms and conditions included in this Solicitation Document.

2. The Offeror shall prepare two copies of the Proposal, clearly marking each "Original Proposal" and "Copy of Proposal" as appropriate. In the event of any discrepancy between them, the original shall govern

3. It is required that proposals should be submitted in two separate sealed envelopes, one containing the technical proposal and one the financial proposal.

4. The separate sealed envelopes should be delivered to the following address no later than **22 September, 2011 at 10:00 a.m** (Jerusalem time) clearly marked as follows:

   Khaled Shahwan
   Deputy Special Representative (Operations)
   United Nations Development Programme (UNDP / PAPP)
   4A Ya'qubi Street
   PO Box 51359
   Tel: 02-6268200
   Jerusalem

   The outer envelope should be clearly marked with the title "RFP – 2011 – 009 AFD Mental Health Project evaluation

5. Any request for clarification related to this RFP should be submitted in writing to proc2.papp @undp.org no later than 9 September 2011. Responses to clarifications will be posted on the following web site on 15 September 2011. No clarifications will be accepted after the 9 September 2011.

6. This procurement activity is anticipated to be finalized within a month from the above bid closing date. Interested bidders may check the outcome of the process through the following link: http://www.undp.ps/en/aboutundp/vend.html.

Should you require further details on the status of your offer, please address your clarification to the email address mentioned in point number 5.

7. It is requested that receipt of this letter is acknowledged and to indicate whether or not you intend to submit a proposal.

Sincerely Yours,

Khaled Shahwan
Deputy Special Representative / Operations

RFP-2011-009

Terms of Reference

AFD Mental Health End of Project Evaluation

Project Background

The AFD Mental Health Project funded by the Agence Française de Développement (AFD) with 2.740.000 Euro was implemented by the United Nations Development Programme / Programme of Assistance to the Palestinian People (UNDP/PAPP) from 2008 to 2011. The project´s main beneficiary is the Palestinian Ministry of Health (MoH) and its staff.

Its main goal was to contribute to the improvement of Palestinian's mental health condition by improving the access to mental health facilities, developing the capacity of professional staff and improving the quality of mental health services provided in the West Bank and the Gaza Strip.

To achieve this, the AFD Mental Health Project constructed, rehabilitated and equipped three Community Mental Health Centers (CMHC) in Jenin, Nablus and Halhoul, and one documentation center in Ramallah. On behalf of the MoH, it also recruited, trained, clinically supervised and covered the salaries of 19 mental health professionals to support the newly established centers, as follows:

- Jenin CMHC: 2 psychologists, 1 social worker, 1 occupational therapist, 1 pharmacist, 1 nurse, 1 clerk.
- Halhul CMHC: 2 psychologists, 1 social worker, 1 nurse, 1 speech & language therapist, 1 clerk.
- Nablus CMHC: 1 social worker, 1 occupational therapist, 1 nurse, 1 clerk.
- Ramallah Documentation Center: 1 librarian, 1 webmaster.

The constructed or rehabilitated CMHCs significantly increased the access to and the delivery of mental health services by the Ministry of Health. Moreover the CMHC in Halhoul is the first specifically dedicated to children and adolescents in the occupied Palestinian territory (oPt).

In order to improve the quality of the mental health service delivery, the project targeted additional mental health professionals and primary health care staff. Extensive training and clinical supervision sessions were conducted tackling theoretical knowledge, practical skills and attitudes towards mental health issues focusing on women, children, family therapy and parenting skills. Moreover, the project facilitated the participation of key MoH staff in internship programmes and workshops inside and outside the country.

At the primary health care level, 51 doctors and nurses graduated from a 12 module certified training programme. These specialized professionals will play a major role in the early detection of psychological disorders as well as in ensuring an appropriate referral to specialized mental health services.

The project also contributed to the harmonization and standardization of referral systems and protocols. A pilot referral system for the Nablus governorate was adopted by the MoH at the end of 2010.

The newly established Documentation Center in Ramallah is the first of its kind in the oPt. It serves mental health professionals, researchers and students with more than 650 specialized books, online sources and subscriptions to international periodic publications.

Finally, an anti-stigma campaign was launched in 2011 to encourage communities to accept people with psychiatric disorders and seek treatment at the different CMHC located throughout the oPt. The campaign included radio programmes and community outreach activities.

By the end of the project in July 2011, all three CMHC and the Documentation Center are fully functional and integrated into the MoH systems and procedures.

For more information, see Annex I: Project Fact Sheet

Partners

The AFD Mental Health Project was implemented by UNDP/PAPP in close collaboration with national and international NGO's specialized in mental health and social development. The partner organizations were Juzoor Foundation for Social Development, Birzeit University Main Library, Palestinian Counseling Center, Gaza Community Mental Health Programme, MDM France and MDM Switzerland.

