Working together – what does it take?

An evaluation of the Action by Churches Together (ACT) psychosocial wellbeing project in Gaza 2009-2011

Nora Ingdal and Dr Abdel-Hamid Afana, Nordic Consulting Group

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Disclaimer:
The views and opinions expressed in this report are those of the authors and do not necessarily reflect the official policy or position of the client, the ACT Alliance.

actalliance

Nordic Consulting Group
Fr Nansenspl 4, 0160 Oslo
www.ncg.no

The front page photo is from the presentation of the Preliminary findings of the Evaluation 30th May 2012 linking the West Bank and Gaza partners by videoconference. In the front to the right (with her back to the photographer), Dr Suheila Tarazi along with her two colleagues Ismain and Said, from the Ahli Arab Hospital, on the left hand side, Omar Majdalawi from DCA, Dr Issa Tarazi from the Middle East Council of Churches, Antti Toivanen from FCA, Gudrun Bertinussen from NCA and Ian Lauritzen from Church of Sweden (photo: Nora Ingdal).

Research team: Nora Ingdal and Dr Abdel-Hamid Afana
Research Associate: Zozan Kaya

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Sincere thanks and appreciation to the actalliance and the ACT Palestine Forum (APF) for entrusting us with the task of assessing and evaluating the results of the first joint project undertaken by the members of the APF.

The psychosocial project was initiated as a response to the urgent need for staff care among the implementing partners following the devastating War on Gaza launched in December 2008. It was the War that brought the actalliance partners working in the occupied Palestinian territory (oPt) closer together. Later the project was transformed into community wellbeing (CWB) project. After more than three years, the partners found that it was time to evaluate the results and lessons learnt of the first joint APF project.

Thanks to a very open and transparent process handled by APF, the research team has been able to listen to the partners, consultants and other stakeholders reflecting on strengths and weaknesses of this project. Thanks therefore to the staff, board members and leadership of the two main implementing partners, the Middle East Council of Churches/DSPR in Gaza and the Arab Ahli Hospital, and to all the other APF members for taking time to share documents, views and reflections. Great appreciations are also extended to all the psychosocial workers and beneficiaries who donated their time to evaluation team. Special thanks also to Rula Daghash in Norwegian Church Aid for a well-handled evaluation process.

It is our hope that the APF would be able to utilise some of the findings and recommendations provided in this report to improve future programming for the sake of the Palestinian society.

Despite all efforts to validate the findings and information brought forward in this report, any errors or mistakes found is the full responsibility of its authors.

Oslo/Gaza/Montreal 15th June 2012

Nora Ingdal & Dr Abdel-Hamid Afana

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0. EXECUTIVE SUMMARY

Action by Churches Together (ACT) is a global movement of more than 130 church- and faith-based organisations. In the occupied Palestinian territory (oPt) 10 members teamed up and formed an ACT Palestine Forum (APF) in late 2008. When the devastating War against Gaza broke out in December 2008, the APF partners immediately started responding in different ways. One of the responses was to initiate a psychosocial project caring for the staff in ACT implementing organisations; the Middle East Council of Churches (MECC), the Arab Ahli Hospital, YMCA East Jerusalem and the Youth Empowerment Centre (YEC).

As lead of the psychosocial work in the international actalliance, the Church of Sweden (CoS) responded to the call, and along with Norwegian Church Aid (NCA) and FinChurchAid (FCA) seconded staff from their respective emergency rosters to Gaza. After the immediate need of staff care was met, the APF decided to transform the psychosocial project to a community wellbeing project (CWBP). NCA on behalf of APF took care of the project management and three ACT Appeals (2009-2011) issued by Geneva raised USD 421.000.

During 2011, the CWB project stagnated due to different views among the partners regarding the direction of the project. The APF decided to commission an external evaluation of the project. Since the PSS/CWB project was the first major joint effort of the APF, the mandate of the evaluation stipulated a dual purpose:

a) **document results**, and if possible to assess the impact of three years of activities.
b) give recommendations to APF for **potential joint future** programming.

A research team of two consultants with combined backgrounds in mental health, psychosocial, evaluation methodology along with in-depth knowledge of the Palestinian socio-economic, political and cultural context was commissioned to undertake the study in the period from March – July 2012. The evaluation utilised a mix of quantitative and qualitative methods and tools like semi-structured interviews, focus group discussions, observation, field visits, desk studies and analysis of financial and statistical information. More than 150 direct and indirect rights holders and duty bearers were consulted.

KEY FINDINGS

The project has led to the creation of three well-trained psychosocial teams in NECC, YEC and the Ahli Arab hospital (AAH). A pool of 18-20 professionals have taken part in more than 20 training sessions and greatly upgraded their knowledge.

The integration of psychosocial support into staff care and the regular health and educational services were found to be key indicators for enacting change on the ground, i.e. partners' working modalities dealing with own staff, patients and rights holders/beneficiaries. This

integration did not take place in the Ahli hospital or in the various YMCA EJ activities, to a limited extent in the NECC clinics and vocational centres. In the YEC centres however the PSS seems well integrated. The research team is therefore unable to conclude as to how lasting the change that has taken place in the PSS teams will be, unless they are able to practice their knowledge into skills.

The main challenges for integrating community-based psychosocial interventions were linked to the type of partners that work with ACT; none of them have strong community-bases and there is limited flexibility in taking on new tasks due to insecurities in funding and future prospective. Although the wellbeing project tried to capacitate the staff to work community-based, this was not endorsed at the management level of the two main implementing organisations (MECC & AAH). Both institutions, but especially AAH, are struggling to survive in a rapidly changing (health finance) environment in Gaza. Combined with the protracted conflict situation which rapidly moves between emergencies to development, none of the partners are willing to take the risk of taking on new projects unless they are certain that they can sustain them.

Despite challenges, the evaluation found strong potentials and willingness for developing the psychosocial support further, especially in MECC and YEC. All partners requested further support and training in transforming their knowledge into practical skills on community and family support level and the non-specialized supports and interventions in addition to how to use the IASC guidelines and integrate them into their daily activities.

Another key outcome (change) that has taken place in the period evaluated is the foundation, structure and competencies of the ACT Palestine Forum itself. It was the War that brought the partners together and the PSS/CWB project was the first pilot for exploring joint cooperation. The results achieved in the APF cannot be solely attributed to this project since coordination has a separate item in the Appeal. However the evaluation notes that the APF has invested substantial resources in building the capacity of its members in international humanitarian standards such as IASC Guidelines, SPHERE, HAP, NGO Code of Conduct and most recently the Accountability in Practice.

