State of Palestine
Ministry of Health

CHILD & ADOLESCENT MENTAL HEALTH NATIONAL STRATEGY 2023 to 2028

‘Every child deserves a childhood,
every child deserves a future’

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MEDICAL AID FOR PALESTINIANS

NO HEALTH WITHOUT
MENTAL HEALTH

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LIST OF ABBREVIATIONS & DEFINITIONS

ACE	Adverse Childhood Experiences
ASD	Autism Spectrum Disorders
CBT	Cognitive Behavioural Therapy
CBO	Community Based Organization
CMHC	Community Mental Health Centre
CAMHS	Child and Adolescent Mental Health Service
COVID-19	Corona Virus 2019
CWF	Community Wellness Focusing (therapy)
FTP	Family Therapy Programme
GBV	Gender Based Violence
GCMHP	Gaza Community Mental Health Project
IT	Information Technology
KPI	Key Performance Indicator
LBW	Low Birth Weight (babies weighing less than 2,500g at birth)
MdM	Médecins du Monde
MHPSS	Mental Health and Psychosocial Support
MHS	Mental Health Strategy
MoEHE	Ministry of Education and Higher Education
MoSD	Ministry of Social Development
MoH	Ministry of Health
MHU	Mental Health Unit
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non-Governmental Organization
OTSD	Ongoing Traumatic Stress Disorder
PCC	Palestinian Counselling Centre
PHC	Primary Health Care
PNA	Palestinian National Authority
PSS	Psychosocial services or approaches
PTC	Palestine Trauma Centre
PTSD	Post-Traumatic Stress Disorder
SANID	Psycho-Social Support Therapy
SDG	Sustainable Developmental Goal
TBD	To Be Determined
TRC	The Treatment and Rehabilitation Centre for Victims of Torture
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WB	West Bank
WHO	World Health Organization

A child is defined as a person under the age of 18 years old according to the United Nations Convention on the Rights of the Child. For the purposes of this document, 'child and adolescent' refers to the age group of 0 to 18 years.

In this document 'Gaza' refers to the Gaza Strip and not solely to the city of Gaza and 'Ministry of Education' refers to the Ministry of Education and Higher Education and not solely to Education.

EXECUTIVE SUMMARY

This national strategy 2023 to 2028 sets key priorities for child and adolescent mental health so that funders, institutions, organizations and community members can align their activities in a coordinated and efficient way.

Funding for child and adolescent mental health projects in the State of Palestine comes from multiple sources, both governmental and non-governmental. This can lead to an array of well-intended activity, but may be of variable quality, poorly coordinated or ineffective. The Palestinian economy is heavily dependent on donors and transfers. At $266 million, 2020 recorded the lowest recorded levels of donor funding for over a decade, making it even more important to utilize funds optimally.

Today's child in Palestine bears the burden of decades of violence, conflict and hardships that have accumulated during their lives and those of their parents and grandparents. Childhood is not a given for Palestinian children, but instead something that must be determined, retrieved, and understood within a complex web of implications mandated by the dynamics of power that are in play. As a testament to the Palestinian people's ability to adapt, endure and demonstrate *sumud* (steadfastness), through strong family and community relations, many children show remarkable resilience. However, there are children and families who require additional support and expert care.

Demand for child and adolescent mental health services is not being met by current clinical services. Clinical pathways to refer vulnerable young people suffering from mental illness do not exist; nor do day or inpatient facilities for young people who require specialist interventions or admission, be it for severe mental illnesses[1]or high risk behaviours.[2] The lack of clear child protection protocols and limited availability of supportive family counselling and therapy compounds the pressure on caregivers. Vulnerable children are left exposed.

Prevention is better than a cure. The best way to prevent mental illness is to promote positive mental health; to build supportive community networks, to help children learn how to cope and even thrive in the most challenging of circumstances. It can feel like an impossible mission, but by looking at young role models, from local community heroes to the world-famous, there are many ways for young Palestinians to find their vocation as adults and contribute to society.

Investing in children's development, mental health and well-being benefits not just the child but society as a whole. Giving children the best possible start in life has a long-lasting impact on their future physical and mental health, social and economic resilience and productivity as adults.

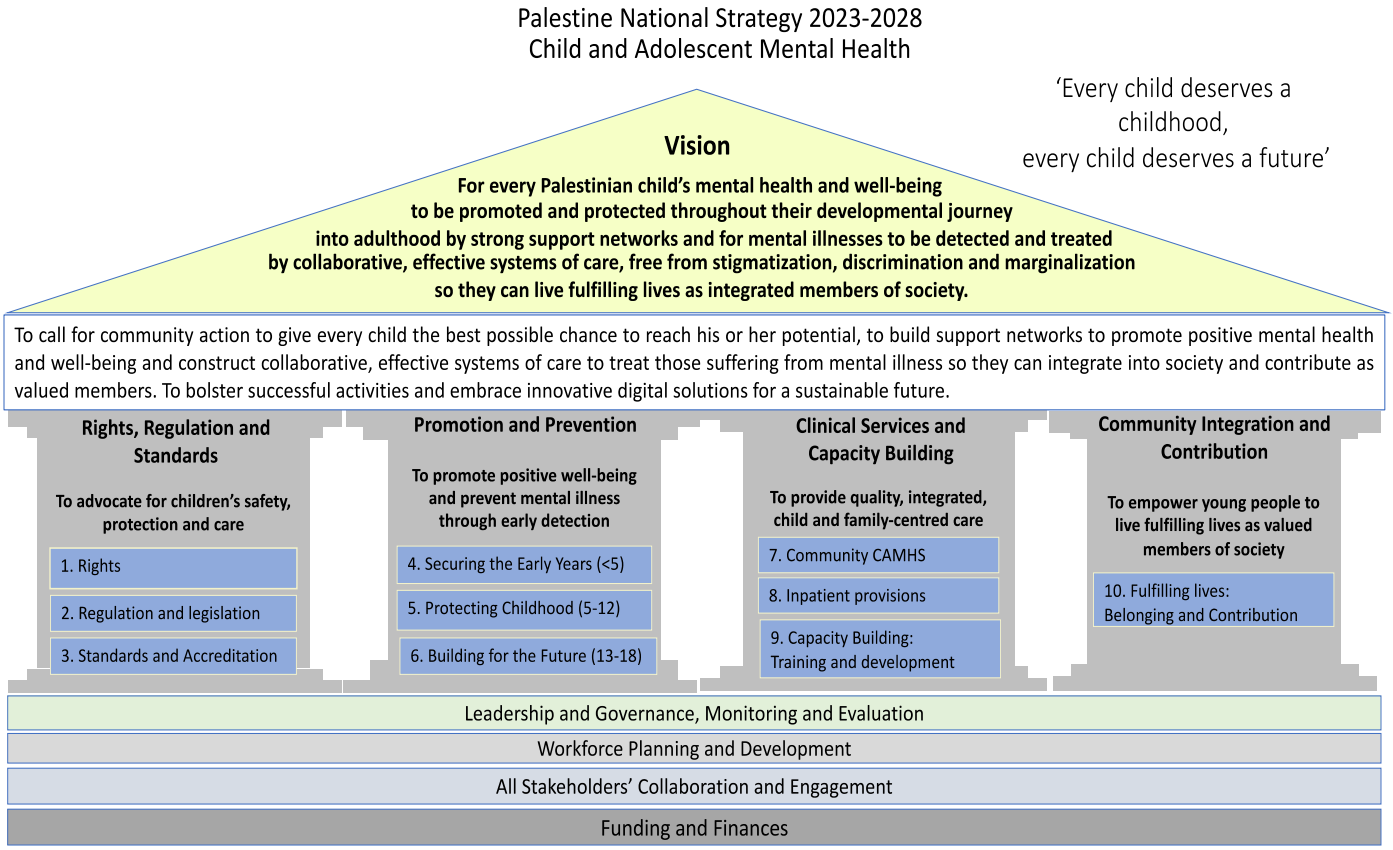
Every child deserves a childhood and a future. This national strategy takes a holistic view of childhood and adolescence, using a multi-level framework for child and adolescent well-being developed by the United Nations Children's Fund (UNICEF). Through comparative research between countries, this model understands child and adolescent well-being as the outcome of a multitude of different factors which interact with each other in different 'worlds'; the world of the child, the world around the child and the world at large (figure 2, page 7).

The strategy's vision is for every Palestinian child's mental health and well-being to be promoted and protected throughout their developmental journey into adulthood by strong multi-sectorial support networks and for mental illnesses to be detected and treated by collaborative, effective systems of care, free from stigmatization, discrimination and marginalization so they can live fulfilling lives as integrated members of society.

The strategy has four pillars and ten initiatives (see below). The first pillar, 'Rights, Regulation and Standards,' supports advocacy to protect children's fundamental rights; the review of regulation and legislation to ensure safe practice by

[1] such as neurodevelopmental, anxiety, trauma or stress-related, mood and psychotic disorders
[2] including self-harm, attempted suicide and substance misuse

professionals working with children and institutional accreditation to raise standards of clinical care. The second pillar, 'Promotion and Prevention,' promotes positive mental health and well-being through three initiatives from birth to adulthood. The 'Securing the Early Years' initiative for under five-year-olds focuses on giving every child the best start in life through developing secure emotional attachments and preventing or reducing toxic stress. The 'Protecting Childhood' initiative for five- to 12-year-olds creates spaces for children to play, learn and grow with 'whole school' approaches to well-being, outdoor play and encouraging families to reduce screen time and increase reading for pleasure. The 'Building for the Future' initiative for 13- to 18-year-olds empowers youth through developing skills for life and citizenship be they socio-emotional, literacy, numeracy and/or technical skills obtained through vocational, apprenticeship and mentorship programmes to prepare them for adulthood. The third pillar, 'Clinical Services and Capacity Building' works on building services and professionals' capacity so as to have sufficient capacity to meet demand and provide integrated, effective and efficient child and family-centred clinical services. Finally, the fourth pillar, 'Community Integration and Contribution,' supports activities that enhance social integration through reducing stigma, and developing a sense of belonging, so children and adolescents engage in and contribute to the community, that is, to their world, the world around them and the world at large.



Aligned with national and international strategies and policies, this strategy allows for international benchmarking as part of a sustainable model of continuous monitoring and evaluation. Digital solutions and enablers are a recurrent theme throughout the strategy; these are powerful ways to build bridges and create networks across a multitude of obstacles and divides.

1. GLOBAL DEVELOPMENTS IN MENTAL HEALTH

a. What is mental health?

Mental health is defined as, 'a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively, and fruitfully, and is able to make a contribution to his or her community (WHO, 2014).' Mental health and well-being are affected by a range of biological, psychological, social, and environmental factors (Figure 1).

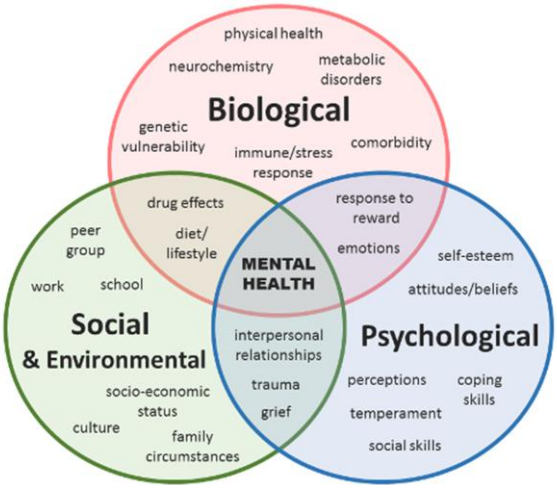


Figure 1 The bio-psycho-social model of mental health

b. The mental health spectrum

The mental health spectrum describes the range of mental states between coping well and thriving (mental health) and not coping (mental illness). People can move along the spectrum in different directions throughout their life. Mental disorders involve significant disturbances in thinking, emotional regulation, or behaviour which are influenced by each person's unique personality, culture and circumstances and thus experienced and present in different ways. Mental illnesses can be diagnosed as mental disorders using categorization systems according to the nature, type and severity of symptoms.[3] These include neurodevelopmental[4] and disruptive behavioural disorders, post-traumatic stress disorder (PTSD) and eating disorders as well as anxiety disorders, depression, bipolar disorder and schizophrenia. Risk taking behaviours such as self-harm, suicide attempts and substance misuse can be the result of an underlying mental disorder.

c. The burden of mental illness

Mental disorders are among the top ten leading causes of the health burden worldwide, with no evidence of global reduction since 1990. Depression alone is predicted to be the number one burden of disease by 2030. In 2019, 1 in 8 people, or 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders being the most common.[5] In 2020, the number of people living with anxiety and depressive disorders rose significantly because of the COVID-19 pandemic. Initial estimates show a 26% and 28% increase respectively for anxiety and major depressive disorders in just one year.[6]

d. Human development and the impact of childhood adversity

Human development is the process in which a person grows from infancy to adulthood. The three major stages of child development are early childhood (birth to age 5), middle childhood (ages 6 to 12), and adolescence (ages 13 to 18). Adulthood can be divided into the young adult stage (ages 18 to 25), middle adult stage (26 to 65) and late adulthood (66 and above). Childhood psychosocial adversity refers to the impact of exposure of different toxic stress conditions or adverse childhood experiences (ACE) on physical and mental health and wellbeing. Mediated through different pathways, exposure to adversity earlier in life interacts with a young person's genetic endowment, leading to a host of biological changes across multiple levels which influence adult outcomes. [7]

e. Prioritizing child and adolescent mental health disorders

There has been a rise in mental health disorders among under 18-year-olds; that is during childhood and adolescence which is a critical period in a young person's development. Half of all mental disorders develop before the age of 15,

[3] The WHO's International Classification of Disorders (ICD-11) or American Psychiatric Association (APA)'s Diagnostic Statistical Manual (DSM-5) are widely used psychiatric classification manuals.
[4] The neurodevelopmental disorders category in DSM-5 includes Intellectual Disabilities and Autism Spectrum Disorders (ASD)
[5] Institute of Health Metrics and Evaluation. Global Health Data Exchange (GHDx) (2022)
[6] World Health Organization, 2022.
[7] Nelson, Charles, 2020.

and 75 percent by early adulthood.[8] 800,000 people die due to suicide every year, and it is the second leading causes of death in young people (aged 15 to 29), behind road injury.[9] Adolescents experience rapid physical, cognitive and psychosocial growth which affect how they feel, think, make decisions, and interact with the world around them. During this phase, adolescents establish patterns of behaviour related to diet, physical activity, substance use, and sexual activity that can protect or put their health and the health of those around them at risk at the time or in the future. Although the early signs of mental disorders frequently appear in adolescence, they are often undiagnosed and go untreated. Young people with mental health disorders are at great risk of dropping out of school, ending up in jail and not being fully functional members of society in adulthood.

f. A multi-level framework for child and adolescent well-being

Based on an ecological approach, a multi-level framework for child and adolescent well-being to allow for international comparisons was developed by the United Nations Children's Fund (UNICEF). Those countries with the highest ranking of child mental health were not those with the highest incomes, nor vice-versa, indicating that child well-being is the outcome of a multitude of different factors which interact with each other in different 'worlds'; the world of the child, the world around the child and the world at large (Figure 2).

