Health Department

TECHNICAL INSTRUCTIONS

AND

MANAGEMENT PROTOCOLS

ON

Mental Health and Psychosocial Support (MHPSS)

Within

UNRWA's Primary Health Care model: Family Health Team (FHT)

TECHNICAL INSTRUCTION SERIES: NO.: HD/DC/01/2017

September 2017

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List of acronyms

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

Section A: Overview

Part I: Introduction

1. Purpose

The purpose of this instruction is to define the strategy and provide technical guidance on the implementation of the Agency's integrated comprehensive, family and person-centered, mental health and psychosocial support (MHPSS) programme. It provides guidance on the different aspects of MHPSS services to be integrated in all UNRWA health centers within the context of the Family Health Team approach. These policies are amenable to management within the financial and human resources available to the Agency. In particular, these guidelines serve **to:**

a. Provide a user-friendly resource that address the needs of the health centre staff and support them in providing evidence-based best practices in their daily work. But the guidelines do not replace basic knowledge and skills
b. Define the basic elements and service standards to maintain the quality of the work of the Agency's intervention strategy to protect and promote the mental health and psychosocial wellbeing of Palestine refugees;
c. Provide the basis for developing training material and as a tool for on-the-job training through supportive supervision for performance improvement
d. Provide management protocols on the most common Mental Health conditions to be managed in UNRWA's primary health care setting;
e. Establish uniform procedures for organization of MHPSS services in a manner that ensure full integration into Family Health Team and optimal use of available resources;
f. Illustrate coordination and referral pathways both within and external to the Agency.

These guidelines have been prepared as a resource to assist health staff working in UNRWA health centers in providing optimal care for clients with MHPSS needs. It defines activities and steps for implementation within the health programme, which is one component of an inter-sectoral Agency-wide strategy, developed in collaboration with other Agency programmes. It is important to note that while engagement with other UNRWA departments is crucial to successfully addressing the full spectrum of Palestine refugee needs across the lifecycle, these guidelines focus on the response within the context of Family Health Teams at UNRWA health centers.

Effective Date: 01 September 2017

Applicability: Applicable in all Fields of UNRWA's operations (Jordan, Lebanon, Syria, Gaza and the West Bank)

2. Evidence for MHPSS in PHC

Despite the large number of people affected by problems of mental health and psychosocial wellbeing, and the ability to successfully prevent and treat these problems, only a small minority of people actually access care for a variety of reasons including lack of knowledge, stigma, and lack of access to qualified facilities. In addition, opportunities to prevent mental health deterioration are often missed in primary health care settings due to lack of knowledge and skills among health professionals.
International research agrees that integrating MHPSS services into PHC is the most viable way of closing the treatment gap, and ensuring that people get the support that they need. It is also an effective way to prevent MHPSS issues and protect individuals and families. In the same manner as

other NCDs, interventions for MHPSS issues can be woven into the existing fabric of PHC. The FHT approach, which is person-centered, family-based, holistic and multi-sectorial, puts UNRWA's healthcare providers in an ideal position to address the full spectrum of MHPSS issues in a systematic and effective way.

It has been reported that globally, one-third of persons visiting PHC have issues related to their mental health and psychosocial wellbeing. It is also recognized, and recommended by the WHO, that around 70% of MHPSS cases can be cared for and managed by those PHC facilities.[1] Among vulnerable groups, one in five children suffers from a mental illness, and the mental health of an aging population suffering from NCDs is influenced by their access to services, education, employment, housing, social services and discrimination and neglect.[2] Evidence suggests that women, the most frequent visitors to UNRWA clinics,[3] have higher rates of mental illness, with an average female to male ratio of 2.3:1 among adults.[4] MHPSS and wellbeing has a direct effect on the physical health and well-being of individuals and their families, and vice-versa. For example, maternal depression impacts the health of the mother and child, possibly leading to a child's poor birth weight, growth restriction, and poor cognitive development.[5]

Evidence also shows that co-morbidity or the existence of psychosocial problems and/or mental illness on one side and physical disability or illness on the other side is common in primary health care settings[6,7]. For example, it is well-documented that Major Depressive Disorder is a risk factor for diabetes and heart disease.[6] NCDs are also risk factors for depressive and anxiety disorders.[7] Furthermore, clients with co-morbid depression (depressive disorder with a physical disability such as an NCD) are less likely to adhere to treatment plans for their NCDs.[8]

Studies have shown that clients with undiagnosed MHPSS issues use primary health care services twice as frequently as those with no MHPSS complaints, for unnecessary care.[11,12] This frequent use unnecessarily overburdens UNRWA health care compromising the quality of care, reducing client consultation time and increasing wait times.

Integrating MHPSS into UNRWA health services platform is the most logical and appropriate approach to respond to the MHPSS needs of the Palestine refugees. Health staff, through the FHT approach model, can establish trusting and long-term relationships across their life course with individuals and families at UNRWA health centers. This relationship is essential to prevent MHPSS problems by promoting healthy lifestyles and by providing early identification and timely preventive and curative interventions for common behavioral, emotional and social problems. This will contribute to the quality of care clients receive, improving adherence to care plans and reducing future complications related to poor care management.

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[1] World Health Organization and World Organization of Family Doctors (Wonca), comp. Integrating Mental Health into Primary Care: A Global Perspective. P. 24.: WHO Library, n.d. www.who.org. Web.

[2] World Health Organization and World Organization of Family Doctors (Wonca), comp. Integrating Mental Health into Primary Care: A Global Perspective. P. 24.: WHO Library, n.d. www.who.org. Web.

[3] UNRWA. Department of Health Annual Report, 2014

[4] Eastern Mediterranean Health Journal, Scaling up mental health care: a framework for action. Vol 21. No.9 (2015). p.680

[5] Bernard-Bonnin, Dr. Anne-Claude. Maternal depression and child development. Paediatrics & Child Health. 2004 Oct; 9(8): 575–583.

[6] Nicholson A, Kuper H, Hemingway H., Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146 538 participants in 54 observational studies. European Heart Journal, 2006, 27:2763-2774.

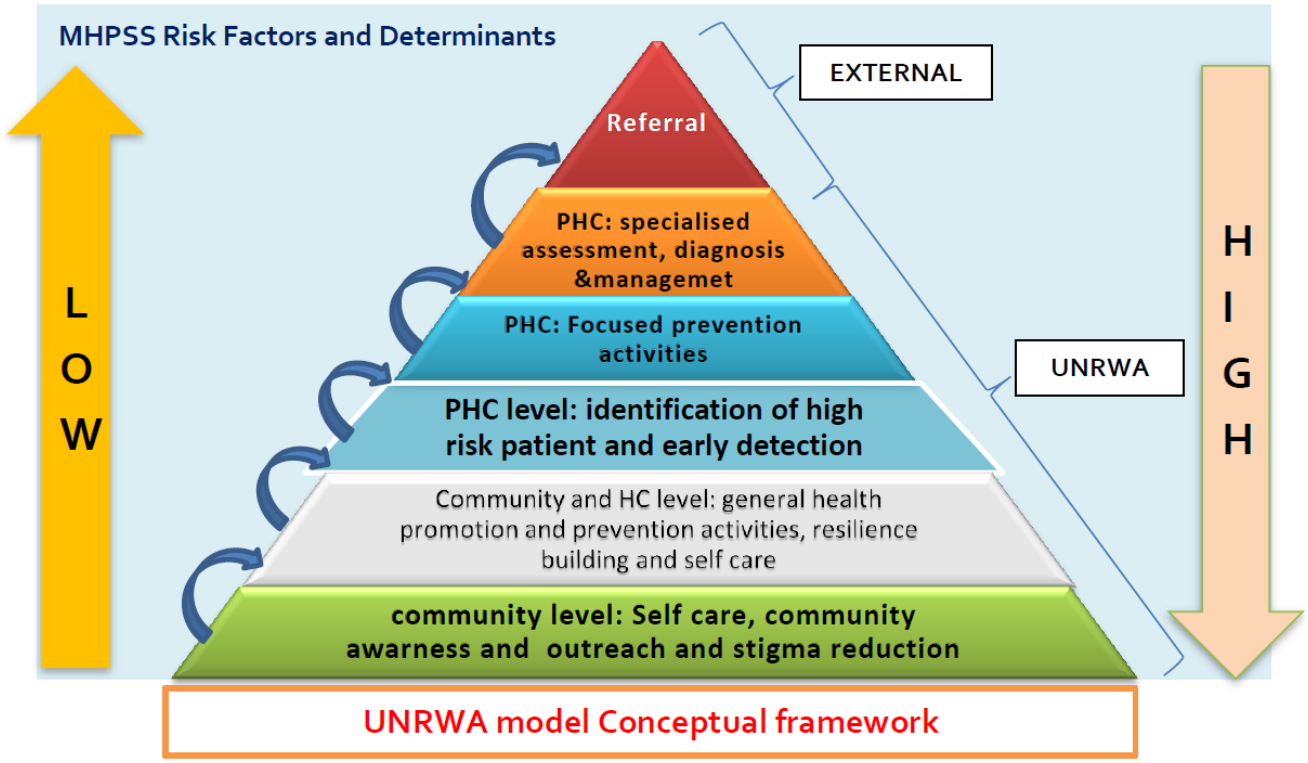
[7] Bush DE et al. Post-myocardial infarction and depression. AHRQ Evidence Report Technology Assessment (summary), 2005, 1–8. Thombs BD et al., Prevalence of depression in survivors of acute myocardial infarction. Journal of General Internal Medicine, 2006, 21:30-38.

[8] Prince M et al., No health without mental health. The Lancet, 2007, 370:859-877.

1. MHPSS Conceptual Framework

The MHPSS conceptual framework is based on the World Health Organization's Pyramid for Optimal Services in Mental Health.[9] As pictured in the adapted model below, the first two steps of the framework emphasizes self-care and informal community care as the foundation for mental health promotion, resilience, and psychosocial well-being. 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 knowledge, information, and education of individuals and families. Informal community care refers to services that are provided in the community, which are not part of the formal health or social services system. These services may be provided by community-based organizations, NGOs, associations, teachers, community health workers, religious leaders, etc, that promote positive development and well-being.
The third and fourth levels of the pyramid refer to MHPSS /family and child protection services integrated into UNRWA's primary health care services. Integrating these services is critical to ensuring comprehensive, quality primary health care, and involves awareness raising and promotion, early detection, counseling and case management, and referrals to external service providers for specialized care if needed. MHPSS services through the PHC package improve accessibility and are less stigmatizing.

The MHPSS programme streamline services and coordinate activities with other UNRWA programmes (Education, Relief & Social Services, Legal, Protection and Infrastructure). When needed coordination is extended to external specialized services such as the Ministry of Health, Ministry of Social Affairs, legal, NGOs, and police (for protection-related cases), as reflected in the top tiers of the pyramid.



[9] http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf

2. MHPSS Risk Factors and Determinants

A consistent body of international evidence shows that mental health and psychosocial well-being is influenced by interplay of individual attributes, family and wider environment in which they live and their socio-economic circumstances. These determinants interact with each other over the entire life-cycle of an individual, and may either protect or threaten an individual's mental health and psychosocial well-being.

Some of the most common MHPSS risk factors and determinants among Palestine Refugees:

- **Individual/Family Attributes such as:** Genetic and biological factors, lifestyle choices (food, substance abuse, alcohol, smoking, etc), domestic violence, disability and physical health,
- **Socio-economic Factors such as:** Poverty, education, unemployment, shelter/housing
- **Environmental Factors:** Armed conflict, violence, restricted movement, urbanization, living conditions in refugee camps and overcrowdings and poor environmental health

3. Identified High Risk Groups for Intervention

More focus will be given to those groups predisposed to developing severe MHPSS difficulties. This way, we can ensure our activities will have the maximum benefit for the most vulnerable clients. Once activities are stabilized and have become routine in health centers, this group may be expanded. Similarly, in fields already conducting these integrated activities, this list may be longer as well.

However, as a minimum, to begin these groups include:

- Uncontrolled patients with diabetes and or hypertension
- High risk pregnant women
- New mothers during postnatal care
- Caregivers of children with growth problems and severe anemia
- Frequent visitors to the out-patient clinic (defined as more than one visit per month)
- GBV survivors and other protection cases
- School Children with special education needs who are referred by schools
- Clients with relevant symptoms identified through normal service provision.
- Survivors of other traumatic events: Persons directly exposed to trauma or witnessing trauma, that includes for instance, persons threatened death, serious injury, shooting, arrest and beating of relatives and neighbors,

4. Identified Mental Health Conditions to be addressed by UNRWA FHT

Based on epidemiological global and regional research and taking into considerations the burden of diseases among Palestine refugees and the available resources in UNRWA primary health care facilities, the Health Department decided to adapt the following modules from mhGAP list: Depression, stress disorders, unexplained medical complaints (which includes anxiety), and epilepsy.[10]. There is a mhGAP module for each one of these conditions which is elaborated upon later in the document.

10 Current epidemiological research shows: depressive disorders rank 3rd in the Middle East region for burden of disease; increasing prevalence of post-traumatic stress disorder and general anxiety disorder due to the increasing levels of violence, armed conflict, forced displacement, and trauma in the region; high prevalence of schizophrenia and other psychotic disorders in the region anxiety disorders such as post-traumatic stress disorder and general anxiety disorder are also on the rise

Section B: Health Center Operations

Part II: Stepped Care Model

The stepped care approach is a collaborative model that can be used by health staff to deal with MHPSS issues and to address the unique needs of each individual and their family. Interventions can include group interventions, counseling, counseling coupled with prescription of medication, or referrals. In this approach, the least intensive intervention appropriate for a person is provided first, and individuals can **"step up or down"** in response to treatment and according to changing needs.

1. Strengths versus Deficits Approaches:

Practitioners in the field of mental health have traditionally been very disease-oriented and deficits-focused, which often rely on psychotropic medication and institutionalized care. In UNRWA MHPSS programme will give more attention to a strengths-based approach to mental health and psychosocial well-being that concentrate on the inherent strengths of individuals, families, groups and organizations, deploying personal strengths to aid recovery and empowerment

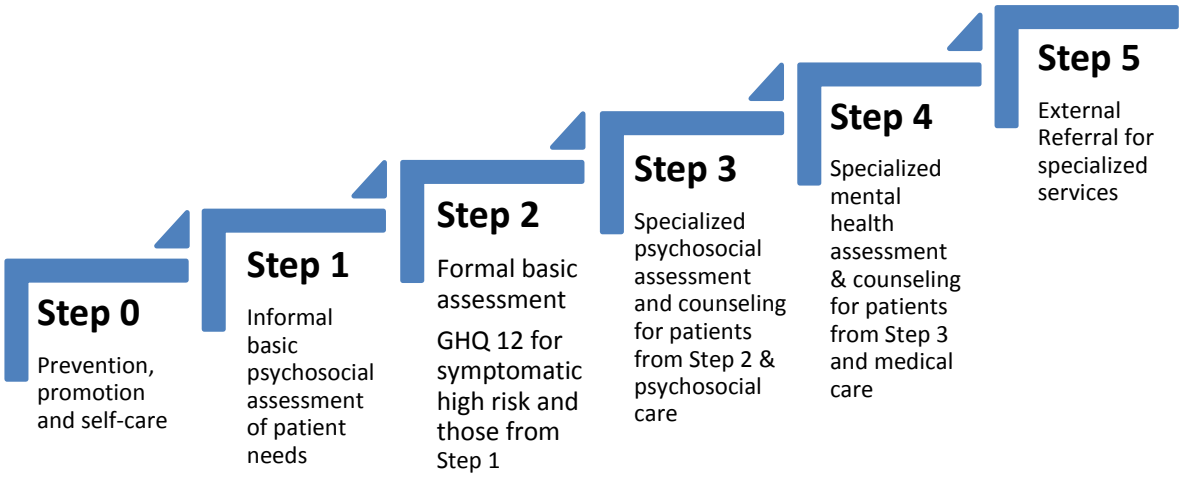
The roles and responsibilities of each category of FHT staff in the stepped-care approach are detailed further in the document.

The FHTs are expected to manage MHPSS issues implementing the following interventions:

- **Early detection of MHPSS and Protection concerns**. Staff are able to recognize risk factors for psychosocial difficulties, common mental health problems, psychosocial and protection issues, as well as high-risk cases, which need immediate specialized care (e.g. suicide).
- **Perform informal basic assessments** to recognize and categorize MHPSS issues, using basic psychosocial assessments.
- **Perform specialized psychosocial assessments** to recognize more profound MHPSS needs and identify capacity to manage cases, either through counseling or further diagnosis and/or referral. we will use the standardized screening tool: the General Health Questionnair-12 (GHQ_12).
- **Manage co-morbidity**. MHPSS should be integrated into all PHC services, including MCH (to address maternal/post-partum depression, for example), as well as NCDs (for co-morbid depression and anxiety, for example).
- **Perform basic counseling/psycho-education** for common MHPSS issues and protection issues. In addition, health staff should advise on basic self-help or protection activities that individuals and families can do to prevent MHPSS stressors and their own health situation.
- **Perform more specialized counselling in certain cases.**
- **Prescribe basic medications.** Medications should not be immediately prescribed to individuals with mild to moderate symptoms. Medications should only be prescribed by doctors for severe cases, high-risk cases and cases where other psychosocial interventions have shown limited effectiveness.
- **Referrals to specialized psychosocial counselling or mental health services**: Based on the effectiveness of interventions and/or the severity of the case. Referrals must be followed up by a designated staff in the HC.
- **Referrals for other social services.** UNRWA has several services that can support these individuals and their families via the RSSP, T-VET, microfinance, and Education programmes. In addition, other national partners in the government and NGO sectors may be able to support.

2. Steps of intervention

The various services in the MHPSS program are to be delivered in a stepped care fashion; All clients receive **Step zero**; those having mild MHPSS problems should receive **Step one** and/or **Step two** only; those who do not respond to Step one and two or who are identified with moderate-severe MHPSS problems from the start should receive **Step three and Step four. Step five** is for clients who need to be referred to specialist because they are not responding to steps: zero-four. There are also some clients who will need step five referral immediately due to the severity of their diagnosis. All interventions in previous steps should be exhausted before graduating to a higher step. At all steps of intervention, other UNRWA departments should be engaged if necessary. For example, a survivor of GBV may need MHPSS support according to the stepped care model, but will also need referral to the protection team.



The interventions in each step must be tailored to the needs of the individual client, depending on the severity of the condition, the availability of family and social support and the response of the client to the intervention/treatment

Steps of intervention

The interventions are based on collaborative stepped care principles that combine tested and effective psychosocial interventions and medical treatments. The treatments are provided in a graded fashion with simpler treatments being provided to all clients and the more sophisticated, resource intensive treatment being reserved for those with more severe MHPSS problems. Doctor, nurses, midwives and other primary care team members work collaboratively to ensure the client receives the optimal level of care.

Step Zero: Prevention, Promotion & Self-Care

Target population: All persons and families registered to the FHT and served community
Responsible Staff: All health staff
Intervention: Health staff are expected to promote the general health and psychosocial well-being of all beneficiaries and prevent MHPSS deterioration before it occurs. This is done through preventing exposures to risk factors, changing unhealthy behaviors, and supporting the building of resilience. Staff

are expected to conduct a basic appraisal of psychosocial well-being, and identify strengths and key problems. They will provide simple health education messages for individuals and groups inside the health center and in the community through outreach activities.

Self-care and informal community care are the foundation for mental health promotion, psychosocial well-being, and resilience. 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. Informal community care refers to services that are provided in the community, which are not part of the formal health or social services system. These services may be provided by community-based organizations, NGOs, associations, teachers, community health workers, religious leaders, etc, that promote positive development and well-being.

Activities: Healthy lifestyle (healthy diet, physical activity, no-smoking….) campaigns, stigma reduction campaigns, positive parenting messages, communication of self-care techniques

Competencies: Effective communication, active listening, relationship and trust building

Step one: Informal basic assessment of client needs

Target population: All persons attending UNRWA HCs

Responsible Staff: All FHT staff

Intervention: As part of the regular general health assessment, responsible staff should conduct a quick, informal basic assessment of clients' MHPSS wellbeing and possible needs. This is not done through a formal screening tool; rather staff do this through active listening and asking relevant questions of the client. After their training, they should be able to identify those clients who may need additional care and support, and possibly another appointment. Special attention should be given to high risk groups.

Activities: Simple forms of counseling: listening to client and discussing problems without offering too much advice, relaxation exercises, providing education about how the clients' physical and social conditions can manifest in a psychological way and advice for managing psychosomatic symptoms.

Competencies: Effective listening and communication skills, and basic counseling skills. Awareness of what psycho-somatization is what its causes are, recognition of symptoms, signs, complaints and how to manage these symptoms.

Advance to Step Two? If throughout the course of the visit, the client is satisfied with the counseling given and does not appear to have additional questions or problems, the staff member can conclude the visit as usual. If it is apparent the client may need further care and follow up, **proceed to Step Two**.

Step Two: Perform basic assessments to recognize and categorize MHPSS conditions

For this we use the international standardized screening tool: the General Health Questionnair-12(GHQ-12).

Target population: Persons in Step one identified as needing additional follow up and care; all high risk group clients and patients identified as having symptoms, signs, complaints related to MHPSS

Responsible Staff: All FHT staff

Intervention:

- For clients identified as having symptoms, signs, complaints related to MHPSS during Step one and not responding to step one interventions, this step two can be conducted in the same visit;
- For clients in one of the following high risk groups should be given special attention and if having symptoms, signs, complaints related to MHPSS, should be given GHQ-12 screening immediately. They are predisposed to MHPSS issues, and therefore prevention and capturing cases at the earliest stages is essential to the success of this model:

- Uncontrolled patients with diabetes and or hypertension
- High risk pregnant women
- New mothers during postnatal care
- Caregivers of children with growth problems and severe anemia
- Frequent visitors to the out-patient clinic (defined as more than one visit per month)
- GBV survivors and other protection cases
- School Children with special education needs who are referred by schools
- Clients with relevant symptoms identified through normal service provision.
- Survivors of other traumatic events: Persons directly exposed to trauma or witnessing trauma, that includes for instance, persons threatened death, serious injury, shooting, arrest and beating of relatives and neighbors,

But never forget GHQ does not give you any answers. It just alerts you to certain issues. You always need to contextualize the information the patient gives you and analyze together with him/her what the best next step could be.

Activities:

- Risk factors for MHPSS should be identified and clients should be provided with more focused counseling, psycho-education and identification of social and family support. Internal referral to Protection, RSS or Education may be appropriate at this stage.
- If the total score is 5 or less, it is unlikely that the person has a mental illness; Step Zero and One should continue at each subsequent appointment
- If the score is 6 – 7, there is an indication of a mild illness; offer counseling and psycho-education. A MHPSS file should be opened for the client, where the score should be recorded. Give a follow up appointment for two weeks from that date. At the subsequent appointment, if the client has improved, the file may be closed. If not, the client should be referred to Step three.
- If the score is 8 – 12 there is an indication of a moderate to severe illness. Go to step three immediately.

Step Three: Specialized psychosocial assessment and internal psychosocial care

Target population: Clients with GHQ-12 score of 8-12; clients from Step two with lower scores who did not improve after two appointments

Responsible Staff: Staff Nurse, Psychosocial Counselor (where available), Medical Officer

Intervention: At this stage, the specialized psychosocial assessment is conducted by the attending health staff, mainly the MHPSS trained nurses or health counselors

Activities: If specialized psychosocial assessment allows for an understanding of symptoms within a broader social and relational framework then provide more counseling, more psycho education, family support, education on sleep hygiene, breathing and physical exercise. Plan for a couple of counseling sessions and follow up for about a month.

If symptoms are severe and no clear logic can be established between social situation and symptoms then facilitate mhGAP diagnosis through Medical Officer in step 4

Step Four: Specialized mental health assessment and care

Target population: All cases from Step three that did not improve based on Staff Nurse or Psychosocial Counselor intervention; serious, emergency cases identified by staff at any step

Responsible Staff: Medical Officer and Staff Nurse

Intervention: Doctor confirms scores of GHQ-12 and reassesses with mhGAP assessment tools,

- If symptoms are consistent with mhGAP conditions not within URNWA's identified scope of assistance, continue to Step Five
- If symptoms are compatible with UNRWA's mhGAP conditions, the doctor will create a care plan with the client that may include just counseling or medication and counseling, or. The client may be referred to PSSC or SN for more in-depth counseling. Make follow up appointment for two weeks.
- If there is improvement after four weeks, continue care management plan as advised in mhGAP and continue treatment for up to nine months (for cases of depression)
- If there is no improvement after one month of treatment, refer to specialized care in **Step Five**

Step Five: External Referral for Specialized Services

Target population: Clients not responding to care plan in Step Four after one month; emergency cases referred from any step, including clients with suicidal and homicidal inclinations; clients with mhGAP diagnosis beyond PHC capacities (including psychosis, bipolar disorder, etc.)

Responsible Staff: Medical Officer

Intervention: The process used for all other external referrals should be followed and is detailed further. It is preferred that once the client has been stabilized externally, that they return to PHC for continuation and monitoring of treatment. This will allow the client to smoothly integrate back into PHC services, will allow their FHT to monitor their health situation, and avoid costly (and possibly further traumatizing) hospitalizations and specialized outpatient services.

Part III: Self-Care

UNRWA health staff are largely Palestine refugees themselves, living in the same communities and neighborhoods as the clients they serve, suffering the same political and social difficulties, and experiencing the same conflict-related stressors. Taking on the additional burden of clients' hardships, in addition to their own, can complicate their own mental health and psychosocial well-being.

In order to mitigate the possible psychosocial consequences of providing MHPSS services on one side, as well as overcoming problems of counter transference (i.e. confusion between clients and counselors' problems). It is essential to keep staff healthy and effective. A systemic and integrated approach to staff care is required at all levels to maintain staff well-being and service efficacy, adapted to the specific situations in each field.

1. Guidance for structured staff care

There are a number of ways staff care can be managed, and it will be the responsibility of each health center to decide what is within their capacity and what is asked for by the staff. A weekly session can be organized by the supervisor, or within the staff themselves for a minimum of 30 minutes during which time they can socialize, discuss difficult cases, or share success stories. But more importantly weekly or bi-weekly 60 – 90 minutes case discussions will help staff work together on difficult cases, help diffuse the pressure associated with them on the concerned staff member and help manage transference issues.

In fields where psychosocial counselors are present, it is possible they may be able to lead some of these self-care sessions, or be available for staff that needs individual support.

There are four major possible categories where UNRWA provides support in order to improve the psychosocial well-being of their staff: individual support, group support, social support, and organizational support. Each aspect requires investment from different categories of staff/management, as detailed below.

1.1 Individual Support:

The aim of individual support is to increase the capacity of the individual staff members to work effectively and protect and promote their psychosocial well-being.

These technical instructions outline the appropriate training and supervision requirements necessary for staff to perform their jobs adequately. In addition Heads of Health centers, in conjunction with field office management staff (Division Head and Assistant Division Head) should work together to ensure the following:

- All staff receive training and ongoing psycho-education on recognizing signs of stress, burnout and compassion fatigue as well as effective coping strategies.
- Ensure staff are sufficiently trained to undertake duties/role and responsibilities and have professional development opportunities.
- Staff to be trained on Psychological First Aid (PFA).
- Confidential time allocated for staff to meet individually with their supervisor and/or counselor.
- Professional supervision, which allows exploration of support needs.
- Confidential spaces for peer supervision as a simple form of helping each other.
- Access to individual specialized counseling services when required.

1.2 Group support:

Aim is to encourage staff to support each other and support the development of healthy teams.

- Provide support to teams who request help in overcoming incidents or conflict
- Enable and empower staff groups to establish supportive networks to meet needs of mutual nature (clinical or personal)
- Establish regular team peer group supervisions for clinical practice/case reviews/discussions
- Provide opportunities for therapeutic group activities; e.g. structured relaxation sessions
- For stress and trauma symptoms, TRE (Tension and Trauma Release Exercises) proved to be effective and can be applied on a group-level. After initial training can be practiced at home.
- Actively engage teams to develop their own approaches to staff care away from direction of management staff (staff welfare committees)

1.3 Social Support:

The aim is to reduce isolation and provide a social outlet for stress. This can be arranged by the Head of Health Center at a time that is suitable for their staff and schedules.

It provide opportunities for staff to socialize with each other away from the work environment, e.g. shared lunches, picnics, sports activities

1.4 Organizational Support:

Aim is to monitor, respond to and mitigate occupational stress.

Ensuring these key points are in place is the responsibility of Headquarters staff – and outlined here in this technical guideline – and in conjunction with each field office as the situation requires.

- Ensure that the organization has adequate and sufficient protocols and human resource policies in place that recognize and support staff welfare (e.g. orientation processes)
- All staff in management and supervisory roles are aware of their roles and responsibilities in ensuring staff care including leaderships and communication skills training
- Support teams undertake serious incident reviews
- Support a feedback mechanism within the organization so that there is communication between all members of the team

Part IV: Psychosocial Support Interventions

When dealing with a broad range of MHPSS issues, psychosocial interventions either when used alone or as adjuncts to pharmacotherapy, have demonstrated significant benefits. Indeed, it is likely that more than 80% of all MHPSS interventions within primary health care in UNRWA can and should be dealt with through psychosocial support interventions.

Proper psychosocial support requires the health staff to first of all listen very carefully to the patients needs and their own way of understanding their problems, then when necessary to counsel very carefully, basically constructing a relationship and facilitating empowerment of the client and finally, where necessary, provide information to the client in a sensitive, inclusive way that is non-judgmental or accusatory. These tenets should guide health staff in every consultation, regardless of whether or not a person has a MHPSS file, and include:

1. Prevention and Promotion

Evidence shows that in combining MHPSS prevention and promotion programs within overall public health strategies reduces stigma, increases cost-effectiveness and provides multiple positive outcomes. Primary prevention for MHPSS issues includes preventing unhealthy or unsafe behaviors that can lead to emotional, social, or physical difficulties in a holistic way through the life cycle.

1.1 Attention to Overall Wellbeing

A holistic approach is essential in proper MHPSS care. Clients often need a range of supports beyond health in order to achieve a healthy overall wellbeing, as they can face extra challenges to their daily routines and basic self-care. Health staff should recognize the importance of all aspects of wellbeing, and liaise with other Agency departments and community services accordingly.

Key health education messages include:

- Acknowledgement of social environment and the challenges it produces in reference to mental and psychical health
- Advice about physical activity, healthy diet and adequate body weight
- Educate people about harmful alcohol use and other risky behavior
- Encourage cessation of tobacco and substance use
- Prepare people for developmental life changes, such as puberty and menopause, and provide the necessary support
- Discuss plans for pregnancy and contraception methods with women of childbearing age
- Enhance right for and capacity of grieving when facing situations of continuous stress and loss.

2. Understanding Protective Factors and Resilience

Protective factors are influences that modify a person's response to a stressor in such a way that the MHPSS problem does not develop into something more severe.

Protective factors include:

- Strong and trusting relationships with relatives, spouse, friends, or colleagues at work
- Having a 'positive' view of oneself, i.e. that one is good at being a mother
- Past experience of having faced and overcome difficulties successfully
- Having experienced a childhood with caring parents and relatives
- Living in a safe community with strong social networks
- Having good physical health
- Having a good level of education

By identifying protective factors, you can build on these to help the person recover and then remain in good mental health. For example, a woman with a supportive family can be encouraged to seek help from her family in times of stress.
Similarly by identifying risk factors, you can encourage the person to reduce these, or reduce their impact and thus help the person recover and then remain in good mental health.

3. Psychosocial Support Techniques

One of the main advantages of psychological interventions versus psychotropic treatments is the active role of the client, he/she is not a passive recipient of treatment (drugs). He/she is the one dealing with or even treating his/her own problems, that shall be represented and reinforced in all interactions.

3.1. Communication Skills

Good communication skills are essential in delivering effective care and reduce stress in clients

- Create **an environment that facilitates open communication**
  - Meet the person in a private space
  - Position yourself to be at the same eye level
  - Welcome the person; introduce yourself and your position/role in an appropriate way
  - Ask the person whether he/she wants other people to stay, respect his/her decision
  - Let the person know that all information will be kept confidential and will not be shared without their permission, except when you perceive a life risk to the person or to others
  - Understand that your task is to offer relationship and within this a space for a non-judgmental communication about issues of the client
  - For sessions with children: Begin and end session with a little game or pleasant ritual Note about the setting with children: Basic tools if possible to be available: colouring pencils, and toy figures; it's easier for children to play or draw social interactions than to describe it.
- **Involve the person as much as possible**
  - Even if the person's functioning is impaired. Always try to involve them in the discussion. This is also applicable for children, youths and elderly people. Do not ignore them by talking only with their caretaker. Always try to explain what you are doing (during physical examination) and what you are going to do
- Be **a good listener**
  - Allow the person to speak without interruption

    - Distressed people may not always give a clear history. When this happens, be client and ask for clarification. Try not to rush them.
    - Do not press the person to discuss or describe potentially traumatic events, if they do not wish to open up. Simply let them know that you are there to listen
    - Use simple language that they can understand. Establishing a relationship with children may require talking about their interests (toys, friends, school, etc.)
- **Be clear and concise**
    - Use language that the person is familiar with. Avoid using technical terms.
    - Stress can impair people's ability to process information
    - Provide one point at a time to help the person understand what is being said before moving on to the next point
    - Summarize and repeat key points
    - It can be helpful to ask the person or caretaker to write down important points. Alternatively, provide a written summary of the key points for the person.
- Respond **with sensitivity**
    - When people disclose difficult experiences (e.g. sexual assault, violence or self-harm), let the person know that you will respect the confidentiality of the information
    - Never belittle the person's feelings or preach or be judgmental, acknowledge that it may have been difficult for the person to share.
    - If referral to other services is necessary, explain clearly what the next steps will be.
    - Seek the verbal consent of the person which should be documented in the file to share information with other providers who may be able to help.
- Do **not judge people by their behavior**
    - People with severe MHPSS conditions may demonstrate unusual behaviours. Understand that this may be because of their illness. Stay calm and client.
    - Never laugh at the person
    - If the person behaves inappropriately (e.g. agitated, aggressive, threatening), look for the source of the problem and suggest solutions.
    - Involve their caretakers or other staff members in creating a calm, quiet space. If they are extremely distressed or agitated, you may need to prioritize their consultation
- Do **not give advice too quickly and focus more on enhancing peoples capacity to solve their own problems**
    - Even when patients ask you for a quick advice, be conscious of the fact that most people do not follow advices and actually are more in need to think things through with a kind listener and come up with their own solutions
    - Make sure people see the different options they have. Make them chose, instead of telling them what to do.
    - Pay attention to the fact that nobody can decide on a good course of action if they do not understand the problem they need to solve.

