mental health and psychosocial support
integration within the UNRWA family health team approach
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About UNRWA

UNRWA is a United Nations agency established by the General Assembly in 1949 and mandated to provide assistance and protection to some 5 million registered Palestine refugees. Its mission is to help Palestine refugees in Jordan, Lebanon, Syria, West Bank and the Gaza Strip achieve their full human development potential, pending a just and lasting solution to their plight. UNRWA services encompass education, health care, relief and social services, camp infrastructure and improvement, and microfinance.

Cover Photo: Integrating mental health and psychosocial support (MHPSS) services through the Family Health Team seeks to improve the quality of life for all Palestine refugees and their families. © 2016 UNRWA Photo by Hannah Wesley
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### Acronyms and Abbreviations

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<th>Full Form</th>
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<tbody>
<tr>
<td>CBOs</td>
<td>Community-based organizations</td>
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<td>CMHP</td>
<td>Community Mental Health Programme</td>
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<td>DM</td>
<td>Diabetes Mellitus</td>
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<td>ED</td>
<td>Department of Education</td>
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<td>EU</td>
<td>European Union</td>
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<td>FHT</td>
<td>Family Health Team</td>
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<td>JFO</td>
<td>Jordan Field Office</td>
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<td>HCs</td>
<td>Health centres</td>
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<td>IDPs</td>
<td>Internally displaced persons</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
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<td>PB</td>
<td>Programme Budget</td>
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<td>MCH</td>
<td>Maternal care health</td>
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<td>LFO</td>
<td>Lebanon Field Office</td>
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<td>MO</td>
<td>Medical officer</td>
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<td>MH</td>
<td>Mental health</td>
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<td>MTS</td>
<td>Medium Term Strategy</td>
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<td>MHPSS</td>
<td>Mental health and psychosocial support</td>
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<td>NCDs</td>
<td>Non-communicable diseases</td>
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<td>MHGAP</td>
<td>Mental Health Gap Assistance Programme</td>
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<td>PAIR</td>
<td>Prevention, Assessment, Intervention and Referral</td>
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<td>NGOs</td>
<td>Non-governmental organizations</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PRM</td>
<td>Participatory ranking method</td>
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<td>PRS</td>
<td>Palestine refugees from Syria</td>
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<td>PSS</td>
<td>Psychosocial support</td>
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<td>SSN</td>
<td>Senior staff nurse</td>
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<td>SN</td>
<td>Staff nurse</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>SMO</td>
<td>Senior medical officer</td>
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<tr>
<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine refugees in the Near East</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WBFO</td>
<td>West Bank Field Office</td>
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executive summary

UNRWA has been the main provider of primary health care to Palestine refugees in Jordan, Lebanon, Syria, the West Bank and Gaza since its establishment in 1949. Through its network of 137 health centres, UNRWA provides care to over 3.5 million Palestine refugees. In the face of a shifting burden of disease – globally and regionally – and a population that is living longer, UNRWA transitioned to the Family Health Team (FHT) model of service provision in 2012. The person-centred, holistic approach focuses on the individual and their family, emphasizes the doctor-patient relationship, and aims to reduce wait times and increase contact time in an effort to improve the overall quality of care and thus, patient outcomes. As of Quarter 3 2015, the FHT approach has been adopted in more than 100 health centres throughout Jordan, Lebanon, the West Bank and Gaza. The transition began in Syria in 2015 and will continue as the security situation allows.

The next step in the Department of Health’s activities is to address an issue often neglected in primary health care (PHC) settings: mental health and psychosocial well-being (MHPSS). Globally, one third of persons visiting PHC facilities have issues related to MHPSS. The WHO recommends that 70 per cent of these cases can be managed at the PHC level. In the Middle East – and within the Palestine refugee community in particular – the impact of socioeconomic stressors, abuse, poverty, protracted displacement and ongoing violent crises likely increase the risk of MHPSS issues.

Historically, there has been no united approach towards MHPSS services within or between programmes. UNRWA is now prioritizing the integration of these services into each of its core activities. In the Department of Health, West Bank and Gaza Fields have been operating psychosocial and protection programmes since 2002, and patients have access to psychosocial counsellors at health centres. In Lebanon, trainings conducted as part of partnerships with the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), the United Nations Children’s Fund (UNICEF) and the EU have equipped five staff nurses with knowledge on the PAIR approach (prevention, assessment, intervention and referral), while all medical officers have been trained in the World Health Organization’s (WHO) Mental Health Gap (mhGAP). Nurses are scheduled to undergo the course in late 2015 and early 2016. In Jordan and Syria, trainings and programmes have been restricted to project-financed initiatives with no field-wide approach or vision. This leads to disjointed, at times unsustainable programming, funded outside of any general framework or minimum standards of practice.
In pursuit of a streamlined Agency-wide approach to supporting the MHPSS needs of Palestine refugees, the Departments of Health, Education, and Relief and Social Services, supported by GIZ, have validated a common approach, focusing on general and focused prevention activities and basic and specialized assessments and, in health, limited specialized care when appropriate. The activities within each department vary, as appropriate for capacities and scope of services provided by the various programmes, but this common approach seeks to ensure streamlined internal (between Agency programmes) and external (outside of Agency) referral pathways across all programmes. In this way, the Agency does its best to ensure consistency across the fields and in its operations to ensure that Palestine refugees receive the highest quality of services possible.

The Department of Health details activities that will take place within health centres and in their surrounding communities and indicates the roles and responsibilities for each staff category. In health centres, limited specialized care will be possible; doctors will undergo the WHO Mental Health Global Action Plan (mhGAP) training for non-specialists, which provides guidelines for diagnosis, prescription, treatments and case management for a variety of common mental health disorders. Core competencies for all staff members at health centres include improved communication skills, awareness of social determinants of health and an ability to detect emergency cases. Midwives and nurses – the core service providers in the Department of Health’s MHPSS package – will be equipped to facilitate community outreach activities, group counselling sessions and support groups, and will be trained on low-level identification and detection of mental health disorders, with knowledge of internal and external referral pathways. Medical officers, staff nurses and psychosocial counsellors (where available) will be equipped to conduct specialized assessments, case management and more individualized counselling, while only medical officers will be able to diagnose and prescribe medication.

While the Department of Health’s package emphasizes non-medicalized approaches to MHPSS well-being (such as community strengthening, outreach sessions, health promotion and prevention, and positive living), we recognize that there will be a small number of patients with more severe mental health disorders that do require medication and management. To that end, doctors and nurses who undergo mhGAP as a part of their training will have a full understanding of common mental disorders, psychotropic medications, their side effects, and proper case management. They will also be trained to identify when the needs of the patient are beyond the capacity of the health centre to respond to and will have information about where to refer patients in such cases. The most common MHPSS problems that we predict can be managed by the Family Health Team include: psychosocial well-being issues/daily life problems, psychosomatic problems, co-morbidity, depression, anxiety, epilepsy and other medically unexplained complaints.

In order to effectively and ethically provide these services in health centres, proper supervision and oversight is essential. The Department of Health will work with other Headquarter (HQ) departments to understand how project-based funding can be used to build and support the capacity of staff, rather than establish services and programmes that will create a vacuum at the conclusion of the project. Additionally, the creation of supervisory positions funded from the Programme Budget (PB) will be prioritized, for the same reasons. A close collaboration with other programmes in the Agency is vital, as internal referrals and feedback mechanisms will allow for comprehensive case management and follow-up to ensure cases do not fall through the cracks. This mechanism will be established in each field, given the varying contexts in which UNRWA operates.

UNRWA and the Department of Health recognize that proper self-care is crucial to the effective delivery of MHPSS services. Equipping staff with the capacity to recognize and respond to patient needs puts them in a potentially risky situation – both mentally and physically. This is particularly relevant in a situation where the majority of service providers are also themselves Palestine refugees, living in the same conditions as the communities they serve, experiencing the same protection and socioeconomic threats as their clients and, as is too often the case, experiencing the same losses and threats to personal safety that come with frequent acute and chronic conflict. Self-care is an important part of the Department of Health’s training package and one that will be reinforced as a part of the roll-out of the MHPSS package in UNRWA health centres.

The annex of this document contains links to roles and responsibilities, referral pathways, a training schedule and the project budget. A package of training materials and detailed technical instructions (including M&E requirements, patient files, flow charts, diagnostic requirements, referral pathways and supervision structures) are also available as separate documents.
introduction

UNRWA has been providing primary health care (PHC) to Palestine refugees for more than 60 years through its network of 137 health centres. In 2011, UNRWA began reforming its traditional model of primary health-care delivery in response to demographic and epidemiological shifts taking place among Palestine refugees. The Agency’s aging population is now suffering from non-communicable diseases (NCDs) – including diabetes and hypertension – which account for 70-80 per cent of deaths. UNRWA has adopted the Family Health Team (FHT) approach, aimed at responding to these shifting needs. FHT takes a life cycle, family and person-centred approach, which allows for doctors and nurses to establish relationships with their patients and to encourage behavioural and lifestyle changes in pursuit of long and healthy lives.

In the years since its inception, the FHT health reform is nearing completion in Gaza, Jordan, Lebanon and West Bank; implementation began in 2015 in six health centres in Syria and will continue in accordance with the security situation. By the end of 2015, the FHT transition will be complete in 115 health centres in the four Fields.