Since the wellbeing project was stopped before it reached the implementation phase, the evaluation team was asked to study carefully potential lessons that can be drawn from this process. Conducting thorough context analysis needs assessment with measureable data and a clear problem statement rooted in the targeted communities before initiating any project is a key lesson learnt; securing local ownership and implementing culturally appropriate projects is another.

The main challenge of the CWB was that the overall objective and log frame of the project was not clear, thus each partner had its own understanding of the concepts. The fact that funds were available from the Appeal made the partners go along with the plans, even if they were not fully convinced. A lesson learnt for the ACT alliance in Geneva – and perhaps in other places like Gaza, is to always ensure that the projects have local owners and that there is a connectedness between the humanitarian and the development work.

Finally an issue to reflect upon further is how to effectively utilise and integrate internationally seconded personnel into newly established or existing projects. The PSS/CWB "project" would most likely not have been initiated without the presence of the international consultants. In the post-Gaza war, there was a dire need for staff care in the implementing agencies and this need was met by the seconded personnel. Moving the staff care to a community-based wellbeing project was however not underpinned by a solid contextual analysis with measurable indicators; it came from ideas and concepts introduced by the different external trainers. Although clearly needed in Gaza – as there is a documented accountability gap between beneficiaries and implementing NGOs and authorities, there was no logic selection of which partners would undertake such an important assignment. The APF chose its existing partners (hospital, charity and NGOs) irrespectively of whether they were suited for this type of community-based project.

Despite all the challenges the APF partners in Gaza went through trying to agree on a joint project, the research team was impressed with their persistence and for staying engaged. Through the lengthy negotiations the APF partners in Gaza started to know each other and did build a potential for future joint work.

Summing up, the research team would conclude that "working together" is never easy – not even in peaceful, stable, democratic and well-established countries. **Working together while living under occupation, constantly under attacks, whether via direct brutal military force or by indirect means, is a completely different reality**. The community wellbeing project sought to enforce a change between the service-providers and their beneficiaries; to enhance the partners' accountability to their constituencies. From the perspective of the actalliance and the church, the accountability towards the poorest and most marginalised is an extremely important issue. The research team therefore sees great added-value in APF continuing to uphold economic justice, accountability and transparency in its work in the oPt. However the joint work needs to be functional and based on mutual interests among the partners.

Below is a summary of 12 key conclusions and recommendations, while specific recommendations for the two main implementing organisations (AAH and MECC) are provided in Chapter 7.

Conclusions	Recommendation	Management response
For the implementing partners (more specific recommendations are found in chapter 7)		
1. The lack of integrating the community-based psychosocial support impeded the potential stronger outcomes of the project.	1. To ensure the sustainability of the knowledge imparted in the well-trained PSS teams at AAH and MECC, psychosocial support should be integrated into the partners' ordinary work. Each partner should tailor the integration to ensure that it meets the needs of the patients/rights holders in the best way.	
2. There is a serious lack of academic research and rigorous evidence-based data linked to the work of the partners, especially at the Arab Ahli Hospital.	2. Research and solid evidence base of the psychosocial work should form the basis for further programming and conducting rights-based advocacy, either jointly or individually. APF or partners are recommended to commission at least one research annually.	
For the ACT Palestine Forum		

Conclusions	Recommendation	Management response
3. The psychosocial wellbeing project in Gaza was the first concerted effort of the ACT Palestine Forum to develop a joint project. It did not provide the expected results, but a foundation has been built for developing future joint projects.	3. ACT partners are recommended to take one step back and critically reflect on what they could have done differently. There is no need to rush into new joint projects. By analysing connectors ("what binds us together") and dividers ("what splits us") joint interests among partners can be identified. Potential new projects need to be driven by joint and mutual interests, not by availability of funding.	
4. The ACT Palestine forum has great potentials for developing a joint program with different sectors and working groups since the information about each member's work is already there. By teaming up, the actalliance can become a strong and influential actor in oPt.	4. APF is encouraged to continue the already started process of making sectoral and geographical mapping of the partners' activities. Developing one program for oPt does not entail that projects would be centrally controlled or accounted for, it is rather to clarify the **ACT response**, i.e. a donor should be able to get an overview of all the ACT partners in oPt and their projects in one place (including website). The ACT Appeal could be one of several donors.	
5. The APF is still quite young and needs time to find its identity and value-added.	5. Lifting the **church** and faith-based identity of the ACT Palestine Forum would help to clarify the **value-added** of the Actalliance. Closely linked to that would be issues like economic justice, accountability and reaching out to the poorest in line with diaconal work.	
6. One of the reasons for the weak results of the CWB project was the lack of a solid context analysis with measureable data, indicators and a clear problem statement with objectives.	6. Before entering into any new joint projects, thorough context/situational analysis with measureable data and indicators (results-based frameworks), including do no harm and gender analysis need to be undertaking. Central in such analysis to ensure that there is a strong local ownership.	
7. Many international consultants have conducted trainings in the project; some more effectively integrated in the project than others. None of the consultants were directly selected by a joint APF.	7. Seconding international consultants should be demand-driven and based on written requests from the APF specifying types of competences required. To ensure that the seconded consultant is integrated into the project/program, TOR should be developed and monitored and the international consultants should work closely with the local counterparts.	
8. Relying on international consultants for capacity-building and follow-up from APF decision-makers in Jerusalem delayed and slowed down the project implementation.	8. Identifying local and regional trainers and capacities for training the APF members and staff. Establish a pool of local trainers. If expertise is not available locally the APF should request internationals and be able to select the consultants based on an assessment of their CVs. Training needs to be functional and demand-driven.	
9. The psychosocial project advisor functioned at times as a coordinator for the APF in Gaza without a proper authority and solid mandate.	9. In order to strengthen the APF in Gaza, a highly qualified coordinator with substantial work experience should be employed with a clear TOR and authority. Alternatively the APF coordinator can rotate between Gaza/West Bank.	
10. Decision-making processes in the APF are lengthy. The Coordinator position has many responsibilities but not clear lines of	10. Decision-making authority must be delegated to the ones with responsibilities (ex. Coordinator, Advocacy, Steering committee) and the APF needs to be committed to joint	

Conclusions	Recommendation	Management response
decision-making authority.	decisions.	
11. APF has made great achievements in the field of advocacy; managed to agree on an Advocacy Plan and made a few joint statements. Still, there are strong diverging views among the partners on which issues to advocate for.	11. In order to identify advocacy issues that most of the APF would agree on, the evaluation recommends that the joint advocacy themes be rooted in the practical work of the partners and have a rights-based focus (Right to health, education, food security, employment etc.)	
For the ACT alliance Geneva		
12. Gaza is isolated and continues to be closed off to most of the world. ACT partners present in Gaza have a unique opportunity to assist ACT Geneva in providing evidence-based and "rooted" advocacy from the reality of the many thousands of rights holders that the ACT is serving.	12. The international churches are encouraged to send delegations and high-level visits to the Holy Land, Jerusalem, and especially to the closed-off Gaza Strip. Advocacy messages from Gaza should be rooted in the local partners key concerns and issues.	
13. The Appeals from oPt are still fragmented and planned according to each partners' projects, and not according to sectors.	13. Support the APF coordinator to plan for *one* program where all partners' projects are included and highlighted. Not everything has to be funded by the Appeal, but at least assist the APF in coordinating the visibility of the partners work.	