3.2. Counseling

Counseling is a 'talking' treatment that provides assistance and guidance in resolving personal, social or psychological problems and difficulties, by a trained person and is based on relationship building between the counselor and the counseled person. . The counseling process aims at making the person become more aware of him/herself, to identify strengths and accept weaknesses. Through counseling, the person gains a clearer picture of the problems, the various options available to change the situation and decide upon a suitable course of action. This enables the person to regain some control over problems and feel less helpless.

Counseling does not include:

- Telling clients what to do
- Making decisions for clients
- Judging clients as good or bad people
- Interrogating clients
- Blaming clients
- Preaching or lecturing to clients
- Making promises that you cannot accomplish
- Imposing your own beliefs on clients

Features of Good Counseling

- **Be a good listener:** the counselor has to listen very carefully to the feelings expressed by the client as well as to the words used to express the feelings with an open mind
- **Be empathic:** Empathy is the ability to put one's own self in the place of the client and feel what he or she could be feeling at the moment. The counselor then feels the frustration, anger, and the fears of the client. The process helps the counselor understand the patient and her/his situation better. It is different from expressing sympathy or pity where the listener only expresses the fact that she/he feels bad for the client. This does not, in any way, make the client feel that she/he is being genuinely understood.

  Some activities that can compromise empathy
  - Pretending to understand when you don't – it's always better to ask for clarification and show interest
  - Not responding at all or giving a superficial response which gives the impression the client was not 'heard' or what she/he expressed was not worth responding to. For example: a lady expresses that she just lost her baby and your response is 'how sad'
  - Giving a long response that says more about the counselor than the client's feelings
  - Just repeating word-for-word what the client said when expressing intense emotion
  - Asking a question or giving advice instead of responding to a feeling expressed e.g. "don't cry, be strong. You have to look after your children now that your husband left"
  - Using words like "I understand" in a superficial way
  - Sharing a personal experience that the counselor thinks to be similar (but may not be)
  - Bringing in her personal moral bias ("that's not the way to treat your husband")
  - Interpretations that suggest personal judgments or blame ("it seems you tend to lose your temper easily")
- **Be non-judgmental:** The counselor has to accept the client irrespective of her/his religion, social status, etc. and respect the client's own views and feelings, even where these are contrary to those of the counselor. If the counselor finds it difficult to maintain this attitude with a particular client, she/he should refer the client to another counselor.
- **Generate trust:** The counselor has to make sure that she/he conveys to the client that whatever is spoken between them is confidential and that she/he would maintain the trust that the client has placed in her/him. If there is a need arises to reveal something spoken during the counseling session to a third person, permission of the client has to be sought.
- **Be patient:** The client may take a lot of time to understand oneself and one's strengths
- **Be observant:** Not just about what the client says, but also the body language used. The client speaking with a smile on her face, but with fists clenched, or a lot of finger twisting going on may indicate a build-up of tension, which the counselor needs to observe.

- **Respect and Acceptance:** Showing respect allows the counselor to create an atmosphere of acceptance where the client feels understood, cared for and respected. This means accepting that the client has a right to think and feel differently from you.

Counseling Skills

a. **Attending behavior:** The counselor should convey interest in what is being said and yet ensure that the client sticks to the point and minimizes needless talk. There are four critical dimensions to the attending behavior:

   - **Eye contact:** Maintain eye contact with the person most of the time, but don't threaten or stare people down. Some people feel shamed when you look at them directly.
   - **Attentive Body language:** Make encouraging gestures; show that you are interested in what the client is saying: do not look bored or keep doing other things while talking. Sit facing the client with your arms opened rather than folded against your chest. Do not keep checking you watch or mobile. Focus on listening to what client is saying.
   - **Vocal qualities:** Keep your tone gentle, speak slowly and clearly
   - **Verbal Tracking:** Keep to the topic initiated by the client

b. **Questioning Skills:** In the course of counseling, it is necessary to use questions to get the person talk further. If used effectively, questions can help to obtain a lot of relevant information. There are two types of questions:

   - **Open ended Questions**: These are very useful in getting the person to talk. They are questions that cannot be answered in a few words or sentences. They encourage the person to talk and give maximum information, for e.g., "Could you tell me more about that? How did you feel when that happened?"
   - **Closed Questions:** These are questions that can be answered in a few words, they help focus an interview and to bring out specifics. e.g., "Where do you live?"
   - **Statements that are questions:** Often it is useful to rephrase what the patient has said and check if one has understood correctly. The patient can then confirm or disconfirm counselor's perception and at the same time feels he /she is being understood. Also in such an interaction the patient feels not only interrogated and questioned but with the power to question the judgement of the counselor.

Avoid:

   - Asking too many questions. It can put people on the defensive and/or confuse them
   - Asking questions phrased as statements, i.e., "Don't you think it would be helpful if you found a job?"
   - Sharing your point of view; it can put the person off
   - "Why" questions. They can cause discomfort and sound threatening and judgmental
   - Long questions that can confuse the client. Keep them short and simple.

c. **Observation Skills:** Non-verbal behaviour in three areas should be observed:

   - Client eye contact patterns: when a person breaks eye contact or shifts his look it could mean that she/he is distracted or uncomfortable in talking about a particular sensitive issue or feels shamed by what he/she is talking about or by the way the counselor reacts

- Body language: Leaning forward while talking means that the person is interested and involved in what she is saying. Leaning back and crossing arms could mean the person is disinterested, defensive or 'closing off'. Always be authentic.
- Facial expressions like biting the lips, flushing and tearfulness can indicate distress
  In this situation, the best approach is to ask a clarifying question and not to assume other possible explanations.

d. **Encouraging words and Paraphrasing skills:** These are skills used to let the client know that the counselor has been listening to what she/he has been saying, has seen their point of view and feelings.

   Encouraging words are just words interspersed in between, like "um", "is it" "really" "ah ha". These also include nodding your head keeping your palms open and other friendly non-verbal gestures. Sometimes just the repetition of a keyword could become an encourager. This usually leads to the person giving further details about the same topic. These words and actions encourage the person to continue talking, while letting her or her know that he is being heard. For example, when a client says that her life is terrible, the counselor says "..terrible?" this encourages the client to elaborate more.
   Confirmations: React according to what the patient is telling you. If you listen to a sad or horrible story, don't pretend it is nice, but show your feeling of sadness or horror. If the patient is funny, laugh. In other words acknowledge with your reactions the reality of what the patient is expressing towards you.
   Paraphrases are the feedback given to the client by the counselor by shortening and clarifying the client's comments. Paraphrasing is not just repetition of words. It is done by repeating some of the counselors own words alongside some important words of the client. Paraphrases help the process of counseling by clarifying for the client what he or she has said, clarifying for the interviewer what the client has said. By feeding back what you have heard, you can check on the accuracy, help clients to talk in more detail about issues of concern to them, or help a talkative client stop repeating the same facts or story.

e. **Clarifying skills:** When the client talks of anything that is not clear or is contradictory to what she/he said earlier, the counselor can clarify rather than draw her own conclusions. Sometimes when a client is anxious he or she can keep talking in an unfocused way or keep moving from one topic to another. In such circumstances it is better to stop the client gently and clarify matters that have been left incomplete or unclear.

f. Focusing on positive strengths of the client: This technique is to identify the positive assets or strengths of the client and reflecting them back to the client. This raises the self-esteem of the client.

Ways in which the counselor can use this skill:

- The counselor can begin by asking what has happened recently that the client feels good about. The counselor can use it to remind a client of something positive, for example "You say you are unhappy about your daughter-in law being rude to you. At the same time you also mentioned how you enjoy playing with your grandson. That must be making you feel happy."
- If the client constantly repeats negative statements, these can be paraphrased and then followed by positive feedback. For example: "Yes, being insulted by your daughter-in-law

really hurts. At the same time, I see a number of positive points — you have a good sense of humor, you seem to have very caring neighbors, and your daughter too seems to care for you a lot."

- But most of all the strengths of the client are important in reference to the conflict he/she has. So the key task is to make him/her aware of these strengths and how he/she can use them in order to deal better with his/her problems.

3.3. Psychoeducation

Psychoeducation is part of every stage of the stepped care model and offered to all MHPSS clients irrespective of illness severity. It helps addresses core symptoms of MHPSS issues like helplessness, tiredness, stress, difficulties in relationships, and lack of sleep.

- **Reassurance and Education:** Some clients may believe that their symptoms are a result **black magic, ill luck, a curse from God**, etc. It is important to understand how a client views their problems, especially for adherence management, as clients who do not believe psychological treatments or medication are necessary for their symptoms are less likely to adhere to these treatments.
- **Education on the link between mind and body** is essential to proper management. For example:
  "*When we are tense or worried, the tension has negative effects on our body because our body and mind are linked. So whenever we are tensed, our body shows the effect of this tension and we experience symptoms like sleep problems, tiredness, palpitations, aches and pains, lack of concentration and interest etc. Many people experience these types of complaints."*
- **Education on the meaning and sense of emotions:** All emotions serve a purpose

  - Emotions allow other people to understand us: Sadness for example has an important social function, it makes other people console us and help us.
  - Emotions allow us to understand others.
  - Emotions help us survive, thrive, and avoid danger. → fear is initially a very important and life-saving emotion. The problem begins when the actual danger is not present anymore, but the feeling of fear persists
  - Emotions can help us make decisions: For example, we adapt our behaviours according to whether we feel joy in certain activities, and therefore repeat it.
  - Emotions can motivate us to take action, for example fear to fail an exam helps us to prepare well.

  Problems arise when emotions become too extreme and too prolonged: when anger turns into hate, sadness into despair and hopelessness, joy into manic extasis, etc.

- **Reassurance includes** acknowledging that some of the symptoms, particularly those of sleep, tiredness, other physical complaints, and psychological symptoms must be making it very difficult to handle every day activities; and that all persons experience symptoms of discomfort at some time.
  "*All of us feel pain and discomfort now and then. We feel tired, suffer headaches or sleep problems now and then. However, when there is tension or stress in our lives, many people become sad and worry a lot. This often puts more pressure on our body and the body feels ill. This is why you are feeling tired and having problems sleeping"*

  Reiterating that none of these symptoms would result in a life-threatening or dangerous illness. For example, for clients whose main symptoms are panic and anxiety:

"Your symptoms of difficulty breathing, dizziness, heart beating fast and fear are because of attacks of anxiety. These are common problems and are not signs of a dangerous illness. In fact, they occur because you are tense or worried about something and this makes you breathe faster than normal. When you breathe faster, this produces changes in your body which make your heart beat fast and make you scared that something terrible is about to happen. There are ways by which you could stop your attack by controlling your breathing."

After providing an explanation of the symptoms, it is important to give the client a chance to ask questions. This can be done by asking the client:

"Do you feel you have understood why you are suffering these symptoms (e.g. disturbed sleep, loss of appetite, loss of interest , etc.) If you would like to ask any questions, please do so."

- **Explain the Diagnosis:** The diagnosis should be explained in a way which is acceptable to the client and will not lead to stigma or embarrassment: for example, avoid saying that the client has a mental illness, and avoid using technical terms such as phobia or panic, unless it is understandable and acceptable. Actually, you should avoid speaking of illnesses. Prefer the use of words like "problem" issue" "difficulty". For example:

  "From what you have told me, you seem to be suffering from a reaction to severe stress. Your complaints are the result of this stress. This is very common; many people attending this clinic suffer from a similar stress reaction, because the social situation is so complicated. We cannot completely avoid the stress, but we can help you deal with it in a better way."

> **Remember: There is no need to use the label of 'mental illness'; this often means something quite different to clients and can alienate them from the counseling.**

- **Give the sick a role:** Many clients are unable to carry out their day to day responsibilities as they did before. This makes them feel guilty and inadequate. In addition, they are sometimes accused of being lazy or stubborn by their family and friends. Therefore, it is important to explain that this is an understandable consequence of their condition and will improve as their condition improves.

For example: *"You may not be able to do the things you have to do or want to do in the same way as before your stress symptoms started. For example, if you had a broken leg, you wouldn't expect yourself to be able to run. The treatment we are offering you will help you get better. When you feel better, you will see that you will be able to do many more things."*

3.4. Psychoeducation within UNRWA FHT

First session: The aim of this initial session is it helps the client understand their problems and provide specific information to help them deal with the problems in their daily life more effectively

During the first session

- **Be a good communicator and adhere to the guidance for good communication**
- **Emphasize confidentiality**
- **Explain** your role and the intervention that you will conduct:

  a. Stress and tension is quite common in our daily life and we need help to handle it

b. Treatments would help the person handle stress and tension more effectively and make them feel better. Many people who have done this have felt better and have had to visit the doctor less often
c. Treatment of the stress-related illness can help improve the physical illness
d. Treatment is most effective if the client adhere to the agreed upon plan of management

- Initiate psychoeducation

e. Ask about psychosocial stressors specially those related to the symptoms
f. Reassure and explain about the link between client's stress and complaints
g. Explain the problem and give hope
h. Look for specific possible answers to deal with specific stressors and patient suggestions,
i. Ask about suicidal ideas and assess suicide risk
j. Teach breathing exercise under guidance, but do not pretend that breathing can overcome all types of stress.
k. Advise on specific symptoms
l. Advice on medication if prescribed
m. Referral to other if needed

- Summarize the main points discussed and give appointment, as is appropriate
- Fill in the relevant section of the MHPSS file

Follow up session

- Review symptoms
- Reinforce coping techniques and other information provided in the previous session related to the problem area
- Introduce specific techniques based on psychosocial problem area identified
- Plan for further intervention in clients who have not improved or worsened since previous visit
- **Repeat the GHQ-12 questionnaire during each follow up visit and compare the score with the previous assessment**
- **If prescribed, advise about adherence to medication and explanation of side effects if any**
- **Always ask about ideas of self-harm to clients who report not feeling any change or feeling they have worsened**
- **For clients who are improving: Emphasize the need to continue practicing the techniques that have been taught or the activities that have been planned and to be optimistic that they are on the road to recovery. Plan for the discharge and advise the client to come back after about 4 weeks or to come earlier if the symptoms worsen again**
- **For clients who are not improving / worsening: consider moving to the next step in the stepped care** model

Following up broken appointment

- **For clients in Step one and two wait for one week after the scheduled date of follow up. Contact client through phone reminder, and other available means and ask to return for the new appointment on a convenient date. Try this twice one month apart, if there is no response then the client is considered defaulter and his file is kept separately for possible re-admission. Defaulters will be counted differently from those for whom we provide successful assistance and care management..**

- **For clients on Step three and above, wait for 2-3 days after the scheduled date of follow up. Contact client through phone reminder, and other available means and ask to return for the new appointment on a convenient date. This should be done three times, one month apart. If there is no response, the client is considered a defaulter as above, and the file can be closed.**
- **A defaulter file can be re-opened when the patient resumes services, the reason for defaulting should be recorded and the patient needs to be counseled on the adherence to the plan of management. The number of defaulters and resuming services, will be considered a quality indicator** and should be reported.

Breathing Exercises

- **Explain that you will be teaching them a practical and useful technique for relaxing the body and mind by controlling breathing. The reason we focus on breathing is because when we feel stressed our breathing becomes fast and shallow, making us feel tenser. Before we can relax our bodies we have to first learn how to breath correctly**
- **Explain that this technique is used not only in medical clinics but also in yoga and meditation.**
- **Explain that sometimes when you first start to re train your breathing it can feel strange and some people feel a bit anxious or light headed, but this is normal and will go away with practice (important to check that the technique is correct as this can also be a sign of poor technique).**
- **It is important when teaching breathing exercises to try and get the person to return to a good pattern of breathing not just 'deep breathing'.**
- **Demonstrate the exercise after explaining the steps. Then, ask the client to do the exercise. Let the client continue the breathing exercise in silence for about 3-5 minutes. Confirm that the patient has learned** the technique correctly and encourage to practice it regularly at home

Guidelines for breathing technique:

- **It will take some practice before you feel the full benefits of this breathing technique.**
- **T**here is no special position; any position which the person finds comfortable is the right one
- **Before we start, we will relax the body. Gently shake and loosen your arms and legs. Let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.**
- **Now place one hand on your belly and the other hand on your upper chest. I want you to imagine you have a balloon in your stomach and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach. Demonstrate breathing from the stomach, try and exaggerate the pushing out and in of your stomach, ask them to notice how the hand on your stomach is moving more than the one on your chest.**
- **Give the person a choice of doing the exercise either with eyes open or closed. Generally, the exercise is more rewarding if the eyes are closed but some clients may feel uncomfortable.**
- **Now try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out; then breathe in. If you can, try and breathe in through your nose and out through your mouth.**
- **The second step is to slow the rate of your breathing down. So we are going to take three seconds to inhale, then two seconds to hold your breath, and three seconds to breathe out. I will count with you.**
- **OK, so breathe in, 1, 2, 3. Hold, 1, 2. And breathe out, 1, 2, 3. Do you notice how slowly I count? [Repeat this breathing exercise for approximately one minute**

- **That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down when you are stressed. OK, now try on your own for one minute**
- **After about 10 seconds, the client should start concentrating his mind on his breathing rhythm and make it slow, regular, steady breaths through the nose. As the exercise progresses, the rhythm can be slowed even further according to the comfort levels of the client**
- **You can suggest that each time the person breathes out, they could say in their minds, the thought "relax" or a word they find relaxing like, peace, or calm or Allah**
- **Continue the breathing until the anxiety has completely subsided and for at least 10 minutes.**
- **If a client complains of palpitations, tingling-numbness in fingers or mouth, chest pain or any other physical discomfort during the exercise, it may mean that he/she is breathing too fast or too deep; slow** down the rhythm to one that is more comfortable

Developing specific answers to specific problems

Many problems and stressors cannot be dealt with through breathing and other relaxation exercises. Here psychoeducation must focus on identifying specific activities the patient can develop alone or with his/her family to deal with stressors and problems. This requires joint creative reflection with the client, the development of an action plan, and then the follow up. For example a patient needs to take medication at a certain time of the day, but tends to forget. Could the burden of remembering be shared with another member in the family? Or could a poster be put up in the bathroom so the patient remember?

Detecting and Managing Emergency Cases

Suicide is a major public health problem in all parts of the world since it causes a large number of deaths that are potentially preventable. One of the key tasks for the primary care team members is the identification and assessment of the risk of suicide in the clients you would be seeing in the course of your daily work. The assessment of suicidal risk must be integrated within the first session of assessment and psychoeducation.

Keep in Mind

- **Since this is a very private experience that the client may feel guilty or embarrassed about sharing, therefore you need to establish a relationship with the person before asking questions about self-harm. A good relationship with the client makes it easier to assess risk.**
- **Ask routinely whether the client is experiencing suicidal ideas or any thoughts of harming themselves. It is important to ask for the presence of suicidal ideas in a gentle and non-judgmental manner.**
- **It is a myth that asking for suicidal ideas introduces the idea in the client's mind. On the contrary, it often reduces anxiety associated with thoughts or acts of self-harm and helps the person feel understood, moreover asking whether the client has experienced suicidal ideas is the only way to identify risk and provide the necessary help to prevent suicidal acts.**
- **Risk may alter over time. Therefore, frequent review of suicidal ideas may be necessary in the same person.**
- **Ask the person to explain their reasons for harming themselves**
- **There is a big difference between really wanting to die or feeling so frustrated and angry, that one does not want to live anymore, or imagines death as space of peace and calm. Many people with suicidal** ideas are actually asking for help and hope that somebody will stop them. Others have mythical fantasies about death, as if, that would solve their problem, as if death were not death but a nicer way of living. Others really want to die, and those are the dangerous cases. Often it is not easy to distinguish between these different perspectives. ***But what is very important is to make clear to patients that one cannot help them if they are dead.***

Assessment: Any person over 10 years of age experiencing any of the following conditions should be asked about thoughts or plans of self-harm in the last month and about acts of self-harm in the last year:

- Any of the mhGAP priority conditions. (Depression, alcohol or drug use disorders, bipolar disorder, psychosis epilepsy, behavioural disorders)
- Persons with chronic pain and or with a life limiting diagnosis;
- Persons with acute emotional distress such as: difficulty carrying out usual work, school, domestic or social activities, marked distress or repeated help-seeking, repeated self-medication for emotional distress or unexplained somatic symptoms
- Persons who have been bereaved by suicide are more likely to have suicidal ideation themselves.

Evaluate thoughts, plans and acts of self-harm during the initial evaluation and periodically as required

Management

a. Has the person attempted a medically serious act of self-harm?

Observe for evidence of self-injury: Look for signs of poisoning or intoxication and ask about frequent poisoning or other self-harm. **If yes** provide urgent medical treatment and refer to hospital, **If no** assess for imminent risk of self-harm / suicide

b. Is there an imminent risk of self-harm/suicide?

Ask about: Current thoughts or plan to commit suicide or self-harm, history of thoughts or plan of self-harm in the past month or act of self-harm in the past year and also access to means of self-harm

Look for: Severe emotional distress, hopelessness, extreme agitation, violence, uncommunicative behavior or social isolation

If urgent risk present: including current thoughts or plan to commit suicide/self-harm, history of thoughts or plan of self-harm in the past month, or act of self-harm in the past year in a person who is now extremely agitated, violent, distressed or uncommunicative, then there is imminent risk of self-harm/suicide and provide urgent first aid and **refer to specialist/hospital.**

If urgent risk not present: there is no imminent risk of self-harm/suicide, but history of thoughts or plan of self-harm in the past month or act of self-harm in the past year **consult psychosocial counselor** if available or refer to senior staff nurse to provide psychosocial support, and maintain regular follow-up.

c. Does the person have concurrent priority mental, neurological or drug use disorders? (Depression, alcohol or drug use disorders, bipolar disorder, psychosis, epilepsy or behavioural disorders). Mange the mental health condition in addition to the previous risk assessment.

d. Does the person have chronic pain? If yes, mange the chronic pain in addition to the previous risk assessment

e. Does the person have emotional symptoms severe enough to warrant clinical management? If yes, assess the symptoms and provide clinical management

3.5. Referral to Specialist:

Referral from the health centre should be made through the Medical Officer: The following cases need to be referred

- Clients with a high suicide risk
- Unusual symptoms (hearing imaginary voices, unreasonable suspiciousness, or severe behavior disturbance)

- Significant memory problems and confused behavior especially in elderly persons
- Clients with moderate- severe depression who need more specialist inputs to recover
- Treatment without significant improvement in symptoms
- Clients who have a combination of problems MHPSS with alcohol/drug dependence
- In all cases other possible physical medical problem such as infections, cerebrovascular accidents, head trauma…….. should be considered, assessed, managed or refereed to other specialist

3.6. Addressing Common Complaints:

These are very common problems in clients coming to primary care facilities and can occur as part of a MHPSS problem or as a separate problem altogether

3.1.2. Sleep problems

Before giving any kind of advice first explore possible reasons for sleep problems:

- Are there issues which currently worry you?
- Has this been going on for longer or only recently?
- Has something important happened before the sleep problems started?
- If married, how is the relationship currently?
- Do you have problems falling asleep? Staying asleep? Do you have bad dreams? Do you wake up early?

Key points to advice clients are:

- First of all try to address some of the issues that came up above
- Differentiate between chronic sleep disorder and specific sleep problems
- Keep to regular hours for going to bed and get enough exercise during the day
- Use the bed for sleep not work or study or TV
- Try not to check messages on phone just before sleep
- As much as possible keep the room at a good temperature with adequate ventilation
- If they suffer from ruminating worrying thoughts, write these down before going to bed, or get out of bed to write them if you wake up in the night and they prevent you from sleeping
- Avoid tea or coffee, cola after 5 pm and drink a glass of warm milk before bed
- Try relaxation exercises to help fall asleep.
- If they cannot fall asleep within 20 minutes or so, they should get out of bed, try out some activity (e.g. walking, etc) try again later when feeling sleepy.
- Avoid sleeping tablets or alcohol to fall asleep

3.1.2. Tiredness & Fatigue

These are typical features in clients with MHPSS difficulties and are commonly seen in primary care settings. The person loses interest in activities and begins to feel tired and weak. This leads to further withdrawal from activities and add to the feeling of tiredness and low mood. These are some steps to break this vicious cycle:

- Check with the person about why he/she feels tired and stressed. Often such symptoms relate to processes of grief, to family conflicts, to depression.
- Explain to the person how by exploring the reason for these symptoms one can sometimes find first steps to solve the underlying problems.

- Explain to the person how there is a vicious cycle, in which one feels tired and fatigued, for this or that reason, and then the symptoms themselves make one feel even more tired and so on. Therefor it is important to work on two issues: Dealing with the cause or root problems, and breaking the vicious cycle of the problems.
- Encourage the person to start with a simple pleasurable activity, of her/his choice, for a set amount of time every day for e.g., stitching for 15 minutes every day in the morning. The 15 minutes could then be increased to a half-hour gradually. Ask to observe the changes after it.
- Do not advise going back to a full day's activity, immediately. There should be a gradual increase in physical activity, according to the needs and capabilities of the client. But all of these advices again depend on the nature of the problem.

3.1.2. Worry about physical health

- Let him/her talk about their physical complaints; if need be even look at his/her prescriptions and medications. Do not ignore or dismiss them.
- Make him/her realize the close connection between physical health and stress, let him/her know that learning to cope with their problems could reduce the intensity of the physical symptoms
- Reinforce that if there is a need for more investigations such as X-rays, the medical doctor will carry them out;

3.1.2. Irritability and anger

- Explain the link between anger and mood and the effect anger have on a person's mind and body, i.e., it raises blood pressure and pulse rate and makes solving problems more difficult.
- The first step in anger control is to understand the reason of anger. Anger is a reaction to something. So this something must be analyzed, understood and dealt with. A person must look at the reason for their anger.
- People should not feel guilty about anger. Violence must be avoided and controlled but that is best done by accepting our feelings and trying to deal positively with them, always avoiding harm to others, but also acknowledging our right to feel whatever we want.
- To try calm down before feelings of anger exacerbate into verbal or physical aggression. This can be done by expressing the reasons for anger to a close friend or relative, or by trying to relax.
- Leaving the anger-provoking situation and returning when the anger has reduced,
- Breathing exercises may help the person calm down.

As a rule, never act or make a decision when angry. The person will most often regret their actions or deeds later on.

3.1.2. Giddiness/unsteadiness/dizziness

Explain some simple methods which can help improve giddiness

- If experiencing giddiness during standing or walking, sit down until the feeling passes
- If he experiences giddiness when getting up from bed, he should rise slowly from the lying down position, sit on the edge of the bed for some time, rotate the ankles and then stand up slowly.
- Missed meals may also be a cause for giddiness. This will improve if he eats something.
- Breathing too rapidly (hyperventilation) may also result in giddiness. Explain this to the client and teach the breathing exercise.

3.1.2. Panic Attacks

Panic attacks are often symptoms of underlying, more severe psychological and/or psychosocial problems. Therefore, never just react to the panic attack and just prescribe this or that exercise, but discuss with client there overall situation. These cases sometimes need specialized psychosocial assessment

- Explain to the person the relationship between his/her fearful feeling and being tense is linked to rapid breathing that is a normal reaction when someone becomes anxious
- She/he should recognize that when the fears begin, physical symptoms start.
- As soon as the fearful thought starts he/she should start controlling her/his breathing.
- The best way to do this is to do the breathing exercise reminding oneself that there is nothing to fear, till one gains control over the breath.
- Explain that you will teach the client a practical and useful technique for relaxing the body and mind by controlling breathing. Teach the breathing exercise.

3.1.2. Fear and Phobias

Do not confuse fear with phobias. Many patients suffer from fear reactions. Especially in environments of conflict and war, of poverty and chronic social suffering, fear is very often a chronic element of daily life. Usually fear is a reaction we have which helps to protect ourselves against threats and dangers. Through fears we learn to be able to react to danger quicker than we consciously perceive these dangers. But when people are chronically exposed to threats, for example of bombings and shootings, or a high level of social violence, then fear becomes an inhibitive factor. People begin to react inadequately, they are fearful all the time, they misjudge risk situations, and worst of all, they begin to silence their feelings and not talk about them anymore. Also certain fears stay with us, even long after the actual threat has gone. For example a war might be over already for months, but the fear of bombing does not go away, and people show sleep disturbances.

Sometimes fears lead to phobias, that are permanent psychological symptoms, in which a person experiences severe fear, where apparently there is no danger. The most common phobia is agoraphobia, where a person fears crowded situations such as markets or public transport, or leaving the house. Such persons often become house-bound. Social phobia is also quite common, where a person fears meeting people in social interactions and thus avoids social meetings, because of fear to be embarrassed or humiliated. If the person is suffering from a phobia, in the first session it would be helpful to teach breathing exercises and give advice on any of the other specific symptoms. In the following session it would be appropriate to work on his/ her fears.

Some steps to help deal with fears

- Break the silence: talk about them and share them
- Try to deal with them or overcome them
- Analyze strategies of managing the threat
- Accept that you cannot get rid of them, but you can share the burden
- Understand that children feel the fear of their parents, and help parents understand that sometimes it is more trustworthy and therefore security giving to acknowledge fear than to deny it.

Some steps to help get rid of phobias from a cognitive behavioral perspective

- Explain that their symptoms are related to a fear of the situation which is irrational
- Grade these fearful situations in a list from the least fearful to the most fearful
- Explain that the only way of overcoming this fear is by exposing oneself to this situation until the fear subsides and can face the situation the next time with confidence.
- Emphasize to the client that avoidance of the situation only serves to make it worse.
- Exposure must be done consistently to build up the client's confidence and overcome the phobia. They can be taught to deal with the fear during exposure by breathing exercises and by reassuring themselves in their minds that the fear is temporary and is because of their phobia (rather than any real fearful feature of the situation).
- Expose the client in steps starting from the less fearful situations; once the client has mastered this situation and can face it with no fear, encourage them to move to the next situation on the hierarchy and, in this manner, move on to the most fearful situation.
- For example, a house-bound person could be first encouraged to take a short walk to the neighbor's home as the first step. This step is practiced daily until no more fear is experienced. The client must not leave the situation under any circumstances. After overcoming this fear, they should move on to the next step up.

3.1.2. Advice on eating healthy

This advice should be given to all clients, tailored according to the client's economic status and current eating patterns.

- Explain to the client that what we eat has a profound effect on our body as well as on the mind
- Eat meals at fixed intervals. Ignoring your meal timings can lead to negative effects on your health like stomach problems such as increased acidity
- Meals should be eaten in a relaxed atmosphere and not in a hurry
- Your diet should have a large amount of fiber. You can do this by regular consumption of whole grain cereals like whole grain breads, fruits and green leafy vegetables
- Limit fat from dairy and meat sources
- Avoid overly spicy food and deep fried foods on a regular basis
- Steamed, boiled, baked and roasted foods are preferred to fried foods
- Avoid munching in between on snacks or fast foods which gives you a lot of unhealthy calories and are responsible for weight gain
- Brisk walk every day and relaxation-meditation exercises help maintain a healthy weight
- Drink plenty of water, especially in summer

Part V: Focused Prevention Activities – Support Groups

The Health Department strategy uses many of the techniques from different PSS approaches and models in its support group sessions. This is an evidence-based model that is feasible for paramedical staff to master, in that many of the key tenants are simple and effective. However, there are many other formats of support group sessions, some better suited to certain high risk groups (i.e. pregnant women/new mothers); fields can use discretion based on available staff capacities and resources.

The participants in the support groups will be selected by the concerned FHT staff from among their clients. This will ensure the relationship between the participant and staff is strong, and the possibility for follow up is high. This also allows the staff member to schedule their appointments so that they do not interfere with their weekly sessions. A staff member must complete the appropriate training in

order to become qualified to conduct a support group session independently. The designated trainer will have the authority to confirm the qualification.

Enrolment in the support group is strictly voluntary to clients; however staff should be ready to explain the possible benefits to a client who is unsure about participation. Clients should understand that if they do decide to participate in a support group, they will need to commit to attending all meetings.

1. Creating the Support Group

Participants To begin, the priority will be given to the most vulnerable clients in our identified high risk groups, as identified earlier in the document. It is suggested that the groups be homogeneous in gender, age category, and risk category (ie uncontrolled NCD client).

Among these clients, priority should be given to those who have progressed to Step three and beyond until saturation has been reached. Each staff member should keep a waiting list for future enrolment containing: name, age, sex, type of risk group, condition (if applicable), level of education, address, phone number, and confirmation of participant consent to participate in group.

Size: There should be no less than six and no more than 10 participants in each support group class. Regular attendance is mandatory for clients, and they should come on time, and prepared to be attentive. Participation is encouraged, but can happen at a different pace for each client.