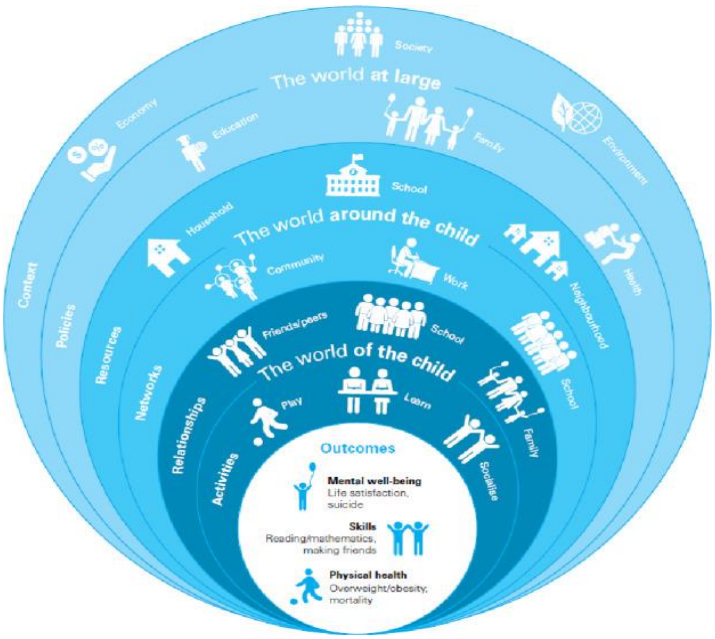


Figure 2: The UNICEF framework for childhood well-being

g. Prevention and treatment of child and adolescent mental illness

There are effective ways to prevent and treat mental disorders. Prevention and treatment reduce individual suffering as well as the economic and social burden on families and the community. Preventing and treating mental illness' net cost is positive, as it results in people being able to contribute to society.

Prevention requires taking a community approach looking at each of the 'worlds of the child' to promote positive mental health. High levels of mental health are associated with living in safety and security, adequate resources (not living in poverty), good quality relationships with family and friends, positive school experiences with a sense of belonging to school and an absence of bullying, access to learning experiences and books, reading for pleasure,[10] opportunities to play outside, good physical health with sleep, diet and exercise routines, being able to participate in

[8] https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
[9] https://www.who.int/news-room/fact-sheets/detail/suicide
[10] Reading enjoyment has educational and personal development benefits. It is more important for children's educational success than their family's socio-economic status (Department of Education UK, 2012).

decisions at home and school, regular community or group activities, a healthy, pollution-free environment and living in an equitable society.

Effective treatments include a range of biological, psychological and social interventions that are delivered in partnership with the young person and their family within their communities, considering the culture and society within which they live. For many conditions, psychosocial approaches (PSS) are effective. However, for those suffering from moderate to severe mental illnesses such as anxiety, depression, PTSD, bipolar disorder and psychosis or engaging in high risk behaviours such as self-harm, attempted suicide and substance misuse, treatments can include specific psychological therapies and the adjunct use of psychiatric medication under expert supervision.

h. Effective mental health services

Whilst effective treatment options exist, most young people with mental disorders do not have access to effective care globally. At least 10% of under 18-year-olds are suffering from a mental disorder yet only a minority of young people are receiving help. Obstacles preventing young people from accessing care include a lack of available services, poverty, stigma and discrimination surrounding mental illness, and the abuse and violations of human rights. Mental health is underfunded almost everywhere with less than one percent of health budgets in lower-income countries allocated towards mental health.

The World Health Organization model for efficient systems of care emphasizes a whole community approach to enable those with fewer needs to manage within informal systems of care in the community and those with greater needs to be managed in different levels of clinical settings from primary healthcare, to secondary specialist outpatient care to tertiary specialist hospital care (Figure 3).

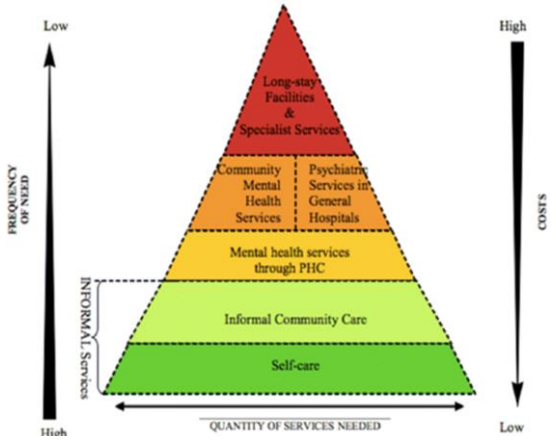


Figure 3: WHO model for efficient mental health services

i. Global objectives for mental health

The WHO Mental Health Action Plan 2013-2030 has four key objectives for all countries around the world. [11]

Key objectives of the WHO Mental Health Action Plan 2013-2030	
1	To strengthen effective *leadership and governance* for mental health through regulation and legislation
2	To provide *comprehensive, integrated and responsive mental health* and social care services in community-based settings with increased service coverage
3	To implement strategies for *promotion and prevention* in mental health with at least two functioning national, multisectoral mental health promotion and prevention programmes
4	To strengthen *information systems, evidence and research* for mental health by routinely collecting and reporting at least a core set of mental health indicators every two years through their national health information systems

[11] WHO, 2013.

2. CONTEXT OF CHILD AND ADOLESCENT MENTAL HEALTH IN PALESTINE[12]

a. Demographic profile

'Palestinian' refers to the indigenous Arab people of the land of 1948 Mandate Palestine. In 2022 there were about 14.3 million Palestinians in the world, of whom 5.35 million are in the State of Palestine; 3.19 million in the West Bank and 2.17 million in the Gaza Strip. [13] A large number of these people are refugees: with an estimated 27 percent in the West Bank and 72 percent in Gaza. In addition, 1.7 million Palestinians live within the State of Israel. There is a large Palestinian Diaspora community of about 8.95 million. Approximately 600,000 Israeli citizens live in illegal Jewish-only settlements in the West Bank. The Palestinian population of the State of Palestine is young with 2.35 million under the age of 18 years, representing 43.9% of the total population. Of these almost two thirds (1.34 million) are registered school students, representing about a quarter of the total population (Figures 4 and 5)

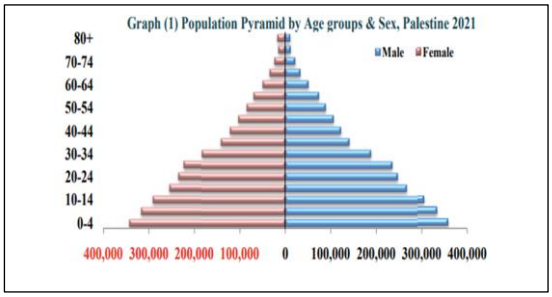


Figure 4: Age Structure

Age group	West Bank		Gaza Strip	
	Males	Females	Males	Females
0-4	207,732	200,377	169,115	163,078
5-9	192,910	182,311	142,111	135,776
10-14	178,664	170,319	139,014	132,908
15-17	100,375	96,391	72,458	69,311
Total	**679,681**	**649,398**	**522,698**	**501,073**

Figure 5: Number of children by age group, region and sex, mid-2022

b. Political and economic context

The 'State of Palestine' refers to the non-contiguous areas of the West Bank, including East Jerusalem, and Gaza. Since the creation of the State of Israel in 1948, Palestinians have lived through wars, military occupation, land confiscation, forced displacement, house demolitions and geographical fragmentation.[14] Following the Oslo accords, the Palestinian National Authority (PNA) was established in 1994 as the recognized governing authority of Palestine. The West Bank was divided into Areas A, B and C and the Israelis withdrew from Gaza. Areas C cover 60% of the West Bank and remain under Israeli control that heavily restrict residents. In Gaza, Palestinians have been living under an Israeli imposed land, air and sea blockade since 2007. Combined with a succession of wars and military attacks this has resulted in a humanitarian crisis and a decline in the Palestinian economy with levels of unemployment reaching 44%, in Gaza (Figure 6). The ongoing occupation and the stalemate in peace negotiations between the PNA and Israel place a heavy toll on the lives, health and security of Palestinians.[15]

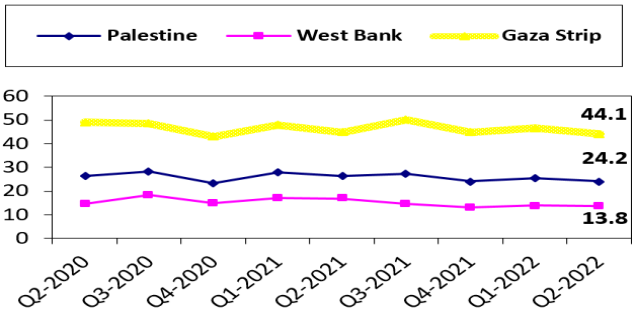


Figure 6: Unemployment rate by region, Q2- 2020 to Q2-2022

In 2020, the economic outlook deteriorated as a result of the annexation of large areas of the West Bank, the economic ramifications of the COVID19 pandemic, faltering aid flows and the loss of hundreds of millions of dollars

[12] Refer to the National Mental Health Strategy for further details regarding the Palestinian mental health context
[13] Statistics and graphics from the Palestinian Central Bureau of Statistics (PCBS) https://www.pcbs.gov.ps/
[14] Granted non-member observer status in the United Nations by the General Assembly in 2012
[15] Ministry of Health, State of Palestine, National Mental Health Strategy 2015 to 2019.

through deductions or leakage to the treasury of Israel. [16] By April 2020, one month after the start of the COVID-19 pandemic, the fiscal revenues of the PNA declined to their lowest levels in 20 years with donations and transfers totaling only $266 million. The World Bank estimates Palestine's poverty rate at 27.7% in 2022, which represents a poor population of 1.5 million.[17] This is further compounded by inflationary pressures from disruptions to the global supply chain due to the war in Ukraine.[18]

In total, 2242 Palestinian children have been killed by Israeli military forces between the years 2000 and 2022.[19] In Gaza, over 1,000 Palestinian children have died as a result of six major military offensives since 2005. In the West Bank, 781 Palestinian children were killed by Israeli military and police forces, settlers, and private security guards between 2011 and 2020. Israeli military and paramilitary police forces deployed in the occupied West Bank, including East Jerusalem, have subjected Palestinian children to physical and psychological violence, both targeted and indiscriminate, by lethal and non-lethal munitions, physical assault, and torture. In the West Bank, including East Jerusalem Israeli soldiers kill Palestinian children in the context of military incursions and demonstrations. Israeli forces deploy crowd-control weapons such as rubber-coated metal bullets and tear gas to disperse protestors. In 2021, 76 children were killed by live ammunition with 15 child deaths in the West Bank and 61 child deaths in the Gaza Strip comprising of 26 children aged 0 to 8 years, 17 children aged 9 to 12 years, 20 children aged 13 to 15 years and 15 children aged 16 to 17 years. Seven children were killed by rockets misfired by Palestinian armed groups in the Gaza Strip.