Acronyms

ACT	Action by Churches working Together
AIDA	Association of International Development Agencies (oPt)
ALNAP	Active Learning Network Accountability/Performance in Humanitarian Action
APF	ACT Palestine Forum.
CoS	Church of Sweden
CBO	Community Based Organisations
CBPS	Community-Based Psychosocial Support
CWB	Community Wellbeing
DCA	DanChurchAid
DSPR	Department of Service to Palestinian Refugees (MECC/NECC)
EAPPI	Ecumenical Accompaniment Programme in Palestine and Israel (WCC)
ELCJHL	Evangelical Lutheran Church in Jordan & the Holy Land
FELM	Finnish Evangelical Lutheran Mission
FCA	FinChurchAid
HAP	Humanitarian Accountability Partnership
HRBA	Human Rights Based Approach
IASC	Inter Agency Standing Committee
IOCC	International Orthodox Christian Charities Inc.
LWF	Lutheran World Federation
MHPSS	Mental Health and Psychosocial Support Services
MECC/	Middle East Council of Churches/
NECC	Near East Council of Churches
NCA	Norwegian Church Aid
oPt	occupied Palestinian territory
PA	Palestinian Authority
PSS	Psychosocial Support Service
QA	Quality-Assurance
SPHERE	Minimum Standards in Disaster Relief
TOR	Terms of Reference
TOT	Training of trainers
UN	United Nations
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Work Agency for Palestine Refugees
VTC	Vocational Training Centre
WCC	World Council of Churches
YEC	Youth Empowerment Centre
YMCA EJ	Young Men Christian Association, East Jerusalem

1. INTRODUCTION

1.1 Purpose

Action by Churches Together (ACT) members present in the occupied Palestinian territory (oPt) teamed up and formed an ACT Palestine Forum (APF) in the autumn of 2008. When the devastating War against Gaza broke out in December 2008, the APF partners immediately started responding in different ways and issued calls for support.

As lead of the psychosocial work in the international ACT alliance, the Church of Sweden (CoS) responded to the call from the APF. The APF initiated a psychosocial support (PSS) project caring for the staff in ACT implementing organisations such as the Middle East Council of Churches/Department of Service to Palestinian Refugees (DSPR), the Arab Ahli Hospital, YMCA East Jerusalem, the Youth Empowerment Centre (YEC) and others. CoS along with Norwegian Church Aid (NCA) and FinChurchAid (FCA) seconded staff from their respective emergency rosters and dispatched them off to Gaza.

After the first 1,5 year the psychosocial project was planned to be transformed into a community wellbeing project (CWB) with focus on building community-based psychosocial support. Key activities were training of trainers and staff in the APF organizations and partners. NCA on behalf of APF took care of the management of the project. Funds from three ACT Appeals issued by ACT Geneva were raised with a total amount of USD 494.000, however less funds were spent.

Towards the end of 2011, the CWB project stagnated due to different views among the partners regarding direction and implementation. The APF thus decided to commission an external evaluation of the project and the results of the three years of work (2009-2011). Since the PSS project was the first major joint effort of the APF, the mandate of the evaluation stipulated a dual purpose:

c) **Document results**, and if possible to assess the impact of more than three years of activities.
d) Give recommendations to APF for **potential joint future** programming.

A research team of two consultants with combined backgrounds in mental health, psychosocial, evaluation methodology along with in-depth knowledge of the Palestinian socio-economic, political and cultural context was commissioned to undertake the study in the period from March – July 2012.

1.2 Methodology

The evaluation has utilised a mix of quantitative and qualitative methods using tools like semi-structured interviews, focus group discussions, observation, desk studies and analysis

of financial and statistical information. The participatory research methods focus on those that foster a *sensitive and mutually beneficial dialogue.* Since the purpose of this evaluation was not only to assess results of a completed project, but identifying lessons learnt and reflections, which would inform future decisions related to joint programming between the ACT members, the research team invested time and effort in engaging the partners in constructive dialogues regarding these issues. A conflict sensitive approach was adopted. This implied that the research team specifically searched for themes/issues/activities that would bring the partners together rather than focusing on areas that would divide them. The research was divided in four phases:

- Desk study: inception report presented at joint workshop between ACT partners in Jerusalem and Gaza
- Field survey: in Jerusalem/Gaza, including a Debrief and validation of preliminary findings with ACT partners Jerusalem/Gaza.
- Analysis, verification and validation.
- Reporting: the draft report was distributed in mid-June for comments and presented at the APF Annual Meeting in Sharm Al-Shaykh 29th June. The final report was submitted to APF in mid-July 2012.

In the inception phase, the research team conducted a mapping of existing literature; previous studies and evaluations, ACT appeals and reports, minutes of meetings in the APF etc. as well as secondary literature dealing with community-based psychosocial issues in Gaza and the occupied Palestinian territory (oPt). Based on the desk review, the research team developed tools for collecting the data for this evaluation, including interview guidelines and questionnaires. An important clarification from Church of Sweden was highlighted in the comments from the partners to the draft inception report; namely the need for ensuring that the evaluation would focus on the psychosocial aspect of the project, not mental health.

During the field survey, the team found that semi-structured interviews appearing to be informal and conversational helped to reduce the social distance between evaluators and interviewees. Focus group discussions were organized with both the participants in the capacity building activities and the "beneficiaries" in the regular activities of the partners that benefited from the psychosocial counselling. A random selection on the spot during field visits was applied to identifying beneficiaries of especially the MECC/DSPR in the three main project locations Rafah, Shejaiye and Qararah. Patients or direct beneficiaries of the Ahli hospital that had benefited from psychosocial counselling were not identified.