Facilitators: Midwives and Practical Nurses will be the main facilitators in the health center, as below, with Staff Nurses supervising and contributing for more difficult groups. Where present, psychosocial counselors will also conduct support group sessions.

- **NCD nurse:** for uncontrolled NCD clients
- **Midwife:** for high risk pregnant women, severely anemic women, and new mothers
- **Dressing room nurse:** for frequent visitors to the outpatient clinic (more than 1 visit per month)
- **Child care nurse:** Mothers of children with growth and developmental problems
- **Staff nurses (psychosocial counselor where present):** GBV survivors and other protection cases
- **All nurses:** clients with symptoms/complaints identified through regular service provision

Length of sessions There will be five consecutive weekly sessions of a total of approximately 1.5 hours per week. Staff may need to budget an additional 30 minutes for preparation and wrap up activities. At the close of the fifth session, participants are "graduated" from the support group. Health centers may choose to mark the occasion with a small celebration, or hold them quarterly, for all relevant participants. Staff should solicit and welcome the participation of the participants and community in these preparations.

Structure of Sessions Full details of each session are contained in the **Annex.** The overall structure of each session is as follows:

- **Minutes 1 – 20:** welcome participants, check in on progress from past week, review and revise homework, conduct opening mediation and practical exercise
- **Minutes 20 – 80:** Main exercise of session, psychoeducation, and experimental exercise
- **Minutes 80 – 100:** Conclude the session by soliciting feedback from participants, responding to their questions, assigning homework, and conducting the closing mediation

2. Staff Responsibilities during Support Group

First Session In addition to the activities conducted during the first session, staff should cover general information about the objective of the next five weeks, what the basic structure of each session will look like, and the importance of commitment to the established schedule.

The support group leader should also get pre-tests from each participant (located in the **Annex**), and solicit input from participants on their expectations for the group. An attendance record

Attendance Record All participants should sign in at the start of every session, and any reasons for non-attendance should be noted

Preparation and Follow up Prior to each meeting, staff should prepare relevant materials and send SMSs or make phone calls to participants to remind them of the upcoming session. At the conclusion of each session, staff should document activities conducted and issues or areas of concern raised

Conclusion At the end of the support group session, all participants should complete the Post-Test (included in the **Annex**). The facilitator should prepare all related documents, including attendance record, notes from each session, overall successes and challenges, and advice for future sessions. Experiences should be discussed with the Head of Health Centre, Senior Staff Nurse, and Psychosocial Counselor (where available) during scientific hour activities, or in a separate meeting.

After the Support Group Once the five sessions have concluded, the support group facilitator should do their best to ensure participants can sustain the progress they made during their sessions by holding a monthly meeting for the three months following the conclusion of the sessions. These meetings can be used to check in on progress, challenges, and answer any lingering questions. It can also be used to promote healthy lifestyles, emphasize the importance of techniques learned during the sessions, and maintain the relationships developed between participants.

Part VI: Mental Health and mhGAP Selected Modules

Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological, and environmental factors. What may start as a simple psychosocial problem can, if not caught and treated early; develop into something requiring more serious management.

1. Risk Factors:

There are several risk factors for mental illness and psychosocial unrest, and it is important to communicate this to the client, so they do not feel at fault:

a. **Stressful life events:** unemployment, heavy workload, breakup of a relationship, debt, death of a loved one, economic problems, loneliness, infertility, marital conflict, violence and trauma
b. **Difficult family background and relationships:** unhappy childhoods, abuse, or assault can contribute to mental illness later in life. Lack of trusting relationships with friends or

spouse, living in a violent relationship and loss of parents early in life can also be risk factors.

c. **Brain diseases**: including brain infections, AIDS, head injuries, epilepsy and strokes
d. **Heredity or genetic**: heredity is an important factor for severe mental illness. However, these disorders are also influenced by environmental factors
e. **Medical problems**: physical illnesses such as kidney and liver failure can sometimes cause a severe mental disorder. Some medicines (e.g. Beta blockers, Methyldopa) can cause depressive illness
f. **Physical health problems**: chronic physical illness, pain or disability, gynecological problems in women, heavy alcohol consumption and tobacco use

2. Informal Basic Mental Health Assessment

A basic mental health assessment involves identifying **stressors** leading to a client's complaint, as well as the **person's own understanding** of the problem(s). It is important also to assess the strengths and **resources** (e.g. available social supports) available to the person for appropriate management of the problem. The basic assessment does not include an official screening tool, and is rather about picking up clues during a consultation. It is important to:

a. Pay attention to the overall appearance of the client. What is their mood, facial expression, body language and speech?

b. Explore the presenting complaint: to do so you can ask the following questions

- What brings you here today?
- When and how did the problem start?
- How did it change over time?
- How do you feel about this problem?
- Where do you think it came from?
- How does this problem impact on your daily life? At school/work or in the community?
- What kind of things did you tried to solve this problem?
- Did you try any medication? If so, what kind (e.g. prescribed, non-prescribed, herbal)? What effect did it have?

c. Possible family history: Do you know of anyone in your family who has had a similar problem?

d. General health history: Ask about any current or previous physical health problem(s), medication(s), allergy to medication, food and other

e. Explore current stressors, coping strategies and available social support: possible questions can include

- What are your most serious problems right now? How severe is the stress in your life?
- How is it affecting you?
- How do you deal/cope with these problems day by day? What kind of support do you have? Do you get help from family, friends or people in the community?

f. Explore possible alcohol and drug use:

- Questions regarding alcohol and drugs can be very sensitive, and possibly even offensive in the Palestinian culture. However, drug and alcohol use is an important and present problem, and therefore should be considered as an essential component of the assessment.
- Explain to the person that this is part of the assessment and try to ask questions in a non-judgmental way. i.e. I need to ask you a few routine questions as part of the assessment.
- Do you take alcohol (or any other substance known to be a problem in the area)? If yes, how much per day/week?

- Do you take any tablets when you feel stressed, upset or afraid? Is there anything you use when you have pain? Do you take sleeping tablets? If yes, what are these tablets, how much/many do you take per day/week? and since when?

g. Explore possible suicidal thoughts and suicide attempts:

- Questions regarding suicide may also be perceived as offensive, but they are also essential questions in the assessment
- Try to ask questions in a non-judgmental way. Staff need to learn how to approach these difficult and sensitive question to avoid any possible clash with the patient/client i.e. what are your hopes for the future? If the person expresses hopelessness, ask further questions such as:
- Do you feel that life is worth living?
- Do you think about hurting yourself?
- Have you made any plans to end your life?

h. Conduct a targeted physical examination: This should be a focused physical examination, guided by the information found during the assessment.

Other Guiding Questions

Ideally, you should ask anyone who attend health services about their mental health. Most people will tell you that they are fine and they don't have any problem. However, simple questions such as the following can provide an indication about a person's mental health:

a. How have you been feeling recently? I am asking not only about your physical health, but also your emotions and feelings

أ. كيف كان شعورك في الايام الاخيرة. انا لا أسالك فقط عن الجانب الجسدي بل النفسي والعاطفي أيضا

b. Have you been feeling under stress recently? If so, why? How is this affecting your health?

ب. هل كنت تشعر بضغط نفسي؟ لماذا وكيف يوءثر ذلك على صحتك ومجرى حياتك؟

For the few who do say they have problems or feel stressed, you can then ask more detailed questions to see whether there is a reason to move to the next step. There are a number of symptoms and/or complaints that a person who is suffering from a mental illness or psychosocial distress may experience, including:

Sleep difficulties	صعوبات في **النوم**
Appetite problems. Anorexia bulimia	مشاكل **في الشهية** بالزيادة او النقص
Feeling of easy fatigue and tiredness	**ارهاق** دائم و تعب عام
Feeling miserable	الشعور بالبؤس و**التعاسة**
Feeling worried all the time	الشعور **بالقلق** والتوتر معظم الوقت
Loss of interest	اللامبالاة وفقدان المتعة
Lack of concentration	نقص في التركيز
Suicidal thoughts	أفكار انتحارية
Aches and pains	أوجاع وآلام متفرقة غير محددة
Palpitations and shallow breathing	تسارع في ضربات القلب والنفس
Irritability	سهولة الغضب أو الاستثارة

Despite knowing these symptoms, in reality, very few clients are correctly identified in the primary health care clinics. Unless specifically asked, clients will not openly discuss emotional complaints or their stressors because they do not expect that the clinic staff is interested in their personal problems.

To overcome this problem, we will adopt a systematic method of identification by asking clients with these symptoms a set of questions about their mental health using the **General Health Questionnaire (GHQ-12)** as a screening tool.

3. General Health Questionnaire 12 (GHQ-12)

The GHQ-12 is one of the most widely used screening questionnaires in the world with 12 questions that are able to correctly identify 80% of people with common mental illnesses when used in PHC. It will also give us an indication of those people who might be experiencing psychosocial distress that could benefit from basic psychosocial support and counseling services.

The GHQ-12 asks about 12 emotional experiences over the previous two weeks. Each question is scored either 0 (which means the symptom is absent) or 1 (which means the symptom is present). Five of the 12 questions are reverse-scored. The total score of all 12 questions are added up to give a single, summary score for each client. This score is then used as a measure of the person's likelihood of having a common mental illness at this point in time. The higher the score, the more likely the person needs follow up. The tool will be used in **Step two**.

GHQ-12 questionnaire		
We would like to know if you have had any complaints and how your health has been in general over the **past two weeks**. In the past two weeks, have you….		
	No	**Yes**
1. Been able to concentrate on whatever you are doing?	1	0
2. Lost much sleep over worry?	0	1
3. Felt that you are playing a useful part in things?	1	0
4. Felt capable about making decisions about things?	1	0
5. Felt constantly under strain?	0	1
6. Felt you could overcome your difficulties?	1	0
7. Been able to enjoy your normal day to day activities?	1	0
8. Been able to face up to your problems?	1	0
9. Been feeling unhappy and depressed?	0	1
10. Been losing confidence in yourself?	0	1
11. Been thinking of yourself as a worthless person?	0	1
12. Been feeling reasonable happy, all things considered?	1	0
Sub Total		
Total Score		

Arabic version:

مقياس الصحة العامة GHQ-12		
الرقم	نريد أن نسألك بعض الاسئلة العامه حول صحتك خلال الأسبوعين الماضيين	الإجابة و التصحيح
		نعم / لا
١	هل كنت قادرا على التركيز؟	٠ / ١
٢	هل اضطرب نومك بسبب القلق؟	١ / ٠
٣	هل شعرت بانك قمت بدور مهم في الحياة؟	٠ / ١
٤	هل شعرت انك قادر على اتخاذ القرارات؟	٠ / ١
٥	هل شعرت بانك تحت الضغط بشكل مستمر ؟	١ / ٠
٦	هل شعرت انك قادر على تجاوز المصاعب؟	٠ / ١
٧	هل استمتعت بنشاطاتك اليومية العادية؟	٠ / ١
٨	هل كان لديك القدرة على مواجهة مشاكلك؟	٠ / ١
٩	هل شعرت انك غير سعيد أو مكتئب؟	١ / ٠
١٠	هل فقدت الثقة بنفسك؟	١ / ٠
١١	هل فكرت انك شخص عديم الفائدة؟	١ / ٠
١٢	هل شعرت انك سعيد على وجه العموم ؟	٠ / ١
	المجموع	

الدرجة	المستوى	نوع التدخل
٥ أو أقل	غير مرضي أو أعراض بسيطة	تقديم مشورة و نصائح عامة للوقايه وتعزيز الصحة
من ٦ الى ٧	أعراض مرضية بسيطه	جلسات تثقيف نفسي ومتابعة بعد اسبوعين
من ٨ الى 12	أعراض مرضية متوسطة – شديدة	تحويل الى الممرضة القانونية وعمل جلسات تثقيف + مضادات اكتئاب + تحويل أذا لزم الأمر

3.1. Target group for screening

- Adult (18 years or more) clients whose answer to basic screening questions indicate a possible further need for follow up

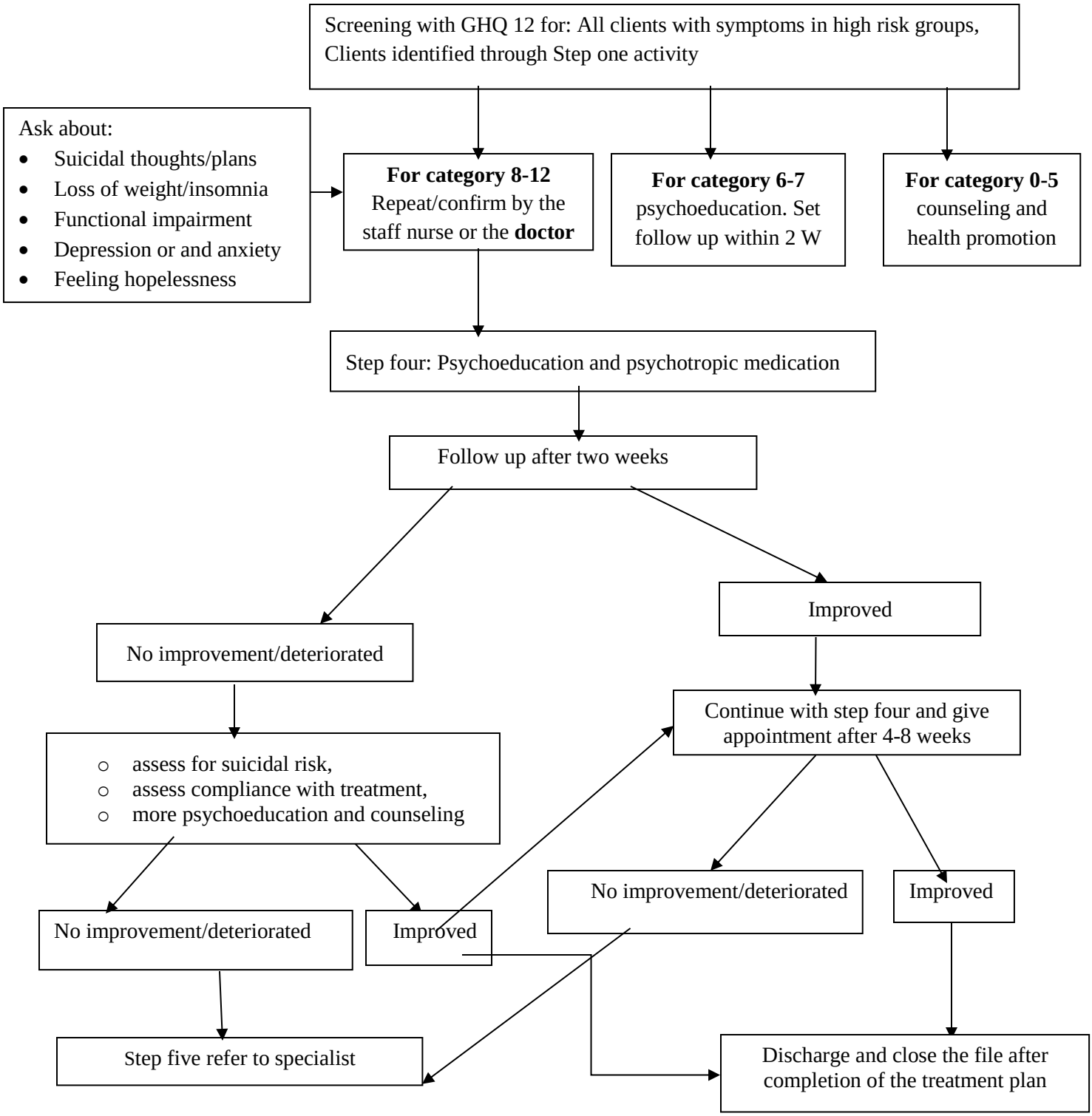
- Special attention should be given to the following high risk groups with psychosomatic complaints:
    - Uncontrolled patients with diabetes and or hypertension
    - high risk pregnant women
    - New mothers, especially during postpartum period
    - Caregivers of children with growth problems
    - Frequent visitors to the outpatient clinic (more than one visit per month)
    - GBV survivors and other protection cases Uncontrolled
    - Survivors of other traumatic events

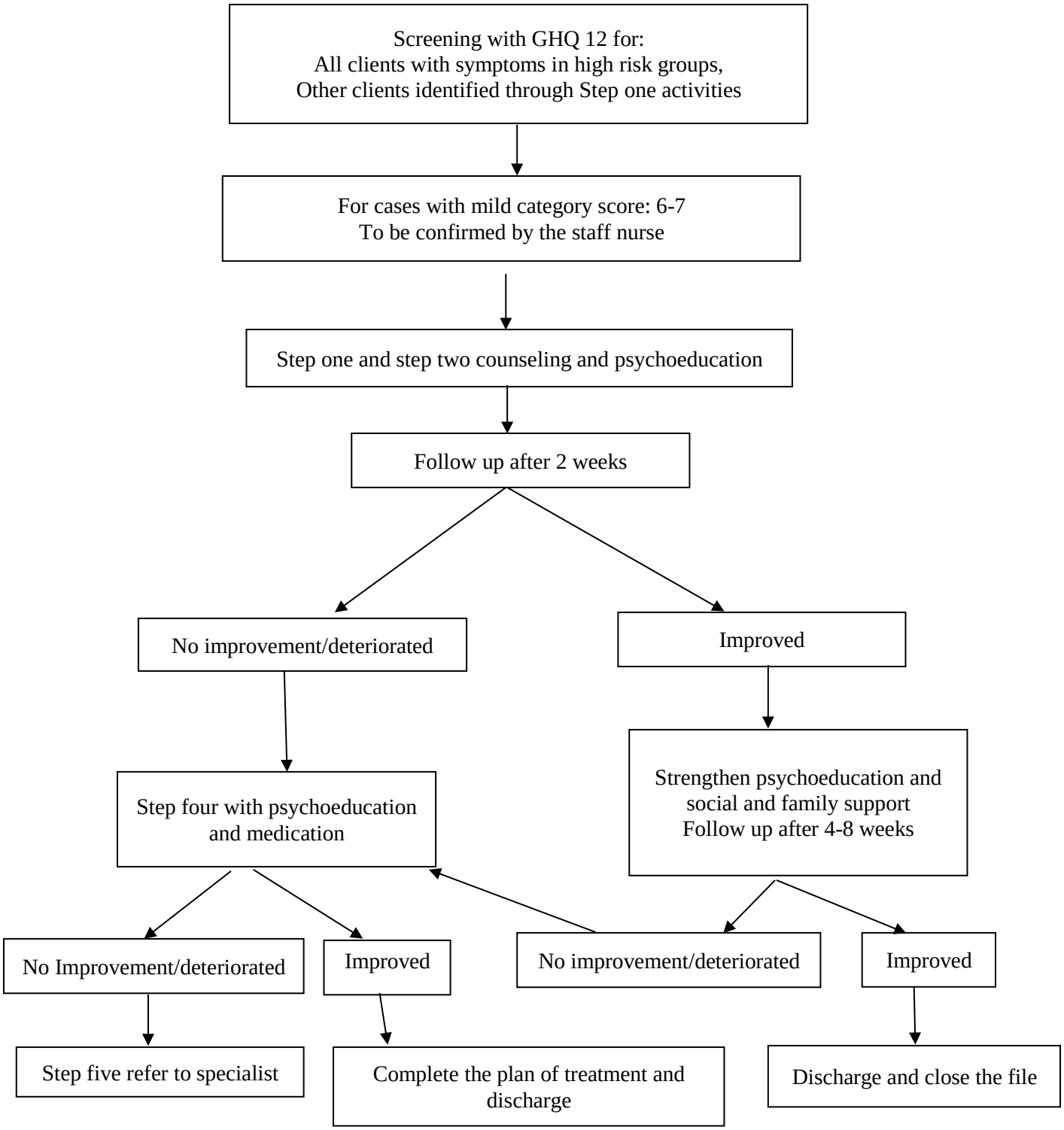
3.2. Administration of Tool

- Clients who are literate can answer the GHQ-12 themselves
- Health staff should conduct the screening for clients who are unable to self-administer
- It is important to allow for privacy for the client to understand and respond to the questions

Scoring

0-5	Minimum presence of mental illness or PSS distress	Basic counseling and health information on health promotion and prevention
6-7	Mild presence of mental illness or PSS distress	Conduct psychoeducation with client and set follow up appointment within 2 weeks
8-12	Moderate-Severe mental illness likely	Refer to staff nurse or MO to conduct mhGAP assessment


Screening with GHQ 12 for: All clients with symptoms in high risk groups, Clients identified through Step one activity
Ask about:
Suicidal thoughts/plans
Loss of weight/insomnia
Functional impairment
Depression or and anxiety
Feeling hopelessness
For category 8-12 Repeat/confirm by the staff nurse or the doctor
For category 6-7 psychoeducation. Set follow up within 2 W
For category 0-5 counseling and health promotion
Step four: Psychoeducation and psychotropic medication
Follow up after two weeks
No improvement/deteriorated
Improved
assess for suicidal risk,
assess compliance with treatment,
more psychoeducation and counseling
Continue with step four and give appointment after 4-8 weeks
No improvement/deteriorated
Improved
No improvement/deteriorated
Improved
Step five refer to specialist
Discharge and close the file after completion of the treatment plan


Screening with GHQ 12 for:
All clients with symptoms in high risk groups,
Other clients identified through Step one activities
For cases with mild category score: 6-7
To be confirmed by the staff nurse
Step one and step two counseling and psychoeducation
Follow up after 2 weeks
No improvement/deteriorated
Improved
Step four with psychoeducation and medication
Strengthen psychoeducation and social and family support
Follow up after 4-8 weeks
No Improvement/deteriorated
Improved
No improvement/deteriorated
Improved
Step five refer to specialist
Complete the plan of treatment and discharge
Discharge and close the file

Part VII. Selected Mental Health Global Action Programme (mhGAP) modules

The mhGAP intervention guide (mhGAP-IG) has been developed for use in non-specialized health-care settings. It is aimed at non-specialist health-care providers working at primary and secondary care facilities. mhGAP-IG was adapted to UNRWA's context by a team of stakeholders from HQ and the fields, using the WHO-supplied mhGAP adaptation guide. The adaptation exercise resulted in the inclusion of four common mental illnesses amenable to treatment in UNRWA primary health care facilities, according to prevalence among the population and availability of resources:

1. **Depression,**
2. **Reactions to Stress and Distress**
3. **Medically Unexplained Complaints**
4. **Epilepsy**

1. Depression

In a primary health care setting the client with depression may present initially with one or more physical symptoms, such as pain or "tiredness all the time." Further inquiry will reveal low mood or loss of interest and enjoyment, and reduced energy leading to diminished activity for at least 2 weeks.

When considering whether the person has moderate-severe depression, it is essential to assess whether the person not only has symptoms but also has difficulties in day-to-day functioning and carrying out his or her usual work, school, domestic or social activities due to symptoms of depression.

Many people with depression also suffer from anxiety symptoms and medically unexplained somatic symptoms.

1.1 Risk factors for depression

Health staff should be alert to the risk factors for depression among, the following categories:

a. defined high risk group,
b. persons who score more than 5 in the GHQ-12 screening and
c. clients attending the outpatient clinic with symptoms suggestive of depression.

Special attention should be given to clients with the following risk factors/complaints:

- Past History of depression
- Anxiety disorders
- Multiple unexplained physical symptoms
- Recent major stress or loss
- Repeated visits to the clinic
- Chronic pain
- Chronic physical illness
- Chronic mental illness
- Post-partum woman
- Complaint of sleep problems, appetite change, weight loss, etc…
- Past history of abuse,
- Elderly with behavioural changes/dementia,
- People with substance/alcohol use issues

- Survivors of GBV and other types of violence
- Survivors of other traumatic events

1.1. Common presentations of depression

- Multiple persistent physical symptoms with no clear cause
- Low energy, fatigue, sleep problems
- Persistent sadness or depressed mood, anxiety
- Loss of interest or pleasure in activities that are normally pleasurable

1.2. Assessment and diagnosis

To confirm the diagnosis of depression, the following steps should be followed:

a. **Ask if the person had at least one of the following core depression symptoms for at least 2 weeks:**
   - Persistent depressed or sad mood most of the day, almost every day (for children and adolescents: either irritability or depressed mood),
   - Markedly diminished interest in or pleasure in activities that are normally pleasurable,

b. **For the last 2 weeks has the person had at least 3 other features of depression:**
   - Disturbed sleep or sleeping too much
   - Significant change in appetite or weight (decrease or increase)
   - Beliefs of worthlessness or excessive guilt
   - Fatigue or loss of energy
   - Reduced concentration and attention
   - Indecisiveness
   - Observable agitation or physical restlessness
   - Talking or moving more slowly than usual
   - Pessimistic and hopelessness about the future
   - Ideas or acts of self-harm or suicide

c. **Does the person have considerable difficulty with daily functioning in personal, family, social, educational, occupational or other areas?**

If NO to some or all of the three questions and if no other priority conditions have been identified, assess for other significant emotional or Medically Unexplained Somatic Complaints.

If YES to all 3 questions, moderate-severe depression is likely. Check for recent bereavement or other major loss in prior 2 months. Follow the above advice but **DO NOT** consider antidepressants or psychotherapy as first line treatment. Discuss and support culturally appropriate bereavement/adjustment. In addition, make the following assessments where appropriate:

Assess for bipolar disorders: Ask about prior episode of manic symptoms such as extremely elevated, expansive or irritable mood, increased activity and extreme talkativeness, flight of ideas, extreme decreased need for sleep, grandiosity, extreme distractibility or reckless behavior. Bipolar depression is likely if the person has had three or more manic symptoms lasting for at least one week, or a previously established diagnosis of bipolar disorder. If a diagnosis of bipolar depression is likely, **refer to specialist**

Assess for associated psychotic symptoms such as delusions, hallucinations and stupor. If present, **refer to specialist**

Assess for other concurrent conditions: Reconsider risk of suicide/self-harm, alcohol or other substance use disorder, look for concurrent medical illness, especially signs/symptoms suggesting hypothyroidism, anemia, tumors, stroke, hypertension, diabetes, HIV/AIDS, obesity or medication use, that can cause or exacerbate depression (such as steroids). In this case, manage both the moderate-severe depression and the concurrent condition. Monitor adherence to treatment for concurrent medical illness, because depression may reduce adherence.

Assess females of childbearing age for pregnancy or breastfeeding: Follow below treatment/advice for the management of moderate-severe depression, but antidepressants should be avoided as far as possible. If no response to psychosocial treatment, consider using lowest effective dose of antidepressants and consult specialist.
Children and Adolescents: If younger than 12 years: Provide psychoeducation to parents, address current psychosocial stressors and offer regular follow-up. **Do not** prescribe antidepressant medication
If 12 years or older: provide psychoeducation, address current psychosocial stressors and offer regular follow-up. Do not consider antidepressant as first-line treatment. When psychosocial interventions prove ineffective, consider fluoxetine (but not other SSRIs or TCAs).

1.3. Management

a. **Psychoeducation:** This is the first response to a diagnosis of depression, it is conducted by the health staff for the client and his or her family for support, whenever possible. The staff member should emphasize the following points when introducing the diagnosis and its management:
   - Depression is very common and can happen to anybody, regardless of age, social status, physical health or gender
   - Depressed people tend to have unrealistic negative opinions about themselves, their life and their future
   - Effective treatment is possible, though it tends to take few weeks before the effects of treatment are noticeable. Therefore, adherence to any prescribed treatment is essential.
   - The following guidance should be communicated to the client:
     - the importance of continuing, as far as possible, activities that used to be interesting or give pleasure, regardless of whether these currently seem interesting or give pleasure;
     - the importance of trying to maintain a regular sleep cycle (i.e., going to be bed at the same time every night, trying to sleep the same amount as before, avoiding sleeping too much);
     - the benefit of regular physical activity, as far as possible;
     - the benefit of regular social activity, including participation in communal social activities, as far as possible;
     - recognizing thoughts of self-harm or suicide and coming back for help when these occur;

b. **Address current psychosocial stressors**
   - Offer the person an opportunity to talk, preferably in a private space. Ask for the person's subjective understanding of the causes of his or her symptoms.

- Ask about current psychosocial stressors and, to the extent possible, address pertinent social issues and problem-solve for psychosocial stressors or relationship difficulties with the help of social services/community services/other resources.
- Assess and manage any situation of maltreatment, abuse (e.g. domestic violence) and neglect (e.g. of children or older people). Contact legal and community resources, as appropriate.
- Identify supportive family members and involve them as much as possible and appropriate.
- In children and adolescents:
    - Assess and manage mental, neurological and substance use problems (particularly depression) in parents
    - Assess parents' psychosocial stressors and manage them to the extent possible with the help of social services/community services/other resources
    - Assess and manage maltreatment, exclusion or bullying (ask child or adolescent directly about it)
    - If there are school performance problems, discuss with teacher or school counselor how to jointly support the student
    - Provide culturally-relevant parent skills training if available

c. Reactivate social networks

- Identify the person's prior social activities that, if reinitiated, would have the potential for providing direct or indirect psychosocial support (e.g. family gatherings, outings with friends, visiting neighbors, social activities at work sites, sports, community activities).
- Build on the person's strengths and abilities and actively encourage to resume prior social activities as far as possible.

d. Structured physical activity programme

- Organization of physical activity of moderate duration (e.g. 45 minutes) 3 times per week.
- Explore with the person what kind of physical activity is more appealing, and support to gradually increase the amount of physical activity, starting for example with 5 minutes.

e. Offer regular follow-up

- Follow up regularly (e.g. in person at the clinic, by phone, or through other available means).
- Re-assess the person for improvement (e.g. after 4 weeks).

f. Prescribe antidepressant medication

Antidepressant refers to a group of medicines that are used in the treatment of mental illnesses that is of a moderate–severe intensity. These medicines have been found to be effective for a number of other illnesses like anxiety and for chronic pain. They generally increase the levels of serotonin which in turn gradually improve the symptoms of mental illnesses. Details on antidepressants and their management and prescription guidelines are in **Part XIII** (later in this section).

1.4. Depression in High Risk Groups

a. Elderly: In the elderly, evaluate medical co-morbidity, current medications, and any potential interactions with antidepressants. Combining counseling with antidepressant medication provide maximum benefits and are effective treatments for most of the common mental illnesses. Selective serotonin reuptake inhibitors (SSRI's) are safe and effective in the treatment of depression in the elderly. As a general rule, start the antidepressant at the lowest available dose and, depending on how the client is tolerating it, build up the dosage gradually over 4-6 weeks.

It is best to avoid using TCA's in clients with coexisting cardiac problems or those with closed angle glaucoma or prostatic hypertrophy.

Depressed elderly clients may take a longer time to recover; about 8 weeks of treatment is reasonable. If there improvement after 8 weeks on a maximum recommended dose of the antidepressant, the same dose should be maintained for 12 months. This is recommended to prevent recurrence, whereas 6 months is the recommended treatment course in younger clients.

More frequent review at **weekly intervals** (by telephone or visit to the Hc) to monitor symptoms and tolerance to medication is recommended in the elderly, especially in early phase of treatment.
Elderly patients with any of the following presentations may require referral to a specialist:

- Suicidal ideas or plans
- Psychotic symptoms
- New and significant cognitive deterioration, e.g. confusion/delirium
- Common mental illnesses in the context of new physical illness or its treatment
- Diagnostic uncertainty

Treatment failure is defined as two courses of different antidepressants in adequate dosage and duration without significant improvement

b. **Pregnant Women/Nursing Mothers***:* Addressing stress during pregnancy and the postpartum period is important, as these periods are physically, psychologically and socially distinct periods in a women's lifetime during which mothers experience concerns about the health of their child, their own health, changes in their bodies and the subsequent effect on changes in their marital relationship. Additionally, worries regarding economic insecurity, breastfeeding, and bonding with the infant can exacerbate the stress often experienced in this period.
First-time mothers have the added stressors of adapting to their new role as mothers and the insecurities associated with their ability to nurture an infant for the first time. These stressors have a significant impact on the mother's psychological wellbeing such as prenatal and postpartum depression, especially when stressors are perceived as stressful.

Women of childbearing age are at particularly high risk for depression; many of them experience high levels of social dificulties and depressive symptoms that are often unrecognized and untreated. Mothers already at risk for depression are particularly fragile during the first months postpartum. Maternal depression is considered a risk factor for the healthy development of children.

The following periods should be given particular attention

- **Antenatal period:** Depression during pregnancy is associated with inadequate prenatal care, poor nutrition, higher preterm birth, low birth weight, pre-eclampsia, spontaneous abortion, substance abuse, and dangerous risk taking behaviour. The substantial morbidity of untreated depression during pregnancy must be weighed against the risk of medication.

- **Post-Partum Period:** Postpartum psychiatric illnesses are generally divided into three categories: postpartum blues, postpartum psychosis and postpartum depression

- **Postpartum blues** is a relatively common emotional disturbance with crying, confusion, mood lability, anxiety and depressed mood. The symptoms appear during the first week postpartum, last for a few hours to a few days and have few negative sequel.
- **Postpartum psychosis** is a severe illness beginning within four weeks postpartum, with delusions, hallucinations and gross impairment in functioning.
- **Postpartum depression** begins in or extends into the postpartum period. It tends to be milder than episodes of depression that occur at other times, with lower levels of anxiety, agitation, insomnia and somatic symptoms. However, the duration seems to be the same in postpartum and non-postpartum depression, and lasts several months

c. Post-Partum Depression: Core features include: dysphoric mood, fatigue, anorexia, sleep disturbances, anxiety, excessive guilt and suicidal thoughts. The diagnosis requires that symptoms be present for at least one month and result in some impairment in the woman's functioning.