Purpose of the assignment

The specific objective of the assignment is to carry out a cumulative, end-of-project evaluation of the AFD Mental Health project. The evaluation will be managed by an Advisory Group of main stakeholders (UNDP/PAPP, AFD and the MoH). This evaluation will:

- Provide the project's main stakeholders (MOH, UNDP/PAPP, AFD) with sufficient information to make a knowledgeable judgment about the performance of the project;
- Document the lessons learned by the main actors throughout the project;
- Provide practical recommendations and baselines to the stakeholders for future interventions.

The proposed evaluation will conduct an institutional review of the mental health sector in the occupied Palestinian territory through the identification of priorities and needs specifically related to mental health. The evaluation should also serve as a baseline on which to measure the impact of the project's activities over the past three years. Moreover this evaluation should provide an analysis of other stakeholders working in the mental health field in terms of strengths and weaknesses to be taken into consideration by the MoH on future interventions.

Tasks of the firm

a) **Preparation phase (1 week):**

Desk review and initial analysis of project documentation (project document, project original agreement with the MoH and its amendments, project progress reports, partner´s reports and MoH annual report) followed by a brief preliminary inception report (electronic copy). The report will provide an outline of the evaluation in terms of:

- Work-plan and timeframe
- Methodology: data collection tools (quantitative and qualitative) and analysis
- Preliminary analysis of available information

The preliminary inception report (aprox. 5 pages) will be presented to UNDP/PAPP and AFD for clearance. UNDP/PAPP will make available additional information about the mental health sector in the oPt, if needed.

b) **Field phase (10 days)**

Conduct field visits and meetings with main stakeholders, project partners, and main beneficiaries followed by a de-briefing session at the end. The field phase should start with an inception meeting with the Advisory Group leading to the submission of the final inception report outlining the issues described in the above section. The

final inception report (electronic copy) should take into consideration the comments made by the Advisory Group during the inception meeting.

The field phase should focus on:

- Collection of quantitative and qualitative data from the field, using tools such as (e.g.) key informant interviews, focus group discussions, questionnaires, and field visits to observe the results of the project leading to a cumulative evaluation of *soft* and *hard* components of the project based on the project document as follows:
  - Soft component evaluation: training provided to newly recruited staff, and the training curriculums developed by the project operators as well as how the qualifications and experience of the center's staff are benefiting the patience's treatment. It should also analyze the implementation challenges, opportunities, and the sustainability and autonomy of the centers.
  - Hard component evaluation in terms of the infrastructures built by the project (location, accessibility, distribution of space, services, etc.) from a user perspective.
- Presentation of preliminary findings and feedback: at the end of the field phase, a de-briefing meeting with the project's stakeholders will be organized to discuss main findings and request feedback.
- The main key informants will be the MoH staff in addition to the partners and professionals working at the centers. If possible, given the sensitivity of dealing with mental health issues, the field phase should also try to gather data from the Center's patients and their families in terms of client satisfaction of the services received.

c) Finalization phase (21 days):

Draft final evaluation report (electronic copy) and request feedback from the Advisory Group. Submission of the final evaluation report no later than 21 days after the end of the field phase.

Output deliverables

The evaluation will be guided by OECD's DAC evaluation criteria for development assistance in terms of *relevance, effectiveness, efficiency, impact and sustainability*. It will include:

- Identify to which extend the objectives of the project were in line with beneficiaries' requirements and sector needs.
- Determine if the project results were attained and the specific objectives achieved.
- It will build a new logical framework with indicators relevant to the objectives of the project like, i.e., increased of frequentation, number case referrals, the quality of services delivered, reduction of stigma, etc., with special attention to the number of clinical sessions delivered (group therapy, individual therapy, occupational work sessions, etc.).

- Evaluate whether the implementation procedures, the management and coordination arrangements were adequate to achieve the project's objectives.
- Evaluate the effectiveness of the hard components (constructed/rehabilitated buildings) and its contribution to facilitating the access to mental health services from a technical (mental health professional) and user's perspective.
- Assess the impact of the project at national level. This should include the contribution of the project to the national policy and system for mental health in the oPt, the role of the project activities in reducing the stigma and in raising awareness of the general public regarding mental health in general and people with psychological disorders in specific.
- Identify the outputs delivered by the project partners and its quality as a good reference for future mental health professionals. This should include an in-depth revision of the training manuals and other resources placed in the community mental health centers.
- Evaluate the sustainability of the center's services technically and operationally.
- Evaluate the gaps and risk factors that should be taken into consideration for future similar interventions.

Location(s) of assignment

The team of consultants will be based in Ramallah (West Bank). Data will be collected from various locations in the West Bank (Nablus, Jenin, Halhoul) and the Gaza Strip (via teleconference). There might be occasional meetings in East Jerusalem.

Time frame

Implementation will be initiated at the beginning of October. The final evaluation report should be submitted no later than 21 November 2011.

Activity/period	2011						
Mental Health project evaluation	Sep	Oct	Nov				
1. Contracting							
2. Inception report and field phase							
3. Final Report (End of November)							

Management and reporting requirements

UNDP/PAPP will function as the facilitator for the evaluation and be responsible for hiring a research firm/consultancy team.