The next chapter of health reform is two-fold. Firstly, to refocus on improving the quality of PHC services in general and for NCD care, in particular. The second is to tackle a major health issue among Palestine refugees that has yet to be addressed in a systematic way: mental health and psychosocial well-being (MHPSS).

It has been reported that globally, one third of persons visiting PHC facilities have issues related to their mental health and psychosocial well-being. It is also recognized, and recommended by the World Health Organization (WHO), that 70 per cent of MHPSS cases can be cared for and managed by the PHC facilities. Among vulnerable groups, one in five children suffers from a mental health condition, and the mental health of an aging population suffering from NCDs is influenced by their access to services, education, employment, housing, social services and freedom from discrimination and neglect. Evidence suggests that women, the most frequent visitors to UNRWA health centres, have higher rates of mental disorders, with an average female-to-male ratio of 2.3 among adults.

Robust, methodological studies documenting the extent of the burden of mental health and psychosocial issues within the Palestine refugee population is limited; however, there is some data based on studies that have been conducted in Palestine, and overall statistics for the host countries in the Middle East provide useful insights. In the region, the impact of stressors, including exposure to violence, poverty, forced displacement and poor living conditions unsurprisingly impact the health and well-being of individuals and families. In fact, the high prevalence of depressive illness and anxiety disorders in the region is almost wholly accounted for by the complex emergency situation across most of the countries. A meta-analysis of epidemiological surveys in conflict-affected populations shows a prevalence of 15.4 per cent for post-traumatic stress disorder (PTSD) and 17.3 per cent for depression. These numbers are markedly higher than the prevalence in countries not affected by conflict. A community screening survey conducted in Palestine reported a psychological distress rate of 51.8 per cent (compared to 15.6 per cent in UAE). In 2010, major depressive disorders were one of the top causes of the disease burden globally and in the Middle East.

These data, coupled with the known socioeconomic and security difficulties of Palestine refugees – including human rights violations, protection issues, violence and abuse – suggest that the prevalence of MHPSS concerns among the Palestine refugee population is greater than global figures. Moreover, data from UNRWA protection-related services – including gender, child protection and disability – also suggest a heavy burden, validating the evidence presented.

In September 2014, UNRWA convened its first meeting to discuss the development of a unified, Agency-wide MHPSS strategy, of which there has been none, to date. However, programming, human and financial resources, and experience in each field – detailed below – varies. UNRWA grew heavily on the evidence base that already exists within the Department of Health to guide the development of this strategy. This next step in the health reform is one that will be taken in parallel by all programmes, to ensure the protection and promotion of the right of every Palestine refugee – woman, man, girl or boy – to achieve the best possible mental health and psychosocial well-being.

In their capacity as FHT health-care providers, UNRWA health centres are now well equipped to address the full spectrum of mental health and psychosocial support (PSS) and protection issues in a systematic way. The FHT approach, which is person-centred, family-based, holistic and multisectoral, puts UNRWA health-care providers in an ideal position to address such critical family health problems – resulting from factors both internal and external to the family – in a comprehensive and effective way.
Scope of the Concept Note

The following document elaborates upon the planned activities and steps for implementation within the health programme, which is one component of an intersectoral Agency-wide strategy, developed in collaboration with other programmes. It is important to note that while engagement with these other departments is crucial to successfully addressing the full spectrum of Palestine refugees’ needs across the life cycle, this concept note focuses on the response within the purview of the health centre and health centre staff and therefore takes a necessarily health-centred perspective.

A chapter detailing the main priorities in collaborating with other departments appears later in the document.

vision: comprehensive, person-centred mental health and psychosocial support services integrated within all UNRWA health centres

The right of every Palestine refugee, adult or child, to achieve the best possible mental health and psychosocial well-being is protected and promoted through the Agency’s basic services in education, health, relief and social services, infrastructure and camp improvement, and protection, including prevention, assessment, intervention and referral.

In pursuit of the WHO definition of health – “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” – patients with mental health disorders will be managed at the PHC level where possible and referred to external, specialized services when necessary. A strong focus on community awareness, health promotion and resilience-building activities will strengthen patients’ capacities to cope with everyday stressors and challenges. In addition to the aforementioned activities, through their interactions with FHT staff, patients will receive basic counselling, diagnoses and case management services when needed. Referrals – for both medical and non-medical purposes – and coordination with other relevant departments and institutions within and outside of UNRWA are crucial to the successful realization of this vision.

mission: integrated mental health and psychosocial support

In UNRWA, programmes will provide mental health and psychosocial support through:

1. A quality inclusive education which respects the rights and diversity of all children, giving them a sense of self-worth and encouragement;
2. A primary health-care service that protects and promotes the mental health and psychosocial well-being of those received;
3. Provision of relief and social services that provide additional support in developing self-reliance and empowerment;
4. Protecting the rights of refugees against both internal and external protection threats that frequently have MHPSS consequences that must be addressed as part of a comprehensive protection response; and
5. Providing the necessary living environment to promote positive development and an enabling environment to interventions that support community well-being.
mhpss terminology

For the purposes of streamlining the terminology used throughout the Agency’s strategy, a common language and definitions were agreed upon by all UNRWA actors during the 2014 planning meeting. Additionally, globally-accepted definitions of key MHPSS concepts – adopted and endorsed by the Agency – are included below to allow for better illustration of the approach being taken by the Department of Health.

Mental Health

We follow the WHO definition of mental health, which is “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution…”

Promoting mental health requires a range of intersectoral strategies that align to create living conditions that allow individuals and their families to adopt and maintain healthy lifestyles and receive access to the appropriate specialized services, when they are needed. Naturally, the health sector can – and should – play an integral role in the promotion and protection of mental health and well-being of individuals and their families. This case is especially true at UNRWA, where 3.25 million of 5.2 million registered Palestine refugees are accessing health centres and services on a regular basis.

Psychosocial Well-Being

We also follow the definition of psychosocial well-being as set by the Interagency Network of Education in Emergencies (INEE): “The term psychosocial underscores the close connection between psychological aspects of our experience (e.g., our thoughts, emotions, and behaviour) and our wider social experience (e.g., our relationships, traditions and culture)… Many psychosocial problems do not require clinical treatment but are rooted in stigmatization, lost hope, chronic poverty, uprooting, inability to meet basic needs, and inability to fill normal social roles such as that of student/learner. Well-being is a condition of holistic health in all its dimensions: physical, cognitive, emotional, social, and spiritual… Well-being consists of the full range of what is good for a person: participating in a meaningful social role; feeling happy and hopeful; living according to good values, as locally defined; having positive social relations and a supportive environment; coping with challenges through the use of appropriate life skills; and having security, protection, and access to quality services.”

Mental Health and Psychosocial Support (MHPSS)

Mental disorders (as defined by the WHO International Classification of Diseases 10), which often benefit from clinical treatment, tend to involve severe psychosocial difficulties in managing thoughts and feelings, maintaining relationships, and functioning in expected social roles. Psychosocial support is “a scale of care and support which influences both the individual and the social environment in which people live and ranges from care and support offered by caregivers, family members, friends, neighbours, teachers, health workers and community members on a daily basis but also extends to care and support offered by specialized psychological and social services.”

We refer to the global standard guidelines developed by The Inter-Agency Standing Committee (IASC), which uses the composite term, MHPSS to describe “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat any mental disorder.” The IASC acknowledges the diverse terms used to describe what some consider to be different, though complementary approaches. However, as it is an intersectoral, inter-agency group, this composite term serves to unite the broad group of actors often involved in this response.

Protection

UNRWA contributes to the protection of Palestine refugees through the services it delivers and also through its protection work more broadly in accordance with its mandate. Refugees are entitled to international protection, which both reflects and aims to respond to their specific situation. Protection refers to all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and spirit of the relevant bodies of law (human rights law, international humanitarian law and refugee law).

In 2012, UNRWA adopted a Protection Policy; other protection tools and standards have also been developed. In particular, a Tool for Incorporating Minimum Standards on Protection into UNRWA Programming and Service Delivery was developed in 2010, along with a set of protection standards against which progress is measured through annual Protection Audits. The Agency has introduced various initiatives to mainstream protection in its service delivery.

In addition to the Agency’s clear mandate for the protection of Palestine refugees, it is mandated by the General Assembly to address the protection concerns
of women, children and persons with disabilities. UNRWA has a Gender Mainstreaming Strategy and GBV programme, a Disability Policy, an Inclusive Education Policy and is currently developing a Child Protection Framework for the Agency. UNRWA has two broad approaches to protection based on its protection policy: internal (programmatic) and external (through private and public advocacy).

UNRWA is a major provider of public services. As such, it is a duty bearer, including for the fulfilment of the human rights of its beneficiaries. It recognizes that protection concerns arise directly from UNRWA service delivery and therefore ensures that protection should be addressed through and within that delivery. Examples of challenges in the Agency’s service delivery include the corporal punishment of children and other kinds of physical violence and abuse in schools and challenges persons with disabilities face in accessing basic social services.