- **Risk Factors**: the following conditions are considered as risk factors for postpartum depression[1]
  - History of previous episodes of post-partum depression: women who have experienced postpartum depression have a 50% to 62% risk for future depression,
  - History of previous mental illness or mood disorders,
  - Depression symptoms during pregnancy,
  - Family history of psychiatric illness,
  - Stressful life events and history of being a neglected child
  - Marital conflict
  - Traumatic childbirth, infant born preterm, stillbirth or neonatal death, infant admitted to intensive care
  - Caring for a special needs or medically 'fragile' child
  - Vulnerable population exposed to socioeconomic factors such as: lack of social support, poverty, lower maternal/paternal education, lower social class, and drug or alcohol abuse

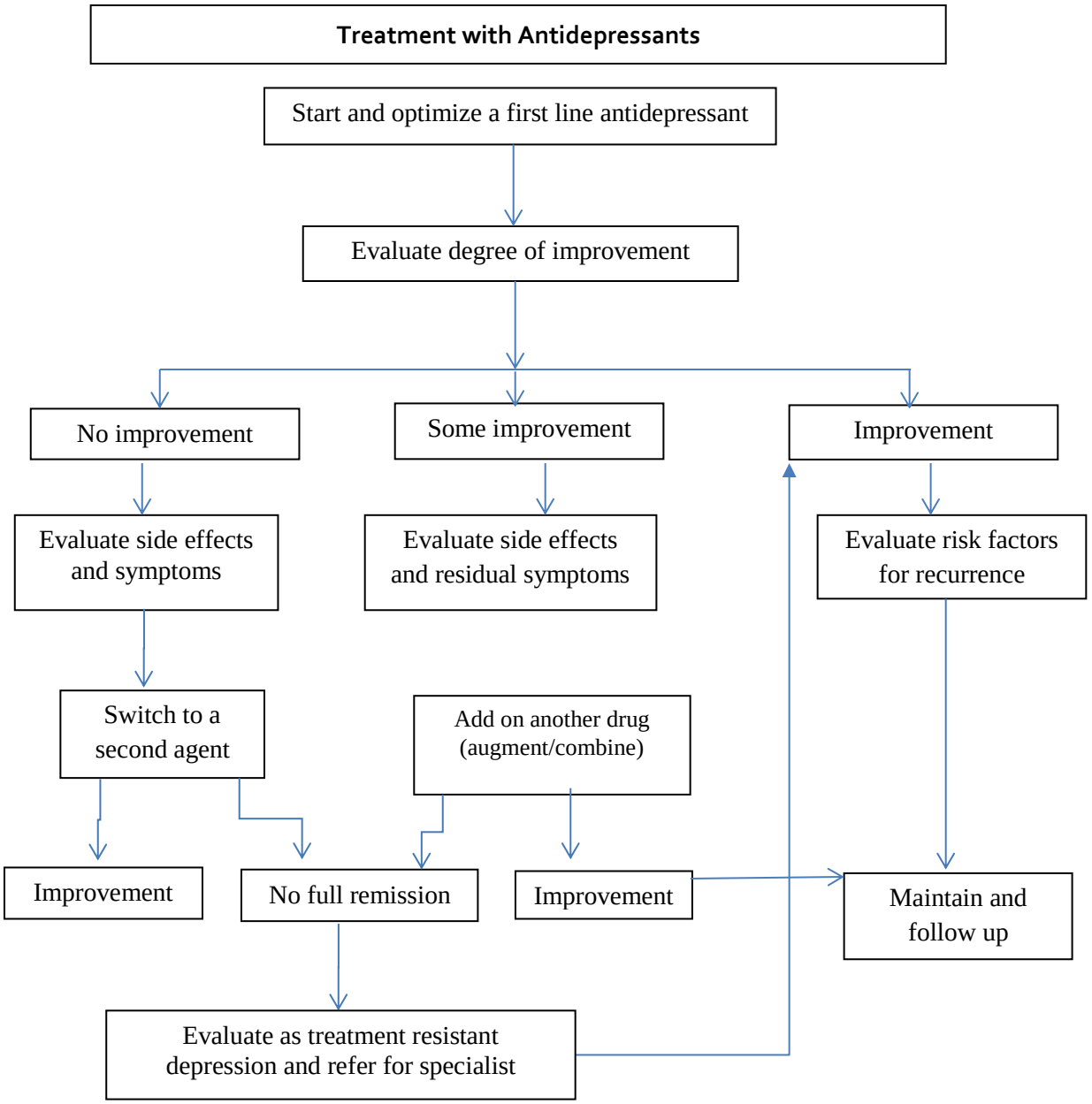
Professional support interventions are important for women identified as at risk of depression in the postpartum period, particularly at six weeks, four months and six months.

- **Leading Questions:**
  - How are you feeling about being a new mother?
  - Are you enjoying your baby?
  - Do you find that your baby is easy or difficult to care for?
  - How are things going in your family?
  - Are you getting enough rest?
  - How is your appetite?
  - During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - During the past month, have you often been bothered by having little interest or pleasure in doing things?
- **Treatment:** There was insufficient evidence to recommend specific interventions for prevention of depression in low-risk women following vaginal delivery. Women and their families should be informed of possible changes in mood in the days following birth, which are often transient and resolve by 10–14 days postpartum. If symptoms persist, these

should be evaluated. As a general rule, use of antidepressants is not recommended during pregnancy and lactation; all non-medication treatments suggested above should be provided. However, when a condition is severe enough to risk the health of mother or child – including risk of suicide or self-harm – antidepressants can be considered.

When medication is required, fluoxetine is strongly recommended, as evidence shows that there are no adverse effects on the fetus or newborn. The mother should be followed up closely to make sure that she is tolerating the medicine and is improving. The standard protocol for fluoxetine can be used in this situation and the client should complete the required 6 months' course to minimize the chances of relapse.

The primary care physician should advocate psychotherapy alone when depression is mild or when a patient has a preference for psychotherapy. For moderate to severe depression combination treatment (psychotherapy + pharmacotherapy) has been shown to be more effective then pharmacotherapy alone



2. Reactions to Stress and Distress

Stress and distress are neurobiological reactions that facilitate the adaptation of the person to external demands. Stress reactions can be caused by pleasant and unpleasant events. In the latter case, stress increases attention and reactivity to perceived or potentially dangerous situations. Health staff frequently encounter people who have been exposed to potentially traumatic events (e.g. serious accidents, physical and sexual violence, disasters) or loss of a loved one. After recent exposure to extreme stressors, reactions are diverse. In most cases, symptoms of acute stress are normal and transient and people tend to recover from them naturally. However, sometimes there is a need to intervene especially when people seek help or when causes considerable difficulty with daily functioning.

After exposure to extreme stressors two major groups of conditions could occur:

a. Illnesses that are more likely to occur after extreme stressor but also could occur without such exposure such as: depression, psychosis, behavioral disorders, alcohol & drug use, self-harm/suicide and other significant emotionally or medically unexplained complaints

b. Problems and disorders that require exposure to extreme stressors:
- significant symptoms of acute stress;
- post-traumatic stress disorder (PTSD); and
- grief and prolonged grief disorder.
-

2.1. Acute Stress

We use the term **symptoms of acute stress** (within one month of the traumatic event) to cover a wide range of non-specific psychological and medically unexplained physical complaints such as: feeling tearful, frightened, angry or guilty, nervousness or difficulty sleeping, nightmares or continually replaying the event in one's mind or physical reactions (eg hyperventilation).

If the experience persists and if the daily functioning remains impaired, then this may lead to the development of a mental illness, such as: depression (at least 2 months after the bereavement), post-traumatic stress disorder (at least 1 month after potentially traumatic event), prolonged grief disorder (at least 6 months after the bereavement) and alcohol and drug use disorders amongst others.

3.1.2. Assessment

- **Within the last month, has the client experienced a potentially traumatic event?**

Any threatening or horrific event such as physical or sexual violence (including domestic violence), witnessing of an atrocity, major accidents, or injuries can be considered potentially traumatic. If a traumatic event occurred more than one month prior consider other conditions such as grief, PTSD or depression.

- **Does the person have significant symptoms of acute stress?**

Symptoms include:
- Behavioral changes (e.g. crying spells, social isolation and withdrawal, aggression, risk-taking behaviors in adolescents, regressive behavior such as bedwetting, or tearfulness in children)
- Excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements

- Extreme emotions (e.g., extreme sadness, anxiety, anger, despair) or being confused or guilty ("I could have prevented it, it's my own fault") and shame ('I can't tell anyone")
- Anxiety about threats related to the traumatic event(s)
- Sleep problems
- Concentration problems
- Recurring frightening dreams, flashbacks or intrusive memories of the events, accompanied by intense fear or horror
- Deliberate avoidance of thoughts, memories, activities or situations that remind the person of the events (e.g. avoiding talking about issues that are reminders, or avoiding going back to places where the events happened)
- Disturbing emotions (e.g. frequent tearfulness, anger) or thoughts
- Medically unexplained physical complaints, such as: hyperventilation, palpitations, dizziness, headaches, generalized aches and pains, dissociative symptoms relating to the body (e.g. medically unexplained paralysis inability to speak, or see)

- **Concurrent physical conditions?**

If yes, manage accordingly. Also check for any other mental, neurological and substance use condition that may explain the symptoms and manage accordingly if found.

3.1.2. Management

- **In all cases:**
    - Provide basic psychosocial support, listen carefully. DO NOT pressure the person to talk, but inquire about his/her needs and concerns, help the person to address basic needs, access services and connect with family and other social supports. Where possible, protect them from (further) harm
    - Offer additional psychosocial support, address current psychosocial stressors, strengthen social support, teach stress management
    - Educate the person about normal reactions to grief and acute stress, (e.g. People often have these reactions after such events. In most cases, reactions will reduce over time)
    - Manage other concurrent conditions.

DO NOT prescribe medications to manage symptoms of acute stress (unless otherwise noted

- **Insomnia**
    - Explain that people commonly develop sleep problems (insomnia) after experiencing extreme stress
    - Explore and address any environmental causes of insomnia (e.g. noise)
    - Explore and address any physical cause of insomnia (e.g. physical pain)
    - Advise on sleep hygiene, including regular sleep routines (e.g. regular times for going to bed and waking up), avoiding coffee, nicotine and alcohol late in the day or before going to bed. Emphasize that alcohol disturbs sleep.
    - Exceptionally, in extremely severe cases where psychologically oriented interventions (e.g. relaxation techniques) are not effective, and insomnia causes considerable difficulty with daily functioning, short-term (3–7 days) treatment with benzodiazepines (Diazepam) may be considered.

Dose: 2–5 mg of diazepam for adults and 1–2.5 mg for the elderly at bedtime.
Caution: benzodiazepines may cause dependence. Use only for short-term treatment. This treatment is for adults only. Do not prescribe benzodiazepines to children or adolescents
Avoid this medication in women who are pregnant or breastfeeding.
Monitor for side-effects frequently in older people.
This is a temporary solution for an extremely severe sleep problem. It should not be used for insomnia caused by bereavement in adults or children and should not be used for any other symptoms of acute stress or PTSD

- **Bedwetting in Children**
  - Be sure that the bedwetting started after experiencing a stressful event. Rule out and manage other possible causes (e.g. urinary tract infection)
  - Explain that bedwetting is a common, harmless reaction in children who experience stress. Children should not be embarrassed in public or punished for that, it adds more stress and makes the problem worse.
  - Provide emotional support to the caretakers
  - Consider training caretakers on the use of simple behavioural interventions (e.g. rewarding avoidance of excessive fluid intake before sleep, rewarding toileting before sleep, rewarding dry nights). The reward can be anything the child likes, such as extra playtime or stars on a chart.

- **Hyperventilation** (breathing extremely fast and uncontrollably)
  - Rule out and manage other possible causes, even if hyperventilation started immediately after a stressful event.
  - Always conduct necessary medical investigations to identify possible physical causes such as lung disease. If no physical cause is identified, reassure the person that hyperventilation sometimes occurs after experiencing extreme stress and that it is unlikely to be a serious medical problem.
  - Be calm and remove potential sources of anxiety if possible. Help the person regain normal breathing by practicing slow breathing.

- **Dissociative symptom(s) relating to the body** (medically unexplained paralysis, inability to speak or see, "pseudoseizures")
  - Rule out and manage other possible causes, even if the symptoms started immediately after a stressful event
  - Always conduct necessary medical investigations to identify possible physical causes
  - Acknowledge the person's suffering and maintain a respectful attitude
  - Avoid reinforcing any gain that the person may get from the symptoms. Ask for the person's own explanation of the symptoms and apply the general guidance on the management of medically unexplained somatic symptoms.
  - Reassure the person that these symptoms sometimes develop after experiencing extreme stress and that it is unlikely to be a serious medical problem.

In all cases, ask the person to return in 2–4 weeks if the symptoms do not improve or at any time if the symptoms get worse.

2.2. Post-traumatic stress disorder (PTSD)

When a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after a potentially traumatic event, the person may have developed PTSD. People with PTSD initially present with non-specific symptoms, such as: sleep problems, irritability, and persistent anxious or depressed mood, multiple persistent physical symptoms with no clear physical cause (e.g. headaches, pounding heart). However, on further questioning they may reveal that they are suffering from characteristic PTSD symptoms.

3.1.2. Assessment

Has the person experienced a potentially traumatic event more than 1 month ago?
If yes, ask how the person has been affected by the event. Was the experience horrific or tragic? Was their life in danger at the time or does it continues to be? **If yes:** Are they currently experiencing symptoms? are they re-experiencing symptoms? These are repeated and unwanted recollections of the event (e.g. through frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror)
In children this may involve replaying or drawing the events repeatedly. Younger children may have frightening dreams without a clear content.

- **Avoidance symptoms:** These involve deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event (e.g. avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened)
- **Symptoms related to a heightened sense of current threat** (hyperarousal symptoms): These involve excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements
- **Considerable difficulty with daily functioning**

If the above symptoms are present approximately 1 month after the event, then PTSD is

Assess for and manage any concurrent mental or physical conditions that may explain the symptoms, as appropriate.

3.1.2. Management

a. **Remember:**
   - Many people recover from PTSD over time without treatment while few others need treatment
   - People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they experienced. They may also have frightening dreams.
   - People with PTSD often feel that they are still in danger and may feel very tense. They are easily frightened or constantly on the watch for danger.
   - People with PTSD try to avoid any reminders of the event. Such avoidance may cause problems in their lives.
   - People with PTSD may sometimes have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood

b. **Advise the person to:**

- Continue their normal daily routine as much as possible.
- Talk to trusted people about what happened and how they feel, but only when they are ready to do so.
- Engage in relaxing activities to reduce anxiety and tension.
- Avoid using alcohol or drugs to cope with PTSD symptoms.
    - **Psychosocial Support:** Address current psychosocial stressors (e.g. when the person is a victim of severe human rights violations, discuss with them possible referral to a trusted protection or human rights agency), strengthen social supports and teach stress management
    - Psychosocial Counseling: Where available, consider referring for specialized care.
    - Antidepressants: Only when cognitive behavioural therapy, EMDR or stress management do not work or are unavailable. DO NOT offer antidepressants to manage PTSD in children and adolescents
    - Follow-up: Schedule the second appointment within 2–4 weeks, and subsequent appointments depending on progress

2.3. Grief and Prolonged Grief Disorder

Grief is the emotional suffering people feel after a loss. People who are grieving may present with a wide range of non-specific psychological and medically unexplained physical complaints. Reactions that are not clinically significant and that do not require clinical management are the most common. They include transient reactions for which people do not seek help and which do not impair day-to-day functioning beyond what is culturally expected. However, there are a few cases that progress beyond "normal" grief; when symptoms cause considerable difficulty in daily functioning, **prolonged grief disorder** may be present.

This condition involves severe preoccupation with or intense longing for the deceased person accompanied by intense emotional pain and considerable difficulty with daily functioning for at least 6 months (and for a period that is much longer than what is expected in the person's culture). In these cases, health providers need to consult a specialist.

3.1.2. Assessment

Has the person experienced a major loss? This could be in family, friends, house, money, job or other proprieties. If yes, how much time has passed since the event(s)? Is there considerable difficulty with daily functioning because of the symptoms?

If a major loss has occurred within the last 6 months: Does the person have significant symptoms of grief, including:

Sadness	Anxiety
Anger	Despair
Yearning and preoccupation with loss	Intrusive memories, images and thoughts of deceased
Loss of appetite	Loss of energy
Sleep problems	Concentration problems
Social isolation and withdrawal	Medically unexplained physical complaints
Hearing the voice of deceased, being visited in dreams	

Check for any concurrent mental or physical conditions that may explain the symptoms, and manage accordingly.

3.1.2. Management

DO NOT prescribe medications to manage symptoms of grief.

Psychosocial Support: Listen carefully. **DO NOT** pressure the person to talk, but ask the person about his/her needs and concerns and help to address them, access services and connect with family and other social supports and protect the person from (further) harm
Offer stress reduction advice and strengthen social support by addressing current psychosocial stressors and advise on stress management techniques

Education: the following messages are useful:

- People may react in different ways after major losses. Some people show strong emotions while others do not.
- Crying does not mean you are weak. People who do not cry may feel the emotional pain just as deeply but have other ways of expressing it.
- You may think that the sadness and pain you feel will never go away, but in most cases, these feelings lessen over time.
- There is no right or wrong way to feel grief. Sometimes you might feel very sad, and at other times you might be able to enjoy yourself.
- Do not criticize yourself for how you feel at the moment.
- Encourage early return to previous, normal activities (e.g. at school or work, at home)

Manage accordingly concurrent mental and physical conditions.

Children

- Answer the child's questions by providing clear and honest explanations that are appropriate to the child's level of development.
- Do not lie when asked about a loss (e.g. Where is my mother?). This will create confusion and may damage the person's trust in the health provider.
- Check for and correct "magical thinking" common in young children (e.g. children may think that they are responsible for the loss; for example, they may think that their loved one died because they were naughty or because they were upset with them).

Follow Up:

- Ask the person to return in 2-4 weeks
- Refer to specialist if symptoms do not improve, or get worse, or if functioning has been impaired for more than 6 months

3. Other Significant Emotional or Medically Unexplained Complaints

As explained in the introduction and concept note, psychological problems often manifest themselves in physical illness. Due to a lack of education and stigma surrounding mental health issues, the client often does not understand how their complaints are related to their stressors at home or work and not to any real physical illness. The most common physical manifestations of MHPSS issues are: tiredness,

sleep problems, palpitations (heart beating fast), headache, other aches and pains, upset stomach, dizziness, and loss of interest daily activities.

It is important for healthcare professionals to recognize and understand the link between the physical and mental, and be aware that treating the physical complaints superficially will often not address the underlying issue.

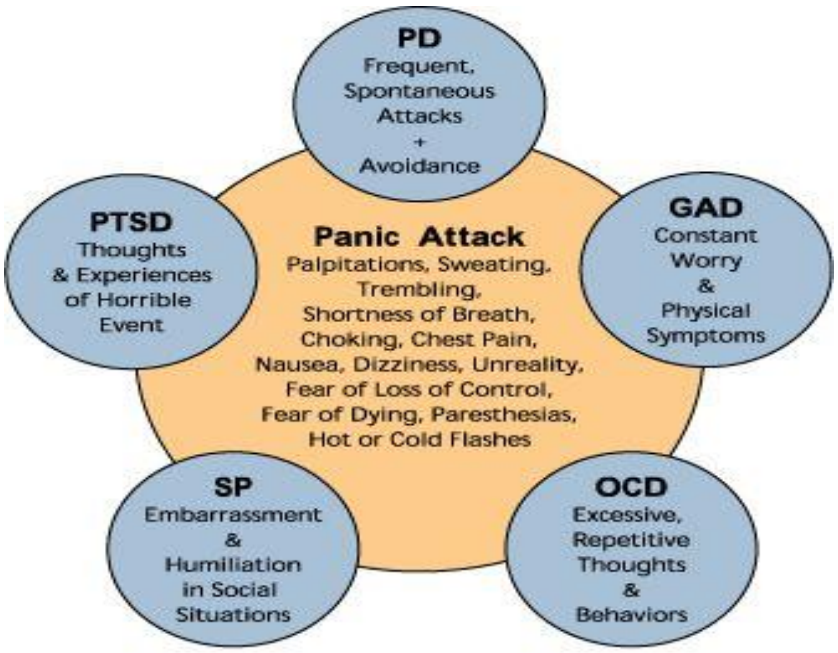
In the mhGAP module "Other Significant Emotional or Medically Unexplained Complaints," includes both "normal" distress caused by traumatic experiences, as well as those illnesses not covered in the remaining modules. These include, but are not limited to: somatoform disorder, mild depression, dysthymia, panic disorder, generalized anxiety disorder, post-traumatic stress disorder, acute stress reaction, and adjustment disorder. The diagnosis should only be given after ruling out moderate-severe depression.

As a general rule, those clients who fall under this category **do not require psychotropic medication**, except in rare circumstances.

5.1. Generalized Anxiety Disorder

Anxiety disorder is a generalized term that refers to a group of psychological disorders characterized by excessive arousal, tension and worry. Phobias refer to specific situations or objects that cause fear and are avoided, such as the fear of being humiliated in public (social phobia) or the fear of a specific animal. Other fears concern being contaminated (obsessive-compulsive disorder), of being away from loved ones (separation anxiety disorder), of gaining weight (anorexia nerviosa), having a serious illness (hypochondriasis), or having multiple physical symptoms (somatisation disorder). Panic attacks are often a symptom of anxiety disorders. Frequent, spontaneous attacks that result in avoiding are called panic disorder.

The generalized anxiety disorder (GAD) is characterized by excessive, exaggerated anxiety and worry about everyday life events with no obvious reasons for worry. People with symptoms of GAD tend to always expect disaster and cannot stop worrying. Eventually, the anxiety so dominates the person's thinking that it interferes with daily functioning, including work, school, social activities, and relationships.



PD=Panic Disorder, GAD=Generalized Anxiety Disorder, OCD= Obsessive-Compulsive Disorder, SP=Social Phobia, PTSD= Post-traumatic Stress Disorder

3.1.2. Assessment

Consider conditions that mimic or are associated with anxiety such as: Hyperthyroidism, thyrotoxicosis, alcohol or drug withdrawal, anaemia, hyperglycemia, hypoxia or hypercapnia due to intermittent respiratory disorders, vertigo due to vestibular disorders
Drugs such as: bronchodilators, insulin, oral hypoglycemic, antidepressants (SSRIs), steroids and thyroxine

Identify common presentations of anxiety in PHC

- Fatigue, insomnia, chronic pain: Consider both depression and anxiety disorders as they commonly coexist
- Frequent visits with multiple symptoms: For example a client with irritable bowel syndrome + headaches + back pain
- Cardiovascular symptoms: Palpitations, chest pain, faintness, flushing, sweating
- Respiratory symptoms: Shortness of breath, hyperventilation, dyspnoea
- Gastrointestinal symptoms: Choking, lump in throat, dry mouth, nausea, vomiting, diarrhoea
- Neurological symptoms: Dizziness, headache, paraesthesia, vertigo
- Musculoskeletal symptoms: Muscle ache, muscle tension, tremor, restlessness

Clients with these symptoms are considered at risk for anxiety disorder and need to be screened with the following two questions: In the past two weeks, have you been bothered by:

Question 1: Feeling anxious, nervous or on edge?

Question 2: Being unable to stop or control worry?

If the client answers **No** to both questions, then anxiety disorder is highly unlikely
If the client answers **yes** to one of the questions, then continue screening to assess the severity of anxiety

Generalized Anxiety Disorder (GAD) Screening Tool

This tool is used as a screening tool and severity measure for Generalized Anxiety Disorder. Depending on client education level and time constraints, it can be self-administered in the waiting room, or you can ask clients the questions during your consultations.

The tool

During the last 2 weeks, how often have been bothered by any of the following problems?				
	Not at all sure	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easy annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Sub Total				
Total score				

Assess functional impairment: ask the clients about how these problems are affecting their ability to do their work, take care of things at home or get along with other people

Not difficult	No anxiety
Somewhat difficult	Mild anxiety
Very difficult	Moderate anxiety
Extremely difficult	Severe anxiety

Scoring

0-5	No functional impairment	Minimal anxiety	Basic counseling and health information
6-10	Mild	Mild anxiety	Treatment steps as below
11-15	Moderate	Moderate anxiety	Treatment steps as below
16-21	Severe	Severe anxiety	Referral to specialist

If the GAD score from 6 – 15, consider the following questions to rule out other conditions, and proceed with treatment options as agreed upon between client and health staff.

Q1: Does the person have moderate-severe depression or any other mhGAP priority condition (other than self-harm)?

The doctor should exclude any mhGAP priority condition, in particular depression before considering anxiety as a diagnosis.

Q2: Does the person have a mixed anxiety and depression?

In this case the client may present with one or more previously mentioned complaints accompanied by a variety of anxiety and depressive symptoms, which will have been present for more than six months. It is important to remember that the depressive or anxiety symptoms should be of insufficient severity to make an independent diagnosis of depressive or anxiety disorders; in such cases, the client should be correctly diagnosed as having a specific anxiety or depressive disorder and not mixed anxiety and depressive symptoms. These patients may be well known to their doctors, and have often been treated by a variety of psychotropic agents over the years.

Main diagnostic features: Low or sad mood, loss of interest or pleasure in daily activities, and prominent anxiety or worry. Multiple associated symptoms are usually present, such as: disturbed sleep, tremor, fatigue or loss of energy, palpitations, poor concentration, dizziness, disrupted appetite, suicidal thoughts or acts, dry mouth, loss of libido, tension and restlessness, irritability.

If the case is depression with anxiety symptoms, <u>treat depression first</u>.
If the case is depression and anxiety disorder, <u>treat anxiety disorder.</u>

Q3: Does the person have a physical condition that fully explains the presence of the symptoms?

In this case, conduct a general medical examination and essential investigations. If a medical condition is identified, initiate relevant medical treatment and follow-up.

If the medical examination and the relevant investigation are negative consider the following In ALL cases:

- DO NOT prescribe antidepressants or benzodiazepines
- DO NOT manage complaints with injections or other ineffective treatments (e.g. vitamins)
- Address current psychosocial stressors
- In adolescents and adults:
    - Address inappropriate self-medication
    - Reactivate social networks.
- Where available, consider: structured physical activity programme, behavioral activation, relaxation training, or problem-solving treatment
- Follow up. Consult a specialist if no improvement at all or if the person (or his / her parents) asks for more intense treatment

Q4: Are there prominent medically unexplained somatic symptoms?
Follow above advice (applicable to ALL cases) plus:
- Avoid unnecessary medical tests/referrals and do not offer placebo
- Acknowledge that the symptoms are not "imaginary"
- Communicate results of tests/examination, saying that no dangerous disease has been identified, but it is important to deal with the distressing symptoms
- Explain how bodily sensations (stomach ache, muscle tension) can be related to experiencing emotions, and ask for potential links between the person's bodily sensations and emotions
- Encourage continuation of (or gradual return to) normal activities
- Advise the person to re-consult if symptoms worsen

Q5: Has the person been recently exposed to extreme stressors (losses, traumatic events)?
Follow above advice (applicable to ALL cases) plus:
- In case of bereavement: support culturally appropriate mourning/adjustment and reactivate social networks
- In case of acute distress after recent traumatic events: offer basic psychological support (psychological first-aid), i.e., listen without pressing the person to talk; assess needs and concerns; ensure basic physical needs are met; provide or mobilize social support and protect from further harm
- DO NOT offer psychological debriefing (i.e. do not promote ventilation by requesting a person to briefly but systematically recount perceptions, thoughts, and emotional reactions experienced during a recent, stressful event)

Q6: Have there been (a) thoughts or plans of suicide/self-harm during the last month or (b) acts of self-harm during the last year?
Manage both the significant emotional or medically unexplained complaints (as above) and the risk of self-harm. If high, **refer to specialist**

3.1.2. Treatment

Start with guided self-care for two weeks and evaluate. **If there is improvement**, continue and follow up every 4 weeks first, then every 6 weeks for 6 months. **If there is no improvement** add psychological interventions and assess after two weeks. **If there is no improvement** add pharmacotherapy and assess after two weeks. **If there is improvement**, continue and follow up after 4 weeks first then every 6 weeks for 6 months. **If there is no improvement** refer to specialist.

Guided self-care:

Psychoeducation: Important messages for clients with anxiety disorders

- Anxiety disorders are common specially with chronic conditions
    - Anxiety is the cause of considerable distress and disability
    - Anxiety is often unrecognized and untreated
    - If left untreated they are costly to both the individual and society
- A range of effective interventions is available to treat anxiety disorders, including psychological therapies and self-care. Medication is also an option if needed
- Individuals do permanently improve
- Involving individuals in an effective partnership with health care professionals, with all decision-making being shared, improves outcomes
- Access to information, including support groups, is a valuable part of any package of care

Physical exercise: Advise client to start a structured physical exercise

Stress Reduction and Relaxation techniques such as deep breathing exercises, progressive muscular relaxation exercises, and problem solving techniques. Demonstrate to the client, use health education materials and advise client to practice daily

Psychological interventions: Mind and body medicine technique can be used in all anxiety disorders. Enrollment in relevant support group is advised

Pharmacological treatment

- Antidepressants can be used: refer to the **medicines** section
- Other medications:
    A. Beta Blockers: Used to reduce physical manifestations of anxiety such as tachycardia
    B. Benzodiazepines: Should NOT be used for routine treatment of panic and anxiety disorders. If used for anxiety disorder the duration should not exceed two weeks

Follow up

- Ensure client compliance
- Reassess diagnosis and treatment
- Consider side effects of medication
- Assess progress achieved (repeat GAD 7)
- If there is improvement continue treatment for at least 6 months and follow up every 6 weeks
- **Refer to specialist** if there is no response after 6-8 weeks of treatment, in cases of severe anxiety (immediate referral), risk of suicide or violence (immediate referral) poor and deteriorating physical health and social isolation

5.2. Medically Unexplained Symptoms

Chronic or persistent medically unexplained symptoms are associated with depression and anxiety
Predisposing Factors: it is more common among Adults > 30y, females, uneducated and low socioeconomic status.

Triggering Factors such as: Physical trauma, chronic illness and emotional conflicts
Maintaining Factors such as: Illness behavior and repeated medications and investigations

Common Complaints

Headaches	Weakness in parts of body
Dizziness or fainting	Fatigue
Chest pain	Palpitation
Back pain	Menstrual problems
Muscle pain	Nausea
Joint pain	Indigestion
Tingling or loss of sensation	Abdominal pain
Sleep problems	Diarrhea
Constipation	Dyspnea

3.1.2. Assessment and management

Assess for functional impairment: Does the person have trouble maintaining work or personal relationships?

- If no, plus a few symptoms: provide reassurance and advice on self-care.
- If mild impairment plus a few symptoms: conduct psychosocial assessment, provide reassurance and psychoeducation
- If moderate impairment plus multiple symptoms: conduct psychosocial assessment, provide reassurance, psychoeducation and pharmacotherapy

Avoid benzodiazepines, instead use TCAs or SSRIs. Start with small dose and increase gradually
Watch for side effects and treat any co-existing psychiatric condition

- **If severe functional impairment plus multiple symptoms**: refer to specialist

6. Epilepsy

Epilepsy is a chronic neurological condition involving recurrent unprovoked seizures caused by abnormal electrical activity in the brain. It is the most frequently treated condition of all mental, neurological and substance use conditions in humanitarian settings in low- and middle-income countries. It affects all age groups including young children. There are two major forms of epilepsy.

Non-convulsive epilepsy has features such as: change in awareness, behaviour, emotions, or senses (such as taste, smell, vision or hearing). These symptoms can be similar to mental health conditions, and as such are often confused with them.
Convulsive epilepsy is characterized by seizures that cause sudden, involuntary muscle contractions alternating with muscle relaxation, causing the person to fall and lie rigidly with or without loss of bowel or bladder control. Seizures are often associated with impaired consciousness, and a convulsing person may fall and suffer injuries. Convulsive epilepsy is associated with greater stigma and higher morbidity and mortality.

Seizures are caused by abnormal discharges in the brain and can be of different forms. Convulsive epilepsy 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, while in some cases, no specific cause can be identified.

Diagnosing Convulsive Epilepsy

a. Does the person have any of the following symptoms:

- Convulsive movements lasting longer than 1-2 minutes
- Loss of, or impaired consciousness
- Stiffness or rigidity of the body or limbs lasting longer than 1-2 minutes

- Bitten or bruised tongue, or other self-inflicted injury
- Loss of bladder or bowel control during episodes
- Post-episode, presence of confusions, drowsiness, sleepiness, fatigue, headache, muscle ache

If convulsive movements and at least two other symptoms are present, suspect convulsive seizure

If only one or two of above criteria are present, suspect non-convulsive seizures or other medical conditions. Manage accordingly if other medical conditions are suspected, consult a specialist if the person has had more than one non-convulsive seizure, and follow up after 3 months to re-assess.

There is no clear criterion for diagnosing or treating non-convulsive epilepsy, the diagnosis is based on the history taken from the patient and his family. Suspected cases will be referred to specialist, who will provide the final diagnosis and treatment.

In the case of convulsive seizure, is there an acute cause?

- Check for signs and symptoms of neuro-infection such as: fever, headache, meningeal irritation (e.g. stiff neck)
- Check for other possible causes of convulsions: head injury metabolic abnormality (e.g. hypoglycemia, hyponatremia) and alcohol or drug intoxication or withdrawal.

If there is an identifiable acute cause of convulsive seizure, treat the cause. Maintenance treatment with antiepileptic medications is not required in these cases.

