# Case study: The occupied Palestinian territory

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| Title of the case study:  Integration of MHPSS into the family health team approach in UNRWA primary health care clinics |
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| DESCRIPTION |
| The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) is a United Nations agency and became operational in 1950. It is mandated to provide assistance and protection to a population of over 5.8 million registered Palestine refugees. Its mission is to help Palestine refugees in Jordan, Lebanon, Syria, West Bank and the Gaza Strip to achieve their full potential in human development, pending a just solution to their plight. UNRWA’s services encompass education, health care, relief and social services, camp infrastructure and improvement, microfinance and emergency assistance. UNRWA is funded almost entirely by voluntary contributions. UNRWA has its headquarters in Amman, Jordan and the Gaza Strip, which coordinate the activities of the five field offices.  UNRWA’s health system has three tiers:   1. 1 headquarters: handles policy and strategy development 2. 5 field departments of health: concerned with operational management 3. 143 health centres: provide health services to Palestine refugees.   UNRWA is a totally donor-driven organization, and its health budget is estimated at around US$ 100 million/year, most of which is directed to staff salary, hospitalization subsidies and medicine procurement. The number of staff is 3300, including 500 medical officers and 1500 nurses and midwives, with the rest being support staff.  UNRWA has contributed to sizeable health gains for Palestine refugees since the beginning. While the population is ageing, it is still predominantly young, with enduringly high fertility rates and increasing life expectancies. Across UNRWA’s areas of operation, 31.5% of refugees are children below 18 years of age. A high dependency ratio of 57.1% suggests a particularly heavy economic burden on families living in a context of high unemployment rates and worsening poverty levels.  UNRWA’s strategy is to focus on: improving the quality of health care delivered through a family health team (FHT) model; improving the quality of medical consultations and care for noncommunicable diseases (NCDs); providing staff with training in family health; integrating mental health and psychosocial support (MHPSS) and protection into the day-to-day activities of health centres; engaging the community in health prevention and promotion activities; and improving hospitalization support to ensure financial protection for the most vulnerable. UNRWA will continue to roll out the health information system and the e-health system, and strengthen the FHT primary health care model, the new norm in health centres in the four fields and expand it to new health centres in the fifth field, namely Syria.  The FHT health reform is supported by the concurrent introduction of electronic medical records (e-health), and the necessary health centre infrastructure upgrades.  Monitoring and assessment is a core component in day-to-day supervisory activities and the management health information system is functioning at all levels; with e-health it has become more friendly and informative.  The following indicators are monitored :   |  | | --- | | Maternal mortality rate/100 000 livebirths | | Degree of alignment with UNRWA protection standards of health services | | Average daily medical consultation per doctor | | Average consultation time per doctor | | Number of health centres fully implementing the eHealth system | | Number of health centres integrating the MHPSS technical instructions into the FHT approach | | Percentage of individuals identified with MHPSS needs provided with assistance | | Percentage of NCD patients coming to health centres regularly | | Percentage of late complications among NCD patients | | Number of EPI vaccine-preventable disease outbreaks | | Percentage of women with live birth who received at least 4 antenatal care visits | | Percentage of post-natal women attending post-natal care within 6 weeks of delivery | | Percentage of diphtheria + tetanus coverage among targeted students | | Antibiotics prescription rate | | Percentage of health centres with no stock out of 12 tracer medicines | | Percentage of individuals identified as experiencing a protection risk (general protection) provided with health assistance (disaggregated by sex, age and disability) | | Percentage of individuals identified as experiencing a protection risk (gender-based violence) provided with health assistance (disaggregated by sex, age and disability) | | Percentage of individuals identified as experiencing a protection risk (child protection) provided with health assistance (disaggregated by sex, age and disability) | | Percentage of protection mainstreaming recommendations from internal protection audits implemented | | Number of staff trained on comprehensive MHPSS response | | Number of individuals experiencing MHPSS needs identified by UNRWA in health centres | | Percentage of preventative dental consultations out of total dental consultations | | Percentage of targeted population 40 years and above screened for diabetes mellitus | | Number of new NCD patients (DM, HT, DH+HT) | | Total number NCD patients (DM, HT, DH+HT) | | Percentage of children 18 months old that received all booster vaccines | | Number of new TB cases detected | | Percentage of 18 months old children that received 2 doses of vitamin A | | Number of active/continuing family planning users | | Number of new enrolments in pre-conception care programme | | Percentage of 4th grade school children identified with vision impairment | | Unit cost per capita | | Number of individuals experiencing a protection risk (general protection) identified by UNRWA in health centres (disaggregated by sex, age and disability) | | Number of individuals experiencing a protection risk (gender-based violence) identified by UNRWA in health centres (disaggregated by sex, age and disability) | | Number of individuals experiencing a protection risk (child protection) identified by UNRWA in health centres (disaggregated by sex, age and disability) | | Percentage of UNRWA hospitalization accessed by SSNP | | Hospitalization rate per 1000 served population | | Hospitalization unit cost |   Briefly describe the process of integration of mental health in general health care/PHC in your country. Please indicate the proportion of PHC facilities that are providing integrated services and provide information about the governance mechanisms/structures put into place to facilitate integration, financing mechanisms, human resource development strategies (including training, deployment and continued development), package of mental health interventions being delivered in an integrated manner, and monitoring and evaluation mechanisms put in place to support the process of integration, including integration of a mental health component in the national health information system (core set of indicators, standard collection, collation, analysis and reporting mechanisms). |
| The plan for integration of mental health in UNRWA is designed with sustainability in mind. The majority of activities and costs are intended to increase the capacity of staff and ensure sufficient supervision to ensure adequate implementation of services.  We anticipate the integration/expansion phase to last approximately three years, during which technical staff will be employed to manage the logistics, finances, ensure accuracy and adherence to reporting mechanisms, and supervise overall implementation. However, once the expansion is complete (beyond year 3), these stand-alone positions are no longer necessary, and the appropriate task shifting will have occurred to General Fund (permanent) staff.  Activities:   * Staffing recruitment: Division and Assistant Division Head posts * Training on MHPSS for focal points: one from headquarters and one from each field * Training UNRWA health staff in the detection, treatment and follow up for identified MHPSS issues * Providing staff with adequate in-job supervision according to technical instructions * Establishing Internal and external referral pathways * Coordinating with other UNRWA departments (relief and social services, education, and protection) * Community engagement for health awareness and partnership * Securing psychotropic medication * Developing educational materials and printing forms * Developing MHPSS technical instructions and guidelines and update other technical instructions to include MHPSS where relevant.     Key expected outcomes June 2017−June 2020  Phase one. First year, Japanese Project, July 2017–June 2018:   * Shared understanding and coordination between all programmes and initiatives is achieved. * MHPSS strategic plan of activities at headquarters and all fields is developed and adopted. * MHPSS unit is developed and managed as another component of the FHT service delivery structure. * MHPSS focal points are identified at headquarters and in each field, with job descriptions and clear roles and responsibilities. * Focal points at headquarters and fields (total 15 senior staff) are provided with adequate training from a recognized international institution specialized in MHPSS. * Mental health specialists are contracted to support the training needs of health staff and provide them with on-the-job guidance. * Adequate on-the-job supervision and support for health staff is ensured during implementation. * Health department HPSS technical instructions and guidelines are developed and other technical instructions updated to include MHPSS, where relevant. * Palestine refugee community is engaged and partnerships built during the process of preparation and implementation of MHPSS health awareness. * Sufficient quantities of the recommended psychotropic medication are secured. * Educational materials and printing forms are developed. * Training needs are identified and provided for 600 staff in the five fields. * A list of MHPSS services providers is developed and regularly updated in each field. * Preventive staff MHPSS services are designed, technically supervised and managed (self-care peer support group for staff is developed and initiated). * MHPSS training of trainers team is developed and trained on WHO mhGAP- IG and psychosocial support and technically supervised. * Partnerships and relationships are initiated at headquarters and in each field with competent local organizations, relevant authorities and UN agencies to optimize MHPSS services to refugees and staff. * Information management and assessment tools are developed to improve MHPSS activities pre and post services delivery. * The MHPSS module is developed as an integral part of the FHTe-health. * MHPSS services are mainstreamed and integrated into the FHT work of 44 health centres in the five fields of operation. * Internal and external referral services are developed within the health programmes. * The physical spaces for all MHPSS efforts are refined. * Regular internal evaluation is conducted by headquarters and field staff to identify challenges and gaps in services provision. * External independent evaluation is undertaken and the lessons learned incorporated into a long-term strategy for sustained MHPSS services in all fields of operation. * Fundraising and resource mobilization is undertaken to secure full expansion to all health centres and the long-term sustainability of MHPSS activities thereafter.   