MHPSS services are one of the many possible responses to a protection issue. However, protection is an important factor in the social, economic and political determinants of health, and it is well understood that threats to protection have implications for physical and mental well-being. There is a strong body of international literature reporting the association between human rights abuses and violations, domestic violence, child abuse, and GBV, increasing the risk of mental disorders for children, women and their families in their lifetimes. Likewise, mental health problems and disorders increase the risk of GBV and domestic violence and abuse. As such, the Department of Health believes that since all protection incidents affect an individual's MHPSS wellbeing, all incidents should therefore include a MHPSS response, in addition to other relevant protection interventions.

Strengths versus Deficits Approaches

The overarching goal of the UNRWA MHPSS package is to avoid the need for recovery in the first place by promoting robust health outcomes and positive development and by preventing or mitigating the effects of the escalation of psychosocial and mental health stressors. However, in situations that do require a response, practitioners and policies in the field of mental health have traditionally been very disease-oriented and deficits-focused. In contrast, a strengths-based approach to mental health and psychosocial well-being will “concentrate on the inherent strengths of individuals, families, groups and organisations, deploying personal strengths to aid recovery and empowerment.” Engaging in well-being-focused goals will promote a positive, strengths-based approach rather than one solely centred on identifying and fixing problems – which often rely on psychotropic medication and institutionalized care.

Stepped Care

A stepped-care approach to managing psychosocial and mental health problems is a collaborative approach in addressing the unique needs of each individual and their family. Interventions can include group interventions, counselling, counselling coupled with prescription of medication, or referrals. All interventions include follow-up and documentation. If basic medications are prescribed, relevant health staff should also be able to discuss with individuals and families the side effects related to medications, how to support the individual while on medication, and alternatives for cases in which the individual does not want to take medication. The roles and responsibilities of each category of FHT staff in the stepped-care approach are detailed further in the document and the Annex.

MHPSS Core Principles

Resilience

“Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. It is not a trait that people either have or do not have. It involves behaviours, thoughts and actions that can be learned and developed in anyone.” In step with the commitment to a strengths-based approach, the UNRWA Agency-wide framework is one of resilience-building, focusing on further developing individual and community strengths and capacities in order to enhance the lives of Palestine refugees across the five fields.

Do No Harm

Because of the sensitivity of issues dealt with in MHPSS work, there is a potential to cause harm. Because of the fluid and multifactorial nature of determinants of health and well-being, it is also difficult to develop a strong evidence base for interventions. However, in an effort to mitigate and minimize the potential harm caused by the Agency’s MHPSS work, we will work in coordination with other Agency programmes, as well as with external actors involved in the same work in each field. Additionally, it is important that we are transparent in our work, that our staff are properly trained and supervised, and that our framework is sensitive to the culture and environment in which Palestine refugees live and work. Particularly with the Palestinian refugee population, it is essential that UNRWA remain cognizant of universal human rights and relationships and dynamics with host governments.

Sustainability

It is important to ensure the sustainability of any framework we seek to implement. While the nature of funding often means that money is provided for activities with a limited duration, we are required to recognize the potential harm that can occur with the creation of systems that potentially leave a vacuum once
funding expires. Therefore, it is imperative that services are integrated into the daily operations of health centre staff and are not disproportionately reliant on temporary, project-funded specialists.

Confidentiality

Respecting confidentiality and guaranteeing the privacy and security of individuals, their families and wider communities must be of paramount consideration at all times. Breach of confidentiality or careless handling of information can have serious consequences for persons of concern, as well as for our partners, our colleagues and even the humanitarian operation as a whole. UNRWA staff must always assess potential risk factors and seek informed consent for the gathering and use of information. Vigorous data-protection methods must be in place to guarantee the security of recorded information. In health centres using the e-Health medical record system, these data-protection methods are in place. However, in health centres still using paper-based records, other methods to ensure confidentiality must be employed. Additionally, individual counselling sessions will be conducted in private rooms, with doors that can be closed, to ensure that patient privacy is protected. Additional training for staff that emphasizes the importance of confidentiality in a setting where it is often a luxury will be included.

Impartiality

Humanitarian action must be taken without any adverse distinction based on nationality, ethnic origin, religion, class, political opinion or other grounds. Priorities for humanitarian action must be determined on the basis of rights and needs alone. The principle of impartiality, therefore, establishes two clear rules of conduct for humanitarian work: non-discrimination and proportionality according to need.

The Imperative to Integrate MHPSS Services into Primary Health Care

Mental health and psychosocial well-being is a major public health issue, with an increasing global recognition that hundreds of millions of people worldwide are affected with psychosocial problems, signs of psychological distress and mental health disorders. The WHO estimates that 154 million people suffer from depression; 25 million suffer from schizophrenia; 91 million are affected by alcohol use disorders and 15 million by drug use disorders. Up to 50 million people suffer from epilepsy, while 24 million suffer from Alzheimer’s and other dementias. Nearly 1 million people commit suicide each year. Mental health and psychosocial well-being has a direct effect on the physical health and well-being of individuals and their families, and vice-versa. For example, post-natal depression impacts the health of the mother and child, leading to a child’s poor birth weight, growth restriction and poor cognitive development. Regional evidence supports integrating the recognition and management of maternal depression and parenting skills training in MCH programmes, one of the Agency’s core services.

Evidence also shows that co-morbidity, which can include the existence of psychosocial problems and/or mental disorders on one side and physical disorders or illness on the other, is common in primary health care settings. For example, it is well documented that Major Depressive Disorder is a risk factor for diabetes and heart disease. Conversely, NCDs are also risk factors for depressive and anxiety disorders. Furthermore, patients with co-morbid depression (depressive disorder with a physical disorder such as an NCD) are less likely to adhere to treatment plans for their NCDs.

Seven Reasons to Integrate MHPSS in PHC

1. The burden of MHPSS disorders is great.
2. Mental and physical health problems are interwoven.
3. The treatment gap for MHPSS disorders is enormous.
4. Primary care for MHPSS enhances access.
5. Primary care for MHPSS minimizes stigma and discrimination.
6. Primary care for MHPSS is affordable and cost-effective.
7. Primary care for MHPSS generates good health outcomes

Social determinants of health (SDH), “the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life,” which include “economic policies and systems, development agendas, social norms, social policies and political systems” have a strong influence on the mental health and well-being of individuals. Social determinants of health can have an even greater impact on populations living in difficult conditions, where marginalization, unemployment, discrimination, GBV and restricted individual agency are widespread. The situation of Palestine refugees is different in every field; however, the common theme of displacement, social inequality, and a lack of a just and durable solution to their plight create a common experience. Of the five fields of operations in which UNRWA has operated since 1948, only Jordan has not experienced acute conflict; civil war in Lebanon endured for 15 years, in addition to smaller-scale military operations over the past several decades. Syria has entered its fifth year of civil war, while two intifadas have disrupted both the West Bank and Gaza. More recently, in 2014, Gaza experienced the 50-day conflict, while the West Bank is subject to spurts of violence on a regular basis, including the most recent unrest in October 2015. While safe from the conflict that has wreaked havoc at times on its neighbours, Jordan...
mental health and psychosocial support

has played host to the millions of refugees who have fled from these surrounding countries over the past 50 years. The country’s limited land and resources, coupled with a lack of employment and infrastructure to support the millions of guests in the country, are fostering an environment of strain and tension with no clear solution. The prevailing climate in the region has led to higher than normal ‘daily life stressors,’ which could induce mild to relatively serious depressive symptomatology, as evidenced in the introduction. Additionally, global wariness towards refugees from the Middle East and North Africa has made travel and freedom of movement a challenge for many from the region, increasing stress and frustration on individuals and families alike and, in some cases, preventing reunification, educational opportunities and freedom from fear and violence.

The WHO has highlighted the enormous treatment gap for mental disorders between those estimated to be suffering from a mental disorder and those receiving the appropriate care and treatment. The treatment gap for people with serious disorders in less developed countries is 76-85 per cent. It suggests that primary health care for MHPSS helps to close this gap by enhancing people’s access to care and promotes respect of human rights by reducing the stigma and discrimination often associated with seeking treatment. Primary care for MHPSS issues facilitates community outreach and health promotion, as well as long-term monitoring and management of affected individuals. It is an affordable and cost-effective approach linked to positive health outcomes.

Studies have shown that patients with undiagnosed MHPSS issues use primary health care services twice as frequently as those with no MHPSS complaints, for unnecessary care. Despite improvements seen as a result of the transition to the Family Health Team model, The Agency’s 137 primary health care facilities continue to be characterized by high patient loads, long wait times and an average of 95 daily medical consultations per doctor. A health promotion and prevention approach can lead to reductions in unnecessary patient visits, thus reducing costs for UNRWA and improving patient/doctor contact time. Additionally, increasing the capacity of UNRWA health centre staff to identify, counsel, diagnose and treat patients with mental health disorders will improve the quality of care patients receive, hopefully improving adherence to care plans and reducing future complications related to poor case management. Better training and awareness for staff themselves, coupled with staff care and outreach can also lead to better outcomes and relationships between our staff and their colleagues and families.

International research and experience agrees that integrating MHPSS services into primary health care is the most viable way of preventing the development of some physical and many mental health disorders. The Agency’s FHT-based PHC model centres on preventing and protecting Palestine refugees from disease through the promotion of healthy lifestyles for individuals and their families. Promoting and protecting mental health and psychosocial well-being within the Agency’s PHC services is a natural solution to preventing both ill physical health and ill mental health among Fatima and her family.