If neuro-infection, head injury or metabolic abnormality is suspected, **refer to a hospital** immediately

Children

In a child (aged six months to six years) with fever, a neuro-infection is suspected if any of the following criteria for complex febrile seizures is present:

- Focal seizure: seizure starts in one part of the body
- Prolonged seizure: seizure lasts more than 15 minutes
- Repetitive seizure: more than one seizure during the current illness

If none of the above three criteria are present in a febrile child, suspect simple febrile seizure. Manage fever and look for its cause. Observe the child for 24 hours. Follow up in three months to re-assess.

Women of Childbearing Age

- If not pregnant: refer to the preconception care clinic, give folate 5 mg/day to prevent possible birth defects if she becomes pregnant.
- If pregnant: **Consult with a specialist** for management. Advise more frequent antenatal visits and delivery in a hospital.
- Treatment: The decision to start an antiepileptic medication in a pregnant woman should be made together with the woman. The severity and frequency of the seizures as well as the potential harm to the fetus from either the seizures or the medication should be considered. If the decision is made to start medication, then either phenobarbital or carbamazepine can be used. Valproate and polytherapy should be avoided. Carbamazepine can be used by women who are breastfeeding.

In the case of convulsive seizure without an identified acute cause, is this epilepsy?

If the person has had 2 or more unprovoked, convulsive seizures on 2 different days in the last 12 months consider as epilepsy. If there was only 1 convulsive seizure in the last 12 months without an acute cause, then antiepileptic treatment is not required. Follow up in 3 months

Management

- **Provide information to client and family**

- **What is epilepsy:**
  - It involves recurrent seizures, which are caused by abnormal electrical activity in the brain. It is **not caused** by witchcraft or spirits
  - It is not contagious; it cannot be transmitted through saliva
  - It is a chronic condition, but with medication and proper management, 3 of 4 people can be seizure-free
- **Lifestyle**:
  - People with epilepsy can lead normal lives. They can marry and have healthy children, and can work productively and safely at most jobs
  - Children with epilepsy can go to school
- **What to avoid:**
  - People with epilepsy should avoid jobs that require working near heavy machinery or fire, cooking over open fires, swimming alone, alcohol and recreational drugs, looking at flashing lights, and changing sleep patterns (e.g. sleeping much less than usual).
- **What to do when a seizure occurs:**
  - If a seizure starts while the person is standing or sitting, help to prevent a fall injury by gently assisting them to sit or lie on the ground
  - Make sure that the person is breathing properly; loosen the clothes around the neck
  - Place the person on his side

- **Initiate or resume antiepileptic drugs**

- If the person has ever used an antiepileptic medication that controlled seizures, resume the same medication at the same dose. If the medication is not available, start a new medication.
- Choose only one antiepileptic drug
- Consider potential side-effects, drug-disease interactions or drug-drug interactions.
- Start with the lowest dose and increase gradually until complete seizure control is obtained
- Important information:
  - Explain medication dosing schedule; medications should be taken at the same time every day
  - Explain side effects; if severe side-effects occur, the person should immediately stop medication and seek medical advice
  - Explain importance of adherence to medication; missed doses or abrupt discontinuation can causes seizures to recur
  - It usually takes a few weeks before effects are noticeable
  - Medication should be continued until the person has not had a seizure for at least two years, at which point the dose should be tapered down slowly over several months to avoid seizures from withdrawal
- **Ensure regular follow-up**

- Month 1 – 3 (or until seizures are controlled): Follow up appointments should take place at least once a month

- Month 3 (or when seizures are controlled) →: Follow up appointments every three months to monitor progress
- At each follow up:
    - Monitor for seizure control and maintain or adjust antiepileptic medication accordingly
    - If seizures are not controlled at the maximum therapeutic dose of one medication, or side effects are intolerable, change to a different medication and gradually increase dose until seizures are controlled. If seizures are very infrequent, and a futher increase of the doze will produce severe side effects, then advise to maintain current dose
    - If two medications were tried as recommended and did not achieve adequate seizure control, **refer to specialist**
    - Do not treat with more than one antiepileptic medication at a time
    - Involve caregivers in monitoring for seizure control. Review lifestyle issues and provide further psychoeducation/support to the person and their family

If a person is convulsing or is unconscious

- **Assessment of seizures**

- Stay calm, most seizures will stop after a few minutes
- Check airway, breathing and circulation, including blood pressure, respiratory rate and temperature
- Check for signs of head or spinal injury (e.g. dilated pupils may be a sign of serious head injury).
- Check for stiff neck or fever (signs of meningitis).
- **Ask the caregiver:** When did this seizure start, is there a past history of seizures, a history of head or neck injury, or other medical problems? Has the client taken any medication, poison, alcohol or drugs?

- **Cases to be referred urgently to a hospital**

- If there is any sign of major injury, shock or breathing problem
- If the person may have had a serious head or neck injury
- Woman in the second half of pregnancy or less than 1 week after delivery
- If neuro-infection (e.g. meningitis, encephalitis) is suspected
- Seizures with more than 5 minutes duration

- **Management of seizures**

- Put the person on their side in the recovery position, if the seizure does not spontaneously stop after 1–2 minutes, insert an intravenous (i.v.) line as quickly as possible and give glucose and benzodiazepines slowly (30 drops/minute) if available and r**efer urgently to the hospital**

Part VIII. Medication Guidelines

The Head of Health Centre, in coordination with the health centre pharmacist should ensure adequate stock of medicines and supplies. The Deputy Chief Field Health Programme in coordination with the Field Pharmaceutical Services Officer and division heads should estimate the field requirements from psychotropic medication. Quantification of the requirements is based on the previous consumption and the forecasted need of new clients.

Medications should be issued to the intended clients, not to relatives or persons acting on their behalf, except when the Medical Officer is convinced that the condition of the client is such that he/she cannot visit the health center for regular monitoring. In such cases, the reason why medicines are issued to persons other than the clients should be recorded. The practice of issuing psychotropic medications for clients who use UNRWA facilities merely for supply of medicines should be discouraged. Such clients should be advised on the importance of receiving comprehensive care including in-depth case assessment and regular monitoring of the outcome of care.

Prescriptions issued by specialists or hospitals for clients referred from the health centre can be dispensed with full documentation. A copy of the approved prescription in such cases should be retained in the client's file.

1. Antidepressants

Antidepressants are used in the treatment of mental illnesses of a moderate – severe intensity other than depression. They have been found to be effective for a number of other uses, such as anxiety and chronic pain. They generally increase the levels of serotonin, which in turn gradually improve symptoms.

General Guidance in prescribing antidepressants

1. The medicine is safe in the long run and has no irreversible side effects
2. There is a 'lag period' before the antidepressants produce benefits. Usually it takes several days and up to 2 weeks for the client to start feeling better.
3. Clients on antidepressants will experience side effects before they start getting better
4. Common side effects include headache, nausea, diarrhea, dry mouth and blurred vision
5. Antidepressants are not addictive
6. The medicine has the best impact if taken regularly as advised. Discontinuation of treatment or non-adherence is the single biggest barrier to recovery.
7. After improvement/recovery, these medicines must be continued for at least 4- 6 months to minimize the risk of relapse

Fluoxetine (SSRI) and **Amitriptyline (TCA)** are the drugs available in UNRWA's essential drug list. In selecting which antidepressant is most appropriate, consider the symptom pattern of the person, the side-effect profile of the medication, and the efficacy of previous antidepressant treatments, if any.

o Tricyclic Antidepressants (TCAs)

- **Common Medications**
  - Imipramine
  - Amitriptyline
- **Dose**
  - **Healthy adults:** Initiate treatment with 50 mg at bedtime. Increase by 25 to 50 mg every 1 – 2 weeks, aiming for 100 – 150 mg by 4 – 6 weeks depending on response and tolerability. If

no response in 4 – 6 weeks or partial response in 6 weeks, increase dose gradually (maximum dose 200 mg) in divided doses (or a single dose at night).
    - **Elderly or medically ill clients**: Initiate with 25 mg at bedtime, Increase by 25 mg weekly, aiming for a target dose of 50 – 75 mg by 4 – 6 weeks. If no response in 6–12 weeks or partial response in 12 weeks, increase dose gradually (maximum dose 100 mg) in divided doses. Monitor for orthostatic hypotension
    - **Adolescents:** Do not prescribe amitriptyline in adolescents.
- **Side effects:**
    - Common side effects often diminish after a few days and include: orthostatic hypotension, dry mouth, constipation, difficulty urinating, dizziness, blurred vision and sedation
    - Serious side-effects such as cardiac arrhythmia are rare
- **Cautions**
    - Risk of switch to mania, especially in people with bipolar disorder
    - Impaired ability to perform certain skilled tasks (e.g. driving) – take precautions until accustomed to medication
    - Risk of self-harm (lethal in overdose)
    - Less effective and more severe sedation if given to regular alcohol users

Time to response after initiation of adequate dose: 4 – 6 weeks (pain and sleep symptoms tend to improve in a few days)

- Selective Serotonin Reuptake Inhibitors (SSRIs)

- **Common Medications**
    - Fluoxetine
    - Sertraline
    - Paroxetine
    - Fluvoxamine
    - Escitalopram
- **Dose**
    - **Fluoxetine in healthy adults:** Initiate treatment with 20 mg daily (to reduce risk of side effects that undermine adherence, one may start at 10 mg once daily and increase to 20 mg if the medication is tolerated). If no response in 4 – 6 weeks or partial response in 6 weeks, increase dose by 20 mg (maximum 60 mg) according to tolerability and symptom response
    - **Fluoxetine in adolescents:** Initiate treatment with 10 mg once daily and increase to 20 mg after 1 – 2 weeks (maximum dose 20 mg). If no response in 6 – 12 weeks or partial response in 12 weeks, consult a specialist.
    - **Elderly clients:** Initiate treatment with 10 mg once daily and increase to 20 mg if the medication is tolerated. If no response in 4 – 6 weeks or partial response in 6 weeks, increase dose by 20 mg (maximum dose 60 mg) according to tolerability and symptom response
- **Side effects**
    - Common side-effects often diminish after a few days include restlessness, nervousness, insomnia, anorexia and other gastrointestinal disturbances, headache, sexual dysfunction
    - Serious side-effects are rare, but include: marked/prolonged akathisia (inner restlessness or inability to sit still) and bleeding abnormalities in those who regularly use aspirin and other non-steroidal anti-inflammatory drugs

- Serotonergic and Noradrenergic Reuptake Inhibitors (SNRIs)

- **Common medications**
    - Venlafaxine

    - Duloxetine
    - Mirtazapine
    - Reboxetine.
- Medications not available in essential drug list

Choosing the right antidepressant

1. All antidepressants are equally effective
2. Side effects and costs vary between antidepressants and are important to consider when choosing an antidepressant
3. Antidepressants need to be taken for at least 6 months
4. For prominent insomnia, use a sedating antidepressant like amitriptyline at night
5. If anorexia and gastric discomfort is present, avoid the use of SSRIs
6. Avoid using TCAs in the elderly and in those with coexisting heart problems
7. If weight gain is a concern, an SSRI is the best choice

Management

Starting

- It is best to start low and go slow with the dose of the antidepressant
- A larger dose initially will not produce a quicker response but will definitely cause more side effects and increase the chance of the client stopping treatment

Follow Up

- Ask the client to come within 2 weeks to review the clinical status (early signs of improvement or not) and to monitor the tolerability of the antidepressant
- If the antidepressant is being well tolerated, we can maintain or increase the dose and ask the client to come back in 4-6 weeks.
- At the third appointment most clients would be expected to have improved. In this encounter you enquire and reinforce taking of the medicine, discuss the benefits of treatment and inform about the danger of a relapse if medicines are stopped prematurely.
- After that the client can be given appointment every 2 months to get support and medicine
- If client claims no improvement after taking an adequate dose for at least 4 weeks, then increase the dose to the maximum recommended level.
- Review at least once a month until fully recovered, and advise to continue for a total of 6 months

Phases of Treatment

The average treatment duration for an episode of mental illness ranges from 2 to 6 months; the shorter duration is often for mild cases, while the longer duration is often for moderate/severe cases and for clients in whom there is a risk of future episodes.

Acute phase

- The treatment goal is to reduce the symptoms and enable the client to continue with her/his life as before the illness
- The acute treatment phase usually lasts 4 to 8 weeks
- To prevent relapse in some clients after being well, it is recommended that clients need to continue the medicine for a period of time even when they are feeling well
- The client should be evaluated once or twice a month by the doctor and the staff nurse

- Clients should be provided information emphasizing the need for the medicine and their benefits, the time lag between starting and the health benefits and possible side effects which may occur earlier but which are usually temporary
- Message should be phrased in a manner to encourage the client to understand that the initial side effects are to be expected and can be managed easily and are not a reason to discontinue the medicine.

Maintenance or continuation phase

- Generally lasts four- six months after remission and aims to eliminate residual symptoms; restore the prior level of functioning, and prevent recurrence or early relapse
- In special cases where the episode of common mental illness has lasted more than six months there is a need for a longer continuation phase going up to 12 months
- During this period, positively reinforce the client for having come back as planned, review symptoms and the presence of side effects
- Reconsider the plan of management and adjust the dose, encourage the client to take the medicine as prescribed, discuss the benefits of treatment and inform about the danger of a relapse if medicines are stopped prematurely and ask the client to come back after a month

Ending Phase

- Aim is to discontinue active treatments and to plan for the discharge of the client from the program
- This is done when the person has no or minimal depressive symptoms for 9 – 12 months and has been able to carry out routine activities for that time period.
- Points to consider in this phase:
  a. Discuss ending the treatment with the person in advance
  b. For TCAs and most SSRIs, reduce doses gradually over at least a 4-week period; some people may require longer period.
  c. Remind the person about the possibility of discontinuation/withdrawal symptoms after stopping or reducing the dose. Inform them that these symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the medication is stopped abruptly.
  d. Advise about early symptoms of relapse (e.g. alteration in sleep or appetite for more than 3 days) and when to come for routine follow-up
  e. Systematically reinforce the health promotion advice given by the staff nurse/counselor
  f. Monitor and manage common antidepressant withdrawal symptoms including: dizziness, tingling, anxiety, irritability, fatigue, headache, nausea, sleep problems
  g. If withdrawal symptoms are severe: reintroduce the antidepressant at the effective dose and reduce more gradually. Consult specialist if significant discontinuation/withdrawal symptoms persist.
  h. Monitor re-emerging depression symptoms during withdrawal of antidepressant: prescribe the same antidepressant at the previous effective dose for another 12 months if symptoms re-emerge

Monitoring Treatment

1. If symptoms of mania emerge during treatment: immediately stop antidepressants and assess for and manage the mania and bipolar disorder.
2. If people on SSRIs show marked / prolonged akathisia (inner restlessness or inability to sit still), review use of the medication. Change to TCAs
3. If poor adherence, identify and try to address reasons for poor adherence (e.g. side-effects, costs, person's personal and cultural beliefs about the illness and treatment).

4. If inadequate response (symptoms worsen or do not improve after 4 – 6 weeks): review diagnosis (including co-morbid diagnoses) and check whether medication has been taken regularly and prescribed at maximum dose. Consider increasing the dose. If symptoms persist 4 – 6 weeks at prescribed maximum dose, then consider switching to another treatment (i.e., psychological treatment or different class of antidepressants)
5. Switch from one antidepressant to another with care, that is: stop the first drug; leave a gap of a few days if clinically possible; start the second drug. If switching is from fluoxetine to TCA the gap should be longer, for example one week.
6. If no response to adequate trial of two antidepressant medications consult specialist

Special Populations

1. **People at risk for self-harm**

- SSRIs are first choice
- Monitor frequently (e.g. once a week)
- To avoid overdoses in people at imminent risk of self-harm/suicide, ensure that such people have access to a limited supply of antidepressants

2. **For adolescents 12 years and older**

- When psychosocial interventions prove ineffective, consider **fluoxetine only** (but not other SSRIs or TCAs)
- Where possible, consult mental health specialist when treating adolescents with fluoxetine
- Monitor adolescents on fluoxetine frequently (ideally once a week), for emergence of suicidal ideas during the first month of treatment
- Tell adolescent and parent about increased risk of suicidal ideas and that they should make urgent contact if they notice such features.

3. **For older people**

- TCAs should be avoided, if possible; SSRIs are first choice
- Monitor side-effects carefully, particularly of TCAs
- Consider the increased risk of drug interactions, and give greater time for response (a minimum of 6 – 12 weeks before considering that medication is ineffective, and 12 weeks if there is a partial response within this period)

4. **For people with cardiovascular disease**

- SSRIs are first choice
- DO NOT prescribe TCAs to people at risk of serious cardiac arrhythmias or with recent myocardial infarction.

Antiepileptic Medications

1. **Phenobarbital:** This medicine is not available in the essential drug list

- **Uses:** A nonselective central nervous system depressant, phenobarbital is primarily used as a sedative, hypnotic and also as an anticonvulsant in subhypnotic doses. It is a long-term anticonvulsant for the treatment of generalized tonic-clonic and cortical local seizures. It is also used in the emergency control of certain acute convulsive episodes

- **Epilepsy Treatment**

- For adults
    a. Give one dose at bedtime
    b. Initiate with 1 mg / kg / day (60 mg tablet) for 2 weeks
    c. If poor response, increase to 2 mg / kg / day (120 mg) for 2 months
    d. If seizures persist, increase the dose to 3 mg / kg / day (180 mg)
    e. Continuous administration for 14 – 21 days is needed to obtain steady levels of phenobarbital in the blood; therefore occurrence of seizures during this period should not be considered as treatment failures
- For children
    a. Give one dose at bedtime
    b. Initiate with 2 mg / kg / day for 2 weeks
    c. If poor response increase the dose to 3 mg / kg / day for 2 months.
    d. If seizures persist, increase the dose to maximum of 6 mg / kg / day

- **Side effects**
    - Dose related: Drowsiness, lethargy, hypersensitivity reactions (angioedema skin rashes, exfoliative dermatitis), fever, liver damage
    - Idiosyncratic: skin rash, bone marrow depression, megaloblastic anemia following chronic use
    - Drowsiness or hyperactivity in children
- **Drug abuse and dependence:** Phenobarbital may be habit forming. Tolerance, psychological dependence, and physical dependence may occur especially following prolonged use of high doses.
- **Use in pregnancy:** Phenobarbital can cause fetal damage when administered during pregnancy

Carbamazepine

- **Uses:** Carbamazepine is an anticonvulsant and specific analgesic for trigeminal neuralgia. It is indicated for the following seizure types:
    - Partial seizures with complex symptomatology (psychomotor, temporal lobe). Clients with these seizures appear to show greater improvement than those with other types.
    - Generalized tonic-clonic seizures (grand mal).
    - Mixed seizure patterns which include the above, or other partial or generalized seizures
    - Absence seizures (petit mal) do not appear to be controlled by carbamazepine
    - Trigeminal Neuralgia, is indicated in the treatment of the pain associated with true trigeminal neuralgia. Beneficial results have also been reported in glossopharyngeal neuralgia. It is not a simple analgesic and should not be used for the relief of trivial aches or pains.
- **Epilepsy treatment**
    - For adults
    - Give medication twice daily
    - Start with an initial dose of 100 – 200 mg/day and increase up to 400 – 1400 mg/day
    - Steady state is reached in up to 8 days
    - For Children
    - Give medication twice daily
    - start with 5mg/kg/day
    - Steady state is reached in up to 8 days

- **Side effects:** Allergic skin reactions (which can be severe) blurred vision, diplopia (double vision), ataxia (staggering gait) and nausea: the latter symptoms are usually seen at the start of treatment or at high doses

- **Drug Abuse and Dependence:** No evidence of abuse potential has been associated with carbamazepine, nor is there evidence of psychological or physical dependence

Phenytoin

- **Uses:** Phenytoin is indicated for the control of generalized tonic-clonic (grand mal) and complex partial (psychomotor, temporal lobe) seizures, and prevention and treatment of seizures occurring during or following neurosurgery
- **Epilepsy treatment**
  - **In adults:** Administer once daily. start with 150 – 200 mg / day and increase up to200 – 400 mg / day. Small dose increments may lead to big changes in concentration, therefore, increments should be by 25 – 30 mg
  - **In children:** Administer twice daily. Start with 3 – 4 mg/kg/day and increase up to 8 mg/kg/day (maximum 300 mg daily)
- **Side effects**
  - Dose Related: drowsiness, ataxia and slurred speech, motor twitching and mental confusion, coarsening of facial features, gum hyperplasia and hirsutism (uncommon)
  - Idiosyncratic: anemia and other hematological abnormalities, hypersensitivity reactions including skin rash, hepatitis

Sodium Valproate

- **Uses:** Sodium valproate is indicated as monotherapy and adjunctive therapy in the treatment of clients with complex partial seizures that occur either in isolation or in association with other types of seizures
- **Epilepsy treatment**
  - **For adults:** Usually is given 2 or 3 times daily. Start with 400 mg / day and increase to a maintenance dose of 400 – 2000 mg / day
  - **For children:** Usually is given 2 or 3 times daily. Start with 15 – 20 mg / kg / day up to a maintenance dose of 15 – 30 mg / kg/day
- **Side-effects**
  - Dose Related: sedation and tremor
  - Idiosyncratic: transient hair loss (re-growth normally begins within 6 months), increase in body weight, impaired hepatic function

- **Psychiatric medications in pregnancy and lactation**

  Pre-conception: Providing appropriate education and guidance to patients considering pregnancy or who may have recently become pregnant is an important component of management. Pre-conception counseling should include a careful review of risks and benefits and a treatment plan for ongoing monitoring.

  Pregnancy: During the first trimester should be carefully weighed against the risks to the mother and the fetus of an untreated episode. Psychotropic medications can be used in the second and third trimester if necessary.

Postpartum: the use of psychiatric medications during lactation are shown in the following table

Agent	Pregnancy risk category*	American Academy of Pediatrics rating	Lactation risk category**
Antidepressants			
Amitriptyline	C	Unknown, of concern	L2
Fluoxetine	C	Unknown, of concern	L2 in older infants, L3 if used in neonatal period
Antipsychotic			
Chlorpromazine	C	Unknown, of concern	L3
Haloperidol	C	Unknown, of concern	L2
Risperidone	C	NA	L3
Antiepeliptic Antiepileptic and mood-stabilizing			
Carbamazepine	D	Compatible	L2
Valproic acid	D	Compatible	L2

N/A = not available

*The US FDA classifies drug safety using the following categories: A = controlled studies show no risk; B = no evidence of risk in humans; C = risk cannot be ruled out; D = positive evidence of risk; X = contraindicated

**Lactation risk categories are listed as follows: L1 = safest; L2 = safer; L3 = moderately safe; L4 = possibly hazardous; L5 = contraindicated.

Part IX: Levels of Responsibility and Authority:

Each member of the health team – including health center staff, area staff, field office staff, and headquarters staff – need to have a thorough understanding of their roles and responsibilities, as well as their authority within the MHPSS model in order to ensure maximum success

Management Positions and Levels of Authority

Responsibilities of management staff are also elaborated in **Part XVI**, later in the document.

1. **Headquarters Level:**

   The Deputy Director of Health is the overall responsible for the implementation of the MHPSS program in the five fields of operation assisted by the MHPSS Program Manager, and or the Chief Disease Prevention and Control officer at HQ who are directly responsible for the implementation of the program as part of the NCD package

2. **Field Office level:**

   The Deputy Chief Field Health Program should maintain normal responsibilities in program management and oversight as instructed by MHPSS program manager and Chief Field Health Program. They should work closely with all division heads to ensure coordination in planning and implementation of training and supervision activities within their program. They have a greater role in the MHPSS program rollout.

The Field Disease Control Officer will be responsible for the implementation of the MHPSS program as part of the NCD package.

During the roll-out period, the Field MHPSS Officer will be:

- Responsible for the organization, implementation and evaluation of the Agency's Mental Health & Psychosocial Support health programme in the Field to which assigned
- Supervises the Psychosocial Counsellors wherever available and fosters the development of team spirit between those working in Education, Health and Relief and Social Services
- Undertakes regular visits to UNRWA health centres in the Field to ensure that the programme is implemented in accordance with the approved policies, strategies and procedures of the Department of Health;
- Monitors the Agency's health information system with respect to MHPSS services and carries out periodic reviews to assess the efficiency, effectiveness and coverage of the programme
- Assists in the organization, implementation and evaluation of training programmes for the development of human resources in the field of MHPSS
- Prepares and validate the monthly reports based on reports written by the Assistant MHPSS and reports from the health centres.
- Ensures the fulfillment of the work plan in accordance with the general objectives of the programme and provides technical, administrative and logistical support necessary for the implementation of the different activities of the programme;
- Ensures organization of forums/workshops for exchanges of experience between all the teams;
- Contributes to the elaboration of education –communication material to be used for internal and external communication (leaflets, brochures, articles for news papers or professional journals);

- Participates in the development and conduct of health services research with respect to the Agency's MHPSS programme
- Acts as the focal point for coordination of all aspects relating to funded MHPSS projects including monitoring, implementation and reporting on the progress
- Maintains close coordination and liaison with relevant government and non-governmental organizations in the Field;

Assistant Field Mental Health and Psychosocial Support Officers

During the roll-out period, the Field MHPSS Officer will be:

- Assist the Field Mental Health and Psychosocial Support Officers in all matters related to the organization, implementation and evaluation of the Agency's Mental Health & Psychosocial Support health programme in the Field to which assigned
- Supervises the Psychosocial Counsellors wherever available and fosters the development of team spirit between those working in Education, Health and Relief and Social Services
- Undertakes regular visits to UNRWA health centres in the Field to ensure that the programme is implemented in accordance with the approved policies, strategies and procedures of the Department of Health;
- Assist the Field Mental Health and Psychosocial Support Officers to Monitors the Agency's health information system with respect to MHPSS services and carries out periodic reviews to assess the efficiency, effectiveness and coverage of the programme
- Assists in the organization, implementation and evaluation of training programmes for the development of human resources in the field of MHPSS
- Prepares, validate and submit the monthly reports based on reports received from health centres.
- Ensures the fulfillment of the work plan in accordance with the general objectives of the programme and provides technical, administrative and logistical support necessary for the implementation of the different activities of the programme;
- Contributes to the elaboration of education –communication material to be used for internal and external communication (leaflets, brochures, articles for news papers or professional journals);
- Participates in the development and conduct of health services research with respect to the Agency's MHPSS programme
- Assist in coordination of all aspects relating to funded MHPSS projects including monitoring, implementation and reporting on the progress
- Maintains close coordination and liaison with relevant government and non-governmental organizations in the Field;

Area Health Officer

- The AHO ensures that the implementation of the MHPSS services is in line with standards established in the relevant technical guidelines
- In his/her assigned area, oversee activities relevant to technical guidance, supervision and training of health center staff

- Build partnership within his area with other governmental and non-governmental organizations to facilitate referrals and avoid duplication of services
- When requested by the head of health center, coordinates and facilitates the referral process from health centers to other UNRWA institutions in the area
- Provide moral and psychological support to staff during difficult times of violence and other situations of elevated stress
- Participate in training courses for health center staff for the purposes of adequate understanding of roles and responsibilities, interventions being performed and priorities in the health center

If Division Head roles are temporary for the duration of the expansion phase, simultaneous capacity building should be occurring between the DH and AHOs so that they may take on a more technical supervisory role after full integration

Health Center Staff

Competencies for PHC Staff in MHPSS

- Early detection of MHPSS risk factors and high-risk cases
- Identification of severe psychosocial problems, common mental health disorders and protection issues
- Basic counseling and psychoeducation skills including verbal and non-verbal communication, active listening, empathy, reflection
- Managing co-morbidity
- Develop management plans and follow-up
- Prescribe medication (Medical Officer only)

Head of Health Centre

The Head of Health Centre is involved in mostly management and administrative coordination of the integration, though has some responsibilities in the provision of care

Integration

- The Head of Health Centre is expected to lead and supervise the overall process of integration and implementation of MHPSS services into the FHT-PHC model in his/her health centre
- Ensure the smooth work flow of all MHPSS activities in his/her health center including the management of any obstacles that may arise during daily work
- In conjunction with Division Heads and Area Health Officers, organize MHPSS related training and on the job supervision to health staff in his/her HC
- Arrange for induction training for new staff in cooperation with Division Heads
- Involve patients, service users and caretakers because they have an invaluable role to play in helping to identify which services need to be redesigned.
- Conduct and supervise activities that strengthen community engagement including outreach activities, work with the local community leaders and conducting public health campaigns
- Health centre friendship committee should be functional and Head of Health Centre should conduct regular meetings prior to and immediately following the integration

Administrative/Management

- Ensure proper recording and reporting for all MHPSS related activities, including proper collection, verification and reporting of data before final submission to the Field Office
- Ensure that an adequate system for clients' feedback about the program is functional in his/her health centre

- Ensure adequate stock of essential medicines in his/her health centre
- Provide moral and psychosocial support to staff during difficult times of violence and other types of stress

Provision of Care

- Conduct all steps of care, with particular focus on **Steps four and five.**
- Report high risk cases for rescue, safety and protection services according to the established referral system in his/her area/field
- Provide MHPSS services to the families assigned to his/her team
- Coordinate with other UNRWA programs and other providers different means of support to the client and his family as needed
- Supervise and facilitate the referral process of MHPSS conditions that need to be referred to specialist or higher level of care
- Respect and maintain confidentiality of the counselling relationship with the clients

Medical Officer and FHT leader

Medical Officers are responsible for providing care throughout all steps – with particular focus on Step four and five – in addition to managerial responsibilities for their FHT

Step Zero:

- Support health center activities related to community awareness and outreach activities, as well as stigma reduction and public health campaigns
- Conduct universal promotion activities and disseminate prevention information on healthy lifestyles and psychosocial well-being
- Provide early intervention and counseling to reduce risk of the development of harmful and unhealthy behaviors for all health center clients, with a special focus on identified high risk groups
- Provide basic counseling on most common MHPSS issues to client's families when required
- Provide moral and psychosocial support to staff in his team during difficult time of violence and other types of stress

Step one:

- Conduct universal promotion activities and disseminate prevention information on healthy lifestyles and psychosocial well-being
- Provide early intervention and counseling to reduce risk of the development of harmful and unhealthy behaviors for all health center clients, with a special focus on identified high risk groups
- Provide basic counseling on most common MHPSS issues to client's families when required
- Provide moral and psychosocial support to staff in his team during difficult time of violence and other types of stress
- Perform basic MHPSS assessment during general medical history and clinical assessment for all clients presenting to the FHT for medical consultation

Step two:

- Provide basic supportive counseling on most common MHPSS issues to client's families when required
- Conduct screening, when indicated, for clients at risk of having MHPSS related complaints
- Perform basic MHPSS assessment during general medical history and clinical assessment for all clients presenting to the FHT for medical consultation

- Conduct GHQ-12 screening for all clients with symptoms in high risk groups, as well as other clients identified through Step one activities

Step three:
- Provide basic counseling on most common MHPSS issues to client's families when required
- Perform specialized psychosocial assessment for all clients complaining of MHPSS difficulties presenting to the FHT, and those clients who are referred by other FHT staff from Step two.
- Coordinate with the other members of the FHT on all aspects of the plan of client management, including counseling, follow up appointments, and referral

Step four:
- Provide basic supportive counseling on most common MHPSS issues to client's families when required
- Perform specialized mental health assessment for all clients complaining of MHPSS difficulties presenting to the FHT, and those clients who are referred by other FHT staff from Step three
- Coordinate with the other members of the FHT on all aspects of the plan of client management, including counseling, follow up appointments, prescription of medication, and referral
- Confirm mhGAP or PSS diagnosis from Step three and the severity of the condition. Prescribe the relevant medical treatment when necessary and offer advice for management and self-care in collaboration with counselors, nurses and other members of the FHT as needed
- Report high risk cases for safety and protection services to the head of health facility and coordinate response
- Initiate and coordinate both internal and external referrals of MHPSS cases to the relevant services, including, but not limited to: specialized mental health care providers and organizations, rehabilitation and physiotherapy services, home care, and diagnostic services.

Step five:
- Coordinate with the other members of the FHT on all aspects of the plan of client management, including counselling or other psychosocial intervention for complex cases 'follow up appointments, prescription of medication, and referral
- Report high risk cases for safety and protection services to the head of health facility and coordinate response
- Initiate and coordinate both internal and external referrals of MHPSS cases to the relevant services, including, but not limited to: specialized mental health care providers and organizations, rehabilitation and physiotherapy services, home care, and diagnostic services.