The total number of Palestinian prisoners and detainees in Israeli prisons reached approximately 4,650 prisoners in September 2022 with 180 child prisoners, representing 3.9% of the total number of detainees.[20] There is a rising trend of younger children being put under house arrest. According to the Prisoner Affairs Commission, 60 Jerusalemite children were placed under house arrest in 2015, 78 in 2016, 95 in 2017, 90 in 2018 and 120 in 2019.[21] Israeli authorities use this policy against children under the age of 14 as Israeli law does not allow children to be imprisoned under this age. Instead, they are placed under house arrest throughout the course of the trial, until they come of age and are then given a prison sentence. The period of house arrest is not retroactively included in the sentence, even if it lasted for years. These children are prevented from attending school, seeing friends or engaging in activities impacting on the mental health of the family as a whole. In 2022, 58 Palestinian schools in the West Bank, including East Jerusalem, are under demolition or 'stop work' orders by the Israeli authorities impacting on hundreds of children's access to education.

c. Legal framework

The Universal Declaration of Human Rights declares that childhood is entitled to special care and assistance. This is reaffirmed in the United Nations Convention on the Rights of the Child, which specifies and details the international standards for children's rights. Palestinian children living in the West Bank, including East Jerusalem, and the Gaza Strip are routinely denied their right to life, education, adequate housing, and access to healthcare, among other denials of rights inherent in a decades-long Israeli military occupation. This systemic discrimination against Arabs by the Israeli authorities and the imbalance of resources between Jewish and Arab populations in the land of Israel/Palestine has been described as 'Apartheid' by international, Israeli and Palestinian human rights organizations.[22,23,24]

[16] UNCTAD, 2020.
[17] World Bank, 2022.
[18] UNCTAD, 2020.
[19] Statistics on child killings and injuries from Defence for Children International (DCI), 2022.
[20] Statistics on imprisonment from Addameer Prisoner Support and Human Rights Association, 2022.
[21] MIFTAH, 2020.
[22] Human Rights Watch, 2022.
[23] Amnesty International, 2022.
[24] BTSELEM The Israeli Information Center for Human Rights in the Occupied Territories, 2021.

d. Key stakeholders

A wide range of partners must be involved if multi-sectorial policies and actions are to be developed for mental health. Structures and processes should exist at all levels to facilitate harmonized collaboration between stakeholders. Potential partners may not be aware of the benefits they can gain from investing in mental health promotion, thus continuous dialogue between service providers and policymakers is essential. There is a need to overcome the problems posed by single-sector approaches and specific organizational objectives, budgets and activities. The health sector can provide leadership by engaging in active promotion and advocacy for mental health and by encouraging others to join in multi-sectorial activities, sharing goals and resources.[25] With this in mind, key stakeholders were invited to a thematic group meeting that was held on 9th August 2022 with representation from Gaza, the West Bank and East Jerusalem.[26]

e. Mental health and well-being status of children and adolescents

Mental health problems are generally high in the Palestinian population. The Ministry of Health (MoH) estimates that one million civilians need mental health support, with 22% of the population suffering from mental illness, 12% higher than the average in other countries.[27] The occupation, poor economic conditions, social problems and the COVID-19 pandemic have aggravated the mental health situation in Palestine.

Children are at higher risk of developing mental illness when living in overcrowded areas with ongoing shelling, siege, and other acts of violence as is the case in Gaza. A significant proportion of Palestinian children experience serious psychological distress especially anxiety and post-traumatic stress disorder (PTSD), with children reporting not wanting to be apart from their parents.[28] Physiological symptoms reported include insomnia, nightmares, sweating, and bedwetting.[29] Palestinian adolescents living in the Gaza Strip and West Bank were found to be amongst the most vulnerable populations in the Middle East region and are more likely to experience psychological disturbances and report significant traumatic experiences. Those adolescents with higher levels of anxiety, depression, and PTSD reported frequent use of negative coping strategies such as negative self-talk or self-isolating. Symptoms of depression, anxiety and Posttraumatic Stress Disorder (PTSD) were prominent amongst children who had been exposed to substantially distressing events, such as destruction of their family house, viewing their family being murdered, bombings and the arrest of family members.[30] While PTSD is typically categorized as resulting from a trauma which has already occurred, it has been argued that in the Palestinian context it is a continual disorder and, consequently, the Palestinian people are actually living with the distress of ongoing-traumatic stress disorder (OTSD).[31] It has also been established that there is a detrimental impact on the overall welfare and health of Palestinian individuals as a result of continually experiencing humiliation and degradation.[32,33,34]

Young people in Gaza are at high risk of developing serious and long-term mental health issues in the domains of emotional, behavioural (conduct) and relationships with peers as well as long term physical conditions including obesity, cardiovascular disease and cancer.[35] Ongoing instability and feelings of entrapment have left many children and young people in Gaza with a deep sense of insecurity, fear and hopelessness, which has had a profound impact on

[25] Regional Office for Europe, WHO, 2005.
[26] List of attendees in the appendix
[27] Health Annual Report Palestine 2021, Ministry of Health, State of Palestine, 2022
[28] Marie M, SaadAdeen S, Battat M, 2020.
[29] Save the Children, 2019
[30] Thabet AA, Abdulla T, El-Helou M, Vostanis P., 2006 and Thabet AA, Abu Tawahina A, El Sarraj, E, Vostanis P., 2008.
[31] Sehwail, Mahmoud, 2005.
[32] Barber, Brian, McNeely, Clea, Olsen, Joseph, Spellings, Carolyn, Belli, Robert, 2013.
[33] Altawil MAS, El Asam A, Khadaroo A., 2018.
[34] Giacaman, Rita et al., 2007.
[35] Springer et al. 2003

their mental health and wellbeing. Palestinian youth are primarily concerned about their future, namely their safety, freedom and employment opportunities.[36]

The suicide rate in 2021 was 0.4 per 100, 000 which was low and less than neighbouring countries.[37] However, for every death by suicide there were approximately 21 suicide attempts with a rate of 7.4 per 100,000. 140 attempts were by females and 69 by males, mainly in the young adult age groups 19 to 27 and 28 to 37. Suicide rates are higher among detainees, particularly child detainees as a reaction to severe psychological stress.[38]

Violence is part of Palestinian children's lives both outside and inside the home. In 2019/2020, the vast majority of children (90.1%) aged 1 to 14 years were exposed to physical and/or psychological punishment from caregivers (father, mother or another caregiver). The percentage of currently married or ever married women aged 15 to 64 years in Palestine exposed at least once to one type of violence by their husbands, during the previous 12 months in 2019, reached 59.3% (52.3% in the West Bank, 70.4% Gaza Strip), 18.5% of which was physical violence.[39]

Levels of literacy are low with only half (52.7%) of children aged 7 to 14 years demonstrating basic reading skills. The percentage of literate females (57.3%) is significantly higher than males (47.8%). Literacy rates vary according to region; in the West Bank, 57.6% of children were successful in obtaining basic reading skills, while this percentage declined to 47.0% in Gaza. The percentage of children with basic numeracy skills in the West Bank is higher than in the Gaza Strip, with 53.7% of children in the West Bank compared to 36.6% in Gaza Strip. These figures are exacerbated by school dropout and child labour.[40]

In terms of physical health indicators, in 2019/2020, low birth weight (LBW) babies accounted for 6.7% of total newborns in the West Bank and 7.9% in Gaza 7.9% among reported live births. In 2019/2020, infant mortality in the State of Palestine was 12 per 1000 and the under-five mortality was 14 per 1000. This compares to a 3 per 1000 infant mortality rate and 4 per 1000 under-five mortality rate in Israel in the same year.[41] Iron deficiency anaemia commonly affects infants with 30.4% of the examined children at the age of 12 months having anaemia in the West Bank in 2021.[42]

Marriage contracts for both sexes under 18 years of age show a decline in early or child marriage. In 2020, child marriage accounted for 11.9% of registered female marriages (4.3% in the West Bank and 19.3% in Gaza) compared with 24% in 2010. Male child marriages accounted for 0.5% of registered marriages in 2020, compared to 2% in 20210. Regarding the marginalisation of women, in 2017 only 19.6% women were engaged in the labour force.[43]

f. Mental health services

The mental health care system in Palestine is fragmented. Basic public health and primary care are offered by four main facilities: The Palestinian National Authority (Governmental), the United Nations Relief and Work Agency for Palestinians (UNRWA), Non-Governmental Organizations (NGOs), and private health care services.[44] In 2002, the WHO, in cooperation with the Palestinian MoH, began the Palestine Mental Health Project to build new community mental health centres (CMHCs). Since 2008, this strategy to integrate mental health into primary care has strengthened the role of MoH and UNWRA Primary Healthcare Centres (PHC) in the identification of common mental health problems, the provision of first level intervention, and referral of severe cases to CMHCs.[45]

[36] The Institute of Community and Public Health, Birzeit University, OXFAM, 2021.
[37] Obtaining accurate official suicide statistics is difficult due to a multitude of factors (Dabbagh, 2005).
[38] Ministry of Health, State of Palestine, National Mental Health Strategy 2015 to 2019.
[39] Palestinian Central Bureau of Statistics (PCBS 04/04/2022)
[40] Official statistics not obtained
[41] UNICEF,2022.
[42] PHIC Health Policy & Planning Unit, Ministry of Health. Health Annual Report Palestine 2021, 2022.
[43] The Institute of Community and Public Health, Birzeit University, OXFAM, 2021.
[44] EMRO, WHO,2006.
[45] Marie M, Hannigan B, Jones A., 2016.

There are now 14 MoH CMHCs in the West Bank (Bethlehem, Hebron, Jenin, Jericho, Jerusalem, Nablus, Qalqilya, Ramallah, Salfit, Tubas, Halhul) and six in the Gaza Strip (one for every district with two in Gaza city). There is one community child and adolescent mental health service (CAMHS) in Halhoul in the North Hebron Directorate of the West Bank, but no specialist services in Gaza. There is in one psychiatric hospital in the West Bank, Bethlehem Psychiatric Hospital, with 180 beds but only 140 beds are open due to staff shortages. There is one psychiatric hospital in Gaza which has three wards with 30 psychiatric beds in total and operates at full capacity.

According to the Ministry of Health Annual Report 2021, 3,607 new patients registered at different mental health centers in Palestine with an incidence rate of 73 per 100,000 population. In Gaza, 1,043 patients registered, with an incidence rate of 49.5 cases per 100,000 population. Schizophrenia had the highest incidence rate with 10.9 cases per 100,000 population. In the West Bank, 2,564 new patients were registered at CMHCs, with an incidence rate of 91.1 per 100, 000 population. As shown in the graph, 'neurotic disorders' is still the most common disease with an incidence of 19.9 cases per 100,000 population.

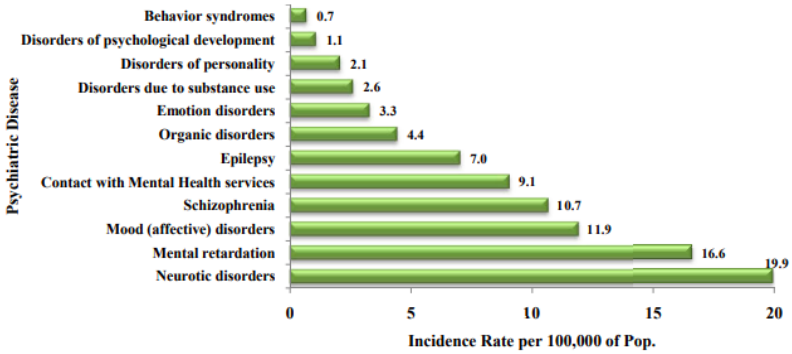


Figure 7: Distribution of New Reported Incidence Rate of Psychiatric Diseases by Diagnosis per 100,000 of population, West Bank, Palestine, 2021

In terms of gender, 56.2% of patients were male and 43.8% female. In terms of age, the highest percentage was among the age group 5 to 24 years accounting for 40.1% of the total which was higher than previous years.

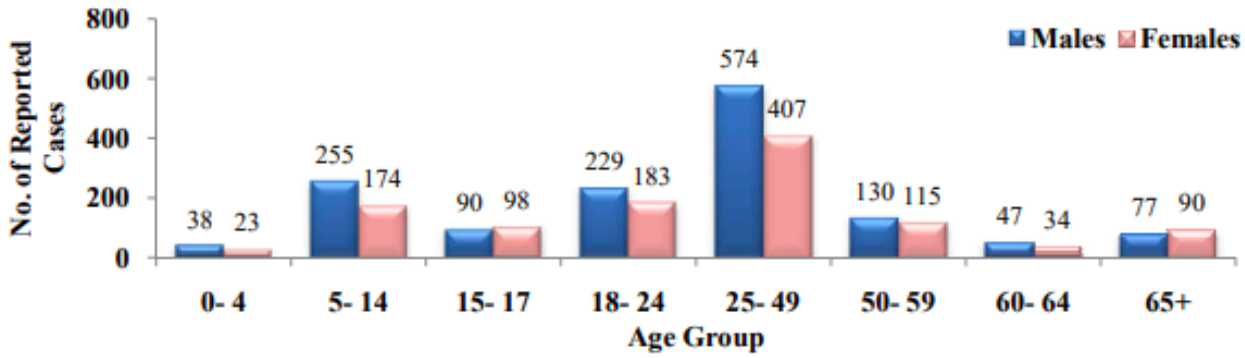


Figure 8: Distribution of New Reported Psychiatric Cases by Sex and Age Groups, MoH, West Bank, Palestine, 2021

In 2020 the total number of children and adolescent appointments recorded for all 14 CMHCs in the West Bank was 22,199 of which 12,798 (58%) were seen in CAMHS, while in 2021 the equivalent figures were 20,922 appointments of which 7,727 (37%) were seen. In Gaza, between 2019 and 2021, 33, 600 children received mental health support in 12 UNWRA centres in Gaza.

There are 765 PHCs in the State of Palestine, of which 606 centers are in the West Bank and 159 are in the Gaza Strip. The number of population per center is 6,435 persons. According to the WHO survey conducted in 2013, one-third of people using MoH primary health care services in the West Bank and Gaza have common mental health problems.

