Technical Evaluation for AFD Mental Health Project

Executive Summary of the Final Report

Prepared by Mr. Olivier Appaix and Dr. Abdelhamid Afana



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]](#footnote-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);

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]](#footnote-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 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.

**Assessment 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:**

The Bethlehem psychiatric hospital:

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.

Self help groups:

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.

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;

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.

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.

## 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.

1. Project document of AFD mental health project. [↑](#footnote-ref-1)
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. [↑](#footnote-ref-2)