Throughout All Steps:
- Record all findings and management plan in client record
- Fill in MHPSS register on daily basis. Open MHPSS file when required and update during each visit.
- Provide feedback and guidance to other members of the FHT
- Respect and maintain confidentiality of the counseling relationship with clients
- Supervise the overall implementation of the MHPSS in his/her FHT

Senior Staff Nurse/Staff Nurse

Senior Staff Nurse will be the main responsible of the MHPSS implementation in the health centre and will conduct the following activities in Steps 0 – 4

Step zero:

- Provide on the job supervision and guidance to Practical Nurses and midwives in all matters related to MHPSS services from Step Zero – Step four
- Conduct and supervise general prevention, resilience building, promotion of mental health and psychosocial well-being and self-care activities in the health center and community

Step one:

- Provide on the job supervision and guidance to Practical Nurses and midwives in all matters related to MHPSS services from Step Zero – Step four
- Conduct and supervise general prevention, resilience building, promotion of mental health and psychosocial well-being and self-care activities in the health center and community

Step two:

- Conduct GHQ-12 screening for all clients with symptoms in high risk groups, as well as other clients identified through Step one activities

Step three:

- Conduct specialized psychosocial assessment for detected cases and, where qualified, provide care for client including psychoeducation and counseling in line with suggested psychosocial interventions
- Develop management plan for clients with PSS needs including, but not limited to: psychoeducation, behavioral activation, counseling, referral to psychosocial counselor, medical officer, or other UNRWA service
- Refer moderate/severe cases potentially requiring medication to doctor in Step four
- Coordinate on care management plans for clients referred from Step three or Step four by doctor or Psychosocial Counselor

Step four:

- Conduct preliminary mhGAP assessment for detected cases and, where qualified, provide care for client including psychoeducation and counseling in line with suggested mhGAP interventions
- Coordinate on care management plans for clients referred from Step three or Step four by Medical Officer or Psychosocial Counselor
- Create care management plan for clients with PSS needs including, but not limited to: psychoeducation, behavioral activation, counseling, referral to psychosocial counselor, medical officer, or other UNRWA service
- Where qualified, provide care for client including psychoeducation and counseling in line with suggested mhGAP interventions
- Refer moderate/severe cases potentially requiring medication to doctor
- Refer mhGAP cases no longer responding to care management plan that are more serious and may potentially require medication to Medical Officer

Throughout All Steps:

- Assist the head of the health centre in all matters related to MHPSS services

- Provide on the job supervision and guidance to practical nurses and midwives in all matters related to MHPSS services
- Respect and maintain confidentiality of the counselling relationship with clients
- Supervise, coordinate, and arrange group counselling sessions conducted by practical nurses and midwives
- Follow up and support cases referred from his/her station to other staff members
- Fill in MHPSS register on daily basis. Open MHPSS file when required and update after each client visit.
- Supervise the data recording process on daily basis, similar to other programs, and report it to the head of the health centre

Practical Nurse

Practical nurses are responsible for conducting activities from Step zero through Step two

Step zero:

- Plan and execute general prevention, resilience building, community awareness, stigma reduction and public health campaigns in health center and community
- Provide promotion of health and well-being and MHPSS education messages that assist, promote and support clients in achieving the highest possible level of mental health and psychosocial well-being

Step one:

- Holistically assess clients attending his/her station for MHPSS difficulties and move to Step two, if necessary. The holistic assessment i**n**cludes asking about past MHPSS complaints, gathering a short social history, identifying gaps in support systems or heightened risk for protection issues
- Complete personal data section on eHealth, ensuring all fields are up to date with history
- Provide mental health and psychosocial well-being education to individuals and groups when required

Step two:

- Provide mental health and psychosocial well-being education to individuals and groups when required
- Conduct GHQ-12 screening for all clients with symptoms in high risk groups, as well as other clients identified through Step one activities
- Open file if GHQ score warrants further follow up and fill in all relevant sections; refer client to staff nurse for Step three activities
- Assess and record client preferences and motivations for treatment and monitor ongoing interventions; inquire about client's progress and relationship with counselors and physicians, where appropriate

In All Phases of Care

- Respect and maintain confidentiality of counseling relationship with client
- Help clients to identify and use the available MHPSS resources inside and outside UNRWA health services
- Follow up and support cases referred from his/her station to other staff members
- Conduct group counselling for clients in coordination with SSN and Head of the Health Centre
- Fill in MHPSS register on daily basis. Open MHPSS file when required and keep it updated

Midwives

Midwives are responsible for conducting activities from Step zero through Step two

Step zero:

- Plan and execute general prevention, resilience building, community awareness, stigma reduction and public health campaigns in health center and community
- Provide promotion of health and well-being and MHPSS education messages that assist, promote and support clients in achieving the highest possible level of mental health and psychosocial well-being
- Identify community needs and resources and conduct culturally sensitive MHPSS community activities (in coordination with the CMHP where appropriate)

Step one:

- Provide mental health and psychosocial well-being education, counseling and support to women, children and families
- Holistically assess clients attending his/her station for MHPSS difficulties and move to Step two, if necessary. The holistic assessment includes asking about past MHPSS complaints, gathering a short social history, identifying gaps in support systems or heightened risk for protection issues. Special attention should be paid to identified high risk groups, as well as husband/wife relationships, sexual mental health and women-headed households
- Follow up and support of cases referred from his/her station to other staff members

Step two:

- Conduct GHQ-12 with all clients with symptoms in high risk groups, as well as any identified during Step one activities
- Conduct individual, group counseling and group support sessions for new mothers and high risk pregnant women in coordination with SSN and Head of Health Centre
- Follow up and support of cases referred from his/her station to other staff members
- Arrange consultation or transfer to other members of the FHT, usually the staff nurse; emergency and high risk cases should be reported immediately
- Refer those clients who need further evaluation through Step three activities to Staff Nurse

In All Phases of Care

- Respect and maintain confidentiality of counseling relationship with client
- Complete the relevant section on the client file, document findings, and keep updated
- Ensure privacy and confidentiality for all MHPSS related services provided
- Fill in MHPSS register on daily basis. Open MHPSS file when required and keep it updated

Pharmacists

Pharmacists are responsible for the general prevention activities and identification of emergency cases in Step zero and Step one. In addition, responsibilities include:

- Review client profiles, including known client risk factors for adverse drug reactions, drug allergies and known contraindications to prescribed medications
- Ensure privacy during the dispensing of psychotropic medications
- Communicate treatment information and expected effects and side effects to clients in a private space

- Communicate with physicians, when needed, to help the client achieve maximum benefit from drug therapy and to prevent medication errors or potential significant adverse reactions
- Respect and maintain confidentiality of all matters related to the clients
- Ensure adequate stock of essential medicines

Counselors in Gaza Community Mental Health Programme

Counselors in the CMHP are responsible for all phases of care from Step zero to Step five, but as they have more training than health center staff, their role will be mainly in Step three – five.

Step zero:

- In conjunction with nursing team, conduct public education sessions on promotion of mental health and psychosocial well-being to increase public awareness, community and individual resilience and reduce stigma surrounding MHPSS issues.

Step three:

- Conduct specialized psychosocial assessment for detected cases and provide care for client including psychoeducation and counseling in line with suggested psychosocial interventions.
- Collaborate with Staff Nurse and Medical Officer in formulation of care management plan for internally referred clients.
- Feedback to FHT staff on progress of client and other medically relevant information.
- Provide individual and group counseling and education in varying levels of intensity on common MHPSS issues, marital and family relationship problems, coping skills advice for maintenance of wellbeing and disease prevention, and education on comorbidities and psycho somatization. Additionally, address psychological factors related to MHPSS well-being such as motivation, leadership, productivity, and health working environments.

Step four:

- Conduct preliminary mhGAP assessment for detected cases and, where qualified, provide care for client including psychoeducation and counseling in line with suggested mhGAP interventions
- Create care management plan for clients with PSS needs including, but not limited to: psychoeducation, behavioral activation, counseling, referral to psychosocial counselor, medical officer, or other UNRWA service.
- Provide medium-term counselling for complex cases
- Collaborate with Staff Nurse and Medical Officer in formulation of care management plan for internally referred clients with mhGAP diagnosis
- Refer moderate/severe mhGAP cases potentially requiring medication to doctor
- Feedback to FHT staff on progress of client and other medically relevant information

Step five:

- In coordination with Head of Health Centre, refer client to community agencies, services and hospitals, when necessary.
- Follow up referred clients and integrate parallel intervention plan at health centre level
- Provide feedback on cases referred by other health staff.

Group Counseling

- Conduct group counseling sessions for clients referred to him/her by staff member per CMHP guidelines and techniques.

- Train practical nurses and midwives in the facilitation of support groups using psychosocial Technique as follows:
  - The counselor should conduct the first group, with the concerned staff member observing.
  - The staff member, under the supervision of the counselor, should conduct the second group.
  - Once the staff member is deemed adequately trained to conduct support group sessions independently, this should be communicated to the Head of Health Center.

In All Phases of Care
- Document and have clients file completed and update using same recording system as FHT staff.
- Respect and maintain confidentiality of the counselling relationship with the clients.

<u>Counselors in WB Community Mental Health Programme</u>
Counselors in the CMHP are responsible for all phases of care from Step zero to Step five, but as they have more training than health center staff, their role will be mainly in Step three – five.

Step zero:
- In conjunction with nursing team, conduct public education sessions on promotion of mental health and psychosocial well-being to increase public awareness and reduce stigma surrounding MHPSS issues

Step three:
- Conduct specialized psychosocial assessment for detected cases and provide care for client including psychoeducation and counseling in line with suggested psychosocial interventions.
- Collaborate with Staff Nurse and Medical Officer in formulation of a care management plan for internally referred clients.
- Feedback to FHT staff on progress of the client and other medically relevant information.
- During sessions, provide counseling and education on common MHPSS issues, marital and family relationship problems, advice for maintenance of wellbeing and disease prevention, and education on comorbidities and psychosomatization. Additionally, address psychological factors related to MHPSS well-being such as motivation, leadership, productivity, and health working environments.

Step four:
- Conduct preliminary mhGAP assessment for detected cases and, where qualified, provide care for the client including psychoeducation and counseling in line with suggested mhGAP interventions.
- Create care management plan for clients with PSS needs including, but not limited to: psychoeducation, behavioral activation, counseling, referral to psychosocial counselor, medical officer, or other UNRWA service.
- Collaborate with the Staff Nurse and Medical Officer in formulation of care management plan for internally referred clients with mhGAP diagnosis.
- Refer moderate/severe mhGAP cases potentially requiring medication to doctor in Step four.
- Feedback to FHT staff on progress of client and other medically relevant information.

Step five:
- In coordination with Head of Health Centre, refer client to community agencies, services and hospitals, when necessary
- Follow up referred clients and integrate parallel intervention plan at health centre level
- Provide feedback on cases referred by other health staff

In All Phases of Care

- Document and have clients file completed and update using same recording system as FHT staff
- Respect and maintain confidentiality of the counselling relationship with the clients
- Conduct group counseling sessions per CMHP guidelines
- Supervise Practical Nurses and Midwives in support group facilitation using Mind and Body Techniques

Physiotherapists

Physiotherapists are responsible for care in Step zero and Step one, but can provide critical support in Step three and four treatment plans, as they have long, extended periods of time with clients – perhaps more than any other staff member.

In All Phases of Care: Conduct general prevention, resilience building, community awareness, stigma reduction, promotion of health and well-being, self-care and other activities that assist, promote and support clients to achieve the highest possible level of mental health and psychosocial well-being.

- Conduct general basic assessment and monitor MHPSS status during provision of physiotherapy services and refer suspected cases to the FHT Staff Nurse if further services are needed
- When requested by Staff Nurse, Medical Officer or Psychosocial Counselor, follow up on client care management plan during appointment. Activities specific to Physiotherapists include education on the link between MHPSS and physical recovery, activating and strengthening social support networks and resilience building activities
- Respect and maintain confidentiality of all matters related to the clients

Other members of the FHT and Health Center Support Staff

Support staff play an important role in the health center, in that they contribute to the environment necessary for a smoothly functioning, stigma-free health center. They should be aware of the basic package of services being integrated, and the basic MHPSS concepts introduced in the 2 day training. They should be able to provide guidance to the client on available services within the health facility. Most importantly, they should respect the privacy and confidentiality of all matters relating to the clients, including, but not limited to, MHPSS needs.

Reporting Structure

Within the health center for all matters related to the implementation of the MHPSS programme, the reporting structure will be as follows:

- Non-medical support staff report to the Senior Staff Nurse
- Medical support staff (pharmacists, lab technicians, physiotherapists) report to the Head of the health centre
- Psychosocial counselors report to head of the Health centre for technical and administrative matters and to the counselor supervisor for technical matters. This is to be agreed in discussion between head of HC and counsellor supervisor
- Practical nurses and midwives report to Staff Nurse
- Staff nurses report to Senior Staff Nurse
- Senior staff nurse reports to: Head of the Health Center
- FHT leaders and doctors: report to the Head of the Health Center

- Head of Health Center reports to: Area Health Officer for technical and administrative matters and to Head of MHPSS programme for technical matters.
- Area Health Officer report to: Chief Area for administrative matters and to Head of MHPSS programme and Deputy Chief Field Health Programme for technical matters
- Assistant Division Head reports to: Head of MHPSS programme
- Head of MHPSS programme to the Chief Field Health programme this is similar to the other divion heads in the field
- Chief Field Health Program reports to Deputy Director for programmes for administrative matters and to the Director of Health and MHPSS Program Manager at HQ.

Part X: Recording, Reporting, Monitoring, and Evaluation

1. Recording

The MHPSS file should be used for recording relevant information including personal data and overall medical and MHPSS assessment. The section titled "Monitoring and follow up" should be used for recording information relevant to assessment, management plan and medicines prescribed.

Files of newly registered clients should be serially numbered in the order of registration and calendar year e.g. the first client registered in 2016 will take number 001/2016 regardless of gender and/or type of disease.

All relevant information with regard to women of reproductive age and clients with NCD files should be recorded on the Maternal Health Record and NCD file. Files of all clients who die should be deleted at end of the calendar year in which the death was notified in order to account for deaths at end of the reporting period.

Files of clients who do not report to the health centre for one year should be kept aside and only re-activated if the client reports back to the health centre for special care.

2. Reporting

An annual statistical report on MHPSS presentations should be prepared at early January each year by all health centres/points providing data on clients who were under supervision in the preceding year. The report should be submitted to the Field Office through appropriate channels. The report will include statistical data on number of clients, age and sex distribution and classification of clients according to MHPSS diagnosis and management plans as at the end of the reporting period.

Other information relevant to standards and outcomes of care will be obtained by analysis of statistical data as well as through rapid assessment of a representative sample of patient files in accord with a standard protocol prepared by Headquarters.

The MHPSS Division Head in the field or the Deputy Chief Field Health Programme should check the reports received from health centers/points, compile the data and prepare a consolidated report on programme activities for subsequent transmittal to Headquarters.

Reporting on defaulters will take place once every six months from Health Centers to the Field and annually to headquarters Amman.

Reporting on screening will take place once every three months from Health Centers to the Field and annually to headquarters Amman.

3. Evaluation of MHPSS programme

Evaluation will be carried out early each calendar year to assess the degree to which the stated objectives and targets of the programme were attained during the preceding year as well as to assess outcomes of care.

Indicators:

- Total number of clients graduated/benefited from support group broken down by age, sex and risk group
- Percentage of clients who completed at least 4 sessions out of all enrolled in the support group
- Total number of persons with MHPSS file opened that year
- % of defaulters/lost to follow up out of the total files opened
- Disease-specific prevalence rates (depression, schizophrenia, epilepsy, anxiety.....)
- Case detection rate of MHPSS issues among served population
- Total control rate among chronic cases of MHPSS issues
- Recovery rate
- Percentage of clients using psychotropic medications out of the total registered clients.
- Percentage of clients on antidepressants
- Percentage of clients referred to the psychosocial counselor (inside UNRWA)
- Percentage of clients referred to a specialist (outside UNRWA)
- Percentage of women with postpartum depression
- Number of group counseling groups completed (5-8 sessions)
- Number of reported cases of suicide
- Number of protection cases identified in health centers (child protection, GBV, general protection)
- Percentage of protection cases responded to, referred to, followed up, closed.)ideally all of these, or at least ¨responded¨ or ¨referred

Section C Annexes

Annex I: 10 Steps to Implement MHPSS

The following steps will provide broad guidance in both launching a pilot, and in the rollout. Not all questions will be applicable in your field, but a thoughtful exercise with key stakeholders should be held to go through these points one by one and determine which are the most appropriate for you to consider as you move forward.

1. **Conduct situation analysis in field: Main questions to ask about your field, and about the health center community:**
    a. What is the situation of the majority of Palestine refugees in your field? What are their biggest MHPSS needs (ie is home demolition a threat? Do PR face daily threats to their safety either from security forces or war? Are certain protection threats particularly high due to crowded living situations with little privacy? Is child marriage a big concern? Is there any gender or age related violence or abuse? Are populations living in chronic or acute conflict situations?
    b. Are there some areas/populations more vulnerable than others (ie: ex-Gazans in Jordan, isolated and nomad communities in WB, PRS in Lebanon, internally displaced PR in Syria and Gaza)? Is/are there additional protections and outreach that need to be put in place to ensure access to PHC services?
    c. If necessary, identify any additional interventions in addition to the main MHPSS package to be introduced (ie trauma counseling, coping mechanisms for grief).
    d. Are there other NGOs, government services or other healthcare providers doing similar or complementary work in your field? Do PR have access to these services? Is it free, or is there a fee? Is there an opportunity to partner with these providers for PR services, trainings or supervision?
    e. Determine which secondary services are available to PR in your field. What is UNRWA's policy on reimbursement for specialist services? Determine to what extent clients will be cared for/followed up after being referred beyond a PHC center. What is our responsibility to the client after the referral? Will medicines purchased outside the essential drug list be reimbursed?
2. **Identify Pilot Health Center(s): Important characteristics for a pilot health center:**
    a. SMO and staff who are already excited about the prospect of integrating MHPSS services into their daily activities;
    b. If some HC staff have additional qualifications in MH, it could be helpful for successful implementation;
    c. Health centers already equipped with space, privacy, and good infrastructure as well as access for persons with disabilities;
    d. A health centre with strong existing friendship committee and good connections with the local community.
    e. In the expansion phase, it will be important to ensure every health center has confidential spaces for consultations and access for persons with disability This might require infrastructural updates. Specifications required for health centers can be found in Section B of this document.
3. **Conduct Preliminary Staff Induction: This consists primarily of sensitization sessions for all health centre staff in order to decrease possible resistance and ensure team engagement and ownership and reduce stigma.**
    a. During these sessions the main concepts and approaches of MHPSS are introduced, in order to sensitize staff to this new introduction, reduce stigma, and help them come around to the ideas to be integrated
    b. Separate meetings with the team and with each category of staff to discuss what their roles and responsibilities will allow for better reception of the main trainings to come

c. Evidence from Saftawi has proved that early inclusion in the planning phases is crucial to success. This allows staff to express concerns, suggest solutions, unique approaches, and play a role in advocating for this integration within the community
d. Arrange for visits within the field to other MHPSS service providers (Other UNRWA clinics, MoH, NGOs, etc..).
e. If possible, arrange for key staff to visit another UNRWA field where MHPSS is already integrated so that they can learn from the experience of their peers and increase their motivation

4. **Identify referral and networks surrounding pilot HC**
   a. Each field has slightly different operational relationships between programs and departments. It is up to the health program in each field to engage with each of the departments prior to the launch of the pilot health center, and during the expansion phase.
   b. These meetings can be organized at the field office level, at the area level, and at the health center level. A template for recording this engagement with key meetings that should happen and questions that should be asked is included in the Annex.
   c. These meetings should also occur where appropriate with external agencies, host governments and local and international NGOs
   d. As a follow up to the situation analysis conducted, determine conditions required for referrals (ie formal agreements vs ad hoc referrals). This may be different by area, or based on status of PR. This needs to be defined for your field in Section C of this document
5. **Engage health center community**
   a. It is important that integration happens hand in hand with the community, in order to achieve maximum success in integration.
   b. Friendship committees should be engaged from the start by the health center staff, and by the trainers. They can be invited to special training/induction sessions, or invited to a Q&A with the field office staff.
   c. Signs and announcements in the health center which announce the upcoming integration can give the community members an idea of what is coming, and the opportunity to ask questions and raise any concerns they might have.
   d. In the expansion phase, if these community groups do not exist, it is advisable to organize them with the help of health center staff (camp committees could include health staff, head of UNRWA installations, popular committees and notables from the pilot health center).
6. **Identify management team**
   a. Both long term and short term technical supervision are essential to successfully integrating MHPSS services into UNRWA's health centers.
   b. Identification of short term supervisors is part of (7) training of staff, and will often include your trainers. Long term, managerial supervision will occur at a field and area level. This will provide a resource for health centers beyond the immediate, intensive supervision period
   c. Details for management team qualifications are available in Section D of this document. Field office management teams are not required to launch the pilot, but should be in place before expansion takes place.
7. **7. Training of staff:**
   a. Determine which training modules are required: If/where staff capacities preclude the necessity for further training, that module may be eliminated or modified from the training package (ie PSS module can be reduced in WB, to account for an already highly integrated model. mhGAP training can be revised as a refresher course in LFO, where all doctors and nurses have already received the course. In JFO, where GIZ has already conducted induction sessions with health centers, Part I of the training may be redundant, etc…)

b. Identify trainers and supervisors: The important questions to ask when preparing for training your pilot health center include: Do you have qualified trainers within your programme (mhGAP and MHPSS)? Is it possible to send current staff on a training course? Is it more cost effective to hire qualified trainers and supervisors from outside the Agency for short term consultancies?
c. In the long run there is a need to have an internal training capacity in each Field and HQ supported when needed by an external resources.
d. mhGAP and MHPSS activities will need to be supervised separately at first, ideally by those who conducted the training. It will be important to follow the supervision schedule validated during the Saftawi pilot, to ensure proper, ethical implementation of services
e. Arrange for replacement staff : For the pilot health center, it will be required to train the entire health center at once. Arranging for the required replacement staff, as well as the resources is crucial to ensuring this success
f. During the expansion phase, a less resource-intensive style of training may be agreed upon, in which case the replacement staff arrangements may not be as important
g. Agree upon schedule of trainings: The pilot health center should be trained together; however it is important to select the model most appropriate for your resources, geographical distribution, availability of trainers and health center size. Trainings can be intensive and full time (as in Saftawi), or can be staggered to allow for staff to continue to attend their duties. The Saftawi experience has revealed the importance of conducting trainings offsite wherever possible. Staff felt that they were being respected, and were in a better mental state to receive and absorb the trainings.

   Fields may decide to create online/self-learning modules that allow staff to complete some work individually.

h. Conduct Training: Include proper pre and post-tests to measure change in staff knowledge, attitudes and behaviors. All tools, resources, materials and further suggestions on conducting training in an efficient way are included in the **training package**

8. **Prepare medicines and other commodities: Before implementation commences, the appropriate stock of designated medicines is available Guidelines are available in the TIs**
9. **Prepare all HC and staff materials**
   a. Health center posters and educational materials, flip charts, flow charts and technical instructions should be printed and ready prior to implementation
   b. Materials used by Saftawi are available at your request, and can be modified if necessary

10. **Begin implementation followed by supervision and M&E**
    a. M&E tools tested and validated at Saftawi are available in the Annex
    b. Supervision is crucial to ensuring activities are conducted according to ethical standards and of a high quality

Annex II: Training, Management and Supervision Structure

Phase 1 (Rollout: Year 1-3)

	Health Center "X" Short and Long Term Supervision												
	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
mhGAP Trainer/Supervisor	Training												
MHPSS Trainer/Supervisor	Training												
Field Office Division Head													
Area Health Officer	Will supervise as capacity allows before training												
Senior Medical Officer													
Senior Staff Nurse													

1. Trainer/Supervisor Requirements

mhGAP Training: The trainer does not need to be psychiatrist, but must have clinical mental health experience; the WHO will help to identify/coordinate appropriate trainers.

mhGAP Supervision: As above, supervisors must have clinical mental health experience; reasons cited by WHO representative include supervisors needing – for example – experience with the full cycle of depression care management (medications take several weeks to begin working, and treatment courses generally last 3-9 months) and the mhGAP course. Doctors and nurses need to appeal to someone with significantly more experience than them for advice on difficult cases and overall care management

MHPSS Training: Trainers need experience in basics of psychology, the social determinants of health, overall tenants of confidentiality, sustainability and do no harm as well as basic PSS support techniques

Conducting group sessions is a hallmark of UNRWA's HD strategy; trainers need to have experience conducting the sessions, teaching others to lead them, and accurately gauging when someone is ready to lead them on their own

Trainers need to understand the difference between PSS counselors' role and the role of nurses and midwives in the health center (ie that health center staff can have a lesser competency than counselors who are able to deal with more difficult cases and are familiar with more in depth methods of counseling.

Some UNRWA staff members are already qualified to conduct such trainings (community mental health program supervisors, psychosocial counselors, some West Bank staff), and obtaining the qualifications to be a trainer are much less rigorous and clinical

MHPSS Supervision: As above, supervisors do not need an advanced qualification, but must meet the above competencies

2. Key Human Resource Requirements during Rollout

mhGAP and MHPSS Trainers/Supervisors (new position): Each field will decide what combination of trainers and supervisors works in their given circumstances, HQ recommends one pair per field, employed full time for the duration of rollout. The pair will conduct the trainings and supervision according to the rollout schedule as defined by the field. HQ discourages the use of existing UNRWA staff, as the responsibilities are full time for 20+ health centers.

Senior Medical Officer & Senior Staff Nurse (existing positions): These roles will be crucial in the immediate rollout phase in overseeing their respective staff. Senior staff nurses will be relied upon to supervise health center nurses and midwives, while SMOs will be responsible for being a first line referral for their doctors; they will also be the focal point through which external referrals are sent. Additionally, the two positions will be in charge of data collection and management, and overseeing reporting to the field office.

Area Health Officer (existing position): It is essential that this person work with the division heads and health center staff to ensure smooth rollout and supervision needs are met. The AHO will not be an expert in MHPSS – though they will participate in the training – but some on the job training from the supervisors will allow them to oversee general technical implementation beyond the rollout and intense supervision phase.

(Assistant) Field Office Division Head (new positions): During the rollout phase, these two positions are crucial in – in partnership with the AHO – the actual coordination of trainings, securing facilities and replacement staff, overseeing supervisors (managerially, if not technically) and being a link between the field office and HQ. Additionally, this role will need to work to verify the quality of external referral networks and facilitate inter-Agency referral pathways and collaboration. These positions will attend the "Mental Health and Psychosocial Support Program Management and Supervision" training course sponsored by NOVA University of Lisbon. Their qualifications do not need to be clinically technical, but they will be required to understand the basic tenants of the program and be able to oversee health center operations beyond the intense supervision phase.

Chief Field Health Program (existing position): The head of the field health program will oversee all aspects of the rollout, supervising and managing the division heads, area health officers and health center staff when required. The extent of their engagement will depend on how much responsibility and autonomy is given to the head and assistant division head.

HQ MHPSS Program Coordinator (new role): This role will oversee the rollout, help coordinate and arrange for trainers, work with field offices on allocating finances, conducting baseline data and work with supervisors. At a HQ level, the position with liaise with other program departments (RSS,

Education, Protection), advocate for funding, publish reports/articles on achievements and create global partnerships.

Phase 2 (Integration: Year 3→)

	Field Level Phase 2 Management/Supervision										
	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	2017	2018	2019	2020	2021	2022
In-house Trainers/ Supervisors								Ongoing Refresher Trainings, Training New Staff			
Senior Staff Nurse		Ongoing supervision to nursing staff									
Senior Medical Officer		Ongoing supervision to health center staff									
Area Health Officer		Ongoing supervision to health center operation									
Field Office Division Head								Beyond P1 develop exit strategy or absorb long term			
HQ Program Coordinator								Beyond P1 develop exit strategy or absorb long term			

In-house mhGAP & MHPSS trainers: Beyond the expansion phase, it will be necessary to have trainers on staff who can conduct refresher trainings, induct new and replacement staff, and serve as supervisors when required. These roles may be filled beyond the rollout phase by particularly exceptional staff who showed an affinity for the training content and were able to pick up on key roles and responsibilities early on. It can be within existing staff on a part time basis. It could be that staff conducts an induction at a "model" MHPSS center where the trainers reside.

Senior Medical Officer & Senior Staff Nurse: As these staff are given more training and become more comfortable with their roles, they will be able to act as direct supervisors to staff and will continue to be the focal point for referrals within the Agency and to outside services.

Area Health Officer: As the capacities of the AHOs are strengthened during the rollout phase, they will incorporate MHPSS supervision the way they do all other health center activities. Additionally, they will act as a liaison between other programs at the area level for referrals and feedback.

(Assistant) Field Office Division Head: Depending on the human and financial resources of the field, one of two decisions will be made beyond a 3 year funding cycle:

a) absorbing at least the Division Head role into the GF through reallocation. This would mean that the DH role will exist, as they do for all other key health activities (NCD, MCH, nursing, etc..). The DH roles and responsibilities will mirror those of other division heads. This scenario is preferable.
b) absorbing the responsibilities of the staff into existing staff roles. This would mean a gradual three year transfer of technical skills to existing division heads so that they may oversee MHPSS integration in their respective programs (NCD, MCH, etc..). While this is true to the idea of full "integration" of the service and downplays the idea of it being a vertical program, it does mean that

some technical oversight is lost, and may be lost in translation. Additionally, the financial investment made in field office staff through the NOVA training course would be lost.

HQ MHPSS Program Coordinator: This role can also go the way of the division head role. After successful rollout, the HQ role will be reduced to M&E and oversight, as with other health activities. The maintenance of this role will be dependent on need and funding availability.

3. Training Requirements:

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: 1 day**
    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 goal of this part of training is to create an environment within the health centre in which clients feel safe. It will also create an atmosphere in which every client is viewed in a different, holistic way – one that recognizes there are many facets to 'health'.
    c. **Psychological First Aid (PFA)** is a human, supportive response to a fellow human being who is suffering and who may need support. It is important in its communication of the Do No Harm principle and self-care basics. It takes 4 hours and should be part of the first day of orientation as it is beneficial for all staff working in the health center. PFA involves:
        i. Providing practical care and support which does not intrude;
        ii. Assessing needs and concerns;
        iii. Helping people to address basic needs (i.e. food and water, information);
        iv. Listening to people but not pressuring them to talk
        v. Comforting people and helping them feel calm
        vi. Helping people connect to information, services and social supports;
        vii. Protecting people from further harm[11]
2. Introduction to psychology/basic MHPSS concepts for **all Family Health Team staff (including psychosocial counsellors and physiotherapists, where available): one day**
    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. Additionally, the two days will serve as a refresher for medically trained doctors and nurses for whom these concepts may have only been introduced during their studies years ago.
    c. 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 doctors, nurses, midwives, and psychosocial counsellors and physiotherapists, where available: 5-6 days**

[11] World Health Organization, War Trauma Foundation and World Vision International (2011). Psychological first aid: Guide for field workers. WHO: Geneva.

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 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. These activities will primarily include facilitating the five session support groups, detailed later in the documents.
c. In the West Bank and Gaza Fields, where psychosocial counsellors exist, they will participate in and contribute to the training, where possible.
d. Preliminary overview and brief introduction to mhGAP conditions to be managed, and their medications

4. mhGAP training on diagnosis, medication and care management for **staff nurses, medical officers and psychosocial counsellors, where available: 6 days**
   a. This technical-level training will give medical officers and staff nurses an understanding of the specific detection, diagnosis, care management, follow-up and referral pathways for clients with mental health illness.
   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.
5. Training on Protection for one day. This training to be coordinated with protection and can be delivered as an integral part of the MHPSS training package.

Each field and health center will need to explore the training schedules and options that work best for their situation, but we consider the above outlined package to be the minimum amount of time required in order to consider staff properly trained.

The mechanism for conducting the training will vary, based on field resources and availability of replacement staff. Possible schedules can include: training the entire health center at one time, which requires replacement staff; training by area, in order to reduce absent staff; training on the job; training after hours; or a combination of schedules. Feedback from the pilot experience is that staff are in a better mindset to learn when they are brought off-site for the training, and that interspersing the classroom training with on-the-job follow up would allow for better retention

Annex III: Infrastructure Requirements

Private and Comfortable Consultation Spaces: Consultations with clients should be conducted in confidence. This means that doors to consultation offices should be closed. Staff should be respectful of a consultation in progress, and should not enter an office without knocking, and receiving permission to enter. Clients should also be encouraged to wait outside the room and not intrude on a consultation in progress. Clients should have a chair to sit in, and should feel physically comfortable during consultation.

Persons with Disabilities: Persons with disabilities are particularly vulnerable to developing MHPSS issues, and UNRWA health centers should be safe spaces for them to seek care. There are a number of simple principles that can be followed to ensure a health center visit is as pleasant as possible for a client.

` Reach, Enter, Circulate, Use: Good accessibility for all persons – but particularly those with disabilities – is built around the RECU principle, which adopts the principle of "unbroken chain of movement" to enable people to:

Reach: move around the community to get to the service you wish to use from your home; affected by pathways, linking pathways, slopes, transport systems, signage, etc..

Enter: being able to get inside the building you wish to use; affected by steps, ramps, handrails, door width, door handles

Circulate: being able to move about inside the building; affected by corridors, thresholds, door widths, resting places, light, signage and dimensions

Use: being able to use the services and facilities; affected by dimensions and design of internal furniture and communication

Key considerations in Accessibility:

Staff awareness of disability and accessibility: This is an important pre-condition to ensuring accessibility of services to all users. It is important to raise awareness among both staff and clients of the HC to ensure that accessibility is considered at all times for example people should avoid parking bikes on the ramps or putting plants along the corridor that will limit circulation etc. Awareness-raising and information sessions are important to ensure staff are able to notice and take action in case of improper or inappropriate use and also inform users.

Consultation with and involvement of persons with disabilities: This means including women and children with disabilities and their family members in planning and design of new facilities and in conducting accessibility checks of existing facilities. This is essential to understanding how the environment and infrastructure affect their ability to reach, enter, move around within and use services

Accessibility features: The most important features of an accessible health center are detailed in the

Disability Inclusion Guidelines created by the Protection Unit. These features must be regularly checked and maintained, to ensure continued access

Annex IV: Support or (suggested) Group Sessions

Structure of group session:

Session No 1: Drawing, Autogenic Training & Biofeedback, Meditation and mindful eating.

a. Welcoming remarks
b. Opening Meditation: use deep breathing exercise relaxation
c. Discussion of group guidelines: Confidentiality, mutual respect, punctuality, commitment and homework.
d. Introductions: each participant will be asked to tell the group about work, family, health, his motive to participate in the group etc.