Interviews were conducted with key figures, organizational leaders, directors; professionals participated in psychosocial training activities. Questions used in both interviews and focus group discussions are described in annex IV. Questions requested participants to mark their reactions on the gained knowledge and skills and record their expectations of the planned training courses. The evaluation was undertaken in accordance with ethical guidelines for research. The nature and purpose of the evaluation were explained in each interview, focus group and data collection occasion. It was stressed to all participants that their involvement in this study was voluntary, however, important as a stakeholder. Plans for dissemination were discussed with some stakeholders. Care has been taken with confidential information, and appropriate measures have been taken to ensure anonymity.

Ahli Arab Hospital (AAH): The evaluation team was able to form a group discussion with the PSS team (6 members, one female) and had interview with general manager of the hospital in addition to observational visit to the hospital departments. The evaluation team was also able to run a focus group discussion with eight (2 male, 6 female) participants from

local and neighbouring community-based organisations (CBOs) that had been trained by the Ahli Arab PSS team.[1] The Ahli Arab hospital team arranged the focus group discussion and participants were involved in previous activities organized by the hospital such as nutrition and cancer campaigns.

Middle East Council of Churches (MECC)[2]: The evaluation team conducted a series of random interviews with beneficiaries coming to the MECC health centres (6 in Shajaya, Gaza and 6 in Kherbat Al Adas, Rafah) and with around 4-6 young boys in each of the Vocational Training Centres (VTCs) in Qararah and Shajaya; conducted a focus group discussion in Shajaya (8 female participants). The evaluation team had a group discussion with the MECC board members (1 female, 4 males); a focus group discussion with the psychosocial team (5 females and 3 males) and an interview with the MECC general director.

Youth Empowerment Centre (YEC)[3]: The evaluation team was able to arrange a visit and a focus group discussion with the team who participated the psychosocial training; eight (8) participants (3 male, 5 female). The previous YEC coordinator who had been mostly involved in the wellbeing project had recently left YEC and there was a gap in the institutional memory regarding YEC's role in the joint APF work. **In YMCA EJ**[4] the team was only able to interview the Gaza director who had attended several trainings and one project coordinator who had attended one training only. A previous YMCA staff that had received training had left.

More than 150 people were consulted both locals and internationals (table 1). Some of these interviews were in person i.e. face to face while others were conducted through telephone or Skype. For a complete list of all people interviewed, see Annex II.

Table 1: List of different interviews

Respondents	Estimated numbers	Interview guideline
Participants in ACT trainings (PSS teams)	20	1
Participants in Arab Ahli Trainings	7	1
Trainers/Consultants	7	2
Actalliance partners (international, national)	32	3, 4
Key informants - coordinating and cooperating partners/resource centres	7	5
International UN agencies (UNRWA, UNICEF)	2	5
Rights holders consulted and observed in the field	80	6
Total	**156**	

In the analysis phase, the research team utilised an analytical framework developed in the inception report with key evaluation criteria such as relevance, appropriateness, efficiency, effectiveness (including gender), sustainability and impact. Indicators for assessing the outcomes are also described in the findings chapter. By triangulating the findings – i.e. making sure that we have at least three sources of information for each main conclusion, the

[1] The training of the CBOs was an element in the PSE111 ACT Appeal (and continued in PSE112), but funded directly to NCA/AAH. And not included in the APF joint psychosocial project.
[2] The full name is Department of Service to Palestinian Refugees, which is an autonomous department of the Middle East Council of Council (MECC), often referred to as the Near Council of Churches (NECC). For the sake of simplicity, this report will refer to it as MECC.
[3] YEC has been funded via two actalliance partners, DanChurchAid and FinChurchAid, but outside the ACT Appeals. However psychosocial staff from YEC was trained by the APF joint project.
[4] YMCA EJ recently became a full member of the ACT alliance. However during the project period, YMCA EJ had funding from the Appeal via IOCC and the staff was trained by the APF joint project.

validity of the findings has been secured. The research team feels quite certain that the validity of the findings rests on solid empirical ground, i.e. a different research team utilising the same methods would have come to similar conclusions.

1.3 Limitations

No major limitations were encountered. There were actually fewer limitations and constraints during the course of this research as compared to what is often the case with evaluating a complex, multi-stakeholder, humanitarian/development project in a protracted conflict area. Common problems like high turnover of staff, lack of archives, lack of access to informants and geographical access were manageable. Permits for the team leader to access the Gaza Strip was secured by APF/NCA in advance of the field survey; permit for the Palestinian team member to access the West Bank/Jerusalem was also obtained so that he could engage with the ACT partners based there.

Furthermore, there were no major Israeli attacks on the Gaza Strip or other security threats during the time of the field survey. Thanks to a well-planned, well-organised and administered evaluation process handled by NCA the research team was able to focus on the research and analysis, and not on logistical issues.

The only constraints worth mentioning is the lack of measureable baseline information of different aspects of the project such as the partners' capacity; the extent (or lack) of cooperation and coordination **prior** to the war/start of the project. Although the team tried to compensate for this by partly reconstructing baselines, i.e. asking partners and beneficiaries questions related to their capacity and coordination, baselines based on beneficiary recall is not a reliable source of information. Counterfactuals were also attempted, that is what would have happened if the psychosocial project had not taken place. By comparing the counterfactual with the actual outcomes, it helped in the final analysis and "weighing" of the evaluation criteria assessment (see chapter five).

1.4 Guide to the reader

This report has seven chapters and four annexes; chapter one is a brief introduction, chapter two provides a background of the psychosocial context in oPt and the Gaza Strip, chapter three provides a description of the ACT alliance and the ACT psychosocial project subject to this evaluation. Chapter four elaborates on the results of the project with main emphasis on the capacity-building efforts. Chapter five analyses the results from the previous chapter along the lines of key evaluation criteria in humanitarian and development settings: relevance/appropriateness, connectedness/sustainability, effectiveness, efficiency and impact. Gender and conflict sensitivity were mainstreamed along all the findings. Chapter six provides some reflections and lessons learnt, while chapter seven sums up the conclusions and recommendations especially for the implementing APF members. References and a list of documents consulted are attached immediately following chapter seven. There are four annexes; the Terms of Reference, the list of people interviewed the work plan and the interview guidelines.