Capacity building has been carried out through curriculum development and staff training, most notably the training of PHC workers in the mental health Gap Action Programme Humanitarian Intervention Guide (mhGAP-IG Version 2.0).

NGOs offer a range of mental health services in the West Bank, Gaza and East Jerusalem, for children and families.[46] NGOs are active in terms of advocacy and policy development, and have participated in projects between the MoH and UNWRA with international partnerships including the UK, France, Italy and Germany, involving not only practical trainings, but also long term supervision programmes for practicing clinicians.

The Maternal and Child Health Handbook contains messages related to psychosocial support and parenting and is distributed by MoH PHCs and hospitals as well as health providers from NGOs and UNWRA. In 2021 MoH centres distributed 42,059 handbooks of which 36,511 were distributed to mothers and 4,068 to children representing 49.6% of live births. In 2021, coverage of all vaccines for children under two years of age in Palestine was above 95%.[47]

The MoH School Health Programme provides medical services, especially preventative ones to all Palestinian students in government and private schools affiliated to the Ministries of Social Affairs, Labour, Awqaf and Religious Affairs as well as some kindergartens. The UNWRA School Health Programme provides services to refugee students in its schools.
In 2021, school health staff visited 1,469 government and private schools, 41% of schools in the West Bank, less than before the COVID-19 pandemic. Tests carried out for the 1st, 5th and 8th grade included ophthalmology, weight, auditory, dermal and dental tests. In Gaza, school health staff conducted these tests and vaccinations for the 1st, 4th, 10th grade students at government schools in addition to those in the 1st, 4th and 7th grade at UNWRA schools. In 2021, the MoH school health programme vaccinated 216,493 pupils in the 1st and 9th grade as per the National Immunization schedule with vaccination rates over 98%. The MoE's strategy is to have counsellors in all schools in order to identify mental health cases and make referrals as appropriate. Currently, 1200 MoE schools have a school counsellor. At UNRWA schools, mental health and psychosocial support (MHPSS) activities are undertaken by 250 counselors distributed in 284 schools hosting around 290,00 students aged from 6 to 15 years old. Using a child-centered developmental approach to deal with children's issues arising at schools, the counselors are supported by 21 MHPSS education specialists. On average each school counselor deals with almost 110 children through individual and group counseling sessions and carry out parental and teacher support sessions in their hosting schools.

g. Gaps and challenges

Mental disorders in Palestine remain underreported and under-treated, while mental health services are underfunded. Considering the extremes of war and conflict experienced in Palestine, the mental health system faces specific challenges linked with occupation and political conflict. Restrictions on freedom and movement limit patients from receiving care outside their area of residence. Further obstacles to accessing care are the cost of treatment, the inconsistent availability of medications on the WHO essential medicines list, insufficient specialists, and the absence of multidisciplinary teamwork. Mental health services are heavily dependent on human resources and current clinical services are unable to meet the burden of need. Regarding child and adolescent mental health clinical services, there is only one CAMHS located in Halhoul, in the Governorate of Hebron. In other areas, children and adolescents are seen by the adult teams or else in the private sector or by NGOs. There are no suitable inpatient provisions for under 18-year olds. Within the public educational system, 1200 schools in Palestine have a dedicated counsellor, 750 schools are without (almost 40%). There is variation in the levels of competency and training of school counsellors.

	Key challenge	Description
Promotion	Political and economic situation	Children and their families are exposed to ongoing political

[46] List of NGOs offering mental health services in the appendix
[47] Ministry of Health, Health Annual Report Palestine 2021, June 2022. Palestinian Health Information Center (PHIC) Health Policy & Planning Unit.

	(Occupation and political violence)	violence
	Promotion of Positive Mental Health	Lack of prioritization of the promotion of positive mental health and well-being in children and adolescents
Prevention	Stigma and lack of awareness surrounding signs and symptoms of mental health conditions	Mental illnesses are under-detected, under-reported and under-treated. Lack of community and physician awareness surrounding the risk factors, signs, and symptoms of mental health conditions.
	Stretched school counselling services	1200 public schools in Palestine have a dedicated counsellor, but 750 schools do not. There is variation in the levels of competency and training of school counsellors to detect cases of mental illnesses and/or suspected abuse and to offer first level interventions.
	Lack of safeguarding policies	Variability in safeguarding policies in educational, social and clinical organisations working with young people.
Service provision	Restrictions of freedom and movement	Limit patients from receiving care outside their area of residence, impacts on the cost of treatment, and affects the availability of medications on the WHO essential medicines list
	Inadequate provision and inaccessibility of specialized services to meet the needs of the population, especially vulnerable groups.	Current clinical services are unable to meet the burden of need. Regarding child and adolescent mental health clinical services, there is only one specialist Child and Adolescent Mental Health Service (CAMHS) located in Halhoul, in the Governorate of Hebron. In other areas children and adolescents are seen by the adult teams or else in the private sector and by NGOs. There are no suitable inpatient provisions for under 18-year olds.
Governance	Lack of system coordination across services	Lack of clear clinical pathway from detection to referral to treatment and recovery across the healthcare system. An updated child protection protocol clarifying roles and responsibilities for cases of suspected abuse is needed.
	Licensing	Lack of clear licensing processes for facilities and professionals; most notably for psychologists and social workers
	Quality standards	Lack of audits and inspections
Specialist Workforce	Supply of specialized professionals	There is a severe lack of human resources namely psychiatrists, psychologists, social workers and nurses. The total number of psychiatrists is 38 (with 18 in the government sector and 20 in the private sector), and the number of child psychiatrists is one. One senior psychiatrist in Gaza was killed during Israeli shelling in 2021. There are currently only five psychiatrists in training in Palestine with limited child and adolescent psychiatry sub-specialty training opportunities. Counsellors, social workers and psychologists practising without sufficient guidance and supervision.
Education	Insufficient specialist training opportunities	Shortage of specialist university programmes and/or practical clinical practice component of training (clinical supervision)
Research	Lack of institutional support and funding	Research dependent on sporadic funding and lacking institutional support
Financing	Lack of funding, reliance on external donors	Unstable financing mechanisms for mental health services leading to inequitable access to care depending on ability to pay.
	Lack of coverage	Lack of comprehensive coverage of mental health services by national insurance; mostly only cover medications.

Support services and IT	Lack of integrated data collection or IT system in healthcare (digital maturity)	Lack of surveillance and monitoring systems on which to develop evidence-based policies.
	Poorly integrated case management system	Poorly integrated case management within and between services.

h. Risk factors and vulnerable groups

Childhood is not a given for Palestinian children but, 'something that must be determined, retrieved, and understood within a complex web of implications mandated by the dynamics of power that are in play.[48]' Major risk factors for poor mental health in children include poverty; poor physical health (low birth weight, poor nutrition, obesity); poor quality relationships (unsupportive families, lack of friends, bullying and abuse); parental unemployment, mental illness (maternal or postpartum depression), and long working hours (reduced time spent with children, fewer family meals); reduced access to good quality health; poor education services (reduced access to books associated with poor academic achievement); lack of belonging at home, school or in the community, discrimination, living in an unequal society and reduced time spent playing outdoors/in nature; poor environment (climate) and adverse childhood experiences (ACE) such as experiencing or witnessing political violence or trauma. In Gaza the biggest source of distress cited by caregivers, children and young people was the threat of conflict, fear of bombs and the constant insecurity caused by the unstable political situation (60%). 45% of caregivers reported their main source of stress being how to provide for their children's needs as a result of poverty.[49] Exposure to conflict creates social and health consequences that contribute to more mortality and disability than any disease.[50] Recent research on smartphone and social media use, particularly in early adolescence, has been linked to feelings of envy, inadequacy, dissatisfaction with life, ADHD symptoms, depression, anxiety and sleep disturbance.[51]

Vulnerable groups of children at higher risk of mental illness include child detainees and the family members of adult detainees, Bedouin, refugees, the residents of Gaza, Areas C and East Jerusalem and those children with physical and intellectual disabilities.

i. Impact on parenting capacity and inter-generational trauma

Adults' capacity to parent and care for their children in a sensitive and attuned manner can be impacted by the insecurity and uncertainty that are a part of daily life for Palestinians living in the context of ongoing political violence and deteriorating socio-economic conditions. People can adapt to traumatic situations by living in 'survival mode' with defensive behaviours around the expression of emotion. Caregivers struggling to respond to their children in an emotionally attuned manner, not only impacts on today's children of Palestine, but may be a mediator in inter-generational trauma; when the trauma of previous generations is passed down from parent to child.

j. Protective factors and 'sumud' (صمود)

Despite living under harsh conditions, many Palestinians have demonstrated a remarkable resilience. Protective factors include close family and community relations, traditions and customs 'addat wa taqaleed' (العادات والتقاليد), investment in education, faith in God, religion and belief in their cause. Life events from birth, marriage and death are commemorated collectively. Research in Gaza found that influential factors which benefit the development and well-being of children who have experienced trauma, include support from caregivers; support and guidance from the community who are suffering the same ordeal including teachers and friends; communal religious beliefs and values; using humour and selflessness as a positive method of distraction; assuming a communal sense of responsibility for the safety of each other and, lastly, a communal element of control and security.[52]

[48] Incarcerated Childhood and the Politics of Unchilding, by Nadera Shalhoub-Kevorkian. New York: Cambridge University Press, 2019.
[49] Save the Children 'A Decade of Distress: The harsh and unchanging reality for children living in the Gaza Strip' 2019
[50] Murthy RS, Lakshminarayana R. Mental health consequences of war: a brief review of research findings. World psychiatry : official journal of the World Psychiatric Association (WPA). 2006;5(1):25–30.
[51] Elhai J, Dvorak RD, Levine JC, Hall BJ. Problematic smartphone use: A conceptual overview and systematic review of relations with anxiety and depression psychopathology. Journal of Affective Disorders. 2017 Jan 1;207:251–9.
[52] Altawil MAS, El Asam A, Khadaroo A., 2018.

The Palestinian value of 'sumud' (صمود) is a term meaning 'steadfastness.' It refers to the resistance of Palestinians to the Israeli takeover and settlement of Palestinian land. The ultimate symbol associated with the concept of sumud and the Palestinian sense of rootedness in the land is the olive tree, ubiquitous throughout Palestine and known to have deep roots in the land. In a recent survey, young people's responses indicated high levels of resilience and positive thinking. Despite all that they have been through, most young people thought that they were doing well (88%); could come up with ways to solve their problems (96%); or get the things out of life that were most important for them (95%); and could find ways to solve problems even when others want to quit (88%).[53]

k. Therapeutic approaches

There are a range of effective therapeutic interventions that can be tailored for the Palestinian context. Therapies developed in the West can take an individual approach such as Trauma-focused Cognitive Behavioural Therapy (CBT) and Eye Movement and Desensitization Reprocessing (EMDR). However, treating people individually does not effectively address the psychological, emotional and physical issues which affect the lives of thousands who are continually experiencing death, loss and evacuation as a consequence of the war situation.[54] In societies experiencing trauma together, benefits from a collective therapeutic approach are reported; psycho-social or therapeutic services are provided to an entire family or community, whilst promoting a sense of agency. The usefulness of three different intervention programmes based on holistic and integrated approaches for PTSD, namely Family Therapy, Psycho-Social Support (SANID) and Community Wellness Focusing (CWF) were all found to be effective.[55] Interpersonal therapy (IPT) has been used effectively in groups internationally to treat depression.[56] A collective approach encouraging local ownership is gaining attention for conditions as diverse as ASD, depression and cancer.

[53] Save the Children, 2019.
[54] Bolton P, Betancourt TS., 2004.
[55] CWF was found to be most effective. Altawil, Mohamad A S et al.,2018.
[56] Columbia University and WHO, 2016.