UNRWA FHT staff already employ strategies and initiatives aimed at promoting the positive physical and mental health of families. Through the FHT approach, health teams currently provide health education

MHPSS in PHC through Family Health Team

When UNRWA started the process of reforming its 137 primary health care centres in 2010, the department approached the process from the point of view of a Palestine refugee family: Fatima, her husband Mohammad and their family. We envisioned what steps a typical visit to the health centre might include for the family and discussed how health reform might seek to address their needs in the most beneficial, holistic way. In the development of the Agency’s MHPSS framework, it was once again important to think of Fatima, Mohammad and their children. Understanding not only the global but the regional burden of disease and ensuring evidence-based activities and interventions were crucial to creating a comprehensive package that can have the biggest impact on Palestine refugees in the Agency’s five fields.

MHPSS Core Values at UNRWA

- Public health approach with a focus on positive development, health promotion and prevention over the life cycle
- Resilience-building through positive mental health and psychosocial well-being development, promoting self-care using a strengths-based approach
- Family-based interventions to protect and promote positive mental health and well-being, as well as the provision of accessible, comprehensive and coordinated services to those in need
- Coordination with internal and external resources for optimal prevention and promotion strategies and to deliver all elements of care
- Evidence-based interventions and services

International research and experience agrees that integrating MHPSS services into primary health care is the most viable way of preventing the development of some physical and many mental health disorders. The Agency’s FHT-based PHC model centres on preventing and protecting Palestine refugees from disease through the promotion of healthy lifestyles for individuals and their families. Promoting and protecting mental health and psychosocial well-being within the Agency’s PHC services is a natural solution to preventing both ill physical health and ill mental health among Fatima and her family.

UNRWA FHT staff already employ strategies and initiatives aimed at promoting the positive physical and mental health of families. Through the FHT approach, health teams currently provide health education
messages to promote healthy living and well-being. Many nurses and midwives in particular are also providing basic counselling to their patients, conducted informally, over the course of a patient’s visit. Successful integration of this package focuses on helping staff to understand that they are already doing the bulk of this work and equipping them with additional strategies to improve and systematize what they already do. These tools and strategies include empathetic listening, family engagement and support, identification of strengths, self-care mechanisms and tools, and problem-solving techniques. Additionally, a better understanding of the core MHPSS principles (resilience, do no harm, sustainability, confidentiality and impartiality) will give staff the confidence to provide these services in a professional way. It will also reassure and generate trust from patients. Evidence has shown the effectiveness of integrating these techniques into the delivery of maternal and child care services by health workers. In addition, ‘focused prevention interventions’, e.g. peer support services in the clinic for vulnerable groups such as pregnant women, the elderly and NCD patients, are a low-cost and highly effective way to provide MHPSS support and care. This method has been employed with great success through the West Bank Community Mental Health Programme and during the ‘Life is Sweeter with Less Sugar’ diabetes campaign, and the techniques will be modelled in other fields.

“Mental health promotion and prevention interventions can improve the mental health of the population by mitigating risk factors, enhancing protective factors for good mental and physical health, and contributing to lasting positive effects on a range of social and economic outcomes.”


Moreover, and more importantly, from Fatima and Mohammad’s point of view, there is no demarcation between mental health, psychosocial support, protection and overall physical health. Patients tend not to think of their health in a specialized way, seeking to pinpoint the variety of contributing factors that determine their overall health status. In other words, Fatima could be experiencing frequent headaches and stomach cramps, but she likely does not realize that they could be a by-product of anxiety caused by a poor relationship with her husband’s family and his current unemployment. Conversely, Fatima’s husband, Mohammad, may not connect the loss of his job, his feelings of sadness and weariness, and his lack of desire to interact with others with his uncontrolled diabetes. It is thus critical to address such conditions in a person-centred, holistic way – rather than in a disease-centred one – that takes into account the social, economic and protection factors that directly influence a person’s mental health, physical health and overall well-being.

Fatima and Mohammad’s circumstances and challenges are common in UNRWA health centres. However, despite the large number of people with MHPSS needs, only a small number of people actually access support and care. Reasons for this gap include: lack of knowledge of available services, stigma associated with seeking care, and a lack of access to qualified facilities. In addition, opportunities to prevent mental health deterioration are often missed in primary health care settings due to a lack of knowledge and skills among health professionals, as well as misperceptions and attitudes – including stigma – by staff regarding MHPSS. Staff also often lack confidence that they can provide quality support without an advanced degree or immersive training. Regional evidence supports the imperative to employ evidence-based methods to improve mental health literacy as a tool to reduce stigma and positively influence social and economic outcomes. Reducing the barriers that Palestine refugees face in seeking care, which includes health education about the availability of care itself, is an important element in the Department of Health’s approach.

In addition to these challenges, we also recognize that there are challenges present in the Agency’s current health centre environment. These include a high workload, overworked staff, multiple disease burdens, and personal and family stress. To that end, we also seek to understand the concerns of Senior Medical Officer (SMO) Dr. Ali and illustrate how we can make this integration seamless and effective within the Family Health Team. It is also important to prove to SMO Dr. Ali that in the long run, the full integration of MHPSS services should reduce the burden on his health centre and staff. Staff education on the evidence presented above will help them understand that:

a) Seeking help for MHPSS problems is not something to be stigmatized;

b) They are already doing much of this work, and the strategies we will give them will make it easier and more systematic;

c) Addressing MHPSS concerns in an integrated way will ultimately reduce the workload; and

d) There are effective strategies of self-care that will improve their own MHPSS, which should create positive outcomes for them and their families.

e) The development of this MHPSS package will ensure that health centre staff are given all the tools and structures they need in order to perform capably within the FHT model.
The Current State of MHPSS in the Department of Health

Despite a clear need for strong MHPSS services for Palestine refugees, there is, to date, no cohesive strategy across the five fields. However, both Gaza and West Bank Fields have a wealth of expertise and experience, as they have been operating programmes since 2002. Lebanon began work towards integrating MHPSS services into health centres in 2014, while Jordan and Syria each have small projects funded by grants, but no unified, field-wide approaches. The Department of Health’s Agency-wide strategy is heavily influenced by the strongest elements of the Gaza and West Bank programmes – mostly related to psychosocial support, health promotion, and prevention, while the ongoing work in Lebanon has helped inform possible training schedules and packages, specifically related to the mental health elements of the package. The proposed package of services contained within this document takes advantage of our significant in-house experience.

Agency-Wide MHPSS Framework Development Process

In February 2014, the Agency convened a meeting, during which time the need for a systematic and unified Agency-wide Psychosocial Support Conceptual Framework was reinforced by internal discussions and consultant assessments. The Agency-wide mission and vision, outlined in the introductory pages of this document, were agreed upon and validated in August 2015 by all core programmes – health, relief and social services, and education, as well as the Protection Unit, resulting in Agency endorsement of integrating MHPSS-strengthening approaches into service-delivery.

Gaza: Community Mental Health Programme

In Gaza, the blockade by Israel and security forces has entered its eighth year, and armed conflicts with heavy causalities and infrastructure destruction have become a regular occurrence in the past decade. Gaza’s Community Mental Health Programme (CMHP) works through the main core programmes of UNRWA with school counsellors, community counsellors and health centre counsellors. In conjunction with managers, supervisors and support staff, the CMHP provides a wide range of services targeting children, youth, parents, the elderly and persons with disabilities, as well as local committees, local organizations, professionals and students.

The programme has been in operation since 2002, when it was established with project funding, which has been sustained annually. While counsellors are present throughout the three programmes, synergy between the departments is negligible. Twenty-four CMHP counsellors sit in Gaza’s 22 health centres, though within the health centre, psychosocial counsellors are quite siloed and not a part of the Family Health Teams. Integration within the health centres could be strengthened in an effort to increase collaboration, transfer of knowledge and case management. This would also serve to alleviate the workload for PSS counsellors, as health centre staff are not currently employing structured strategies to address MHPSS in the general patient population. While medical officers are able to prescribe any of the mental health medications on the essential drug list, diagnostic capabilities are limited, as is knowledge of the rational use of psychotropic drugs and the accompanying counselling and follow-up required. Therefore, medicines are often under- or mis-prescribed, creating a barrier for those who would benefit from them.

In 2014 the CMHP conducted 78,136 individual counselling sessions, reaching 15,103 beneficiaries; 10,802 group counselling sessions, reaching 11,839 beneficiaries; and 33,646 awareness sessions, reaching 117,862 beneficiaries.

West Bank: Community Mental Health Programme

In the West Bank, Palestine refugees live under occupation, facing daily threats and restrictions on their movements and frequent clashes with the Israeli security forces, increasing everyday stressors. What started in 2002 as the Community Mental Health Programme, also with project funding, was absorbed into the Programme Budget in 2010, where it has continued to reside. While initially it was also a siloed programme that mirrored the structure in Gaza, the integration of PSS counsellors into the schools, health centres and relief programmes is more comprehensive. Medical officers have the ability to prescribe medications, but the same limitations apply as in Gaza. The programme has a heavy emphasis on the role of nurses and midwives in MHPSS activities, and the community activities and support groups proposed as a part of our Agency framework are drawn heavily from the West Bank’s activities. Despite the clear strengths of the programme, staff have expressed a need for additional training, particularly in case management for those taking medication. Through training, it will also be possible to reduce the number of referrals to psychosocial counsellors, thus allowing them to work with the most high-risk and needy patients.