2. Psychosocial, economic and political context

2.1 The occupied Palestinian territory

What remains of the historic "Palestine"[5] is today most often referred to as the occupied Palestinian territory (oPt) and comprise of the West Bank including East Jerusalem and the Gaza Strip. The total Palestinian population in oPt is around 4.1 million people; 2.5 million (62%) live in the West Bank, while 1.6 million (38%) live in the Gaza Strip. Breaking up the West Bank according to who controls the inhabitants:

- Area A (18% of the oPt, 55% of population) under the Palestinian civil and security control.
- Area B (20% of the territory, 41% of the population) under Palestinian civil and shared Israeli-Palestinian security control.[6]
- Area C (62% of the territory, 5.8% of the population) under Israeli civil and security control.

The Gaza Strip is under control of the Gaza self-rule authorities, which won the Parliamentary elections in 2006 (Hamas). However the area is still considered occupied according to international law, as foreign powers control both the entry and exit of all goods, products and humans. The exit to the north is controlled by Israel, while the southern exit is controlled by Egypt. Palestinians in oPt are therefore living under two different authorities. This has tremendous implications on the service-delivery in all sectors, including transportation, electricity, energy as well as social sectors of health, education and psychosocial conditions.

Conditions were made even more difficult in Gaza when, on 27 December 2008, the Israeli security forces launched 'Operation Cast Lead' against Hamas in Gaza, which lasted for 22 days. The 1612 Monitoring Group on Grave Violations against Children reported that an estimated 350 Gazans children were killed, and another 1,800 were injured. According to OCHA/oPt, 1,383 deaths of Palestinians were confirmed by two independent sources, 13 Israeli soldiers were killed.[7]

Decades of occupation and political conflict have led to widespread human suffering and population displacement among the four million inhabitants. Reports indicate that the impact of the protracted conflict on the population's mental health and wellbeing is significant; a number of quantitative studies have reported high levels of psychosocial problems among children, adolescents, men and women. They point out very high levels of prevalence of mental disorders, particularly those associated with stress, violence and trauma (Khamis V. 2005; Quota and Odeh, 2005; Punamaki et al, 2005; Afana, et al, 2002; Canetti et al, 2010). There are other negative consequences to war and violence that affects Well-being

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[5] Historic Palestine as defined under the British Mandate up to 1947 included today's Israel, the West Bank and the Gaza Strip. When Israel was established in 1948 more than 750.000 Palestinians fled the country. Today the Palestinian population consists of approximately 6 million in exile and 4.1 million living in West Bank and Gaza.

[6] Since the breakdown of the negotiations and return to conflict with the second Intifada in September 2000, there has been no effective coordination between Israeli and Palestinian security authorities.

[7] United Nations Office of the High Commissioner for Human Rights, 'Report of the United Nations Fact-finding Mission on the Gaza Conflict', 25 September 2009.

and human survival that was described in the first level of the IASC guidelines psychosocial intervention layers. These factors includes amongst others:

House demolitions: Human Rights Watch[8] documented the complete destruction of 189 buildings, including 11 factories, 8 warehouses and 170 residential buildings, leaving at least 971 people homeless. The 12 incidents documented in this report account for roughly five percent of the homes, factories and warehouses destroyed in Gaza during the conflict. Overall, some 3,540 homes, 268 factories and warehouses, as well as schools, vehicles, water wells, public Infrastructure, greenhouses and large swathes of agricultural land, were destroyed, and 2,870 houses were severely damaged leaving more than 51.000 people without shelter.

Water supply is contaminated and unsafe for human consumption. Before the 2008/9 crisis 80% of the water supplied in the Gaza Strip did not meet WHO standards for drinking. During the attacks the water network was severely damaged, and as a result of damage to the waste treatment system the aquifer has been contaminated. In Gaza, where Palestinians rely on an aquifer that has become increasingly saline and polluted, the situation is worse. Only 5%-10% of the available water is clean enough to drink.

Poverty: 89% of people living under poverty line. Because of rising poverty and the blockade, Palestinians have reduced both the quality and quantity of their food intake. More than half the households are experiencing food insecurity, spending about two thirds of their income on food (the prices of which are rising rapidly). UNRWA's food programmed provides only about 60% of the daily calorie needs of the one million refugees.

Unemployment: according to the Palestinian Central Bureau of Statistics (PCBS), the unemployment rate in the Gaza Strip is 42% (compared to 16% in the West Bank, 20101).[9]

Devastation of agriculture and fisheries; e.g. fishermen in the Gaza Strip, a total of 46% of agricultural land in the Gaza Strip was assessed to be inaccessible or out of production (FAO, 2010).[10]

2.2 Moving towards Community Wellbeing

A major development in the effort to standardize monitoring systems for psychosocial programming came about when the Inter-Agency Standing Committee (IASC) Taskforce on Mental Health and Psychosocial Support[11] decided to develop guidelines for minimum standards in emergencies.

As seen in the figure, 1 below, the multi-layered support hierarchy provides clear illustrative intervention layers that are not separable and have to be implemented simultaneously in emergency and war situations.

The guidelines came to bridge the overlap between mental health and psychosocial interventions. The base of the pyramid is the basic and physiological needs such as food,

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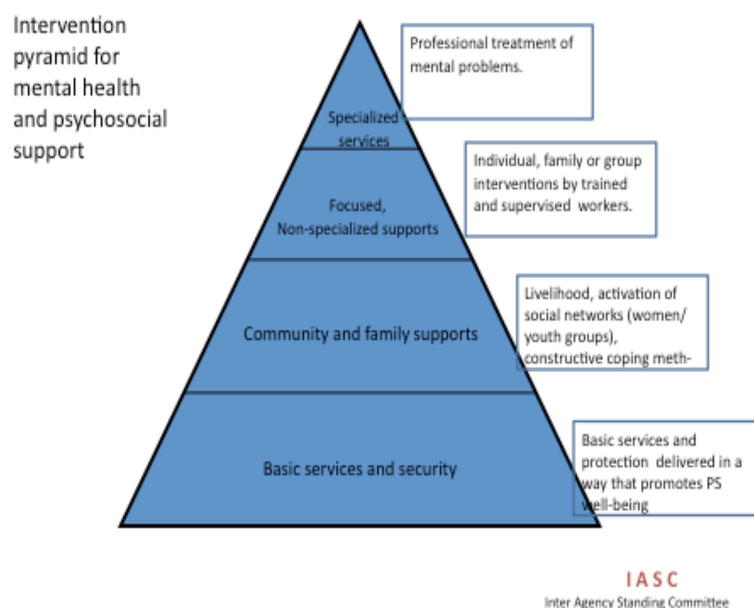
[8] Human Rights Watch (2010) "I lost everything" Israeli's Unlawful Destruction of Property during Operation Lead Human Rights Watch Report.
[9] PCBS website retrieved in January 11th 2012
[10] FAO (2010) Farming without land, Fishing without Water: the Gaza Agriculture Sector struggles to Survive, FAO report in May
[11] http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_mhps-default

shelter, water etc. The intervention response at this level is in order to meet these needs, advocate, and document their impact on mental health and wellbeing.