3. PALESTINE NATIONAL STRATEGY FOR CHILD AND ADOLESCENT MENTAL HEALTH

a. Rationale

A national strategy will assist all stakeholders be they funders, governmental institutions, non-governmental organizations or individual community members to align with key national priorities and work in a more efficient and coordinated manner.

b. Alignment

The strategy is aligned with the WHO Action Plan (2013 to 2020), National Mental Health Strategy Palestine (2015 to 2019), Early Childhood Development and Interventions Strategy (2017 to 2022), Adolescent Youth Health Strategy (2022 to 2026), National Suicide Prevention Strategy (2022). Relevant MoH policies, protocols and regulations include the child and adolescent suicide protocol (2022) and the early intervention centres regulation (2021). It is aligned with all UN Sustainable Developmental Goals (SDGs), especially those pertaining to the absence of poverty, good health and well-being, quality education, decent work and economic growth, reduced inequalities, sustainable cities and countries and peace, justice and strong institutions.[57]

c. Vision

The vision is for every Palestinian child's mental health and well-being to be promoted and protected throughout their developmental journey into adulthood by strong support networks and for mental illnesses to be detected and treated by collaborative, effective systems of care, free from stigmatization, discrimination and marginalization so they can live fulfilling lives as integrated members of society.

d. Mission

The mission is to call for community action in recognition that every child deserves the best possible chance to reach his or her potential; to build strong community support networks around each child to promote positive mental health and well-being and construct collaborative, effective systems of care to treat those suffering from mental illness so they can integrate into society and contribute as valued members; to bolster successful activities that are already in place and to embrace innovative, digital solutions and adapt them to the local context for a sustainable future.

e. Approach

This strategy takes a collaborative, innovative, community action and rights-based approach to child and adolescent mental health. Involving all sectors is fundamental to ensuring that programmes reflect priorities, have widespread support and are sustainable. All initiatives focus on participatory planning models, such as statutory committees with long-term mandates, formal partnership groups, specialized working groups and more informal arrangements. NGOs are essential partners in ensuring accountability in mental health; a vital component of a modern civil society raising people's awareness of issues and their concerns, advocating change and creating a dialogue on policy. Strengthening the health promotion role of organizations concerned with civil, cultural, economic, political and social rights, including those that defend the rights of children and people with physical and mental disabilities is encouraged.

f. Key Priorities

1. Safety and security. To advocate at local, national, and international levels for all children to have the right to live in safety and security, free from discrimination, marginalization and violence
2. Reducing poverty. To attend to children's basic needs of food, shelter and access to health care and education through distributing resources to those in greatest need for a fairer society
3. Early development. To give every child the best start in life through developing secure emotional attachments with his or her family and community (birth to five years)
4. Protecting childhood. To create spaces for children to play, learn and grow through 'whole school' approaches to well-being and outdoor activities (five to 12 years) and parenting guidance in the digital age; using schools to

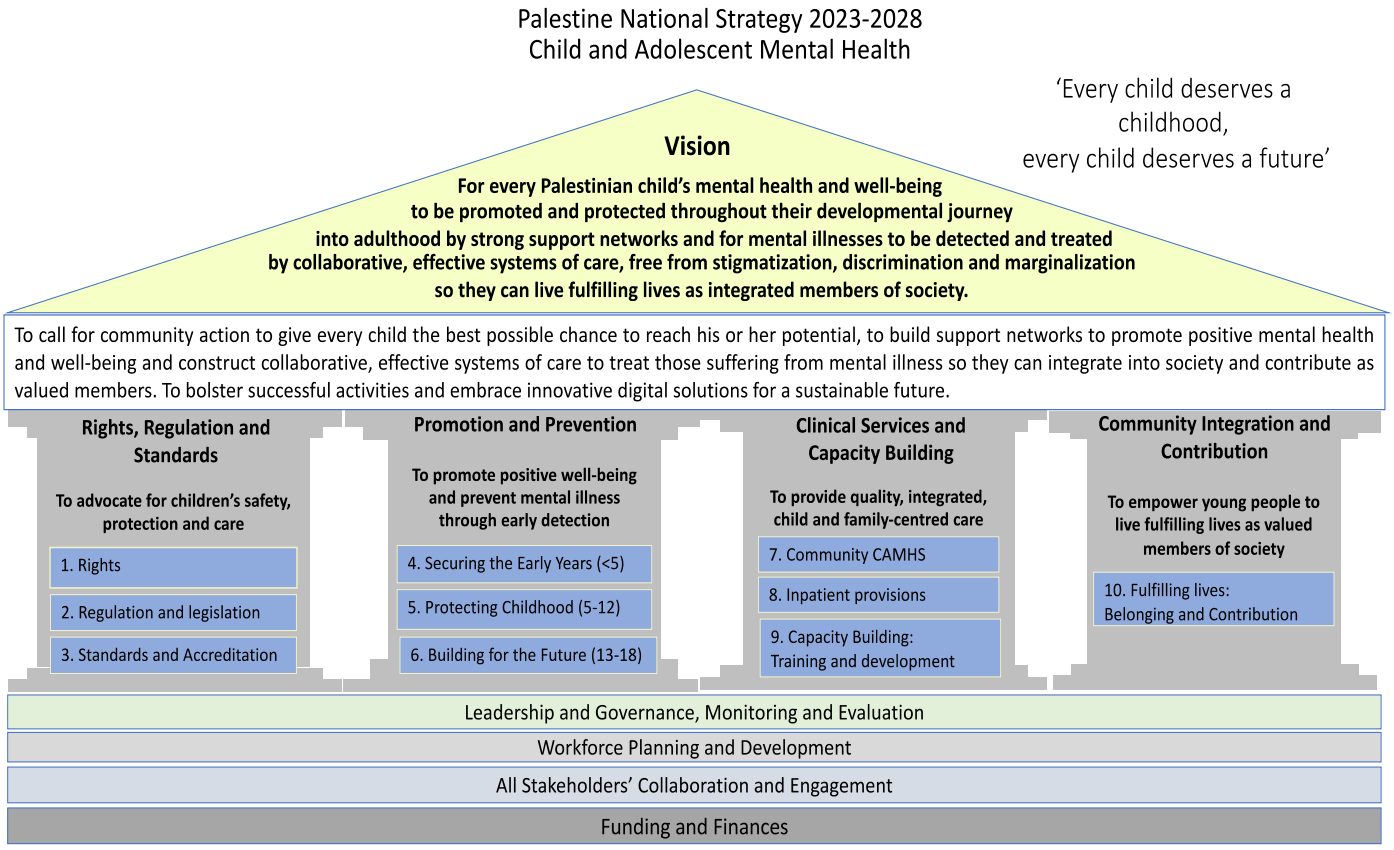
[57] Namely 1, 3, 4, 8, 10, 11 and 16. The UN's 17 Sustainable Development Goals can be found at https://sdgs.un.org/goals

enrich children's emotional development and literacy, social interactions and identify early signs of distress or illness.

5. Building for the future. To nurture skills for life and citizenship to prepare adolescents for adulthood and the digital age developing socio-emotional, literacy, numeracy and technical skills through vocational, apprenticeship and mentorship programmes (13 to 18 years)
6. Vulnerable groups. To give special attention to child detainees, residents of Gaza, Area C, and East Jerusalem, Bedouin, refugees and those with physical and/or intellectual disabilities and their families and carers.
7. Physical health. To promote healthy sleep, diet and exercise habits and to prevent and treat physical disease
8. Child protection protocols. To protect children at risk of physical, emotional, sexual abuse and/or neglect
9. Effective clinical pathways. To establish efficient systems of care to enable those with fewer needs to manage within informal systems of care and those with greater needs to be managed in different levels of clinical settings
10. Professional development. To train people working with children and adolescents on how to promote positive mental health and well-being and detect early warning signs; to develop strong mental health university programmes for social workers, counsellors and psychologists; to offer training and supervision to clinicians working with children to deliver specialist services for those suffering from mental illnesses; taking into account the high levels of trauma experienced in the community.

g. The Four Pillars of the Strategy

The strategy has four pillars: 1) Rights, regulation and standards 2) Promotion and prevention; 3) Clinical services and capacity building 4) Community integration and contribution. Driven by the vision, mission, and key priorities, in the templar graphic below, the roof is formed by the vision and mission, supported by four pillars divided into ten initiatives (in blue). The foundations are the enablers on which the strategy's success depends: leadership and governance, monitoring and evaluation; workforce planning and development building; collaboration and engagement of all stakeholders; funding and finances.



i. The first pillar 'Rights, Regulation and Standards' refers to advocacy to protect children's rights, to review regulations and legislation; ensure safe practice and accreditation; foster accountability and transparency, and thus raise standards of care. Initiatives include advocacy reports and campaigns, reviewing regulations or writing new

legislation as well as the creation of new regulatory practices in the form of peer reviews and the accreditation of educational and clinical services. Advocacy takes a right-based approach recognises that every child deserves a childhood and a future. All initiatives will campaign for children to be able to live in safety and security; have good quality relationships with family and friends; positive school experiences with a sense of belonging to school and an absence of bullying; access to learning experiences and books; opportunities to play outside, adequate resources (absence of poverty); good physical health with sleep, diet and exercise routines; participation in decisions at home and school; regular community or group activities; a healthy environment (climate) free from pollution and living in a reasonably equitable society.

ii. The second pillar 'Promotion and Prevention' refers to promoting positive mental health and well-being and detecting early signs of mental illness in vulnerable populations. Early development initiatives for birth to five-year-olds will focus on giving every child the best start in life through developing secure emotional attachments with his or her family and community and reducing or preventing ACE. Protecting childhood campaigns for five- to 12-year-olds creates spaces for children to play, learn and grow through 'whole school' approaches to well-being and outdoor activities and supports school-based resilience and psychosocial interventions; to reduce screen time and nurture reading for pleasure. Building for the future for 13- to 18-year-olds empowers young people through developing skills for life and citizenship be they socio-emotional,[58] literacy, numeracy or technical; to prepare for adulthood through vocational, apprenticeship and mentorship programmes. All adolescents are encouraged to participate in community sporting or recreational activities. These initiatives build on current activities; embrace innovative digital solutions and adapt successful international models for the local setting to prevent or reduce alcohol or substance misuse in teenagers such as the Icelandic Planet Youth programme.

iii. The third pillar 'Clinical Services and Capacity Building' focuses on providing integrated, effective and efficient child and family-centred services through building new services and training staff and thereby building capacity to meet demand. These initiatives will establish efficient systems of care based on the WHO model to enable those with fewer needs to manage within informal systems of care; and those with greater needs to be managed in different levels of clinical settings. The ultimate goal is for every child to be seen within their own community by professionals with the appropriate level of expertise: primary health workers, psychiatrists, psychologists, counsellors, nurses or social workers. This expertise is developed through clinical experience, training and supervision.

iv. The fourth pillar 'Community integration and Contribution' refers to community activities to enhance integration by reducing stigma; developing a sense of belonging at home, in school or in the broader community and empowering young people to engage actively in and contribute to the community; to their world, the world around them and the world at large. This includes building digital communities in order to build collaborative local and international networks.

h. Vulnerable groups

Vulnerable groups, namely child detainees and the family members of detainees, Bedouin, refugees, the residents of Area C, East Jerusalem and Gaza and those with physical and/or intellectual disabilities will be included in all these initiatives but given special attention and resource allocation.

i. Digital solutions

Digital solutions are integral to the preparation, planning, implementation and monitoring of the strategy. Now recognized by governments and healthcare providers around the world, embracing digital transformation can facilitate greater efficiency and effectiveness of clinical services through virtual interventions, electronic medical

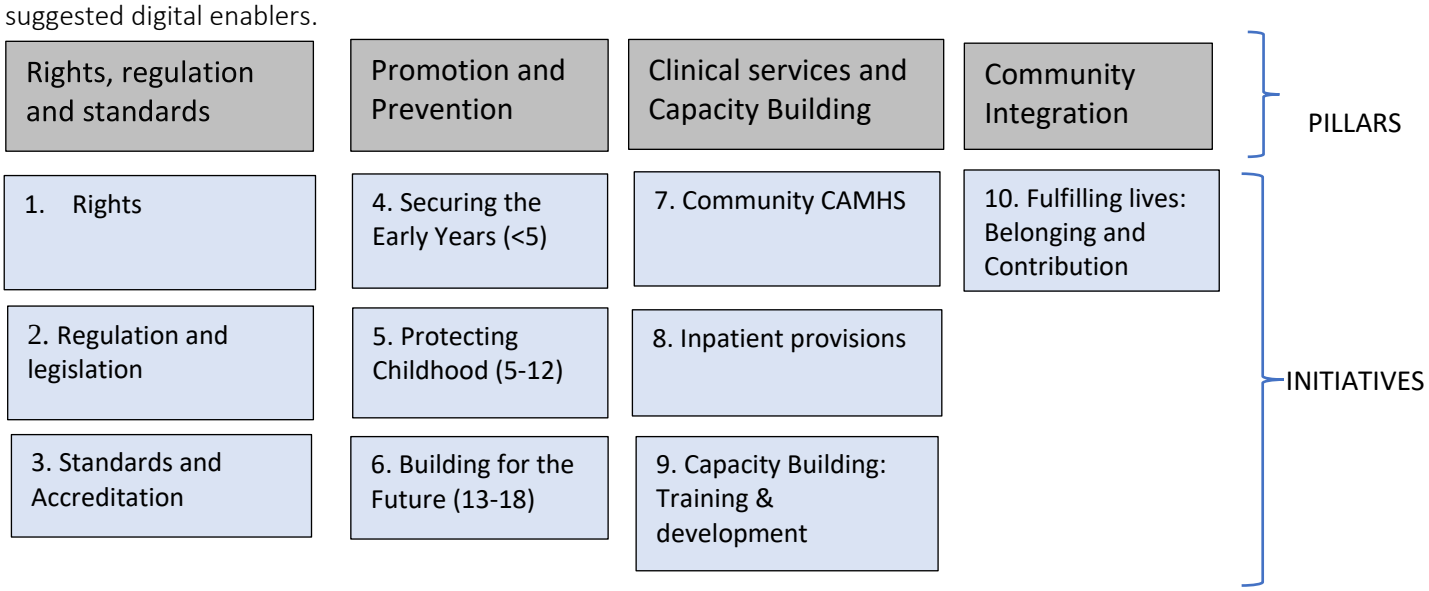
[58] including emotional regulation and mental health literacy skills

records (EMR), training and supervision, stakeholder communication and quality improvement.[59] Cybersecurity measures should be in place, taking into account the privacy and confidentiality aspects of personal health data.

[59] The Global Digital Health Partnership (GDHP) is an international collaboration group supporting the implementation of digital health globally.

4. ACTION PLANS FOR THE TEN INITIATIVES

To achieve the mission of the strategy, the four pillars were divided into ten initiative. The proposed activities are interrelated with one another and aligned with those of the Mental Health Strategy (MHS) 2015 to 2019. This section provides a description of each initiative in terms of outcomes, activities, owners and targets. The MHS' 'Strategic Priority Actions' (SPA) and Key Performance Indicators (KPIs) relevant to each initiative are included, as well as suggested digital enablers.