The main exercise:

1. **Drawings**:
   - The facilitator will present: what is drawing, types of drawings, benefits of drawing and the relationship between drawing and the mind and the body
   - Ask each member to do a drawing for her/himself :
     - as you see yourself now,
     - with your biggest problem
     - with your biggest problem solved
     - as you want like to see yourself
   - Share drawings
   - Collect drawings
2. **Meditation:**
   - explain:
     - What is Meditation?
     - The different kinds of meditation
     - Short and long term benefits of meditation?
     - How to get started and how to choose the most appropriate kind of meditation to do now and in the future
   - Discuss what might happen in meditation
   - Start practical exercise: Do a meditation. (If there is time, you can do more than one) meditation but provides an opportunity for participants to share after each exercise). Meditations may include: Soft Belly, Shaking and Dancing, Walking Meditation, Mindfulness Meditation and others.
   - Invite participants to try a meditation exercise as "homework" and see what they notice over the course of the week.
   - Share experience
   - Closing meditation
3. **Mindful Eating**
   - Explain: why we include mindful eating in the skill's group
   - Discuss whole foods vs. process foods and effects on health

- Discuss the typical Palestinian diet
- Discuss what basic good diets look like?
- Do an eating Meditation
- Share experience
- Invite participants to do a take home assignment, for example, notice how you feel after eating or experiment with limiting something like dairy or wheat
- Closing meditation

e. Give instructions for homework,
f. Closing Meditation

Session No 2: Autogenic training and biofeedback

a. Welcoming remarks
b. Opening Meditation: use deep breathing exercise relaxation
c. Discussion of group guidelines: Confidentiality, mutual respect, punctuality, commitment and homework.

Main exercise:

Provide background Information on:

- Fight or flight response and self - regulation,
- acute vs. chronic stress,
- how the nervous, immune and endocrine systems adapt to chronic stress,
- discuss the sympathetic and parasympathetic parts of the NS, discuss the interaction of mind and body (psycho-neuro-endo-immunology)

Discuss autogenic: What is it? How does it work? Why is it helpful? Use imagery in autogenic and discuss phrases and how they affect physiology.

Discuss biofeedback: What is it? How do bio-dots work with brain and body? When might it be helpful? What is the goal? What are the pitfalls? How do you put on and use the bio-dot?

Practical exercise: Autogenics & Biofeedback

Share: How was this for you? What did you notice?

d. Give instructions for homework (using the bio-dots how, when, where etc.).
e. Take home message: we can control and affect our physiology.
f. Closing Meditation

Session No 3: Exercise of relaxed breathing and movement

a. Welcoming remarks
b. Opening Meditation: use deep breathing exercise relaxation
c. Discussion of group guidelines: Confidentiality, mutual respect, punctuality, commitment and homework

M**ain exercise:**

Explain: respiratory system, what is breathing, the difference between deep and shallow breathing, what is stomach breathing, the effect of breathing on stress, worries and fatigue, what do mean by energy? What is the best type? How does mood influence our movement,
Discuss the interaction between breathing, movement and the mind and the body.
Implement a deep breathing exercise and movement exercise.

Session No 4: Guided imagery and self-awareness

a. Welcoming remarks
b. Opening Meditation: use deep breathing exercise relaxation
c. Discussion of group guidelines: Confidentiality, mutual respect, punctuality, commitment and homework.

Main exercise

- Discuss:
  - what is imagery?
  - what is visualization?
  - define active vs. receptive imagery
  - give examples of the power of imagery
  - discuss the use of all senses in imagery
  - how, when and why is imagery helpful?
  - discuss imagery and the mind and body connection
  - review how an image can affect physiology and psychology
  - discuss how participants can use imagery in various ways
- Practical exercise
- Share

d. Give instructions for homework,
e. Closing Meditation

Session No 5: Genogram and future planning

a. Welcoming remarks
b. Opening Meditation: use deep breathing exercise relaxation
c. Discussion of group guidelines: Confidentiality, mutual respect, "I Pass", punctuality, commitment and homework.

Main exercise:

- Discuss
  - What are Genograms and why do we use them?
  - How can genograms help us better understand ourselves, the ways we interact with others, and how we experience the world around us?
  - How is a Genogram different from a family tree?
- Explain how we can follow a trait, behavior, health condition, addiction…etc. through our family lineage using a genogram.

- Explore how Genograms can differ from one family member to another and from one point to the next in our lives.
- Experiential: Create a genogram
- Sharing of genograms
- Closing meditation

Annex V: Inclusive and non-Discriminatory Language

Recommended	Instead of
A person with a disability/ a person with disability Plural: Persons with disabilities or people with disabilities	'PWD','PWDs', 'Handicap', 'handicapped people', 'the disabled, and people'
A person without a disability/ a person without disability Plural: Persons without disabilities or people without disabilities	'Normal people' ,' The normal or People living normal lives', 'Able-bodied', 'sighted', 'hearing', 'able-bodied', 'normal', 'healthy', etc..
A person with a physical/ sensory/ intellectual/ mental/psychosocial disability OR a person with physical/ sensory/ intellectual/ mental/psychosocial disability Plural: Persons with physical/ sensory/ intellectual/ mental/psychosocial disabilities or people with physical/ sensory/ intellectual/ mental/psychosocial disabilities	'Handicapped', 'Crippled', 'Physically challenged' ,' The physically disabled', 'Physically challenged person', ' A cripple'. Mentally retarded / handicapped Retard Mentally challenged Mentally deficient / Intellectually disabled PWID (for person with intellectual disability) or intellectually challenged' 'crazy', 'mad' 'mental' or 'insane'
A person who uses a wheelchair Plural: Persons who use wheelchairs or people who use wheelchairs	'Wheelchair person', 'confined to a wheelchair'
A person who is deafblind A person with low vision A person who is blind Plural: Persons who are deafblind or people who are deafblind Persons with low vision or people with low vision Persons who are blind or people who are blind	The blind Problems with sight Misty vision PVI
A person who is hard of hearing A deaf person Plural: Deaf people or deaf persons Persons who are hard of hearing or People who are hard of hearing	the deaf the hard of hearing deaf and dumb
A person with a speech disability/ a person with speech disability Plural: Persons with speech disabilities or people with speech disabilities	'Dumb ', 'Dumb person/people', 'Mute / Mute person', 'Speech impaired person', 'PWSI', 'Problems with talking', 'The speech impaired'
A person with a mental health problem Plural: Persons with mental health problems or people with mental health problems	Insanity/ Insane / Lunatic Mentally sick / Mentally imbalanced Mad person / Mentally ill person / Psycho / Crazy people
A person with epilepsy	People with the epilepsy illness

Plural: Persons living with epilepsy or People living with epilepsy	People who fit An epileptic
A person with a disabling illness Plural: Persons living with disabling illnesses or People living with disabling illnesses	The sick
A person living with HIV Plural :People living with HIV	AIDS-infected People living with HIV and AIDS 'PLWHA'
Client Service-user	Patient Victim
A person with a brain injury Plural: People with brain injuries	Brain damaged people Stroke victims, car crash…
Person with Down syndrome	Mongol, retard
Person with cerebral palsy	spastic
Person with autism	autistic people
Person with Attention Deficit Hyperactive Disorder (ADHD)	Hyperactive
People with brain injury	brain damaged people
People with paraplegia	paraplegic people
Person living with depression	suffers from depression

Guiding Principles and Language

Sustainability: It is important to ensure the sustainability of any framework we seek to implement. Therefore, it is imperative that services are integrated into the daily operations of health centers and are not disproportionately reliant on temporary, project funded specialists. Any project funding offered in the future must support the capacity building of existing staff, support the improvements to infrastructure that may be required, or include continuing education training for key leadership. It is not appropriate for project funding to support any short term addition of specialists, including psychologists and psychiatrists.

Do No Harm: Because of the sensitivity of issues dealt with in MHPSS work, there is a potential to cause harm. However, in an effort to mitigate and minimize the potential harm caused by UNRWA's MHPSS work, we will adopt globally accepted and evidence based interventions. 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. It is also essential that UNRWA remain cognizant of universal human rights and relationships and dynamics with host governments.

Resiliency: "Resilience is the process of adapting as well as possible 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 behaviors, thoughts and actions that can be learned and developed in anyone", but it also always refers to processes in the community, networks etc. It is thus not a static condition to be

obtained but a continuous process UNRWAs framework is one of resilience building, focusing on further developing individual and community strengths and capacities.

Confidentiality: Respecting confidentiality and guaranteeing the privacy and security of individuals, their families and wider communities must be of paramount consideration at all times. Break of confidentiality or careless handling of information can have serious consequences for personas of concern as well as for our partners, our colleagues, and even the humanitarian operation as a whole. Vigorous data-protection methods must be in place to guarantee the security of recorded information. Additionally, privacy should be ensured during individual counseling sessions.

Impartiality: Humanitarian action must be taken without any adverse distinction based on nationality, ethnic origin, religion, class, political opinion or other ground. 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.

Annex VI: Protection section

Definitions

The definitions of protection cases were endorsed Agency-wide in 2015, and should be used by all field offices and HQ Departments when reporting on protection activities. These definitions align with RBM reporting and international standards. All databases and information collection and management tools should reflect these definitions;

All MHPSS trainings should include a specific session on protection case identification, management, and referral. This session can be conducted by a member of the field office protection team, or one of the MHPSS trainers, as long as the content has been approved by a protection focal point.

There are three categories of protection cases within which UNRWA will collect data: general protection, GBV, and child protection. GBV and child protection comprise the majority of cases detected in health centers, though each field will have unique general protection threats they may see through the course of daily activities. Staff should be familiar with all definitions.

The tables including definitions are available in both English and Arabic in the **Annex**.

Assistance within the scope of health

Each field has different capacities to care for protection cases; it is not within the scope of this document to be prescriptive about the mechanisms in each field. Generally, health staff are not trained in dealing with sensitive protection cases. However, minimum humanitarian standards should be maintained when dealing with protection cases which should be outlined in each field's SOPs created in conjunction with Protection Units.

Informed consent should be given before any referrals are made. In the event that consent is not given by the client or their guardian, the most health staff can do is provide information and allow the client to leave. A health staff member should not try to address the case unless they have special training to do so. This could cause further harm to the survivor, and could potentially put them in danger.

Supervisors should be consulted in such cases, in order to protect both client and staff member. This is particularly important in child protection cases, when a guardian may have an agenda for refusing care that is in the best interest of the child.

Standard Operating procedures, including roles and responsibilities, standard forms and Referrals pathways need to be defined in conjunction with Protection Units in each field. This process is ongoing in each field office.

Identification of protection issues
Gender Based Violence (GBV)

1. **Physical Signs of GBV**[12]

Head, Neck and Oral Examination

a. Bleeding (or dried blood), swelling, abrasions and trace evidence (ex. fibres, leaves, etc.). Matted, sticky hair could be caused by seminal or body fluid.

[12] Adapted from IASC, Caring for survivors of sexual violence training pack, 2010.

b. Injuries related to hair pulling.
c. Injuries caused by biting (ears, nose, cheeks).
d. Injuries caused by sharp instruments (ex. slashing the face) or by blunt force (ex. punch in the nose).
e. Injuries related to attempts to silence the survivor (ex. rag stuffed in her mouth).
f. Injuries to lips, gums, palate and throat from forced oral sex.
g. Bite on neck, stab wounds, marks from attempted strangulation (by hand or by cord/rope).

Upper Body: Arms, Chest, Torso

h. Injuries/marks on wrists from restraints (by cord/rope).
i. "Defensive injuries" – wounds on arms and/or hands which are held in a defensive position (could be bruises, sharp or blunt force trauma).
j. Injuries to hands – including defensive injuries, burns (ex. cigarette burns to the palms).
k. Injuries to breasts from biting, sucking, squeezing, pulling, pinching, burning (ex. cigarette burns), slashing or piercing.
l. Injuries to chest and abdomen from whipping, kicking, punching, stabbing, biting, cutting. Document if the injury reflects the shape of the article used to inflict it (ex. electric cord, belt buckle).

Examine the abdomen noting injury patterns that predict internal damage (ex. a boot print bruise on the lower abdomen could correlate with damage to the small intestine).

Lower Body: Buttocks, Legs and genital parts

a. Injuries or marks lower legs from restraints.
b. Injuries to buttocks or legs from whipping, kicking, punching, stabbing, biting, cutting. Document if the injury reflects the shape of the article used to inflict it (ex. electric cord, belt buckle).
c. Burn injuries including from cigars or cigarettes (especially on the soles of feet).

For genital examination, refer to trained doctors.

2. Signs of distress and extreme distress

a. Physical reactions: shock symptoms, high blood pressure, headaches, palpitations, startle-reflex, sleeplessness, dizziness or disorientation, fatigue, hyper-arousal.
b. Emotional reactions: irritability, feeling overwhelmed, anxiety, fear, sudden mood shifts, denial, isolation or 'numbness', feelings of hopelessness.
c. Thoughts (Cognitive) reactions: nightmares, reliving the incident, responses to triggers, dissociation, concentration and memory problems, blaming yourself.
d. Behavioural reactions: nervousness, decreased appetite, suicide-attempts.
e. Social reactions: changes in the interaction with others, like withdrawal, isolation or fear to be alone, rejection, changes in the relationship with family etc., partly caused by the reactions of people around the survivor, partly caused by the emotional, behavioural and cognitive reactions of the survivor.

Children affected by violence, abuse and exploitation

Physical and Psychological signs: Children could be exposed to different levels of violence and experience different degrees of traumatic events. Age, gender, personal temperament, and prior history of violence will influence how a child reacts to and is affected by violence and abuse.
Here are some of the factors that can influence children's reaction to violence[13] (and in particular domestic violence):

a. Age, gender and socio-economic context.
b. The severity of the violence: life-threatening event, weapons involved, serious injuries, etc.
c. The child's perception of violence (a child might consider normal violence against him or her, or could experience it as life-threatening)
d. Secondary adversity events: losing a relative or friend, displacement, etc.

Children's reactions and symptoms on the short-term:

a. Hyper-vigilance and hyperarousal. The child may become nervous, hyper active, easily upset.
b. Avoidance: the child becomes shy and withdrawn, avoiding people or situations, becoming extremely quiet, isolating him or herself from normal life.
c. Trouble going to sleep or staying asleep, having frequent nightmares.
d. Sudden violence towards peers, aggressive behavior.
e. Loss of appetite.
f. Children younger than 5 years old could experience developmental regression: bed-wetting again, asking for bottle feed again, fears of dark, etc. They can also experience intense separation anxiety.

Children's reactions on the long term:

a. School absentee, low academic performance
b. Moderate to severe Symptoms of post-traumatic stress disorder.
c. Chronic somatic complaints (stomachaches, headaches, fever)
d. Depression
e. Anxiety
f. Alcohol and substance abuse
g. Run away from home
h. Suicidal thoughts and suicide attempts
i. Sleep difficulties
j. Poor concentration and distractibility

Assessment:

When a health care staff suspects a child could be victim of violence, s/he should further enquiry on the family situation of the child. Ideally the child would be interviewed without the presence of parents, but when not possible, doctors will enquiry by using indirect questions. When asking a child in front of his/her parents, it is important to pay attention to who answers which questions: if the mother or father

[13] *Domestic Violence and Children*; the National Child Traumatic Stress Network, 2010

response on behalf of the child, not allowing him/her to provide response; of if a child looks at the parents seeking approval before responding a question, this could indicate the parents' intention to hide sensitive information. In a sensitive manner, the doctor can still ask the child to respond. "Control questions" are also useful in gathering information from children and parents.

Questions can be asked by any health care provider who has received training and is aware of the dynamics of violence against children, knows how to assess and make question to children; understands the concept of "best interest of a child" and how to determine it and knows how to refer cases to relevant service providers outside health centers.

Indirect questions: Asking a child questions about their normal day to day, likes and hobbies, could give provide with very useful information on his/her family environment.

a. How are you doing at school? Do you like to study?
b. What would you like to do when you grow up? Do you want to be like your father/mother? What do they do? And your grandparents and uncles? Do they live in your house?
c. How do you go along with your siblings? And with your friends? What activities do you like to do after school?
d. Do you behave well at home? When you misbehave, who gets angrier at you, mum or dad?
e. Do you stay up until late? How well do you sleep? What do you dream when you sleep?
f. I see you have hurt your (part of the body), do you practice sports?
g. Do you feel your chest hurts even if you haven't had any injuries?

Control questions, or proving questions: These are questions aimed at checking and verifying the consistency of the facts given by a person or a child. It consists in asking for the same information in different ways and at different times, or presenting information that differs from the one the child has provided. For example, when asking a child how he hurt his arm, a child says he fell of the stairs while returning home from school around noon, and that he was alone at that time; you change subject and talk about something different (the school grades, for example) and a while later you ask the child "so you told me you fell of the stairs in the evening when you were playing with your brother". The degree of consistency or inconsistency on the child's answers could indicate that the child is hiding the real way in which he hurt himself.

What is most important when assessing a child suspected to be survivor of violence, is to develop trust with him/her, encouraging the child to talk and share his/her feelings. A few tips on how to talk to children are:

a. keep eye contact; sit at the same level, if possible sit in chairs not far from each other
b. Take the time to talk to the child about his personal life: where is s/he from, how many siblings s/he has, favorite sports, school subjects, friends, etc. Answer yourself the same questions, tell something personal about yourself, and use sense of humor.
c. Let them talk and tell their stories, even if s/he is talking about something seemingly not related to your question, it could provide you useful information.

d. Don't blame, don't judge. Do not tell or insinuate the child how s/he has to behave, and that whatever has occurred is his/her fault. Do not make any comment that may feel the child you are judging him/her.

Use a simple language that the child can understand, use appropriate jokes and try to get the child to tell you jokes as well.

Management: What to do when you have identified a protection case[14]

a. If you have the client's consent, you can contact a case manager and facilitate the contact between the case manager and the client
b. All information should be kept confidential, even if family or community members request feedback on support given (which cannot be provided). However, there is an exception for cases involving children: depending on the situation and the age of the child, parents would be informed and issues would be discussed with them, except in those cases in which a family member is the perpetrator.[15]
c. During the course of normal duties personnel should be alert to signs of abuse and neglect and refer these signs to case managers after seeking consent from the client. However, personnel should avoid asking the client direct and specific questions that can lead to stigma and put clients and personnel at risk.
d. If personnel become aware of cases of suspected child abuse or neglect from outside of the Agency, they should refer them in accordance with SOPs in each field office. It is important that anyone with a concern about a child's safety feels comfortable to come to discuss or report.[16]

What to do if UNRWA personnel suspects abuse by another personnel

Allegations of violence, abuse and exploitation committed by UNRWA personnel should be reported to the DIOS hotline (please see below) or any DIOS investigation staff as soon as possible to ensure that important evidence may be preserved and the UNRWA investigator(s) can assess the proper course of action, taking into account the totality of the circumstances. The Agency prioritizes investigations into allegations of sexual abuse and exploitation.

DIOS Hotline Contacts

Email: hotline@unrwa.org; Phone: Jordan: 06 5808686, Gaza: 08 2887127; West Bank and Jerusalem: 02 5890772, Syria: 01 16116717, Lebanon: 01 830441

DOES AND DONTS FOR CASE IDENTIFIERS

If approached by person who seeks help to address a protection concern you should:

a. Ensure that discussion with client is done in a confidential and quiet place.
b. Comfort the client using statements such as: "It's not your fault", "I believe you", "I am sorry

[14] This and other paragraphs are part of the upcoming UNRWA Guidelines to address protection cases, to be published in 2017
[15] Adapted from Interagency Emergency SOP for prevention and response to GBV and violence, abuse and neglect of children in Jordan, 2014.
[16] UNRWA Child Protection Framework, Pillar 2: Safeguarding Children, paragraph 64.

this happened to you", "You are very brave for telling me".

c. Listen with a non-judgmental attitude.
d. Understand the referral pathway and be aware of the services available in your area. Provide this information to the client inform the client about the opportunity to be referred to counseling and psychosocial support services.

If approached by a client who seeks help, you <u>should not:</u>

a. Advise/encourage the client to seek a certain type of service. Limit your interaction to providing information and not advising the client on your preferred option.
b. Ask questions about the incident or issue to the client. Remember that it is not your role to decide whether the person is saying the truth or not, whether he/she really needs help or not. Asking the client to tell his/her story several times will traumatize the client unnecessarily since the service will not be provided by you.
c. Raise expectations – be honest and accurate (e.g. don't say things like "they will give you money, they will solve all your problems").

WHAT TO DO WHEN YOU IDEANTIFY A CHILD PROTECTION CASE

When a child, or his/her parents, disclosure an incident of violence the child is victim of, you should immediately report according to the system develop in your health centre and area/field office. The same principles that apply to report and refer cases of GBV and protection (see principles under Principles Chapter), apply as well when reporting cases of violence and abuse against children: humanity, do not harm, safety, confidentiality, dignity and respect, non-discrimination, consent and security of information. Only staff trained to address cases of child protection should be involved in providing a response to a child survivor of violence; disclosure of cases identified by health staff should be made to trained staff within the health centre or within the organization.

But there are also other important principles that need to be observed when identifying and responding to cases of child protection:

Best Interest of the child.

The "best interest of a child" encompasses a child's physical and emotional safety (their wellbeing) as well as their right to positive development[17]. As describe in Article 3 of the United Nations Convention on the Rights of the Child (CRC), the best interest of the child should *provide the basis for all decisions and actions taken, and for the way in which services providers interact with children and their families*. When deciding on the course of action for a child survivor of violence, abuse and exploitation, health staff will assess the physical, emotional and developmental needs of the child and will prioritise the interventions that will ensure children's right to safety and on-going development.

The "best interest determination" is the process to determine what is best for a child for a particularly important decision, and balances all relevant factors in order to assess the best options for the child.

[17] Interagency Guidelines for Case Management and Child Protection; Child Protection Working Group, 2014.

The process shall ensure proper participation of the child without discrimination. It involves all decision makers from relevant service providers and experts. Most commonly, the best interest determination process is applied when there is a need to identify durable solutions; when temporary care arrangements are needed to ensure the safety of the child and when the child has to be separated from his/her parents against their will.

Often, when responding to violence against children, there is no one ideal solution possible, but rather a series of acceptable choices that must seek the best interest of the child, or minimize the harm to him or her development.

Meaningful participation of children

Children of all ages, and in particular adolescents, have the right to be consulted, express their views and participate in decisions that affect their lives. Children should be made aware of their right to participate in decision making by health staff and social workers. The child's participation and consultation helps health staff and social workers to ensure, as much as possible, that the determined course of action is not against his/her wishes. It also ensures children's understanding on the implication of certain decisions, or in participating in certain services.

Young children also have the capacity to understand what is happening to them and to take decisions, however it will require more time and skilled staff to ensure the child properly comprehends the decision making process and its implications.

Child empowerment and resilience building

Health staff and social workers have a role to play in empowering children and their families to recognize, prevent and respond to child protection concerns themselves[18]. When assessing a child and his/her family situation, health staff must also enquire on the positive coping mechanism, protective networks, resilient strengths that allow the child and his/her family to better care for themselves.

Most children are resilient if given proper help following an incident of violence or abuse, with families and communities playing the most important role in children's recovery. Crucial to a child's resilience is the presence of a positive, caring and protective adult. Although a long-term relationship with a caregiver is best, even a brief relationship with one caring adult- mentor, teacher, and nurse- can make an important difference. Other protective factors could be: participation in positive social and cultural activities; feelings of self-esteem and self-efficacy; religious or spiritual believes; a competence at doing something that attracts praise and admiration; and good performance at school.

What to do when you identify a case of GBV

- Conduct a physical exam.
- Treat physical injuries.
- Acute psychological distress /refer immediately

[18] Interagency Guidelines for Case Management and Child Protection; Child Protection Working Group, 2014.

If you identify sexual violence, Always refer to specialized services (as per SOP)- but always provide information on the need for the survivor to access the following treatment within 24-72h: .

- Treatment of sexually transmitted infections.
- Treatment to prevent HIV.
- Reproductive health care services including pregnancy prevention.

Always make sure that:

a. You do not force or pressure a survivor to have ANY examination, intervention or treatment against his/her will. This includes not making treatment conditional on consent for any other part of her/his care.
b. Enable a survivor to make her/his OWN decisions about receiving health care and treatment.
c. Provide a survivor with appropriate information in a language s/he can understand so s/he can make informed choices.
d. Respect the choices made by the survivor

In addition, a health care provider should ensure that:

a. A survivor receives care in a private area.
b. A survivor is offered the possibility of a support person of the survivor's choice to be present for the exam.
c. Other than the support person if requested by the survivor, only people who are necessary to provide medical care to the survivor will be present for the exam.

- All medical and health status information is kept PRIVATE and CONFIDENTIAL

Psychosocial first aid[19]

Most individuals experiencing acute mental distress following exposure to extreme stressful events are best supported without medication. Health care providers should be able to provide very basic psychological first aid (PFA). PFA reflects the principles of a survivor-centred approach. It includes:

a. Protecting from further harm (in rare situations, very distressed persons may take decisions that put them at further risk of harm);
b. Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the survivor may be ready to give;
c. Listening patiently in an accepting and non-judgmental manner;
d. Conveying genuine compassion;
e. Identifying basic practical needs and ensuring that these are met;
f. Asking for survivor's concerns and trying to address these;
g. Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances; explaining that people in severe distress are at much higher risk of developing substance abuse problems);

[19]Adapted from ***IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings***, Action Sheet 6.2, pg 119-120. © Inter-Agency Standing Committee 2007. http://www.humanitarianinfo.org/iasc/content/products/default.asp

h. Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual support);
i. Encouraging, but not forcing, company from one or more family member or friends;
j. As appropriate, offering the possibility to return for further support;
k. As appropriate, referring to locally available support mechanisms or to trained health care providers.

Referrals of protection cases

Beyond the assistance which can be provided within the scope of health, the assistance to protection cases includes psychosocial support, lega aid, specialized child protection case management, shelter, etc. Referrals should follow referral pathways developed in each field office.

Once a safe and confidential referral system is in place, personnel are trained on SOPs and agreements (MoU) are made with partners, and once UNRWA personnel have obtained the written informed consent from the client, UNRWA personnel can conduct the referral, which is the most common response UNRWA provides to identified protection cases. When UNRWA personnel make a referral, it is important to ensure that within that particular service there is an internal referral focal point trained to receive referrals, record information, provide feedback on referrals received, and document feedback on referrals provided by other agencies. These are the more specific key steps to follow when conducting a referral:

a. If the client agrees to referrals, he/she must give his/her written informed consent before any information is shared with others.
b. Parental consent should be obtained in cases including children (except where it might put child in danger or otherwise be against their best interest).
c. Provide information to the client on how to access the identified services, providing name and contact of the focal point, facilitate access when poverty or disabilities are a barrier (for example financial support for transportation, financial support to cover service fees, physical presence to help in dealing with the service provider), and in the case of unaccompanied children.
d. Document the referral.

Referrals should be made using a standard referral form which should include language in the context of disclosing information to external parties.

THE DIFFERENCE BETWEEN A FORMAL REFERRAL AND PROVIDING INFORMATION

Please note that providing general information on services is not to be considered a referral. Similarly, provision of information to an individual about how they can independently approach a service provider to seek services is not to be considered a referral (even if such information is provided on a one-to-one basis).

It is typically recommended to use one or more of these ways when making a referral:

a. **Accompany the client (child or adult):** In life threatening situations, it is recommended that the case manager accompany the client to the service provider. For child protection and GBV

cases, ensure that accompanying the client does not put the client at risk or is stigmatizing. The referral should be documented by a referral form. Depending on the nature of the case, other clients may also need to be accompanied, for example, in cases of clients with disability, a family member, caregiver or the caseworker may be required to accompany the individual based on his/her wishes and capacity.

b. **2. Referral by phone:** For emergency or urgent cases if accompanying the client is not possible or is not in their best interests a referral by phone is recommended. The referral should always also be documented by referral form to the receiving organization. When you call, chose a quiet place where details of the case are not heard by others. Only share very basic information that allows the receiving agency/department to take action.

c. **Referral by email :** Email referrals are the preferred way to document all GBV and sensitive child protection cases. For urgent cases, email referral should be done in order to document the referral, followed by either an in person or phone referral. When using email for referral, it should only be sent to the relevant focal point from the referral pathway, and those not involved in managing the case should not be put in copy. Efforts should be made to put in place a password protected system for sending such emails.

Informed Consent: When referring a case, there is a need to share information with service providers, but the very simple action of sharing information about a protection case can have serious and potentially life threatening consequences, especially in GBV cases.

UNRWA personnel should therefore explain to the client how information will be used and that clients have the right to control how information about their case is shared with other agencies or individuals. In addition:

a. The client must be made aware of any risks or implications of sharing information about her/his situation.
b. The client has the right to place limitations on the type(s) of information to be shared, and to whom
c. If a client agrees to referrals, she/he must give written informed consent before any information is shared with others.
d. All information should be kept confidential, even if family or community members request feedback on the support given. The number of people informed of the incident and the information shared should be limited. Identifying information about a client should never be shared in meetings and protection cases should never be discussed.

When is consent really informed? To ensure consent is genuinely informed, you must explain to the client:

a. All the options that are available.
b. That information will be shared with others in order to access other services.
c. What is going to happen as a result of accepting services.
d. The benefits and risks of the service.
e. He/she has a right to decline or refuse any part of the service.

f. The limits to confidentiality.[20]

Obtaining informed consent from clients, especially sexual violence survivors, may require time to build trust. You must ensure that they fully understand the options and support them to take an informed decision. During case management, informed consent is an ongoing process which involves discussing different options over time with the client.

For more information please refer to UNRWA Guidelines to address protection cases – to be published in 2017.

Exceptions to informed consent

Confidentiality and informed consent should always be required prior to a case manager undertaking a referral, except in **very exceptional circumstances** where there are compelling reasons to do so in order to**:**

- Avoid risk of harm to the client(s), witness(es) and/or the public *such as* when there is evidence that:
- a client is at immediate risk of his/her own life
- a client is at immediate risk to seriously harm another person
- child abuse or neglect is suspected and it is in the best interests of the child
- Ensure the proper administration of justice such as when UNRWA personnel directly witness abuse or when UNRWA personnel have information that will ensure facilitation of a criminal investigation or prosecution of for example Sexual Exploitation and Abuse allegations (for definition and instructions, see below).

When there is a lack of consent in such exceptional circumstances, the case supervisor should always be informed and should make a decision in consultation with the case manager.

Mandatory reporting: Engaging with National Authorities

Many national governments have enacted laws and policies that mandate certain organizations and/or persons in helping professions (teachers, social workers, health staff, *etc*.) report actual violence and abuse (*e.g*. physical and sexual violence, neglect, emotional and psychological abuse). In UNRWA's five field offices, host governments or authorities may require the reporting of criminal offences in specific circumstances. However, Agency's documents, including the information contained therein, are inviolable and the Agency is immune from all forms of legal process. Therefore, when it comes to dealing with national authorities in the context of protection cases, the Agency cannot be compelled to disclose information to national authorities. Similarly, personnel are immune from legal process in relation to words spoken or written or acts performed or information obtained in their official capacity. Accordingly, personnel cannot be prosecuted for or compelled to disclose information relating to their official functions. Engagement with national authorities may be done on a voluntary basis and in a manner that safeguards the Agency's privileges and immunities. The UNRWA Legal Privileges and

[20] Adapted from Interagency emergency SOP for prevention and response to GBV and violence, abuse and neglect of Children in Jordan, 2014.

Immunities Instruction sets out detailed guidance concerning the Agency's engagement with national authorities.

While the Agency may choose to voluntarily disclose information about protection cases to national authorities, this should be done in a manner that is without prejudice to applicable privileges and immunities of the Agency and its personnel, which may require a waiver of privileges and immunities if legal process has been issued against the Agency or its personnel. The Agency may also voluntarily disclose information to national authorities, independent of receiving a request. Generally, disclosure of information about protection cases to national authorities would be done only with the consent of the client and without prejudice to applicable privileges and immunities. In exceptional cases, such as if there is a need to avoid risk of harm to the client(s), witness(es) and/or the public, or to ensure the proper administration of justice, the Agency may need to consider whether to refer the matter to national authorities without consent of the client.

In any protection case where engagement with national authorities becomes an issue– whether in response to a request for information, or directly in order to ensure the safety and security of a client – the issue should always be referred to the relevant Field Office Director for decision in consultation with the Field Legal Office and Department of Legal Affairs, even where the client has provided consented to the Agency contacting national authorities.

Mandatory reporting: Protection against Sexual Exploitation and Abuse (PSEA) and other misconduct alleged to have been committed by UNRWA personnel must be reported

The UN Secretary General's Bulletin[21] provides that all forms of sexual exploitation and abuse[22] alleged to have been committed by UN personnel must be reported internally through established agency reporting mechanisms. It is an obligation for all UNRWA staff to internally report on PSEA cases through established procedures.

Misconduct may be defined as any failure to comply with obligations under the Charter of the United Nations, UNRWA Staff Regulations and Staff Rules or other relevant administrative issuances, UNRWA Financial Regulations and Rules, or the Standards of Conduct of the International Civil Service, including any request or instruction by any staff member to violate any of these rules or standards. It is an obligation for all UNRWA staff to internally report on misconduct through established procedures.

! INFORM THE CLIENT ON MANDATORY REPORTING AND ITS CONSEQUENCES
Before beginning an interview: it is important to explain to clients that UN personnel must report misconduct, including PSEA, and the possible consequences of reporting.

Collect data on protection cases

[21] UN Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Abuse, ST/SGB/2003/13, 9 October 2003.

[22] The term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions, UN Secretary General's Bulletin, 2003.

New indicators in the 2016-2021 MTS include 8 related to protection and MHPSS. The methodology is available in the **Annex**. The protection indicators include cases that are identified and cases that are responded to following the tool below.