The evaluation firm will report to UNDP/PAPP and AFD, who will together with MoH assure the quality of work progress and final products.

RFP-2011-009

Research institution/Consultant team profile

UNDP/PAPP seeks the services of a competent, experienced and independent firm specialized in conducting the project final evaluations. The consultant team carrying out the tasks should be composed of 2 experts with the following profiles and qualifications.

- A solid and diversified academic background and professional experience in evaluation of development and capacity building projects (for one expert). Technical background and/or experience in health would be considered an asset.
- At least one of the evaluators should have solid background in the field of mental health.
- Experience in community mental health would be a plus.
- Experience in the occupied Palestinian territory or in fragile contexts.
- Full working knowledge of English.
- At least one of the experts must have full working knowledge of Arabic.
- Excellent report writing skills.
- Fully conversant with the principles and working methods of project cycle management.
- Knowledge of UNDP aid delivery methods and UNDP guidelines for the evaluation of external actions would be considered an asset.
- Very good communication skills in dealing with local authorities/agencies/actors.
- Must not have been directly involved in the preparation or implementation of the AFD Mental Health project or any of its components or sub-contracts.

Proposal Content

The technical proposal should describe the approach and methodology that will be applied by the consultant to meet the objectives and scope of the assignment and should include the following:

1. The methodology that will be followed in carrying out the evaluation (OECD-DAC criteria).
2. A work-plan on week-by-week basis for the proposed activities including key milestones.
3. Description of methodological tools that will be used and provided.
4. Company Profile including description of company's services.
5. List of projects undertaken within the last 2 years that are related to this requirement.
6. Contact of 3 previous clients that can be used for reference purposes to whom similar services has been provided and completed.
7. Staffing Plan and profile of each staff included in the plan. A matrix should be provided to show which staff will work on what activities and for what duration.
8. CV's of the **core/key staff** members who will participate in conducting the assignment.

The quotation should be valid for a minimum of 120 days from the date of bid closing and should be duly signed by the official representation of your organization and stamped.

Evaluation Process

Evaluation will be undertaken by first evaluating the technical proposals. In order for proposals to be considered technically compliant, the technical evaluation score must exceed the minimum as shown below:

No	Description	Minimum Score required	Maximum score attainable
A	Technical proposal	70	100
B	Financial proposal	N/A	N/A

Proposals not attaining the minimum technical score will be considered technically non-compliant and disqualified. Financial Proposals will only be opened if the technical proposal attains the required minimum score.
Weightings that will be applied in order to evaluate technical and financial proposals are shown in the above table.

Technical Evaluation Criteria

The following criteria will be used to evaluate the technical proposals:

No	Criteria		Maximum Score	Sub Total
1	Expertise of Firm /Organization Submitting Proposal		30	
	a	Does the Company Profile reflect the requirements of the TOR?		7.5
	b	Do projects undertaken within the last 2 years relate to the TOR? (Minimum 2 years experience in provision of similar services to TOR)		7.5
	c	Quality of References provided by 3 previous clients		7.5
	d	Quality of examples of Evaluation methods		7.5

No	Criteria		Maximum Score	Sub Total
2	Staffing Plan		30	
	a	Is overall staffing plan sufficient to undertake TOR?		5
	b	Are profiles of each staff adequate to undertake TOR?		9
	c	Team Leader (minimum post-graduate degree & 5 years relevant experience)		5
	d	Evaluators previous experience and level of education (minimum post-graduate degree & 5 years relevant experience)		5
	e	Knowledge of the evaluators with the Palestinian health system		6
3	Evaluation Plan including key milestones		10	
	a	Evaluation plan clearly demonstrates what will be undertaken at each phase		5
	b	Project will be completed within the time specified in the TOR?		5
4	Methodology		30	
	a	Clearly illustrates how the evaluation will be conducted to cover all required elements of DAC		12.5
	b	Clearly illustrates how data will be collected		5
	c	Clearly illustrates how each activity will be evaluated to insure that the overall evaluation covers all project components		5
	d	Clearly illustrates how the final report will be developed and finalized.		7.5

Maximum Total Score 100

Financial Proposal

In a separate envelope the financial proposal should be submitted that consists of the following documents:

- Lump sum amount for provision of requirement
- Lump sum should be broken down to show the following level of detail:
    - Daily rates of staff
    - Administrative costs
    - Overhead and profit
    - Any other applicable costs
- Proposed payment schedule linked to the work plan submitted in the technical proposal

Award of contract: Contract will be awarded to the firm meeting the minimum 70% score in the technical evaluation and offering the lowest price.

Payment schedule

- 20% upon the finalization of desk review and initial analysis of project documentation.
- 40% of the total amount upon finalization of the field phase.
- 40% upon completion of the evaluation exercise and endorsement of the final evaluation report by the main stakeholders

Logistics

The contract will be made with UNDP/PAPP. The work will be facilitated and supervised by a UNDP Programme Analyst in coordination with the project management unit.