FIRST PILLAR: RIGHTS, REGULATION AND STANDARDS

Initiative 1	**Children's Rights**	
Description	**Multi-sectorial advocacy at the local, national and international levels for every child's right to safety and security with their basic needs of food, shelter and access to healthcare and education met**	
Main outcome	**Improved levels of safety and security and reduced levels of children living in poverty**	
Main stakeholders	All governmental and non-governmental bodies and organisations internationally and locally. All Palestinian ministries, WHO, UNWRA, UNICEF and all NGOs and CBO's advocating for children's rights.	
Activity Breakdown	Activity Description	Owner
1.1	To campaign for every child's right to a childhood and a future; to play in safety free from political violence; to end killings, injury, detention, house arrest, house demolitions.	TBD
1.2	To advocate for 'safe schools' at local, national and international levels	TBD
1.3	To advocate for the rights of all children, with special attention given to vulnerable groups of child detainees, residents of Gaza, Area C, and East Jerusalem, Bedouin, refugees and those with physical and/or intellectual disabilities	TBD
1.4	To advocate for the elimination of poverty; for children's basic needs to be met in terms of food and shelter (including fuel) and access to healthcare and education	TBD
Preliminary KPI	Name	Target
1.1	Number of campaigns for every child's right to a childhood and a future, free from political violence, regardless of ethnicity	Annual
1.2	Number of campaigns advocating for 'safe schools' agreement and/or number of school-based activities to improve physical and emotional safety in classrooms	Annual
1.3	Number of campaigns for the rights of vulnerable groups	Annual
1.4	Number of campaigns advocating for the rights of children to have their basic needs met	Annual
MHS SPA & KPIs	No relevant SPA	
Digital Enablers	Use of social media platforms and networks	

Initiative 2	Regulation and legislation	
Description	Updating policies, protocols and regulations for children's safety, protection and care	
Main outcome	Improved regulation and legislation pertaining to children's mental health	
Main stakeholders	Ministries of Health, Education and Social Development, WHO, UNWRA in collaboration with educational, heath, and community centres be they international or local NGOs or CBOs.	
Activity Breakdown	Activity Description	Owner
2.1	To review, update and implement a national Child Protection Protocol	TBD
2.2	To review and implement Early Intervention Centre regulation	TBD
2.3	To write and implement Clinical Pathways for Developmental Delay (including suspected ASD) from detection to rehabilitation	TBD
2.4	To write and implement Clinical Pathways for Mental Illness from detection to treatment to recovery	TBD
2.5	To raise awareness and implement Suicide Protocol for Children and Adolescents	TBD
2.6	To build a mental health unit or designate beds in a general or paediatric hospital	TBD
Preliminary KPI	Name	Target
2.1	Child Protection Protocol completed and implemented	Yes/No
2.2	Early Intervention Centre regulation completed and implemented	Yes/No
2.3	Clinical Pathway for Developmental Delay completed and implemented	Yes/No
2.4	Clinical Pathway for Mental Illness completed and implemented	Yes/No
2.5	To raise awareness and implement Suicide Protocol for Children and Adolescents	Yes/No
2.6	A mental health unit or specialist beds designated in a general or paediatric hospital	Yes/No
MHS SPA & KPIs	SPA 1. To develop legislation related to mental health • Development of national mental health legislation in line with international human rights instruments • Adoption of MoH policy to designate psychiatric beds at general hospitals	
Digital Enablers	To upload all national policies, protocols and regulations on to a digital platform and use digital methods to raise awareness amongst practicing professionals	

Initiative 3	Standards of Clinical Care	
Description	Raising standards of care to strive for clinical excellence through promoting value and evidence-based practice with appropriate use of guidelines and protocols	
Main outcome	Improved clinical care provided by children and adolescents mental health services	
Main stakeholders	Ministries of Health, Education and Social Development, WHO, UNWRA , UNICEF in collaboration with international or local NGOs or CBOs working in child and adolescent mental health.	
Activity Breakdown	Activity Description	Owner
3.1	To conduct self-reviews of CAMHS services using quality standards	TBD
3.2	To conduct peer review of CAMHS services with international partner	TBD
Preliminary KPI	Name	Target
3.1	Number of self-reviews of CAMHS services conducted using quality standards	3
3.2	Number of peer reviews of CAMHS services with international partner	2
MHS SPA & KPIs	SPA 7. To improve the quality of psychiatric care. • The proportion of mental health facilities monitored at least once a year using quality standards	
Digital Enablers	On-line peer reviews if travel restrictions, digital platform to view all service reviews	

SECOND PILLAR: PROMOTION AND PREVENTION

Initiative 4	Securing the Early Years (under 5-year olds)	
Description	**Promoting secure emotional attachments and psychosocial stimulation under the age of five years**	
Main outcome	More children with secure attachments to caregivers and access to psychosocial stimulation	
Main stakeholders	Ministries of Health, Education and Social Development, WHO, UNWRA in collaboration with educational, heath, and community centres be they international or local NGOs or CBOs working with children during the early years and their families.	
Activity Breakdown	Activity Description	Owner
4.1	To mandate training on infant mental health (attachment, promoting breastfeeding) and post-partum depression for all peri-natal professionals including nurses, midwives, social workers, paediatricians and primary health care physicians through innovative, digital and face to face courses – linked to salary or license.	TBD
4.2	To develop training on psychosocial stimulation programmes for early year professionals through innovative, digital and face to face courses	TBD
4.3	To campaign to reduce screen use in under two-year olds	TBD
4.4	To increase access to quality early learning centres for under five-year olds	TBD
4.5	To initiate reading for pleasure programme with daily story telling for all babies and toddlers	TBD
4.6	To set up screening for developmental delay and other risk factors linked to national immunisation programmes	TBD
Preliminary KPI	Name	Target
4.1	Number of peri-natal staff (nurses, midwives, social workers and PHC doctors) completed mandatory training on infant mental health	>50%
4.2	Percentage of early year professionals trained on psychosocial stimulation	>90%
4.3	Number of campaigns to reduce screen use in under two-year olds	Annual
4.4	Percentage increase in the number of children attending early learning centres	50%
4.5	Percentage of parents reading daily for pleasure with babies and toddlers	>50%
4.6	National screening programme set up for developmental checks linked to national immunisation programme and clinical pathway for developmental delay	Established/ not
MHS SPA & KPIs	SPA 6. Develop interventions for mothers, children and adolescents with mental health problems • Percentage of health and non-health professionals trained to provide early childhood care and development • Recognition and management of perinatal mental disorders integrated into the training programmes of all Mother Child Health Professionals	
Digital Enablers	On-line training modules on infant mental health and psychosocial stimulation for all staff with test and certificate of completion	

Initiative 5	Protecting Childhood (5 to 12-year olds)	
Description	Creating spaces for children to play, learn and grow through 'whole school' approaches to well-being, embracing a healthy lifestyle, regular reading for pleasure and outdoor activities	
Main outcome	Improved levels of mental and physical well-being, literacy and numeracy	
Main stakeholders	All ministries, in particular Ministries of Education, Social Development, Urban Planning and Health in collaboration in collaboration with educational, heath, and community centres be they international or local NGOs or CBOs working with school aged children and their families.	
Activity Breakdown	Activity Description	Owner
5.1	To develop 'whole school' physical and mental well-being programmes with anti-bullying policies, promoting belonging, pro-social behaviour, creativity and teamwork	TBD
5.2	To actively encourage daily reading for pleasure with access to books, parents and other adult role models reading to children at school and home	TBD

5.3	To create spaces for play and learning inside and outside – every district to have a local play area, to promote outdoor play and connecting with nature. Enhance protective environments creating more safe spaces	TBD
5.4	National guidance on safe use of social media for 10 to 14-year olds	TBD
Preliminary KPI	Name	Target
5.1	To develop nation-wide 'whole school' programme with pre- and post-well-being surveys with mandatory training for all staff with school leadership support	Yes/No
5.2	Number of campaigns to promote daily reading for pleasure in school age children	Annually
5.3	To mandate that every district has a local play area to promote outdoor exercise and play	Yes/No
5.4	To issue guidance on safe use of social media for 10 to 14-year-olds	Yes/No
MHS SPA (KPIs)	SPA 9. Disseminate strategies to strengthen the mental health of the population • Number of schools implementing mental health education or well-being programmes	
Digital Enablers	On-line surveys of students' well-being, digital campaigns regarding benefits of reading for pleasure and playing for children.	

Initiative 6	**Building for the Future (13 to 18-year-olds)**	
Description	**Empowering young people to prepare for adulthood through developing socio-emotional, literacy, numeracy or technical life skills**	
Main outcome	**Increased engagement of adolescents in pro-social activities developing valuable life skills including coping skills and resilience skills, problem solving, self-efficacy, confidence, critical thinking, socio and emotional literacy and technical skills**	
Main stakeholders	Ministries of Education, Social Development, Urban Planning, Agriculture, Economy and Health in collaboration in collaboration with educational, heath, and community centres be they international or local NGOs or CBOs as well as institutions of higher education (colleges and universities) and local businesses and social enterprises.	
Activity Breakdown	Activity Description	Owner
6.1	For all educational programmes to have a mental health component engaging young people in identifying and talking about their emotions, life circumstances and raising awareness regarding early warning signs and seeking assistance.	TBD
6.2	To establish vocational programmes to learn new practical and technical skills with employment opportunities	TBD
6.3	To encourage apprenticeships locally to learn new life skills;	TBD
6.4	To nurture mentorship programmes to develop life skills and open up opportunities with local and international partners	TBD
6.5	To expect every adolescent to participate in at least one weekly community, sporting or recreational activity	TBD
6.6	To promote at least one family meal every day with parents	TBD
Preliminary KPI	Name	Target
6.1	Number of vocational programmes to learn new practical or technical skills with employment opportunities	TBD
6.2	Number of apprenticeships to learn new life skills	TBD
6.3	Number of mentorship programmes to develop life skills and open up opportunities with local and international partners	TBD
6.4	Percentage of adolescents participating in at least one regular community sporting or recreational activity.	>90%
6.5	Number of adolescents sharing one family meal each day with family members	>90%
MHS SPA & KPIs	SPA 9. Disseminate strategies to strengthen the mental health of the population • Number of schools implementing life skills education	
Digital Enablers	On-line vocational trainings, linking up with vetted mentors locally and internationally virtually.	

THIRD PILLAR: CLINICAL SERVICES AND BUILDING CAPACITY

Initiative 7	Community Child and Adolescent Mental Health Services (CAMHS) for Every Child	
Description	Establishing access to CAMHS in every community in the West Bank, including East Jerusalem, and Gaza	
Main outcome	For every child to be seen in his or her community by professionals with the appropriate level of expertise	
Main stakeholders	Ministry of Health, WHO, UNWRA, UNICEF and relevant international and local NGO's and CBO's working in the fields of child and adolescent mental health.	
Activity Breakdown	Activity Description	Owner
7.1	To establish at least one 'model' CAMHS MoH training centre in West Bank and Gaza	TBD
7.2	To set up CAMHS services in each governorate, alongside adult CMHCs	TBD
7.3	A designated CAMHS Clinical Lead to work closely with key stakeholders to streamline clinical pathways between PHC, CAMHS and inpatient facilities	TBD
7.4	Clinical Lead to oversee training, supervision and outreach to PHC staff in CAMHS	TBD
7.5	Patient files include mental health indicators and referral and back referral system	TBD
Preliminary KPI	Name	Target
7.1	Number of CAMHS training centres established	1
7.2	Clinical Lead of CAMHS role established with clear responsibilities	Yes/No
7.3	Number of CAMHS services with Clinical Lead	100%
7.4	Number of PHCs with outreach CAMHS clinics	30%
7.5	Digitalization of patient files in primary, secondary and tertiary care	Yes/No
MHS SPA & KPIs	SPA 5. Scale-up community mental healthcare • Number of community mental health services, • Number of available multidisciplinary mental health teams, • Number of community-based rehabilitation services SPA 4. Integrate delivery of evidence-based interventions for priority mental conditions in primary health care supported by referral system • Integration of mental health as an integral part of Family Medicine • Proportion of PHC facilities with a least one staff trained to delivery of non-pharmacological interventions • Proportion of persons seen in primary health care services with psychological problems and common mental health disorders SPA 2. Strengthen a routine information system • Existence of a patient file which includes referral and back referral • Routine data at national level available on core set of mental health indicators	
Digital Enablers	Assess digital maturity on which to base digital solutions to streamline a stepped model of care between PHC, CMHCs and inpatient facilities so as to offer 'Connective Care' with interoperable systems.	