When collecting, analysing and sharing protection related information and data the most important consideration is to ensure that processes are safe and ethical. These imperatives are to 'do no harm' or put anyone at risk at any point and to protect sensitive information and personal data.
In general, it is important to always ensure the following when managing protection information and data:

Use Standard tools and definitions

a. Use the same classification agency wide (see tool below). This will allow the comparison of data across field offices and strengthen UNRWA analysis of protection threats and vulnerabilities.
b. Use standard tools to collect and analyze information. Example of this tool is below and attached (excel form)

Data security and protection

a. Collect, store and share information safely and ethically. Key actions to take to ensure data protection include the following:
    a. Only selected individuals can access information
    b. Paper documentation is avoided. In case there is paper documentation, it is stored in its own individual file and is coded, and kept in a locked filing cabinet.
    c. Internet/Web-based databases have security protocols in place.
    d. Access to computers should be password protected.
    e. Documents shared by email including referrals and case information should be password protected and safe systems are in place for recording/filing passwords and related files.
    f. All forms with identifying information, including consent forms, are kept separate from intake forms, which are coded and include details of the incident.
    g. Completed intake forms should never be transferred or shared between agencies to maintain the safety, security and confidentiality of information.
    h. Ensure that data management is constantly supervised.

General Protection	No of individuals directly identified with a case	Disaggregation of data					No of individuals referred by others	Disaggregation of data					Location	Type of Response			Total No of individuals provided with services	Disaggregation of data					Comments
		Boys	Girls	Men	Women	PWD		Boys	Girls	Men	Women	PWD		Direct Service provided	Internal referral	External referral		Boys	Girls	Men	Women	PWD	
Barriers to access to services																							
Physical Violence																							
Arbitrary detention																							
Issues related to legal status																							
Civil documentation																							
Torture																							
Human Trafficking																							
Housing, Land and Property																							
Restriction of freedom of movement																							
Psychological/emotional abuse and neglect																							
Other legal matters including family law, labour law, administrative law																							
Refoulement/ deportation																							
Onward movement and return																							
Rejection at the border																							
TOTAL																							

GBV case	No of individuals directly identified with a case	Disaggregation of data					No of individuals referred by others	Disaggregation of data					Location	Type of Response			Total No of individuals provided with services	Disaggregation of data					Comments
		Boys	Girls	Men	Women	PWD		Boys	Girls	Men	Women	PWD		Direct Service provided	Internal referral	External referral		Boys	Girls	Men	Women	PWD	
Rape																							
Sexual assault																							
Physical assault																							
Forced marriage (includes child and early marriage)																							
Psychological / Emotional abuse (includes neglect, threats violence, forced isolation, harassment / intimidation, gestures, etc.)																							
Denial of resources, opportunities or services																							
TOTAL																							

Child protection	No of individuals directly identified	Disaggregated			No of individuals referred by others	Disaggregated			Location	Types of Response			Total No. of individuals provided with services	Disaggregated			Comments
		Boys	Girls	PWD		Boys	Girls	PWD		Direct Service provided	Internal referral	External referral		Boys	Girls	PWD	
Child associated with armed forces/groups																	
Child labour and worst forms of child labour																	
Child in contact with the law																	
Corporal punishment																	
Sep/unaccompanied child																	
Birth registration																	
Child Abuse, Neglect and Physical Violence																	
Total																	

$$\%\ \text{of individuals provided with assistance / services} = \frac{\text{Total no of individuals provided with services}}{\text{No of individuals directly identified} + \text{No of individuals referred by other departments}} * 100$$

% of individuals provided with assistance/services=43/(34+12)*100=93.4%% - Note: The same individual can receive a number of services through direct intervention, internal referral or external referral, but the no for the percentage indicators is counted by “individuals” who received services and not the number of services s/he received.

Types of assistance include:

Type	Internal/External		Definition
Mental health and Psychosocial support	INTERNAL	EXTERNAL	Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder (IASC)
Health care	INTERNAL	EXTERNAL	Includes primary health care and financial support to access secondary and tertiary care, including rehabilitation services. Includes CMR.
Legal aid	INTERNAL	EXTERNAL	Legal aid is the provision of assistance through legal counselling, advice, assistance and representation. Legal assistance can be provided on matters including Civil registration, family law, legal stay, labour law, administrative law, housing land and property and criminal law.
Shelter support, material improvement and rehabilitation	INTERNAL	EXTERNAL	Material improvements for those living in inadequate shelter.
Food, NFI and cash assistance	INTERNAL	EXTERNAL	Assistance provided either through vouchers, food distributions, emergency kits or cash (SSN, cash distributions; emergency/protection cash).
Education, Special Education and Vocational training	INTERNAL	EXTERNAL	Support to access mainstream basic education, provision of recreational activities or learning support. Includes access to specialized education centres for people with disability and vocational training to practically equip clients with relevant skills and expertise for labor markets.
Registration and recording	INTERNAL	n/a	This includes ensuring access to official registration and/or recording with UNRWA in order to facilitate access to services as entitled as a registered/recorded refugee. Excludes civil registration.
Protection Counselling/Information provision	INTERNAL	EXTERNAL	Provision of information and advice to address Palestine refugees needs, including providing information on services available, their accessibility within UNRWA and among partners, etc.
Safe and Confidential Referral	INTERNAL	EXTERNAL	A safe and confidential referral is described as the process of formally requesting services for a client from another sector or organization (e.g.

			case management, cash assistance, health care, psychosocial etc.) through an established procedure and/or form. Confidentiality is the principle and legal obligation that requires service providers to protect information gathered about their clients and ensure it is accessible only with a client's explicit permission, except in exceptional circumstances such as when serious safety concerns are identified or where service providers are required by law to report abuse.
Economic and livelihoods opportunities	INTERNAL	EXTERNAL	Increasing the economic capacity of households through livelihood generation activities to promote self-reliance and resilience. This includes Livelihood programmes such as microfinance/microcredit, loans, skills development to promote and preserve the use of human capital, skills and assets and prevent households from further exacerbating poverty and protection vulnerabilities.
Safe house/shelter services	n/a	EXTERNAL	Temporary emergency **shelter** and confidential **services** to individuals at risk, including children and GBV survivors.
Specialised Case Management	INTERNAL	EXTERNAL	Case management is a way of organizing and carrying out work to address an individual's needs in an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or programme's objectives.
Security/police	n/a	EXTERNAL	Services provided by security services to protect survivors, their families and witnesses.
Family tracing	n/a	EXTERNAL	The activity to locate people and put them back into contact with their relatives. This work includes looking for family members, restoring contact, reuniting families and seeking to clarify the fate of those who remain missing.

Annex VII. Agency Wide Protection Definitions Master list

These definitions have been endorsed in 2015 and should be used by all field offices and HQ Departments when reporting on protection activities, for RBM reporting and as standard definitions when developing databases and information collection and management tools.

General Protection

Protection broadly encompasses activities aimed at obtaining full respect for the rights of all individuals in accordance with international law – international humanitarian, human rights, and refugee law – regardless of their age, gender, social ethnic, national, religious, or other background.[23] Protection is what UNRWA does to safeguard and advance the rights of Palestine refugees.[24]

This category includes cases of child survivors of protection. For example, protection issues affecting children like barriers to accessing services, civil documentation (excluded birth certificate) and trafficking should be included here.

Issue	Definition
Barrier to access to services **(Includes children)**	Refers to cases of individuals unable, because of protection related reasons, to access both external or UNRWA services, including Health, Education, RSS, Infrastructure & Camp Improvement, Emergency Assistance (Cash Transfer Programme and Special Hardship Assistance Programme). It includes individuals who cannot access UNRWA services for the following reasons: unable to register with UNRWA; lack of nationally approved civil documentation; eligibility issues (children of MNRs; Non-IDs and Non-registered; separated and divorced women; children not living with the UNRWA registered head of household); unavailability of service in determined location; physical inaccessibility to shelter and UNRWA facilities (such as for persons with disabilities). Also includes cases where individuals are unable to access services due to geographic isolation or emergencies.
Physical Violence (non GBV, non child protection)	Intentional use of physical force or power, threatened or actual that results or is likely to result in injury, death, psychological harm, mal-development or deprivation.[25]
Arbitrary detention **(This type of detention of children should be recorded under Child Protection**	Any involuntary confinement or deprivation of liberty, even for a relatively short period, including arrest, imprisonment and house arrest that is not permitted under domestic and international law. "Arbitrary" does not just mean "against the law". The Human Right Committee has advised arbitrary detention must be interpreted more broadly to include

[23] IASC-endorsed definition.
[24] UNRWA, Protection Policy, 2012.
[25] United Nations, World Report on Violence Against Children, 2006.

'Children in contact with the law')	elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity and proportionality.[26] Although each case has to be assessed individually, clear examples include detaining family members of an alleged criminal who are not themselves accused of wrongdoing (no lawful reason for detention), detention without trial as punishment for exercising the right of freedom of expression in non-violent protest or based on discriminatory grounds including race or ethnicity (detention prevents enjoyment of other rights including the right to non-discrimination) or a person detained without benefiting from protections of the right to a fair trial.
Issues related to Legal status (Includes Children)	All issues related to obtaining or renewing a visa or residency permit in the host country
Civil documentation (including passport, other documentation) (Includes Children except for Birth registration that should be recorded under Child Protection)	All issues including registration of, marriage, death and identity papers and travel documents *Issues related to birth certificate are under Child Protection*
Rejection at the Border (Non-admission) (Includes Children)	In the refugee context, the refusal to allow an asylum-seeker entry into a prospective country of asylum. Rejection at the border may result in a violation of the principle of *non-refoulement* (UNHCR).
***Refoulement*/Deportation (Includes Children)**	Non-refoulement ("refouler") is a principle contained in the UN Convention on the Status of Refugees and reflected in customary international law whereby States shall not expel or return ("refouler") a refugee in any manner whatsoever to the frontier of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion.27 This includes return to a third country where the person risks being moved to another territory where she/he would face persecution. The principle of non-refoulement where a person faces the risk of the death penalty, torture or other cruel and inhuman treatment is also reflected in international human rights law, including the Covenant on Civil and Political Rights and the Convention Against Torture. This category also includes those who are at-risk of refoulement or

[26] Human Rights Committee, General Comment 34 – Article 9 Liberty and Security of Person, CCPR/C/GC/35 (16 December 2014) para. 12.

27 Convention Relating to the Status of Refugees (Refugee Convention), Article 33.

	deportation.
Torture **(Includes Children)**	Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes such as obtaining from him/her, or a third person, information or a confession, punishing him/her for an act s/he or a third person has committed or is suspected of having committed, or intimidating or coercing him/her or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.[28]
Human Trafficking **(Includes Children)**	The recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.[29] This includes Child Trafficking which is the recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation.[30]
Housing, Land and Property	This includes any matter concerning the right to adequate housing, security of tenure, the need for formal lease agreements, protection from unlawful/forced eviction (including destruction and seizure of property), and protection from exploitative treatment by landlords.[31] Destruction of real or personal property belonging individually or collectively to private persons, or to the State, or to other public authorities, or to social or cooperative organizations. Destruction of property is prohibited under international humanitarian law, except where such destruction is rendered absolutely necessary by military operations.32 Destruction of property and demolitions authorized under domestic law may also offend international human rights obligations if

[28] United Nations, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984.

[29] Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, Adopted and opened for signature, ratification and accession by General Assembly resolution 55/25 of 15 November 2000, Article 3.

[30] Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, Adopted and opened for signature, ratification and accession by General Assembly resolution 55/25 of 15 November 2000, Article 3.

[31] UNHCR, 2016 Technical Guidelines: Increase Awareness about Housing, Land & Property Rights

32 Geneva Convention IV relative to the Protection of Civilian Persons in Time of War, Art 53.

	taken for punitive reasons, including collective punishment.
Restriction of freedom of movement **(Includes Children)**	Freedom of movement/restriction of freedom of movement is protected by international human rights law, in particular Article 12 of the Covenant on Civil and Political Rights, meaning that everyone lawfully within the territory of a State enjoys, within that territory, the right to move freely and to choose his or her place of residence including protection against all forms of forced displacement. The Covenant on Civil and Political rights recognizes only limited situations where freedom of movement may be restricted to protect national security, public order (ordre public), public health or morals or the rights and freedoms of others.[33]
Onward movement and return **(Includes Children)**	This category includes: a. Palestine refugees who have sought asylum abroad or are requesting international protection in a current State. b. Palestine refugees who are abroad and have difficulties with their travel or identity documents and require assistance. c. Palestine refugees who have returned, voluntarily or forcibly to an UNRWA area of operation. d. Palestine refugees seeking UNHCR assistance for durable solutions
Other legal matters including family law, labour law, administrative law **(Includes Children)**	All issues related to refugees enacting their rights through bodies of civil law on matters such as family law, labour and administrative law. This category excludes matters relating to civil documentation, legal status and housing, land and property issues.
Psychological/emotional abuse and neglect **(non- GBV and non-Child Protection)**	**Psychological/emotional abuse** is defined as harmful behavior that can cause mental or emotional pain, distress and trauma. It is non-physical in nature and can involve both verbal and non-verbal abuse which can scare, humiliate and isolate a person. Examples include: threats and provoking fear of violence, humiliation or ridicule, blaming, intimidation and controlling. **Neglect** is defined as intended or unintended failure to fulfill a caretaking obligation. Neglect occur when a person deliberately withholds, or fails to provide, appropriate and adequate care and support needed by another person. It may be through a lack of knowledge or awareness, or through a decision not to act when they know the adult in their care needs help. It may seriously impair the health or well-being of an adult.[34]

[33] International Covenant on Civil and Political Rights, Article 12.
[34] ADCAP, Minimum Standards for Age and Disability Inclusion in Humanitarian Action, 2015.

Gender-based violence (GBV)

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and are criminalised under national laws. The term "gender-based violence" (also referred to as sexual and gender-based violence, SGBV) is often used interchangeably with the term **violence against women** (VAW). The term "gender-based violence" highlights the gender dimension of these types of acts. It is important to note that men and boys may also be survivors of gender-based violence, including sexual violence. (IASC GBV Guidelines)

This category includes cases of child survivors of GBV. GBV against children should be recorded under this part and not under Child Protection.

Issue	Definition
Rape (includes gang rape and marital rape.) **(Includes Children)**	Non-consensual penetration of the vagina, anus or mouth with an object or body part. (GBVIMS)[35]
Sexual assault (includes attempted rape and all unwanted sexual contact without penetration, and female genital mutilation) **(Includes Children)**	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching. This incident type does not include rape, i.e., where penetration has occurred. Female genital mutilation/female genital cutting (FGM/FGC) is an act of sexual violence that impacts sexual organs, and as such will be classified as a sexualized act. This harmful traditional practice should be categorized under sexual assault. (GBVIMS)
Physical assault (includes hitting, slapping, kicking, shoving, etc. that is not sexual in nature) **(Includes Children)**	An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. (GBVIMS)
Forced marriage (includes child and early marriage) **(Includes Children)**	Forced marriages are marriages in which one and/or both parties have not personally expressed their full and free consent to the union.[36] This includes any marriage where at least one of the parties is below the age of 18, as people under 18 are not able to give full consent.
Psychological / Emotional abuse (includes neglect, threats violence, forced isolation, harassment / intimidation, gestures, etc.) **(Includes Children)**	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, name-calling, humiliation, forced isolation (e.g. by preventing a person from contacting their family or friends), stalking. This category includes all sexual harassment defined as: unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature (with no physical contact).
Denial of resources, opportunities or	Denial of rightful access to economic resources/assets or livelihood

[35] UNFPA, IRC, UNHCR, UNICEF, Gender Based Violence Information Management System, http://www.gbvims.com/

[36] Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices CEDAW/C/GC/31-CRC/C/GC/18 (4 November 2014) para. 23.

services (includes denial of inheritance, earnings, access to school or contraceptives, etc.) **(Includes Children)**	opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner/spouse or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

Child Protection

Child protection is defined as preventing, and responding to violence, exploitation, abuse and neglect.[37]

Staff must record here the cases specific to child protection which are not already included under General Protection (ex. Trafficking) and GBV (ex. Forced marriage of children).

Issue	Definition
Child associated with armed forces/groups	Any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities. [38] UNICEF notes this includes girls recruited for sexual purposes and for forced marriage and children accompanying armed forces/groups including irregular non-government armed forces.
Child labour and worst forms of child labour	**Child labour** under the Convention on the Rights of the Child is work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development' (Article 32). Article 3 of ILO Convention No. 182 elaborates on the worst forms of child labour including all forms of slavery, prostitution and pornography, illicit activities and work likely to harm children's health, safety or morals[39].
Child in contact with the law	A general term used by UNICEF to refer to all children in contact with the justice system including criminal justice, civil justice and administrative justice systems. This includes children in conflict with the law (as a result of being alleged, accused or recognized as having infringed the criminal law in that state or territory) and child survivors or witnesses.40
Corporal Punishment	Corporal punishment is defined by the Committee on the Rights of the Child as: any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. In the view of the Committee, corporal punishment is invariably degrading. In addition, there are other non-

[37] UNRWA, Child Protection Framework, 2016

[38] Paris Principles and Guidelines on Children Associated with Armed Forces or Armed Groups, February 2007. This definition is also used by the ICRC.

[39] UNRWA, Child Protection Framework, 2016.

40 UNICEF Toolkit on Diversion and Alternatives to Detention 2009, Glossary of terms relevant to children in conflict with the law, available at www.unicef.org/tdad/glossary(4).doc

	physical forms of punishment that are also cruel and degrading and thus incompatible with the Convention. These include, for example, punishment which belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules the child[41].
Separated child/ Unaccompanied child	Separated children are children separated from both parents or from their previous legal or customary primary care-giver, but not necessarily from their relatives. Separated children may include children who are accompanied by other adult family members. Unaccompanied children are children who have been separated from both parents and relatives and not being cared for by an adult, who by law or custom is responsible for doing so.[42]
Child Abuse, Neglect and Physical Violence	A deliberate act (single or persistent) of ill treatment that can harm or is likely to cause harm to a person's safety, well-being, dignity and development. It includes all forms of physical, psychological or emotional ill treatment.[43] Physical violence can be threatened or actual and results or is likely to result in injury, death, psychological harm, mal-development or deprivation. This definition also includes the failure of parents, caretakers, community and society to meet a child's physical and emotional needs when they have the means, knowledge and access to services to do so or failure to protect the child from exposure to danger.[44] Cases of violence based on gender should not be recorded here. Any physical and psychological violence based on gender should be recorded under GBV. Examples: A father beating his daughter because she wants to go to school should be recorded under GBV. while A father beating his children because he is drunk should be recorded under Child Protection.
Birth registration	Birth registration is the official recording of a child's birth by the government that establishes the existence of the child under law and provides the foundation for safeguarding many of the child's civil, political, economic, social and cultural rights. Article 7 of the Convention on the Rights of the Child specifies that every child has the right to be registered at birth without any discrimination.[45]

[41] UNRWA, Child Protection Framework, 2016.
[42] Inter-agency Guiding Principles on unaccompanied and separated children, 2004.
[43] Modified from Save the Children.
[44] United Nations (2006), World Report on Violence Against Children, p. 54: New York. Amended to include societal and community neglect.
[45] UNICEF, http://www.unicef.org/protection/57929_58010.html

Annex VIII. Common Monitoring Matrix 2016-2021

Protection/MHPSS Indicators – Health Department
Strategic Outcome 2

Output 2.0.d

Indicator	Degree of alignment with UNRWA protection standards of health services
Definition	UNRWA protection standards are defined in the "Tool for Incorporating Minimum Standards on Protection into UNRWA Programming and Service Delivery." The alignment with health programing and service delivery with the first five of UNRWA's six common standards are assessed for the purposes of this indicator: 1. Safety and dignity 2. Targeted service delivery 3. Accessibility, equity and impartiality 4. Participation 5. Coordination The methodology to assess degree of alignment is described in "Tool to Assess Degree of Alignment of Programing and Service Delivery with UNRWA Protection Standards." The methodology comprises a combination of desk review, workshops with frontline staff and feedback from beneficiaries. The tool provides a series of questions to consider when assessing each of the five protection standards. A four level scoring system is used to build an overall score with regard to degree of compliance. The levels are as follows - Little or no evidence (score: 0) - Some evidence (score: 1) - Strong evidence (score: 2) - Proven and consistent approach (score: 3) Both the above mentioned tools (UNRWA Protection Standards and Assessment Methodology) are available on the UNRWA Intranet protection page.
Numerator	Cumulated score from the Protection Audit which includes an assessment of the degree of program alignment with the 5 UNRWA common protection standards on a ranking system
Denominator	15 (ie 5 of UNRWA's common protection standards are assessed on a ranking system of zero (0) to three (3). Maximum score is 15.)
Data Source	Annual protection audits carried out at field office level. These audits are carried out by protection and health teams jointly for a representative number of health centers for which the average score will be calculated. Total score will be converted to percentage.
Unit of Measurement	%

Frequency of Collection	Annually/Q4
Baseline (End 2015)	46% (excluding Syria)
Target	70%

Output 2.1.f

Indicator	Number of health centers integrating the comprehensive MHPSS and Protection technical instructions into the Family Health Team approach
Definition	The MHPSS technical instructions include redefined roles and responsibilities for health center staff, referral pathways within and without health centers, definitions of protection threats, care management guidance and clinical instructions for doctors who have the authority to prescribe mental health medication. Implementing the comprehensive approach indicates that all FHT staff have undergone intensive PSS training, while medical doctors and staff nurses have been trained in the mhGAP. Modules that must be covered and their duration are outlined in the concept note. Fields will also be required to confirm protection case referral pathways based on existing capacities and SOPs in order to be considered as fully integrating MHPSS. The MHPSS technical instructions will be finalized by Q3 2016.
Numerator	143 (As of Q1 2016 this includes 22 HC in Gaza, 43 in West Bank, 25 in Jordan, and 27 in Lebanon. All functioning Health Centers (15) and health points (11) in Syria will be included. If the situation in Syria changes, numerator and denominator will be reflected accordingly.)
Denominator	143 (As of Q1 2016 this includes 22 HC in Gaza, 43 in West Bank, 25 in Jordan, and 27 in Lebanon. All functioning health centers (15) and health points (11) in Syria will be included. If the situation in Syria changes, numerator and denominator will be reflected accordingly.)
Data Source	Checklist
Unit of Measurement	Number
Frequency of Collection	Annually/Q4
Baseline (End 2015)	0
Target	143

Output 2.1.g

Indicator	Number of individuals experiencing MHPSS needs identified by UNRWA in health centers provided with assistance.
Definition	The denominator should capture all MHPSS cases for which a file was opened in the health center. The person could be experiencing basic daily

	life issues, other psychosocial concerns, or a mental health issue as indicated below.*** The types of MHPSS needs are categorized in the patient record. The denominator can also capture high risk patients enrolled in a focused prevention activity, even if a file is not opened for them. The numerator should be the number of those files that are subsequently closed. Closed cases can indicate that a person has completed a support group course, is no longer seeing the staff nurse or psychosocial counselor for counseling, that they are no longer on medication for their MH condition, or that they have been successfully referred externally, or internally to another department. It is possible that a person can be provided assistance for both a MHPSS need and a protection need, at which point double counting is acceptable. As specified below, there are some patients whose ongoing assistance will prohibit the closure of the MHPSS file. However, as assistance is being provided (as with diabetic patients), they will be counted towards the numerator of this indicator. This indicator will be collected via paper MHPSS files until which time the MHPSS eHealth module is functional and rolled out. In early years of MTS, data may not be collected from 100% of health centers. Both the paper file and eHealth module will allow for disaggregation by man, woman, boy, girl and disability. Training on the definition of disability will be coordinated with protection. In the interim, those fields where some form of MHPSS assistance is already provided (through psychosocial counselors or protection committees), these figures can be used until the MHPSS record is in place. For the purposes of target setting, we will ultimately strive to provide 100% of cases with assistance. We recognize that we will not be able to successfully care for everyone with MHPSS needs in our health centers, but as external referrals count as assistance provided, the patient can still be provided with assistance. The goal is that with the streamlined MHPSS services in daily health center activities, less patient files will be started, and of those that are, more patients are assisted. There will be some MHPSS files that are not closed, because medication or counseling is an ongoing process. However, as they are being provided with ongoing assistance, they will be counted towards this indicator. Therefore, we can realistically aim for 100% by 2021.
Numerator	No. of individuals experiencing MHPSS needs identified that are provided with assistance at health centers (including external referrals)
Denominator	Total no. of individuals experiencing MHPSS needs identified
Data Source	Paper MHPSS files (MHPSS eHealth module under development) in health centers that are implementing the comprehensive MHPSS technical instructions; current PSS counselor records and other established recording

	mechanisms in the interim
Unit of Measurement	%
Frequency of Collection	Quarterly/ Q1, Q2, Q3, Q4
Baseline (End 2015)	To be included
Target	100%

Output 2.1.p, q and r

Indicator	Percentage of individuals identified as experiencing a protection risk (general protection) provided with health assistance in line with UNRWA standards (disaggregation by sex, age and disability). Percentage of individuals identified as experiencing a protection risk (GBV) provided with health assistance in line with UNRWA standards (disaggregation by sex, age and disability). Percentage of individuals identified as experiencing a protection risk (child protection) provided with health assistance in line with UNRWA standards (disaggregation by sex, age and disability).
Definition	Types of protection risks should be categorized according to the list and definitions beow.* Assistance is provided to individuals either internally by UNRWA services, or externally through a referral to another actor. Types of services provided are listed and defined below.** The term **"health assistance"** captures the responses to protection cases identified and referred – either internally or externally – through the health department, as well as those provided with counseling or informational assistance in health center. This indicator will feed into SO1, where data from SO 1, 2, 3, 4 and 5 (which capture various types of assistance) will be aggregated. Additional definitions of health assistance are in the protection risk matrix below.* Disaggregation of PwD by (sex and age) should be reported in the comments box. UNRWA will be building its capacity throughout the MTS period to ensure that assistance is provided increasingly in line with international standards. To begin with, assistance will at the very least be delivered prioritizing DO NO HARM. International protection standards are set by the key protection guidelines and handbooks endorsed by the IASC or the Global Protection Cluster. Relevant to UNRWA work are refugee operations guidelines, Minimum Protection mainstreaming standards of the Global Protection Cluster, Handbook on the Protection of Internally Displaced Persons, ICRC Professional Standards, Child Protection Minimum Standards, and guidelines for GBV in emergencies.

	UNRWA guidelines (to be developed by protection) will reflect global standards and will be the benchmark to measure whether the intervention is in line with the standards. In the West Bank, a protection database has been developed, whereas in other fields, Protection focal points in health centers currently report to Protection colleagues. Data will also need to be reported to Health Programs in each field. In early years of MTS, data may not be collected from 100% of health centers. Disaggregation features (gender, adult, child and disability) will be available on the MHPSS eHealth module under development. For the purposes of target setting, ultimately, the Health Department will strive for 100% of cases provided with assistance
Numerator	No. of protection cases identified that are provided with assistance at health centers
Denominator	Total no. of protection cases identified
Data Source	Health program protection database (in West Bank), eHealth MHPSS module and paper file (when available), protection focal points in health centers.
Unit of Measurement	%
Frequency of Collection	Quarterly/ Q1, Q2, Q3, Q4
Baseline (End 2015)	n/a
Target	100%

Output 2.1.5

Indicator	Percentage of protection mainstreaming recommendations from internal protection audits implemented
Definition	Audits are conducted every year by FOs (protection and department colleagues in cooperation) to measure the degree of alignment of UNRWA core programmes with UNRWA common protection standards, to increase awareness and understanding of protection amongst programmes, to identify gaps and ways in which protection can be further integrated into UNRWA programming and service delivery, as well as practical steps to take this forward in. As a result of this exercise, each field office protection audit identifies issues that need to be addressed to better mainstream protection within programme service delivery. Recommendations are developed as a result of group discussions and endorsed by the audits participants. Recommendations included in audits are numerated and annually followed up. Through the RBM Action Tracking Feature, it is possible to monitor the implementation on a regular basis.

	However, the key means for monitoring this indicator will be a narrative part which will support the analysis of the impact of these activities, ensuring that qualitative aspects of this indicator are captured and highlighted. Both fully and partially implemented recommendations will be considered. For the purpose of this indicator, recommendations related specifically to the health department activities will be measured.
Numerator	Number of recommendations fully or partially implemented
Denominator	Number of recommendations
Data Source	RBM Database (action tracking) and narrative from FO Protection focal point in HD
Unit of Measurement	%
Frequency of Collection	Annual/Q4
Baseline (End 2015)	73%
Target	80%

Activities

Output 2.1.1.b.

Indicator	Number of UNRWA health staff members trained on comprehensive MHPSS response
Definition	The numerator should capture the number of staff who have received the package of MHPSS training required according to job category. The contents of each component of the training package are detailed in the MHPSS concept note. All components have elements of protection identification and knowledge of referral pathways. **Medical Officers:** mhGAP package + introduction to psychology + one day introduction (~11 days) **Staff Nurses & Psychosocial Counselors:** mhGAP package + PSS support techniques + introduction to psychology + one day introduction (~16 days) **Practical Nurses, Midwives and Physiotherapists:** PSS support techniques + introduction to psychology + one day introduction (~8 days) **All other health center staff**: 1 day introduction (1 day) Once all staff have been trained in the comprehensive MHPSS package, any stand alone or refresher training that addresses components of the package in a thorough way may be counted in subsequent years towards the number of staff trained. The number of staff trained will **not be cumulative** over 7 years, but will capture those trained each year. Targets should be set according to MHPSS roll out plan, and maintenance/refresher training goals beyond full implementation

Numerator	Number of UNRWA staff members trained on MHPSS as identified above.
Denominator	2,452 (Doctors, specialists, pharmacists, dental surgeons, nurses & paramedical staff. Subject to updating as a result of HR adjustment exercise under progress)
Data Source	Training reports; participants lists, evaluation forms from HD (and protection, if conducted separate from Health)
Unit of Measurement	#
Frequency of Collection	Quarterly/ Q1, Q2, Q3, Q4
Baseline (End 2015)	n/a
Target	To be included

Output 2.1.1.c

Indicator	Number of individuals experiencing MHPSS needs identified by UNRWA in health centers
Definition	The number should capture all MHPSS cases for which a file was opened in the health center. The person could be experiencing basic daily life issues, other psychosocial concerns, or a mental health issue. The types of MHPSS needs are documented in the patient record drop down option. High risk patients enrolled in a focused prevention activity, even if a file is not opened for them, are also included in this category. It is possible that a person will be identified as experiencing a MHPSS need and a protection need, at which point double counting is acceptable. This indicator will be collected via paper MHPSS files until which time the MHPSS eHealth module is functional and rolled out. In early years of MTS, data may not be collected from 100% of health centers. Both the paper file and eHealth module will allow for disaggregation by man, woman, boy, girl and disability. Training on the definition of disability will be coordinated with protection. For the purposes of target setting, it is expected that identified cases will increase for the new MTS period, with a gradual tapering off once identification mechanisms are fully functional, and prevention and promotion campaigns have become mainstream in the community. Additionally, once MHPSS services are fully integrated in every staff member's daily tasks and patients are better able to manage their own daily life problems, the number of identified patients should decrease.
Numerator	Number of patients with MHPSS issues for whom a file is opened identified by UNRWA
Denominator	N/A

Data Source	Paper MHPSS files (MHPSS eHealth module under development) in health centers that are implementing the comprehensive MHPSS technical instructions; current PSS counselor records and other established recording mechanisms in the interim
Unit of Measurement	#
Frequency of Collection	Quarterly/ Q1, Q2, Q3, Q4
Baseline (End 2015)	n/a
Target	To be included once baselines are collected

Output 2.1.1.0, p, q

Indicator	Number of individuals experiencing a protection risk (general protection) identified by UNRWA (disaggregation by sex, age and disability) Number of individuals experiencing a protection risk (GBV) identified by UNRWA (disaggregation by sex, age and disability) Number of individuals experiencing a protection risk (child protection) identified by UNRWA (disaggregation by sex, age and disability)
Definition	The numerator should capture all protection cases that UNRWA staff have identified through health center daily activities and community outreach. At the core of a protection case are individuals/families with underlying vulnerabilities and/or specific needs for which targeted services for an individual/family are required (as opposed to regular service delivery) as the result of a specific protection threat or risk. The types of protection issues are included in the table below.* Protection cases can be linked to documented human rights violations that have occurred to individual refugees that may be captured by another indicator under SO1, 3, 4, or 5. It is accepted that a situation may be counted more than once. The number of cases will be categorized by 3 types: 1) general protection, 2) GBV & 3) Child Protection, with the understanding that the majority of protection cases identified at the health center level will be Types 2 and 3. In the West Bank, a protection database has been developed, whereas in other fields, Protection focal points in health centers currently report to Protection colleagues. Data will also need to be reported to Health Programs in each field. In early years of MTS, data may not be collected from 100% of health centers. Disaggregation features (gender, adult, child and disability) will be available on the MHPSS eHealth module under development. For the purposes of target setting, it is expected that identified cases will increase for the new MTS period, with a gradual tapering off once identification mechanisms are fully functional, and prevention and promotion campaigns have become mainstream in the community. Additionally, once MHPSS services are fully integrated in every staff member's daily tasks,

	protection incidents are also expected to decrease.
Numerator	Number of new protection cases identified by UNRWA
Denominator	N/A
Data Source	Health program protection database (in West Bank), MHPSS eHealth module (under development), protection focal points in health centers
Unit of Measurement	#
Frequency of Collection	Quarterly/ Q1, Q2, Q3, Q4
Baseline (End 2015)	n/a
Target	To be included

[11] WHO recommendations on postnatal care of the mother and newborn. 2013