Phase two. Second year, June 2018–June 2019:   * MHPSS services in the health centres implementing the integration during the first phase are sustained. * An additional 600 health staff are trained on mhGAP-IG and psychosocial support interventions. * The roll-out of MHPSS services is expanded to an additional 45 health centres in the five fields, increasing the total number of health centres implementing the MHPSS services to 89 clinics. * An external independent evaluation is conducted for the MHPSS services provided. * Operational research is encouraged among staff and clients utilizing the MHPSS services.   Phase three. Third year, June 2019–June 2020:   * MHPSS services in the health centres implementing the integration during the first and second phase are sustained. * The remaining health staff are trained on mhGAP-IG and psychosocial support interventions and refreshment training is conducted for all health staff. * The roll-out of MHPSS services is expanded to the remaining 44 health centres in the five fields, increasing the total number of health centres implementing the MHPSS services to 143 clinics. * Operational research is encouraged among staff and clients utilizing the MHPSS services.   Indicators:   1. Number of health staff trained on mhGAP: the target for this training is all doctors, staff nurses, midwives and psychosocial counsellors (wherever applicable). Training should be completed for the health staff of the health centre planned for expansion. 2. Number of health centres implementing MHSS services. 3. % of health staff satisfied with the MHPSS services. 4. % of clients satisfied with MHPSS services. 5. % of clients identified with MHPSS issues out of the total first visitors in each health centre. 6. % of clients identified with MHPSS issues referred for specialized MHPSS services of the total number of clients with MHPSS issues in each health centre 7. % of clients identified with MHPSS issues identified as mhGAP by priority condition out of the total number of clients with MHPSS issues in each health centre. 8. % of clients identified with MHPSS issues prescribed psychotropic medications by priority condition out of the total number of clients with MHPSS issues in each health centre. 9. % of clients identified with protection issues out of the total clients with MHPSS issues. 10. % of clients identified with protection issues referred for specialized services out of the total number of clients with protection issues in each health centre. |
| What challenges did you face?   1. Funding, this is longstanding challenge for UNRWA. Funds were eventually secured in project form from Japan. 2. Staff overload: UNRWA staff are dealing with average of 86 patients/clients per working day (6 to 7 hours). 3. Staff resistance to new activities, including MHPSS integration. 4. Lack of facilitators in the areas of mhGAP. 5. Infrastructure of some health facilities is rented and lacks provisions for privacy. 6. Rules and regulations of hosting authorities may not allow medical officer to prescribe psychotropic medications. 7. Cultural beliefs and sigma regarding persons with mental health disorders. |
| What are your future plans for the intervention/action?   * Full integration in all UNRWA health centres within 3 years. * Continuous medical education (in-service refreshment training, online) and on-the-job support for staff implementing MHPSS. * Continuous coordination with WHO Regional Office for the Eastern Mediterranean and WHO offices in hosting countries. * Establishing a referral system within UNRWA and with concerned health facilities in hosting countries. * Ensuring the availability of psychotropic essential drugs at all health centres. |
| IMPACT OF INTERVENTION/ACTION |
| Any studies conducted to evaluate the process and impact of integration of mental health in PHC? |
| * Yes, pilot study was conducted in Gaza, assessed and evaluated before designing the three-year plan. * Satisfaction survey was done among staff and clients in the piloted health centre. * KAP survey among staff was conducted in the Jordan field. |
| What impact has the integration had (e.g. number of people treated, impact on patient outcomes, or reduction in stigma)? |
| To date, UNRWA has just started the training and integration in 11 health centres with 435 staff trained:   * 5 health centres in Gaza with 300 staff trained and implementation in early stages * 2 health centres in Jordan with 40 staff trained * 2 health centres in West Bank with 50 staff trained * 2 health centres in Syria with 45 staff trained. |
| Are there any published studies/reports? Please provide references. |
| Yes:  <http://www.hdbp.org/psychiatria_danubina/pdf/dnb_vol29_sup3/dnb_vol29_sup3_157.pdf> |
| ADDITIONAL INFORMATION |
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| Key references/documents (we can link electronically to these) attached with case study |
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| Do you have any documents that you would be willing to share to be adapted and implemented in other settings, such as training manuals or intervention manuals?   1. Technical instructions on MHPSS 2. UNRWA documents for recording and reporting |
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