Initiative 8	Inpatient Child and Adolescent Mental Health Services (CAMHS)	
Description	**Establishing specialist CAMHS inpatient provisions in the West Bank and Gaza**	
Main outcome	For every young person with a mental illness of sufficient severity in nature or risk to have access to a specialist CAMHS inpatient bed	
Main stakeholders	Ministry of Health, WHO, UNWRA, UNICEF and relevant international and local NGO's and CBO's working in the fields of child and adolescent mental health	
Activity Breakdown	Activity Description	Owner
8.1	To estimate minimum number of psychiatric beds required for under 18-year-olds	TBD
8.2	To set up one CAMHS inpatient provision in a separate section of an established psychiatric hospital or ward with specialist teaching and training component and four provisions of psychiatric beds within established paediatric or general hospitals	TBD

8.3	To establish three inpatient provisions in the West Bank and two in Gaza	TBD
8.4	To establish digitally mature services streamlined with community clinical provisions	TBD
Preliminary KPI	Name	Target
8.1	CAMHS inpatient task force to establish requirements for inpatient provision	Established/Not
8.3	3 CAMHS inpatient provisions in the West Bank	3
8.4	2 CAMHS inpatient provisions in Gaza	2
MHS SPA & KPIs	SPA 8. Designate beds in general hospitals or develop capacity in general hospitals to manage acute mental health problems • Proportion of general hospitals with staff trained to manage acute mental health problems • Liaison system between general/paediatric hospitals and CAMHS established • Beds dedicated for mental health inpatients	
Digital Enablers	Fully digitalized inpatient service provision interoperable with community services	

Initiative 9	Capacity Building for Child and Adolescent Mental Health and Well-Being	
Description	To assess current capacity and work to enhance skills	
Main outcome	Increased capacity to promote well-being and detect and treat children and adolescents with mental illness	
Main stakeholders	Ministries of Health, Education, Economy, WHO, UNWRA, UNICEF and relevant international and local NGO's and CBO's working in the fields of education and child and adolescent mental health and relevant professional bodies including the Palestinian Medical Council and Union of Psychologists and Social Workers.	
Activity Breakdown	Activity Description	Owner
9.1	To assess training needs for proposed clinical provision at PHC, CAMHS and inpatient provisions for multidisciplinary teams of psychiatry, psychology, social work, nursing and allied health professionals (speech and language pathology and occupational health)	TBD
9.2	To offer specialist trainings for PHC, CAMHS and inpatient provisions (clinical)	TBD
9.3	To set up supervision networks – locally and internationally – for CAMHS professionals; psychiatrists, psychologists, counsellors, social workers, nurses and allied health professionals	TBD
9.4	To develop mandatory training programme for school counsellors for detection and first level interventions and raise awareness regarding the clinical referral system and provisions as well as child protection pathways and protocols	TBD
9.5	To ensure every school has a trained counsellor	TBD
Preliminary KPI	Name	Target
9.1	Training needs assessment for proposed clinical service provision completed	Yes/No
9.2	Number of specialist trainings conducted	Annual
9.3	Percentage of CAMHS staff supported by supervision network	>90%
9.4	Mandatory training programme established for all school counsellors in psychological first aid, strengthening resilience and positive coping strategies, and awareness training regarding Child Protection Protocol and Clinical Pathways. Integrated as part of annual school induction process.	100%
9.5	Every school has a trained counsellor	100%
MHS	SPA 3. Ensure Specific Focus on Trauma and Crisis Intervention • Number of healthcare workers trained in trauma intervention and recognition and management of priority mental health problems (first level interventions) SPA 4. Integrate delivery of evidence-based interventions for priority mental health conditions in PHC supported by referral system • Mental health is integrated in governmental PHC clinics in the West Bank and Gaza SP5. Scale-up community mental health care	

	• Number of community mental health centres • Number of available multidisciplinary community mental health teams • Number of community-based rehabilitation services SPA 6. Develop interventions for mothers, children and adolescents with mental health problems • Percentage of health and non-health professionals trained to provide early childhood care and development • Training module on recognition and management of perinatal mental disorders is developed and integrated into the training programmes of all Mother Child professionals.
Digital Enablers	To develop virtual mandatory training for school counsellors with test and certification, linked to database and rates of counsellors trained to track progress

FOURTH PILLAR: COMMUNITY INTEGRATION AND BELONGING

Initiative 10	Fulfilling lives: Belonging and Contribution	
Description	Activities to nurture young people's sense of belonging to the family, school, community and broader society and to build 'social capital' through relationships, building communities, including the diaspora. Empower caregivers to maintain strong, supportive and protective family units for children.	
Main outcome	Improvement in well-being through an enhanced sense of belonging and contribution	
Main stakeholders	ALL STAKEHOLDERS	
Activity Breakdown	Activity Description	Owner
10.1	To develop community resources for self-help with the development of resources offering psychological first aid and guidance for young people on mental health and well-being	TBD
10.2	To strive for patients' full recovery and integration into the community so as to reduce stigma and marginalization.	TBD
10.3	To work with urban planning to adapt the community environment, playing outdoors, connecting to nature, more safe and well-managed spaces	TBD
10.4	To support youth centres and conduct youth-led community activities and involvement	TBD
10.5	To enhance parenting capacity through family programmes, addressing parental mental illness, reducing domestic violence, physical and psychological abuse of children, policies and subsidies for disadvantaged families, support for open and supportive family environments and upbringing with a reduction in the use of corporal punishment.	TBD
10.6	Neighbourhood and community education on awareness of wellbeing, socio-political determinants, involving youth in policy-making agendas, create a more supportive and encouraging environment for youth. Engaging marginalized families and youth living in extreme poverty, abused, at risk of substance misuse	TBD
Preliminary KPI	Name	Target
10.1	Community self-help resources identified and/or developed in Arabic	Yes/No
10.2	Recovery and integration integral part of patients' care plans – training for CAMHS	100%
10.3	At least one communal play areas in every district	>50%
10.4	Percentage of young people enrolled in youth-led community programmes	>50%
10.5	Family programmes conducted to enhance parenting capacity in every district	>50%
10.6	Number of 'whole neighbourhood' activities which engage marginalized families	Annual
MHS	SPA 9. Disseminate strategies to improve mental health literacy, reduce stigma and discrimination, and promote evidence-based interventions strengthening the mental health of the population • Anti-stigma module developed and integrated into Health Education and Life Skill Education • In all districts, parenting skills, GBV and drug use programmes are implemented with mothers and families	
Digital Enablers	The use of digital platforms and social media to disseminate information and promote community connectivity	

5. MONITORING AND EVALUATION, SUSTAINABILITY AND RESEARCH

a. Monitoring and Evaluation

The monitoring and regular evaluation of the ten initiatives and their linked activities, and the transparency in processes and procedures, is critical to the strategy's overall success. The strategy is owned by the Ministry of Health with close inter-ministerial coordination with the MoE and MoSD. The MoH will assign each initiative an owner and each activity a named leader, who will be responsible for planning and implementation, monitoring and evaluation according to agreed descriptions and KPIs. The Mental Health Unit will be responsible for establishing a realistic timeframe and digital platform to upload and update progress with regular reports on the progress of every initiative and activity over the five-year period 2023 to 2028.

The KPIs for the National Strategy for Child and Adolescent Mental Health are aligned with those of the National Mental Health Strategy (2015 to 2019), the National Strategy for Early Childhood Development and Intervention (2017 to 2022) and the WHO Mental Health Action Plan (2013 to 2030). One of the key objectives of the WHO Action Plan objectives is for countries to report a core set of mental health indicators at least every two years.

b. Sustainability

Strategies and programmes fail due to the lack of a sustainable model. Every initiative and activity should be considered in terms of immediate impact and future sustainability. Costly 'one off' trainings are discouraged. Instead, well-chosen, larger scale, cost-effective trainings are promoted so that more professionals can benefit. Specialist trainings or long-term supervision should be selected for those individuals who are well-placed to put their new skills into practice; such as part of a university curriculum for healthcare professionals or for 'frontline' practicing clinicians. Train the trainer models have such a 'multiplier' effect and reduces independence on external expertise and funding.

c. Benchmarking

International benchmarking of children's mental health and well-being before, during and after strategy implementation is recommended. Representative samples can be surveyed, and the results compared internationally. The strategy's success could be evaluated and compared with other countries internationally. In addition to the four key objectives of the WHO Mental Health Action Plan 2013 to 2030 pertaining to leadership and governance; increased service coverage; promotion and prevention; strengthening information systems; and evidence-based practice and research and the 17 SDG goals, the UNICEF framework is a suitable international measure of children's well-being.

d. Research and publication

The strategy provides an umbrella under which to encourage and promote research and publications on Palestinian child and adolescent mental health and well-being. Academic collaboration at the national and international institutional level using recognized guidelines is highly encouraged.

REFERENCES

1. Addameer Prisoner Support and Human Rights Association. Statistics. Available from: https://www.addameer.org/statistics
2. Altawil MAS, El Asam A, Khadaroo A. The Effectiveness of Therapeutic and Psychological Intervention Programs in PTC-GAZA. Journal of child & adolescent trauma. 2018 May 22;11(4):473–86.
3. Amnesty International. Israel's Apartheid against Palestinians : Cruel System of Domination and Crime against Humanity, Amnesty International; 2022. Available from: https://www.amnesty.org/en/wp-content/uploads/2022/02/MDE1551412022ENGLISH.pdf. Accessed 6 Nov. 2022.
4. Appraix O, Afana A. Technical Evaluation for AFD Mental Health Project: Final Report. United Nations Development Project; 2013.
5. Barber B, McNeely C, Olsen J, Spellings C, Belli RF. Effect of chronic exposure to humiliation on wellbeing in the occupied Palestinian territory: an event-history analysis. The Lancet. 2013;382:S7.
6. Berens AE, Jensen SKG, Nelson CA. Biological embedding of childhood adversity: from physiological mechanisms to clinical implications. BMC Medicine. 2017 Jul 20;15(1):135.
7. Bolton P, Betancourt TS. Mental Health in Postwar Afghanistan. JAMA. 2004;292(5):626–8.
8. Bronfenbrenner U. Ecological models of human development. In: In International Encyclopedia of Education (Vol 3, 2nd ed). Oxford: Elsevier; 1994.
9. BTSELEM The Israeli Information Center for Human Rights in the Occupied Territories. This is Apartheid: A regime of Jewish supremacy from the Jordan River to the Mediterranean Sea. BTSELEM The Israeli Information Center for Human Rights in the Occupied Territories. 2021 Jan; Available from: https://www.btselem.org/publications/fulltext/202101_this_is_apartheid
10. BTSELEM The Israeli Information Center for Human Rights in the Occupied Territories. This is Not a Vibrant Democracy: This is Apartheid. BTSELEM The Israeli Information Center for Human Rights in the Occupied Territories, 2022Available from: https://www.btselem.org/publications/202210_not_a_vibrant_democracy_this_is_apartheid
11. Dabbagh, Nadia. Suicide in Palestine: Narratives of Despair. Covent Garden, London: Hurst Publishers; 2005.
12. Defence for Children International (DCI). Child fatalities and injuries. Available from: https://www.dci-palestine.org/fatalities_injuries
13. Department of Education UK. Research evidence on reading for pleasure. Educational standards research team, Department of Education UK; 2012.
14. Elhai J, Dvorak RD, Levine JC, Hall BJ. Problematic smartphone use: A conceptual overview and systematic review of relations with anxiety and depression psychopathology. Journal of Affective Disorders. 2017 Jan 1;207:251–9.
15. GDHP. The Global Digital Health Partnership (GDHP) is a collaboration of governments and territories, government agencies and the World Health Organization, formed to support the effective implementation of digital health services. Available from: https://gdhp.nhp.gov.in/
16. Giacaman R, Abu-Rmeileh N, Husseini A, Saab H, Boyce W. Humiliation: The invisible trauma of war for Palestinian youth. Public health. 2007 Sep 1;121:563–71; discussion 572.
17. Global Happiness Council. Global Happiness Policy Report 2018 [Internet]. World Government Summit; 2018. Available from: https://www.worldgovernmentsummit.org/api/publications/document?id=304a8bc4-e97c-6578-b2f8-ff0000a7ddb6
18. Greenbaum CW, Veerman P, Bacon-Shnoor, N. (Eds.). Protection of Children during Armed Political Conflict : A Multidisciplinary Perspective. Intersentia ; Distribution for North America Gaunt; 2006.
19. Hanna Kienzler, Zeina Amro. 'Unknowing' and mental health system reform in Palestine. MAT [Internet]. 2020 Nov 6 [cited 2023 Jan 6];2(3). Available from: http://www.medanthrotheory.org/article/view/4613
20. Herman H, Saxena S, Moodie R. Promoting Mental Health: concepts, emerging evidence, practice: report of the World Health Organization. Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne: World Health Organization; 2005.