In 2014, 7,049 individuals received consultations and counselling services through a team of 21 psychosocial counsellors in the West Bank Field Office’s (WBFO) 42 health centres, while over 33,000 individuals and families were reached through public awareness and education activities and sessions on topics including psychological first aid, crisis intervention, life skills, youth and mental health, GBV, sexual and reproductive health and rights, sexual harassment and the internet, early marriage...
and sexually transmitted diseases (STDs), sexual abuse, neglect, verbal abuse and psychological abuse. The programme also worked through support groups to promote the prevention of GBV at the community level. WBFO established 19 mother-to-mother groups, 22 peer groups and 145 support groups for UNRWA sanitation workers.

The services provided through the CMHP in the West Bank and Gaza are robust, and many of the strategies are reflected in the coming pages. However, we recognize the luxury that psychosocial counsellors represent and understand that the adoption of some of these activities may have to be more modest in fields where they are not present and while staff are adjusting to this new approach.

Lebanon

In Lebanon, Palestine refugees are second-class citizens, with restrictions on work, housing, education and travel. Since 2014, GIZ and UNICEF project funds have supported trainings for front-line staff in health, education, and relief and social services on the PAIR approach. Five nurses were targeted through this two-year training programme. Through the principles embodied by the PAIR approach, they were trained on topics including prevention; intervention; referral processes; interdisciplinary working; relationships with colleagues in their own department, other departments and PSS groups; ethical and professional conduct; and self-care. These five nurses are referred to as the core group of trainees. Each of the core group members has been responsible for forming a ‘multiplication group’ in their Area. In health, this has resulted in five multiplication groups, each consisting of six to eight health centre staff. In these multiplication groups, which convene on a bi-weekly basis, the focus is on three issues:

1) Trainings on the content of the PAIR approach;
2) Case discussions; and
3) Staff care and peer support.

To date, there remains a gap in the capacities of the remaining health centre staff who have not received comprehensive PSS trainings and who may still be resistant to integrating MHPSS into health centre activities, as it is often perceived as creating an extra workload. Additionally, the experience of the patient when visiting a health centre has not noticeably changed. The overall methodology of the PAIR approach is endorsed by the Department of Health and is reflected in our training materials and some initiatives, but any future activities and trainings will target all front-line staff, not just select focal points. This approach should create a structure in the health centre that allows for these activities to have the highest impact on both staff and patients.

The core group members are designated MHPSS focal points, as they are allowed to carry out specialized assessments and interventions (counselling), though all cases are discussed with medical officers (MOs) prior to moving to a specialized assessment phase. If the focal points determine a case must be referred to external specialized services, they must also go through the MO in charge.

GIZ funding has also facilitated a thorough mapping of the referral pathways present within and outside UNRWA in Lebanon. The resulting framework has helped to realign Agency activities into a more streamlined process, seeking to minimize gaps in service delivery and follow-up.

EU funds have supported training in the WHO Mental Health GAP (mhGAP) for all medical officers, with plans for all nurses and midwives to undergo the training in late 2015/early 2016. The training program is a four-day classroom course followed by on-the-job supervision and follow-up sessions on priority topics as identified by UNRWA. The project – funding for which is implemented by a programme manager based in the health department at the Lebanon Field Office (LFO) and supported by GIZ – has also enabled LFO to hire four psychologists and two psychiatrists. These staff work in conjunction at health centres in care management, diagnosis and prescription where necessary and conduct informal sessions with health centre staff on common MHPSS needs, sensitization and self-care.

In Lebanon, there is a dearth of secondary resources for mental health referrals. This is a concern if UNRWA will be increasing its capacity to detect and refer these cases without having resources to refer cases beyond the scope of PHC once funding for psychologists and psychiatrists expires in 2016. It is also not within the scope of the proposed package of MHPSS services to introduce unsustainable, project-funded specialists in the future. Discussions are ongoing about a sustainable exit strategy for specialized care.

Syria

In Syria, Palestine refugees are nearing a sixth year of conflict, and the majority have become internally displaced persons (IDPs) or have fled the country altogether, suffering multiple displacements in their lifetimes. Any MHPSS activities in Syria to date have been small and project-funded, with a concentration on staff self-care. In October 2015, GIZ met with key leadership from the Syria Field Office (SFO) to understand how they could best support the team. Any proposed activities will be in line with the MHPSS health strategy.

Jordan

While refugees in Jordan enjoy many of the same
rights as their Jordanian counterparts, marginalized and overlooked communities remain, and the country continues to shoulder the burden of refugees fleeing conflicts in surrounding countries. Currently, project funding supports a programme in Marka Camp that increased the capacity of social workers to identify people at risk and engage in case management. While there is some interaction with the health department, training of health staff was limited, and the project is geographically specific.

GIZ is finalizing an 18-month agreement with JFO to introduce the PAIR approach with 12 nurses in Jordan health centres beginning in April 2016. Additionally, GIZ will conduct induction trainings with all 24 health centres, leading the sensitization and stigma reduction initiatives that are crucial to the success of this model. The content and style of trainings and capacity-building will reflect Lebanon's activities; however the Department of Health will work with the organization to ensure activities are in line with the vision outlined in this strategy.

The Current State of Protection within UNRWA

The Syrian conflict has had a devastating impact on Palestine refugees. In 2014, out of approximately 550,000 Palestine refugees registered in Syria, over 50 per cent are estimated to have been displaced within Syria or to neighbouring countries. In Gaza, the massive Israeli military operation in July and August 2014 had a devastating impact, with an estimated 2,254 Palestinians killed, including 538 children and 306 women. Around 11,000 injuries were reported, estimated to result in 1,000 long-term or permanent disabilities. Eleven UNRWA personnel were among those killed. Seventy-two Israelis were killed during the conflict, including 66 Israeli military personnel and six civilians. In the West Bank, there are a multitude of protection concerns linked to the Israeli occupation, including deaths, injuries and forced displacement from Israeli security forces operations. The repeated displacements experienced by Palestine refugees has led to the erosion of social and economic capital, as well as the depletion of resilience and coping mechanisms.

Many Palestine refugees are excluded from key aspects of social, political and economic life. This is often linked to military occupation, as well as their legal status, with the result that in many contexts they do not enjoy the same basic human rights as other citizens. Vulnerable groups among Palestine refugees, including women, children and persons with disabilities, face disproportionate protection challenges. Such challenges arise from violence and abuse in a range of different contexts, not only those restricted to armed conflict and crisis. There is a high prevalence of GBV, most of which is perpetrated against women and many cases of which affect children. In times of crisis and displacement, women and children become especially vulnerable to GBV due to the collapse of traditional protection mechanisms and changing gender roles. The protection challenges of vulnerable groups from violence and abuse require targeted prevention and intervention programmes that promote and facilitate necessary psychosocial and other kinds of support processes at the individual and community levels.

Women and children comprise the majority of health centre visitors throughout the Agency’s five fields of operations. Experience throughout the Agency’s five fields indicates that women choose to come to the health centre first when in need of GBV or child protection support. Therefore, while a training package for health staff will focus more strongly on protection cases which staff have the ability to engage in direct response (specifically GBV and child protection), it will also include an overview of the full spectrum of protection threats and their implications for mental health and psychosocial well-being.
Conceptual Framework – Basic package of Services

The Department of Health has adapted elements of both the World Health Organization’s Pyramid for Optimal Services in Mental Health and the IASC Intervention Pyramid for mental health and psychosocial support in emergencies (pictured below) to create a model that reflects the unique context of UNRWA operations and the mental health and psychosocial support services that will be available within a health centre, as well as in the immediate community.

Elements of both of these pyramids are important factors in the Department of Health’s MHPSS strategy, as they refer to structures that must be in place in order for the activities that will take place within the health centre to have maximum success. ‘Self-care’ refers to the ability of individuals and families to protect themselves and their communities from risk factors that affect mental health and psychosocial well-being. This level relies on the knowledge, information, and education of individuals and families. ‘Informal community care’ refers to resources that are available in the community, which are not part of the formal health or social services system. These resources may be made available by community-based organizations, NGOs, associations, religious leaders, and other bodies that promote positive development and well-being. In the context of the UNRWA community, these structures may also be supplemented by other programmes, including relief and social services, education and protection, in addition to community-based activities that may be conducted through the Department of Health.

The ‘UNRWA Health Centre Pyramid of Care’, which expands upon the primary health care/focused, non-specialized support level of the two pyramids, details the structure through which MHPSS support will be provided through Family Health Teams. Seeking and receiving mental health services through a general primary health care package is less stigmatizing for the individual and more accessible than specialized care. Integration of services is also more efficient, given the prevalence of co-morbidities and psychosomatization. Additionally,
proper integration and delivery of key health education messages will have a positive, protective effect on all patients who visit a health centre, potentially reducing their need to seek specialized services at a later time. At all levels of the health centre pyramid, interprogramme collaboration will be encouraged in an effort to provide a comprehensive response and to ensure quality follow up.

The role of each staff member at each level of the pyramid is detailed further later in the document and in complete detail in the Technical Instruction document.