At the second level, psychosocial intervention would focus on family and community network and try to restore family and community network systems and support. The third layer focus on people who needs psychological first aid and emotional support. This intervention doesn't require specialized mental health service and or professionals; a trained and supervised worker can provide the service at this layer and in case people more specialized services they could be referred to the fourth layer of the pyramid. As described in the guidelines, very few people need that type of specialised mental health services as survivors have their own resilience, capacities and resources.

Figure 1: Intervention pyramid for mental health and psychosocial support (IASC)



The ACT psychosocial project started in 2010, where the goal was "to protect and promote the psychosocial wellbeing of women, men, youth and children living in Gaza" and then moved from providing support to empowerment, from passive receipts of services to active participants and focuses more on the third level of pyramid, with family and community support. However, it was obvious to evaluation team that the distinction between the two concepts (psychosocial and wellbeing) was not explicitly described and understood by APF and ACT partners. Therefore, evaluation team finds it useful to briefly describe these three concepts.

2.2.1 Psychosocial approach

The term psychosocial refers to the dynamic interactions and inter-relationship between psychological and social factors that influence individual wellbeing such as social influences, cultural and religious background, socioeconomic status, and interpersonal relationships. Community based psychosocial support (CBPS) is an approach in which humanitarian relief

integrates psychosocial aspects into the response. The approach comes to widen the perspective of the medical model to include not only the biological reactions to disasters and wars, also the social, cultural, spiritual and rights of individuals, families and communities. It is not only targeting individuals, the entire community and family are targeted for services (CBPS Act Alliance Guiding Principles).

CBPS interventions deal with a broad range of issues that aims at preventing psychopathological and promote the social cohesion and infrastructures as well as independence and dignity of people. To reach that aim different disciplines are highly needed to avoid "do no harm" by over-emphasizing pathology that reinforces dependence, victimhood and powerlessness, at the expense of coping capacities, individual resources and resilience[121]. As indicated by IASC Guidelines, in emergency situations the percentages of people who develop sever mental disorders such as psychosis may increase up to 1% compared with mild to moderate mental disorders such as PTSD, 5-10%. In most communities people find their own cultural and social copying strategies to deal with adversities and people recover overtime without medical interventions.

The foundation of all community-based psychosocial work is the recognition of the affected community's capacity for recovery, resilience and future rebuilding and development. Psychosocial support goes beyond the initial phases of emergencies and distressing events. It is important to foster capacity building towards self-governance and collective decision making for ongoing community development. All communities and individuals have resources and strategies for dealing with difficulties, illness, and distress. It is the responsibility of humanitarian workers to respect, understand and enable the community and individuals in their own recovery. The strategies for dealing with difficulties can never be supported when individuals' basic human rights are abused.

2.2.2 Community Wellbeing

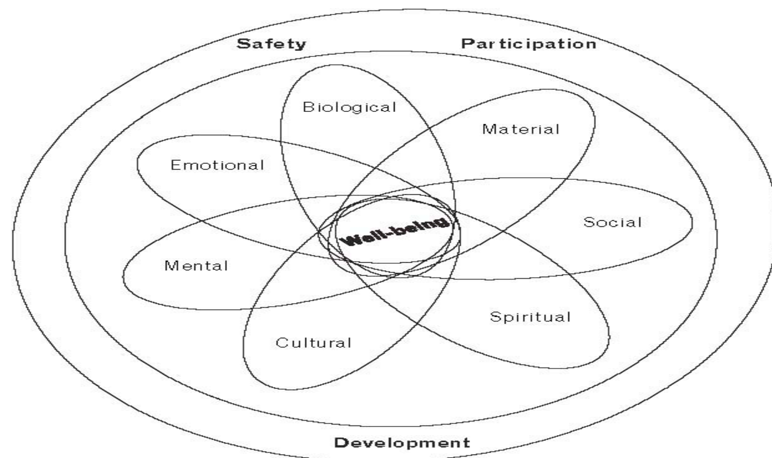
Community Well-being' is a concept that refers to an *optimal quality of healthy community life*, which is the ultimate goal of all the various processes and strategies that endeavour to meet the needs of people living together in communities. It encapsulates the ideals of people living together harmoniously in lively and sustainable communities, where community dynamics are clearly underpinned by 'social justice' considerations. As described by William and Robinson (2006) the wellbeing is composed of seven main dimensions: biological, psychological, economic (or material), emotional, socio-political, cultural and spiritual (figure 2).

To achieve a sense of wellbeing, people rely on social interaction; mental stimulation and learning; physical security and safety; and religious and spiritual beliefs. Their material and biological as well as their psychosocial needs must be met in terms of food, water, and shelter, and sanitation, physical and mental health. They also need economic stability. Following a disaster, the manner in which people's basic needs, safety and security are met has an impact on their wellbeing and recovery. There are some other concepts and terms related to the wellbeing namely community planning and profile; community development

[12] William, J. and M. Robinson (2006). "Psychsocial intervention, or integrated programming for well-being?" **Intervention 4** (1): 4-25.

and participation; community empowerment and engagement; capacity building and community renewal. The concept of wellbeing was introduced to the APF partners in a workshop conducted by Church of Sweden in Gaza in November 2010.[13]

Figure 2: The concept of wellbeing



2.2.3 Empowerment

Empowerment is a complex concept that has different meanings in different sociocultural and political contexts. It does not translate easily into all different languages. In Arabic language, one would say empowerment [**tamkin**] is about self-abilities and strength, control, self-power, own choice, capable of fighting for one's rights, independence, making decision, independent economically and probably many other more could be listed. However, most definitions focus on issues of gaining power and control over decisions and resources that determines the quality of one's life. Most also take into account structural inequalities that affect entire social groups rather than focus only on individual characteristics (UNICEF, 2011).[14]

In the development discourse, empowerment is closely linked with the **human rights-based approach** and theory of change; people benefitted from a project [beneficiaries] should be empowered to see themselves as **rights holders.** Through training and capacity-building the rights holders should be able to claim their rights (to health, education, food, security, life etc.) in accordance with legal frameworks, UN Conventions etc. from the decision-makers (the **duty-bearers**) in a certain area (http://hrbaportal.org).