21. Human Rights Watch. A Threshold Crossed: Israeli Authorities and Crimes of Apartheid and Persecution, Report 27. Human Rights Watch; 2022. Available from: https://www.hrw.org/report/2021/04/27/threshold-crossed/israeli-authorities-and-crimes-apartheid-and-persecution
22. Institute of Health Metrics and Evaluation. Available from: https://vizhub.healthdata.org/gbd-results/
23. Layard R, Hagel A. Healthy Young Minds: Transforming the Mental Health of Children. Report of the World Innovation Summit for Health (WISH) Mental Health and Wellbeing in Children Forum; 2015.
24. Marie M, Hannigan B, Jones A. Mental Health Needs and Services in the West Bank Palestine. International Journal of Mental Health Systems. 2016;10(1):1–8.
25. Marie M, SaadAdeen S, Battat M. Anxiety Disorders and PTSD in Palestine: A Literature Review. BMC Psychiatry, 2020;20. Available from: https://doi.org/10.1186/s12888-020-02911-7
26. Medicines du Monde / Doctors of the World. No Peace of Mind: a new study on the mental health of Palestinians living under Israeli occupation (A Report), 2022. Available from: https://doctorsoftheworld.org/blog/no-peace-of-mind/ August 2022
27. MIFTAH The Palestinian Initiative for the Promotion of Global Dialogue and Democracy. Locked in: Israel's house arrest policy against Palestinian children. Available from: http://www.miftah.org/Doc/Factsheets/miftah/English/Factsheet_HomeArrest2020En.pdf
28. Ministry of Health, Ministry of Education and Higher Education, Ministry of Social Development, State of Palestine. National Strategy for Early Childhood Development and Intervention (2017 to 2022). State of Palestine; 2017. Available from: https://www.unicef.org/sop/media/206/file/ECD%20National%20Strategy.pdf
29. Ministry of Health, State of Palestine. Mental Health Strategy 2015 to 2019, 2015. Available from: https://www.un.org/unispal/document/auto-insert-198619/
30. Murthy RS, Lakshminarayana R. Mental health consequences of war: a brief review of research findings. World psychiatry : official journal of the World Psychiatric Association (WPA). 2006;5(1):25–30.
31. Nelson CA, Bhutta ZA, Burke Harris N, Danese A, Samara M. Adversity in childhood is linked to mental and physical health throughout life. BMJ [Internet]. 2020;371. Available from: https://www.bmj.com/content/371/bmj.m3048
32. Palestinian Health Information Center (PHIC) Health Policy & Planning Unit Ministry of Health. Health Annual Report Palestine 2021, Ministry of Health; 2022. Available from: https://site.moh.ps/Content/Books/
33. Patel V, Flisher A, Hetrick S, Mcgorry P. Mental Health of Young People: A Global Public-Health Challenge. Lancet. 2007 May 1;369:1302–13.
34. Patterson A et al. Building the Foundations for Mental Health and Wellbeing: A strategic framework and action plan for implementing promotion, prevention and early intervention (PPEI) approaches in Tasmania, Dept. of Health and Human Services Mental Health Services Division; 2009. Available from: http://www.stors.tas.gov.au/au-7-0095-02021
35. Report prepared by Palestinian Health Information Center (PHIC) Health Policy & Planning Unit Ministry of Health. Health Annual Report Palestine 2021, Ministry of Health, State of Palestine; 2022. Available from: https://site.moh.ps/Content/Books/Hqgu4D5vfT6bDhDUtl36GHhx9oYlCS9JplXYDfOMKrnDt6YoDPkPdl_I6mhnD3xb5MaPpX1mx6k6J4WowTnGUc1135KRHMmuMwEi1Zh1QUmFY.pdf
36. Save the Children. A Decade of Distress: The harsh and unchanging reality for children living in the Gaza Strip, Save the Children International; 2019. Available from: https://resourcecentre.savethechildren.net/document/decade-distress-harsh-and-unchanging-reality-children-living-gaza-strip/
37. Saymah D, Tait L, Michail M. An overview of the mental health system in Gaza: an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). International Journal of Mental Health Systems. 2015 Jan 16;9(1):4.
38. Sehweil M. Responding to Continuing Traumatic Events. International Journal of Narrative Therapy and Community Work. 2005;3(4):54–6.
39. Shalhoub-Kevorkian N. Incarcerated Childhood and the Politics of Unchilding. Cambridge: Cambridge University Press; 2019.

40. Springer KW, Sheridan J, Kuo D, Carnes M. The long-term health outcomes of childhood abuse. An overview and a call to action. J Gen Intern Med. 2003 Oct;10:864–70.

41. Thabet AA, Abdulla T, El-Helou M, Vostanis P. Effect of trauma on children mental health in the Gaza strip and West Bank, (pp. 123–138). In C W, Greenbaum, P, Veerman, & N, Bacon-Shnoor (Eds) Protection of children during armed political conflict: A multidisciplinary perspective, Intersentia ; Distribution for North America Gaunt; 2006.Available from:https://www.academia.edu/20877279/EFFECT_OF_TRAUMA_ON_PALESTINIAN_CHILDRENS_MENTAL_HEALTH_IN_THE_GAZA_STRIP_AND_WEST_BANK

42. Thabet AA, Abu Tawahina A, El Sarraj, E, Vostanis P. Exposure to war trauma and PTSD among parents and children in the Gaza strip. European child & adolescent psychiatry. 2008;17(4):191–9.

43. The Institute of Community and Public Health, Birzeit University. Youth Wellbeing in the Occupied Palestinian Territory: An in-depth, multi-level and interdisciplinary study into wellbeing and gender equality among Palestinian youth. Oxfam, 2021 Apr; Available from: https://policy-practice.oxfam.org/resources/youth-wellbeing-in-the-occupied-palestinian-territory-an-in-depth-multi-level-a-621182/

44. Tkacz J, Brady BL. Increasing rate of diagnosed childhood mental illness in the United States: Incidence, prevalence and costs. Public Health in Practice. 2021 Nov 1;2:100204.

45. Treatment and Rehabilitation Center for the Victims of Torture. Palestinian society needs in the West Bank, in particular specialist mental health services for children and adolescents. TRC; 2022.

46. UNICEF Innocenti. Worlds of Influence: Understanding what shapes child well-being in rich countries, Innocenti Report Card 16, Florence: UNICEF Office of Research; 2020. Available from: https://www.unicef-irc.org/publications/pdf/Report-Card-16-Worlds-of-Influence-child-wellbeing.pdf

47. United Nations Conference on Trade and Development (UNCTAD), Assistance to the Palestinian People : Developments in the Economy of the Occupied Palestinian Territory Report. United Nations; Trade and Development Board, Sixty-seventh session, Geneva; 2020.

48. United Nations Educational, Scientific and Cultural Organization. Global Citizenship Education, Paris: UNESCO; 2015. Available from: https://unesdoc.unesco.org/ark:/48223/pf0000232993

49. World Bank. Palestinian Territories' Economic Update, 2022. Available from: https://www.worldbank.org/en/country/westbankandgaza/publication/economic-update-april-2022

50. World Health Organization. Mental health : facing the challenges, building solutions: report from the WHO European Ministerial Conference, World Health Organization Regional Office for Europe; 2005. Available from: https://apps.who.int/iris/bitstream/handle/10665/326566/9789289013772-eng.pdf?sequence=3&isAllowed=y

51. World Health Organization. Community Mental Health Development in the occupied Palestinian territory: A Work in Progress with WHO. WHO Office for West Bank and Gaza: World Health Organization; 2006.

52. World Health Organization. Mental health systems in the Eastern Mediterranean Region: Report based on the WHO assessment instrument for mental health systems. [Internet]. Regional Office for the Eastern Mediterranean: World Health Organization; 2010. (EMRO Technical Publications Series). Available from: https://apps.who.int/iris/handle/10665/119926

53. World Health Organization. Mental Health Action Plan 2013-2022 [Internet]. Geneva: World Health Organization; 2013. Available from: https://www.who.int/publications/i/item/9789241506021

54. World Health Organization. Preventing suicide: a global imperative. 2014.

55. World Health Organization. Mental Health Atlas 2014. Geneva: World Health Organization; 2015.

56. World Health Organization and Columbia University. Group Interpersonal Therapy (IPT) for Depression (WHO generic field-trial version 1.0). Geneva: World Health Organization; 2016.

57. World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings; mental health Gap Action Programme (mhGAP) - version 2.0 [Internet]. 2016. Available from: https://www.who.int/publications/i/item/9789241549790

58. World Health Organization. WHO Global Health Observatory Adolescent Health [Internet]. Geneva: World Health Organization; 2017. Available from: http://apps.who.int/gho/data/view.wrapper.MortAdov?lang=en

59. World Health Organization. Mental Health and COVID-19: Early evidence of the pandemic's impact. [Internet]. Geneva: World Health Organization; 2022. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Mental_health-2022.1
60. Adolescent mental health fact sheet. Available from: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
61. Suicide fact sheet. Available from: https://www.who.int/news-room/fact-sheets/detail/suicide
62. Palestinian Central Bureau of Statistics (PCBS) [Internet]. 2022. Available from: https://www.pcbs.gov.ps/

APPENDIX A ATTENDEES AT THEMATIC GROUP MEETING 09/08/2022

Child & Adolescent Mental Health National Strategy

	Organization	Type
1.	Ministry of Health (MoH)	Government
2.	Medical Aid for Palestinians, UK (MAP)	International NGO
3.	Royal College of Psychiatrists, UK (RCPsych)	Professional Body
4.	Ministry of Education (MoE)	Government
5.	Ministry of Social Development (MOSD)	Government
6.	UNRWA	UN Agency
7.	WHO	UN Agency
8.	UNICEF	UN Agency
9.	UNFPA	UN Agency
10.	Palestine Red Crescent	National Society
11.	Palestinian Child Institute - Al Najah University	Academic Institution
12.	Palestinian Medical Relief Society (PMRS)	NGO
13.	Palestinian Counseling Center (PCC)	NGO
14.	QADER for Community Development	NGO
15.	Treatment and Rehabilitation Center for Victims of Torture (TRC)	NGO
16.	Médecins du Monde (MdM)	International NGO
17.	Italian Agency for Development Cooperation (AICS)	International Agency
18.	Médecins Sans Frontières (MSF)	International NGO

APPENDIX B LIST OF NON-GOVERNMENTAL ORGANIZATIONS

Centre	Services	Location
West Bank		
Bethlehem Arab Society for Rehabilitation	Medical and rehabilitation services including children and family counselling.	Beit-Jala, West Bank
Guidance and Training Center for the Child and Family (GTC)	Psychiatric and psychological services for children and families.	Bethlehem
Juzoor Foundation for Health and Social Development	National public health organization conducting advocacy, CPD programmes and health promotion (positive parenting and life skills for youth)	Ramallah
Mental Health Families and Friends Society (MHFFS)	Aims to improve health services provided to those with intellectual disabilities. Referral to services and training to gain new skills.	Not specified
Palestinian Counselling Center (PCC)	Provision of therapeutic services, prevention programmes, capacity building and advocacy for mental health.	HQ in Jerusalem with clinics in Jerusalem, Ramallah, Qalqilya, Nablus and Gaza.
Palestinian Working Woman Society for Development	Mental health awareness, fight gender-based violence, referral to services and counselling. Toll-free telephone line.	HQ in Ramallah. Offices in Nablus, Jenin, Tulkarim, Bethlehem, Yatta, Gaza
Qader for Community Development	Promotion of the better well-being of persons with disabilities.	Beit Jala
The Treatment and Rehabilitation Centre for the Victims of Torture (TRC)	Multi-disciplinary treatment and rehabilitation team. Individual, family and child therapies. Mainly for tortured Palestinian ex-detainees.	Headquarters in Ramallah. Offices in Jenin and Hebron.
Gaza		
Gaza Community and Mental Health Programme (GCMHP)	Multi-disciplinary teams offering clinical and specialist training services.	Gaza
Community Training Centre and Crisis Management (CTCCM)	Offers psycho-social support to children and families across Gaza, including the thousands of Palestinian children traumatized by the recent Israeli offensive.	Gaza
Palestine Trauma Centre – UK	Offers clinical and specialist training services.	Gaza

SPECIAL THANKS TO

RAJIAH ABU SWAY (WORLD HEALTH ORGANIZATION); MOHAMMAD ALQURM (MINISTRY OF SOCIAL DEVELOPMENT); DR EYAD ALAZZEH (HALHOUL COMMUNITY CENTRE, MINISTRY OF HEALTH); DR MAI AL KAILA (MINISTRY OF HEALTH); DR IVONA AMLEH (UNITED PALESTINIAN APPEAL); FARAH AQEL (DUBAI HEALTH AUTHORITY); DR CAIRO ARAFAT (ABU DHABI EARLY CHILDHOOD AUTHORITY); DR RASHA BAYOUMI (UNIVERSITY OF BIRMINGHAM DUBAI); PANJI CHAMDIMBA (UNICEF); DR JOSHUA FEDER (PALESTINIAN CHILD INSTITUTE, AN-NAJAH NATIONAL UNIVERSITY); PETRA GARCIA (MEDECINS SANS FRONTIERES SPAIN); MOHAMMED HAWASH (MINISTRY OF EDUCATION); DR MUAYAD JOUDA (GAZA PSYCHIATRIC HOSPITAL); DR IBRAHIM KHAMAYYES (DR KAMAL PSYCHIATRIC HOSPITAL, BETHLEHEM, MINISTRY OF HEALTH); ALINE PLENER (MEDECINS SANS FRONTIERES FRANCE); PROFESSOR RITA GIACAMAN (BIRZEIT UNIVERSITY); DR SAMAH JABR (MINISTRY OF HEALTH); DR SOUHA MANSOUR (FORMERLY THE GUIDANCE AND TRAINING CENTER FOR THE CHILD AND FAMILY, BETHLEHEM); DR SYLVIE MANSOUR (FORMER MENTAL HEALTH ADVISOR FOR MOH); MICAELA PASINI (UNICEF); KANAR QADI (UNICEF); DR ALI SHAAR (AN-NAJAH NATIONAL UNIVERSITY); DR IYAD ZAQOUT (UNWRA)

ALL MEDICAL AID FOR PALESTINIANS (MAP) STAFF, MAHA KHATIB, AISHA MANSOUR, HANA'A QAYASSE, ENAS TINA, ESLAM ZAKARNEH

VOLUNTEERS FROM THE ROYAL COLLEGE OF PSYCHIATRISTS, UK, DR NADIA DABBAGH, AGNES RABOCZKI, PROFESSOR MOHAMMED AL-UZRI