**Level One: Community Awareness and Outreach, Stigma Reduction, Public Health Campaigns**

Prevention of psychosocial problems can be achieved through the promotion of positive development and education about the importance of the prevention of unhealthy or unsafe behaviours in order to avoid the onset of MHPSS problems. It is also about reducing and mitigating protection threats such as violence, abuse, coercion and exploitation that give rise to MHPSS needs.

This work can be done on a patient-by-patient basis, but is more effective when it addresses the general population. Stigma against those with mental health needs, cultural acceptance of certain types of violence and a lack of education on social determinants of health will work against the successful implementation of the package outlined in this document. It is crucial to affect an attitude change among the general population before we can expect to see a change in health status.

Level one activities will include community outreach efforts, work with the local friendship committees, engagement with community leaders and public health campaigns. It is also crucial that all UNRWA programmes work together in promoting the well-being of all Palestine refugees in their fields.

**Level Two: General Prevention Activities**

As detailed by global evidence in the introductory pages of this paper, the health programme can prevent the onset of, or quickly address, the majority of MHPSS complaints before they progress through basic health promotion, self-care methods and health education activities conducted within the health centres.

General prevention acknowledges the linkages between the physical and the mental. It also encompasses a general shift in the approach taken to health centre visits – one in which general prevention is an automatic part of the consultation, where social and economic issues are considered in the overall health profile of a patient and not as separate issues. Additionally, FHT staff are able to provide psychosocial support through advising individuals and families on self-care and behavioural change activities to promote resilience, address well-being stressors and prevent mental health deterioration. The majority of these activities will be conducted by nurses and midwives, with a special emphasis on pregnant women, new mothers and NCD patients, as the evidence stated above highlights the vulnerability these particular groups have for developing MHPSS issues.

The FHT model is holistic and person-centred and seeks to address lifestyle and behaviour modifications that will improve patient quality of life; the intention is that this will mitigate future health complications. MHPSS at the level of general prevention is the responsibility of all staff.

**Level Three: Early Detection/Basic Assessment**

In the delivery of general prevention activities, all frontline staff should have the ability to detect MHPSS needs that require a response. This capacity involves the ability to carry out a basic assessment that could trigger a focused prevention activity or the use of an internal referral pathway that will lead to a more specialized assessment.

Basic assessment consists of:

1. Detecting the first signs of psychosocial needs;
2. A rapid assessment of the refugee(s) involved incorporating strengths and resources; and
3. Deciding on a course of action/basic response.

All staff will have the ability to detect ‘red flag’ symptoms and signs, while nurses, midwives and doctors will have the capacity to make a basic assessment of a patient based on their interactions during a visit. A standardized tool for basic assessment will be used throughout the fields. As medical officers at UNRWA health centres do not have adequate time to do a full assessment for every patient they see, a basic assessment is indispensable to later stages of patient care and case management. Pregnant women, new mothers and uncontrolled NCD patients will be actively assessed on a regular basis, while all other patients will be passively assessed. If a staff member feels that an assessment is warranted, they will be able to conduct it accordingly.

There are four possible outcomes of a basic assessment:

1. Referral to a focused prevention activity;
2. Referral to a specialized psychosocial assessment;
3. Referral to a specialized mental health assessment;
4. Referral for an emergency case; or
5. No further action taken, as basic assessment did not yield any results warranting a follow up.

**Level Four: Focused Prevention**

Focused prevention aims to reduce the impact of an
existing psychosocial need, though it can also occur as a part of day-to-day health promotion activities. It includes the provision of non-specialized support and the strengthening of relationships and support to deal with needs in a constructive manner.

Focused prevention occurs when UNRWA staff intervene to address behavioural, social or physical difficulties:

1) As soon as possible (after identification) to halt or slow progress;

2) To encourage personal strategies to prevent repeated occurrences; and/or

3) By implementing programmes to support well-being so as to not exacerbate needs.

Focused prevention involves activities that may occur as a result of a basic assessment, but that are also a part of the day-to-day activities that take place within a health centre. For instance, support groups and education sessions should be available to all groups of patients, particularly pregnant and new mothers, NCD patients and the elderly. When capacity and resources allow in each field/health centre, groups can also include more marginalized or at-risk groups.

Patients may be enrolled in these groups by self-referral, but it will also be the job of front-line staff to identify those in need of additional support through a basic assessment. These focused prevention activities are meant to preclude the need for one-on-one counselling. These activities do not require a patient to be ‘diagnosed’ and do not require a specialized assessment; however, they can also be part of a care management plan developed as a result of one.

Examples of Focused Prevention Activities:

- Home visits for pregnant women and post-birth
- Support groups for new mothers
- Support groups for pre-diabetic patients
- Support groups for uncontrolled, double-burden NCD patients
- Integrated early childhood development and parenting skills education
- MCH services
- Home visits to the elderly and family education on elderly care
- School health

Specialized Psychosocial Assessment

A psychosocial assessment assumes a holistic approach in reviewing specific psychological, physical, social, welfare and protection concerns, as well as a recognition of the client’s creativity, strengths, resources and resilience in order to gain a broad understanding of their life situation. A specialized psychosocial assessment can lead to more focused prevention activities, a mental health special assessment or more focused individual counselling.

A specialized psychosocial assessment can only be conducted by trained staff nurses and medical officers. The result of a PSS assessment is not a specific diagnosis, but a definition of sources set out in a contextualized/holistic way. The process will propose a specific course of action with potential for specialized psychosocial care. The assessment could also indicate the need for a specialized mental health assessment. Case management and further assessments/treatment will follow the stepped-care model.

Specialized Mental Health Assessment

A specialized mental health assessment – and any subsequent diagnosis or prescription – can only be conducted by a medical officer trained in the WHO mhGAP Intervention Guide (mhGAP-IG). Diagnosis and any medication prescribed will be accompanied by the appropriate counselling and case management. Staff nurses will also be trained in the package, so that they work closely with medical officers for patient follow-up. Technical guidelines and protocols for mental health cases will be according to the mhGAP-IG, linked in the Annex and detailed fully (in its adapted form) in the Technical Instructions.

Level Six: Referral for Specialized Services

The Agency’s FHT will be equipped to provide specialized care to a limited extent according to the stepped-care model. The roles and responsibilities of appropriate staff members in conducting these activities are detailed further in later sections.

When the needs of the patient are beyond the scope of our Family Health Team’s capabilities, they will need to refer to a more specialized level of care, which could include psychologists, psychiatrists and established mental health centres. Additionally, referrals between departments at UNRWA, such as the Department of Education, Department of Relief and Social Services, microfinance programmes, protection, etc., may be appropriate for patients. Referrals must be followed up by the staff nurse, who acts as a case manager to ensure seamless reintegration into the health centre and appropriate follow up and monitoring of the patient.

Externally, health centres may work with community services and organizations to provide specialized care.

Level Five: Specialized Assessments and Care at the PHC Level

In health, there are two levels of specialized assessments: psychosocial and mental health.
partners in holding education and awareness sessions within the clinic on mental health and psychosocial issues. Specific protocols and resources for referrals will be field- and, potentially, area-specific and will be developed as a part of the integration process.

**Conceptual Framework – Supervision**

The success of this model relies heavily on a strong supervisory structure with technical oversight by qualified managers. The proposed model of the health department is ambitious and dependent on funding. While ideally, a model with psychosocial counsellors in every health centre, area-level MHPSS supervisors and technical expertise in the field offices would allow us to deliver the strongest package of services, we acknowledge that it might not be possible in the current funding environment.

In an effort to make this model cost-neutral, or at least cost-sustainable, we will adjust the management and supervisory structure as necessary. However, at no point do we accept inadequate or insufficient technical oversight and expertise. We would be violating the do no harm principles we have committed to in this package if we increase capabilities to identify and diagnose MHPSS issues without providing the structure which allows staff to adequately address and manage those issues and seek support from a qualified supervisor in cases of uncertainty. Supervisory structures will be determined on a field-by-field basis, in the absence of funding to allow for an Agency-wide structure.

### UNRWA Health Staff Expected Competencies

<table>
<thead>
<tr>
<th>MOs: Diagnosis, Rx, case management, external referrals</th>
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<tbody>
<tr>
<td>MOs, staff nurses, PSS counsellors (where available):</td>
</tr>
<tr>
<td>Screening, case management, one-on-one counselling</td>
</tr>
<tr>
<td>Midwives, practical nurses:</td>
</tr>
<tr>
<td>Community outreach, group counselling sessions and support groups, low-level identification and detection, and knowledge of referral pathways</td>
</tr>
<tr>
<td>All health centre staff:</td>
</tr>
<tr>
<td>Communication skills, awareness of social determinants of health, basic psychological first aid and ability to detect emergency cases</td>
</tr>
</tbody>
</table>

### Expected Competencies for PHC Staff in MHPSS

- Early detection of patients with risk factors for and/or at high-risk of MHPSS problems and protection issues, and identification of common mental health disorders
- Basic counselling and psychoeducation skills, including verbal and non-verbal communication, active listening, empathy and reflection
- Effectively managing co-morbidity
- Develop management plans for patients
- Prescribe first-line medication and follow-up and monitor potential side effects
- Identify serious cases beyond the capacity of PHC (including those requiring immediate care, such as suicide and homicide risk cases) and refer to a more specialized level of care as appropriate
- Follow-up on cases being managed within the health centre, as well as those referred outside
Expected Roles of UNRWA Health Centre Staff

The basic competencies that we require health centre staff to have in order to adequately perform their functions within a MHPSS-FHT are as follows. The detailed Roles and Responsibilities table can be found in the Technical Instructions.