However, in complex and contracted conflicts like in the Gaza Strip, people live outside a state and in fact under two different authorities (West Bank and Gaza), and the responsible state according to international humanitarian law [Israel] is not protecting people, rather the opposite it is the perpetrator. In such settings, a human rights-based approach has little validity. Rather it is useful to consider duty-bearers on local governance levels.

[13] The community wellbeing seminar in Gaza, 30.11-1-12.2010, training material developed by Ian Lauritsen. Report written by Maher Wahbe.
[14] UNICEF (2011) Gender Influences on Child Survival, Health and Nutrition: A Narrative Review. New York: United Nations Children's Fund.

3. ACT alliance

3.1 ACT alliance

The ACT Alliance serves as a membership organization and coordinating body for over 131 churches and church-related organisations that work together in humanitarian relief and development programs in 140 countries around the world. Through the combined efforts of members the ACT Alliance mobilizes $1.6 billion (US) annually and employs over 33,000 people. The Alliance is the result of a merger of ACT International (formed in 1995) and ACT Development (formed in 2007) in 2010. Its membership is drawn from the World Council of Churches (WCC) and the Lutheran World Federation (LWF). The alliance is supported by an international Secretariat of 22 staff based in Geneva, Switzerland. Of the approved members, 70% are from the global south, 28% from the global north, and 2% are global organisations. The current work is guided by the ACT Alliance Strategy 2011-14.[15]

ACT vision:
United in the common task of all Christians to manifest God's unconditional love for all people, the ACT Alliance works towards a world community where all God's creation lives with dignity, justice, peace, and full respect for human rights and the environment.

ACT mission
As churches and church-related organisations, we work together for positive and sustainable change in the lives of people affected by poverty and injustice through coordinated and effective humanitarian, development, and advocacy work.

3.2 ACT Palestine Forum

According to ACT policy guidance[16] members can form National Forums if more than two ACT partners are present in a certain geographical area. Implementing partners can be non-voting observers in these forums.

National forums are defined as: "shared platforms or spaces comprising members of the ACT alliances at country levels:

- with common interests defined broadly by their commitment to the mission, vision and values of ACT in humanitarian assistance and development work; and
- With their focus and ways of working adapted as appropriate to the specific context and communities they serve, and to their particular country."

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[15] Working for Justice, Investing in Quality - actalliance Strategy 2011-14. Approved by the ACT Governing Board 21 April 2011

[16] ACT National Forums (2008) *Consolidated Policy and Guidelines of ACT International and ACT Development*, February 2008.

The ACT members, which have a presence in oPt teamed up and formed an ACT Palestine Forum (APF) in April 2008 and signed a MoU in October the same year. The members had just started meeting when the devastating War against Gaza broke out in December 2008. The APF partners immediately started responding in different ways and issued calls for support. The first efforts were fragmented and uncoordinated (GEG Evaluation 2010); however in the years since 2008 great improvements have taken place in the APF. The partners have agreed upon a Memorandum of Understanding (MoU) between themselves, they have developed an emergency preparedness plan, an advocacy strategy, trained the partners in the SPHERE humanitarian minimum standards for disaster, the Humanitarian Accountability Partnership (HAP) and other tools. Every year, annual APF meetings have been held, and every month a meeting steered by the ACT coordinator.

Since the inception, APF members have included the Middle East Council of Churches/Department of Service to Palestinian Refugees (DSPR), International Organisation of Orthodox Charities (IOCC), YMCA East Jerusalem (YMCA-EJ), Lutheran World Federation (LWF), NCA and DCA. In 2009 the ELCJHL and the Episcopal Diocese of Jerusalem began attending meetings of APF. Additional attendees have included FCA, CoS, CWR, CWS and Christian Aid, and most recently the Swedish Diakonia.

In the West Bank and Gaza Strip APF members work in partnership with a variety of religious and secular organisations including Ahli Arab Hospital, Greek Orthodox Church in Gaza, Union of Agricultural Work Committees (UAWC), and the Youth Empowerment Center (YEC). The Gaza-based APF members (including Christian Aid) as well as the director of Ahli Arab Hospital began actively participating in monthly meetings of the APF by video-linked conference calls with Jerusalem in mid-2009 (2010 GEG Evaluation).

The overall vision of APF is that members have the capacity to respond to emergency and long-term development needs in oPt in a relevant, effective and coordinated manner, which enables the Palestinian society to cope and develop effectively.

The MOU also list a few more objectives:

- Improve the coordination and effectiveness.
- Increase the professional capacity of ACT Members.
- Create linkages from emergency response to long-term sustainable development initiatives

However, an important limitation is started in the MOU, the "**APF does not aim to replace …. The development initiatives or advocacy work undertaken by individual members."**

In other words, even if the branding policies of the actalliance insists that all members should replace or add to their logo "actalliance" this has not been fully implemented by members such as YMCA EJ, the ELCHL and IOCC to mention a few. The lack of branding is linked to the local organisations' strong identity as indigenous Palestinian organisations and their concern of confusing the clients/rights holders if they change their name. For the Lutheran World

Federation and the well-known Augusta Victoria Hospital the actalliance logo was added to their annual report for the first time in 2011, and the same with DSPR/MECC. The process seems to slowly move forward. In 2012, a well-established organisation in oPt joined the ACT alliance, Diakonia Sweden. Diakonia has worked in oPt for more than 20 years through local Palestinian partners in fields such as supporting local civil-society for democracy, children's literature, the International Humanitarian Law programme and a regional Rehabilitation Programme which aims at empowering people with disabilities to change structures for inclusion at all levels of society, in Palestine, Lebanon and Jordan.[17]

3.3 Previous studies and reviews

The research team studied one previous evaluation related to the ACT Psychosocial program in Gaza, “Evaluation of ACT MEPL-81, Gaza Crisis Evaluation, 4/14/2010, by Brian Majewski, and Hannah Vaughan-Lee, Global Emergency Group (GEG)” (table 2). There were other evaluations of components of the ACT appeals, but these were studied specifically. Not relevant to the psychosocial project.

Table 2: Summary of the key recommendations from 2010 GEG Evaluation (MEPL-81)

Key issues	**Status 2012**
Gender sensitivity in humanitarian work.	Gender is planned to be mainstreamed in the Actalliance[18] Not all partners follow 6 principles in ACT Gender Guidelines (ex. lack of gender-disaggregated data).
Emergency Preparedness Plan & ACT emergency response fund	Emergency Plan developed in workshop in Turkey (2011), not known to all partners, work-in-progress.
ACT policies and guidelines, minimum standards	Great improvements since 2010: training on SPHERE minimum standards, HAP, IASC guidelines, Accountability in Practice, and ACT Advocacy, Capacity-Building, reporting policies.
Information sharing about the context and activities	Regular monthly APF meetings share information. Attendance among APF partners vary.
Strengthen Coordinator role with clarified authority	Authority of coordinator has been strengthened (MOU), roles and responsibilities clarified internally between APF members, rotating chair and vice-chair.
Strengthen log frame, M&E, use SMART indicators.	PSS/CWB project still lacking log frame, SMART objectives, weak indicators, especially on the outcome level. Monitoring & Evaluation function in APF is strengthened also via the current evaluation, but much work remains.