The Role of all Health Centre Staff

All health centre staff will undergo a basic introduction and sensitization to the topic of MHPSS, which will cover the basic concepts of public health, social determinants of health, the global burden of MHPSS, human rights, stigma and mental health, the Agency-wide vision for integration of MHPSS services, and the specific package that will be introduced in the health centre. The goal of this introduction is to give each member of the health centre a new lens through which to view their daily work and the patients they interact with, whether as clerks, doorkeepers or lab technicians. Patients need to walk through the door to the health centre and know that they are in a safe space; they need to know that there is no stigma associated with seeking help and that no one will gossip about their visit, or share the details of their complaints. This shift in mentality does not happen overnight, but it’s important to work with all health centre staff from the start, in the hopes that eventually this new mindset will become second nature.

The Role of Nurses and Midwives

Nurses and midwives play a central role in the Department of Health’s MHPSS strategy. In a setting where doctors have less than five minutes with a patient and are still seeing an Agency average of 95 patients per day, nurses and midwives are the main point of contact for patients. By default, they see pregnant women, new mothers and young children frequently. These appointments often present an opportunity for women to share the problems and challenges they are facing at home, with their families or internally. The relationship that often develops between these women and the nurses and midwives has, in the past, been an opening for discussions about protection, GBV and violence in the home. Nurses and midwives will be given further training on key health education messages they can provide during these visits to increase their effectiveness.

In their role, nurses and midwives will have the ability to make basic assessments, provide basic counselling and refer women to focused prevention activities which they can also lead. Additionally, trained staff nurses will be qualified to conduct a specialized assessment, one-on-one counselling and serve as a case manager for more complex cases.

Medical Officers

Medical officers will undergo the same training as nurses and midwives, but it is anticipated that their main role – until patient/doctor contact time increases significantly – will be in specialized mental health assessments, diagnoses, prescription if required and external referrals. They will also be responsible for working closely with staff nurses on case management and follow-up of referred patients.
mental health issues managed at health centres

The mhGAP-IG details 11 categories of mental health issues that can be managed at the PHC level: moderate-severe depression, psychosis, bipolar disorder, epilepsy/seizures, developmental disorders, behavioural disorders, dementia, alcohol use and alcohol use disorders, drug use and drug use disorders, self-harm and suicide, and other significant emotional or medically unexplained complaints. As it is not appropriate, nor feasible for UNRWA health staff to manage all 11 types of problems, we have selected – through a WHO-validated modification exercise – depression, epilepsy, stress (including PTSD) and medically unexplained symptoms. However, introductory trainings will cover all 11 modules to give doctors and nurses the capacity to detect and refer, rather than diagnose and manage. When necessary, medical officers will be equipped to prescribe psychotropic drugs for cases not responding to the lower levels of the stepped-care model. Specific flow charts detailing diagnosis and medication options are available in the Technical Instructions.

Moderate-Severe Depression
A person in the mhGAP-IG category of Moderate-Severe Depression has difficulties carrying out his or her usual work, school, domestic or social activities due to symptoms of depression. Common presentations include low energy; fatigue; sleep or appetite problems; persistent sad or anxious mood; irritability; low interest or pleasure in activities that used to be interesting or enjoyable; multiple symptoms with no clear physical cause; or difficulties in carrying out usual work, school, domestic, or social activities.46

Epilepsy/Seizures
Epilepsy is a chronic condition, characterized by recurrent unprovoked seizures. It has several causes; it may be genetic or may occur in people who have a past history of birth trauma, brain infections or head injury. Epilepsy is characterized by convulsive movements or fits/seizures during which time loss of consciousness, stiffness and rigidity of the extremities, and tongue biting or injury occur. After the convulsion, fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches or weakness on one side of the body may occur.47

Other Medically Unexplained Complaints
People in this category have anxiety, depressive or medically unexplained somatic symptoms. They do not have any of the mhGAP conditions. People may experience either ‘normal’ distress or a mental disorder not covered in the mhGAP-IG (e.g. somatoform disorder, mild depression, dysthymia, panic disorder, generalized anxiety disorder, post-traumatic stress disorder, acute stress reaction, adjustment disorder, etc.). The management of these complaints does not include psychotropic medications, and the treatment focus is on psychosocial support.48

Other MHPSS Problems

Daily Life Issues
In addition to the mhGAP disorders listed above, all categories of UNRWA staff will also be able to address daily life problems that affect PSS well-being. These problems refer to social and environmental stressors related to daily life that cause stress on an individual and family. These may include family problems or problems related to the primary support system; problems related to social environment (e.g. death of a loved one or adjustment to life-cycle transition such as marriage or birth); work-related, housing, economic, or education problems; and problems related to medical condition or physical health. Psychosocial issues can be largely addressed by health centre staff by standardizing the basic counselling already provided through UNRWA services.

Psychosomatic Problems
These refer to physical diseases that seem to either be caused or made worse by stress or anxiety. As cited above, Major Depressive Disorder is a risk factor for diabetes and heart disease.49 NCDs are also risk factors for depressive and anxiety disorders.50

Co-Morbidity
This refers to the coexistence of mental disorders and physical illness in a person (for example diabetes and depression). Evidence suggests that co-morbidity is the rule, not the exception. For example, patients with co-morbid depression (depressive disorder with a physical disorder such as an NCD) are less likely to adhere to treatment plans for their NCDs.51 Therefore, health staff must be able to address both the mental health consequences of communicable and non-communicable diseases and the physical health needs of individuals with mental health disorders.
Training Towards Core Competencies

In order to achieve a full integration of MHPSS services into the Agency’s PHC, and in order to ensure staff are able to properly deliver these services within their defined roles and responsibilities, they will need to be trained in a comprehensive way. While each field should consider which training schedule is best for their context and resources, there are four key areas in which staff should be trained:

1) Introduction to MHPSS for all health centre staff
   a) These introductory sessions will serve to give a general overview of what MHPSS well-being is and the prevalence of mental health diseases in the region and globally. It will also serve to sensitize staff to the widespread nature of these issues and reduce the stigma about those who have MHPSS issues and those who seek help for them.
   b) The final goal of this part of training is to create an environment within the health centre in which patients feel safe. It will also create an atmosphere in which every patient is viewed in a different, holistic way – one that recognizes there are many facets to ‘health’.

2) Introduction to psychology/basic MHPSS concepts for all Family Health Team staff (including psychosocial counsellors and physiotherapists, where available)
   a) These sessions will focus on the nurses and midwives who do not have advanced degrees. It will give them a basic introduction into the general psychological concepts that will inform their daily work in this new integrated model. Information about mother/child bonding, child development and the connection between protection and health issues will be discussed.
   b) While these sessions will not give trainees a thorough course in psychological concepts, it will serve to give an overview of key concepts and help make the connection between the above concepts and the way their jobs will shift in this model.

3) PSS support skills/protocols training for all nurses, midwives, and psychosocial counsellors and physiotherapists, where available
   a) This training will be the most technical aspect for nurses and midwives; it will focus directly on the methods and techniques staff should use in order to incorporate these concepts into their daily work. Trainings will include sessions on improving communication and listening skills, basic counselling skills, support group facilitation skills, and key health education messages that should be delivered during consultations.
   b) It is expected that after this technical aspect of training, nurses, midwives and physiotherapists are equipped to deliver key health messages and conduct the priority ‘Focused Prevention Activities’ agreed upon by the Field Office.
   c) In the West Bank and Gaza Fields, where psychosocial counsellors exist, they will contribute to the training, where possible.

4) mhGAP training on diagnosis, medication and case management for staff nurses, medical officers and psychosocial counsellors, where available
   a) This technical-level training will give medical officers and staff nurses an understanding of the specific detection, diagnosis, case management, follow-up and referral pathways for patients with mental health disorders.
   b) The content and package of training will consist of the WHO mhGAP, which will serve as the technical instructions for the mental health aspect of services.
mental health and psychosocial support

The Department of Health anticipates rolling the MHPSS package out to health centres on a schedule similar to that of the roll-out of the Family Health Team approach. A phased approach allows all fields to define a timeline that is appropriate for their resources and capacities and allows all fields to begin implementation at once, rather than moving field by field. The total amount of time it will take to complete this process will be better estimated after the first few health centres have made the transition; at that time, we will be better able to estimate the time and resources needed to prepare and properly supervise the transition in each health centre.

Figure 1: Number of Health Centres Implementing Family Health Team Approach in Gaza, the West Bank, Jordan and Lebanon (2011-2015)
### Stepped-Care and Interventions with Roles and Responsibilities

*Roles and responsibilities may vary according to the context in each field and health centre, given available staff and capacity, including space*

<table>
<thead>
<tr>
<th>Step</th>
<th>For whom</th>
<th>Timing</th>
<th>Intervention</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Prevention:</strong> Resilience-building, health promotion, self-care</td>
<td>All individuals attending PHC services</td>
<td>Any contact</td>
<td>Basic counselling, active listening, education, family support</td>
<td>All FHT staff</td>
</tr>
<tr>
<td><strong>Early Detection</strong></td>
<td>All individuals attending PHC services</td>
<td>Any contact</td>
<td>Recognition of symptoms, signs, complaints ‘Watchful Waiting’</td>
<td>Nurses, MOs, midwives (MWs)</td>
</tr>
<tr>
<td><strong>1. Basic Assessment (Non-emergency)</strong></td>
<td>Patients identified as possibly having an MHPSS problem</td>
<td>Any contact</td>
<td>General questions to determine whether patient needs referral to focused prevention activity or specialized assessment</td>
<td>Medical officer, Staff nurse, Midwife, PSS counsellor (where available)</td>
</tr>
<tr>
<td><strong>2. Mild MHPSS Problem</strong></td>
<td>Patient screened and found to have mild MHPSS or protection problems</td>
<td>At initial contact</td>
<td>Psychoeducation, referral to focused prevention activity and follow-up appointment within four weeks</td>
<td>Medical officer, Staff nurse, Midwife, PSS counsellor (where available)</td>
</tr>
<tr>
<td><strong>3. Moderate MHPSS Problem</strong></td>
<td>Patients screened and detected as having a potential mental health disorder or mild mental health problems that are worsening</td>
<td>At first consultation or after follow-up visit</td>
<td>Conduct specialized psychosocial assessment Develop a management plan including: Enrolment in focused prevention activity, psychoeducation and follow-up appointment within two weeks.</td>
<td>Medical officer, Case manager (SN, or PSS counsellor where available)</td>
</tr>
<tr>
<td><strong>4. Recurrent-Severe MHPSS Problem</strong></td>
<td>Patients who are severely ill at first consultation or whose symptoms persist at follow-up despite following health promotional advice given earlier</td>
<td>At first consultation or at follow-up, if not responding to Step 1, proceed to Step 2</td>
<td>Conduct specialized mental health assessment Medication if required, in conjunction with psychoeducation and follow-up</td>
<td>Medical officer, Case manager (SN or PSS counsellor where available)</td>
</tr>
<tr>
<td><strong>5. Severe/Critical</strong></td>
<td>For patients who do not respond to Step 2 and patients with complex presentations</td>
<td>For patients who do not respond to Step 2 or initial contact</td>
<td>Continue all existing treatments and refer for specialized care and follow-up</td>
<td>Medical officer, Case manager (SN or PSS counsellor where available)</td>
</tr>
<tr>
<td><strong>Assessment and Identification of High-Risk Cases (e.g. Suicidal)</strong></td>
<td>For high-risk patients exhibiting suicidal tendencies or emergency protection issues</td>
<td>Immediately</td>
<td>Referral for specialized care Follow-up</td>
<td>Medical officer, Case manager (SN or PSS counsellor where available)</td>
</tr>
</tbody>
</table>
Staff/Self-Care

In order to help health centre staff to take the above roles and responsibilities, it is essential to establish and implement strategies to promote positive mental health and psychosocial well-being and prevent mental health deterioration. Health centre staff have been dealing with patients suffering from a variety of MHPSS concerns for years; however, this more systematic approach may potentially put staff at an increased risk of MHPSS problems themselves. It is crucial to strengthen the existing staff support and supervision systems, which further underscores the importance of PB-funded positions that provide supervision and oversight to staff. By strengthening and modifying the existing staff support and supervision systems, UNRWA will ensure best practices and necessarily technical and emotional support for staff facing and dealing with MHPSS cases. The staff support group will be provided with training plans and materials and will be given the tools necessary to conduct trainings with HC staff.

Collaboration with Other Programmes

MHPSS promotion cannot be done by our health centres alone; it requires a multisectoral approach, which includes developing joint initiatives and partnerships with other UNRWA departments, as well as other service providers outside of UNRWA. Collaboration with other departments is crucial to ensuring the seamless integration of the new MHPSS package of care. The Departments of Education, Relief and Social Services, and Protection will play integral roles in identification, referral and follow-up of MHPSS cases, while in Gaza Field, the Community Mental Health Programme has its own structure of supervisors and case management, which can play a role in coordinating field-wide referrals. Additionally, strong protocols with the Department of Safety and Security will ensure the safety of health centre staff, who will be dealing with potentially culturally-sensitive issues.

Defining these relationships, referral pathways and coordination roles will be undertaken at the field level, and protocols are under development.
annex

Training Package

Part I Training:
Title: Introduction to MHPSS
Participants: All health centre staff (support staff included)
Duration: One full day
Main topics:
- Global burden of disease
- Better understanding that MHPSS issues are curable, they do not make people different, and they are similar to any other health need (diabetes, hypertension, etc.)
- General communication skills
- Self-care messages
- Psychosomatization
- The importance of creating a safe space for patients (including confidentiality and privacy concepts)
- Recognition of emergency cases

Part II Training:
Title: Introduction to basic psychology and MHPSS concepts
Participants: All health staff
Duration: Two full days
Main Topics:
- Bio-psychosocial and spiritual model
- Difference between psychology and psychiatry
- Link between MHPSS and:
  » Protection threats
  » Political restrictions
  » Physical manifestations
- Concepts of child development (including mother/child bonding)
- Health protection and promotion (key concepts)
Part III Training:

**Title:** PSS Support Skills/Protocols

**Participants:** Senior staff nurses, staff nurses, practical nurses, midwives, psychosocial counsellors, Deputy Field Nursing Officer

**Duration:** Five days

**Main Topics:**

- Counselling and communication skills
- Support group facilitation skills
- Key messages to be delivered to high-risk patients (NCD patients, women of reproductive age, elderly patients, etc.)
- Stress management and problem-solving techniques
- Knowledge of referral pathways within health centres and with other Agency departments (protection, education, RSS, etc.)
- Will include participatory exercises and activities
- Overview of detection and referral for cases within the selected modules of mhGAP
- Introduction to resilience and techniques for improving resilience in patients
- Self-care

Part IV Training:

**Title:** mhGAP-IG

**Participants:** Medical officers, senior staff nurses, staff nurses, PSS counsellors

**Duration:** Eight days

**Main Topics:**

- Introduction to each of the 11 modules
- Thorough overview of depression, epilepsy/seizures, unexplained physical symptoms and stress (including PTSD and grief)
- Trainings will also include general principles of care and psychosocial support and case management techniques
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**Anticipated Timeframe for the Introduction of MHPSS at UNRWA Health Centres**

- **Training Jordan HC Staff**
- **Training Lebanon HC Staff**
- **Launch of pilot MHPSS-PHC (West Bank)**
- **Training WB HC Staff**
- **Training Staff at HC level**
- **Development and training package: Consultation with experts**
- **Tool development and training package: Consultation with CSOs and AHOs**
- **Introduction to sensitization meetings**
- **Launch of pilot MHPSS-PHC (Gaza)**
- **Strategic Planning phase (Agency Level)**
### Three-Year Budget (all figures in US$)

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<th>Field 3 Year Totals</th>
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<td>mhGAP Training Costs</td>
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<td><strong>Total Cost (Field and Total)</strong></td>
<td>1,250,776</td>
<td>900,498</td>
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</table>
endnotes

2. Ibid., p.24
5. Ibid., p.678
6. Ibid., p.678
7. Ibid., p.679
11. UNRWA. Department of Health, Annual Report 2014
18. Martin H. Teicher and others, “Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum”, *Proceedings of the National Academy of Sciences of the United States of America*, vol. 109, No. 9 (2010).
22. Inter-Agency Standing Committee, *IASC guidelines on mental health and psychosocial support in emergency settings*, Inter-Agency Standing Committee (Geneva 2007).
34. The median untreated rate, or treatment gap, for schizophrenia including other non-affective psychoses was 32.2 per cent. For other disorders the gap was: major depression, 56.3 per cent; dysthymia, 56.0 per cent; bipolar disorder, 50.2 per cent; panic disorder, 55.9 per cent; GAD, 57.5 per cent; and OCD, 59.5 per cent. Alcohol abuse and dependence had the largest treatment gap at 78.1%. The treatment gap varied widely between countries (examples of this are in the “results” section on page 2 of the article)
37. UNRWA Department of Health Annual Report, 2014
38. Inter-Agency Standing Committee, *IASC guidelines on mental health and psychosocial support in emergency settings*, Inter-Agency Standing Committee (Geneva 2007).
42. The mhGAP is an evidence-based, globally endorsed initiative which “provides the full range of recommendations to facilitate high quality care at first- and second-level facilities by the non-specialist health-care providers in resource-poor settings. It presents integrated management of priority conditions using protocols for clinical decision-making.” World Health Organization, *mhGAP Intervention Guide For Mental, Neurological And Substance Use Disorders In Non-Specialized Health Settings: Mental Health Gap Action Programme (mhGAP)*, (Geneva, 2010), p. iii.
43. UNRWA, Department of Health Annual Report, 2014
46. World Health Organization, *mhGAP Intervention Guide For Mental, Neurological And Substance Use Disorders In Non-Specialized Health Settings: Mental Health Gap Action Programme (mhGAP)* (Geneva, 2010), p. 9
47. Ibid., p. 21
48. Ibid., p. 79