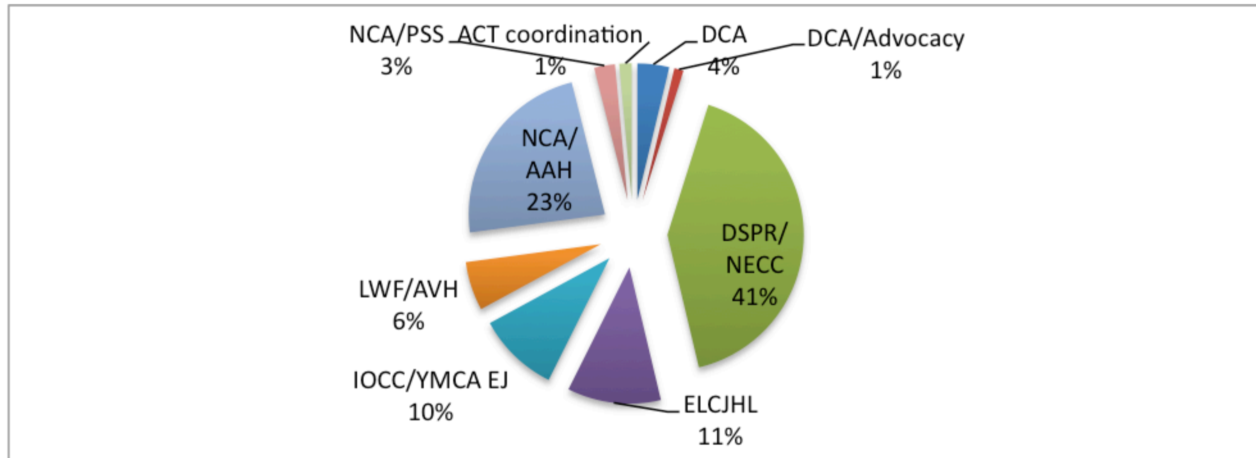
3.4 Financial aspect

Since the outbreak of the second Intifada on 29th September 2000 ACT has launched eight appeals to mobilize funding for response to the suffering caused by the conflict and related

[17] www.diakonia.se/opt
[18] ACT Alliance, *Gender Equality Policy Principles*, 06 September 2010

humanitarian crisis. The psychosocial support project constituted one of many components in the ACT Appeals. As seen below, figure 4, the other components varied slightly from year to year, but among the "regular" components were support to the Ahli hospital in Gaza, the educational project of the Evangelical Church in the West Bank, the clinics and vocational schools of the MECC in Gaza.

Figure 3: Recipients of funds targeted through Appeals PS101, 111 and 112 (in %)

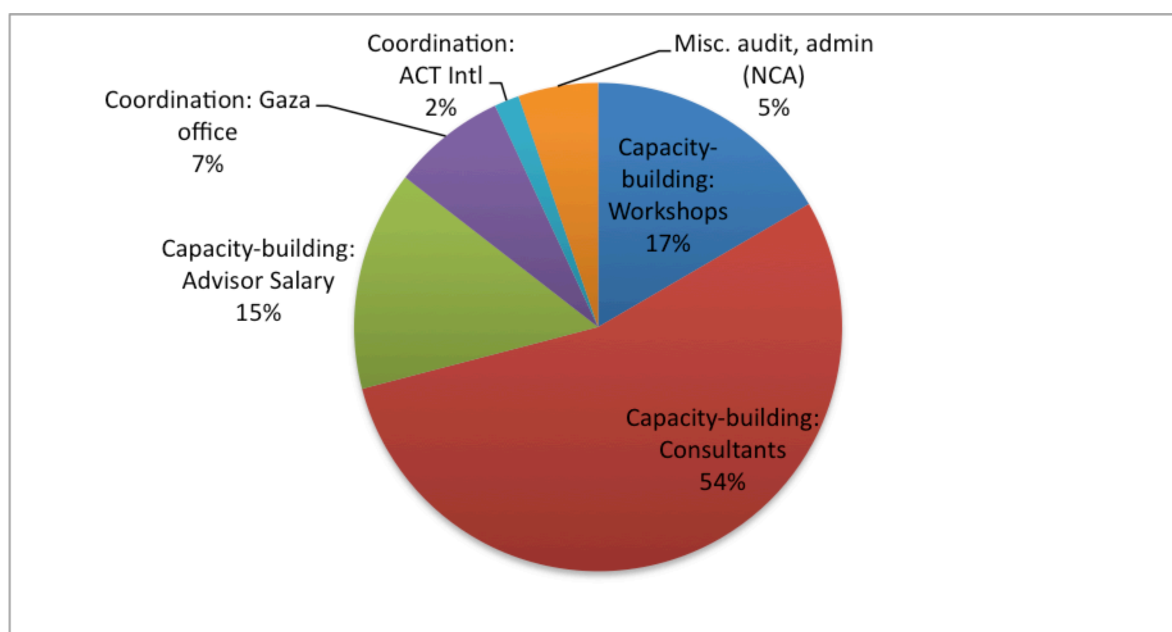


As seen in the above sector distribution, the DSPR/MECC – being the largest implementing organisation on the ground in the Gaza Strip, has been targeted with 41% of the funds of the Appeals for the years 2010 – 2012. It should be noted that the analysis is based on the targeted amounts, not the actual expenditures and audit reports.

The Arab Ahli Hospital (via NCA) is the second largest recipient, followed by ELCJHL and IOCC/YMCA EJ with 11 and 10 percent respectively. The transportation for cancer patients from Gaza to Jerusalem via Augusta Victoria/LWF was targeted with 6%. DCA had 4% and one per cent was originally set aside for the advocacy work, but this was later changed. The psychosocial wellbeing project handled by NCA had around 3% of the funds.

Coming to the PSS/CWB project, funds from three ACT Appeals issued by ACT Geneva channelled into the project was a total of USD494 466, while due to lack of progress in the report led to an under expenditure in the project. Total amount spent during the three years was therefore USD 421 812. In the below, figure 5, an analysis of how the funds have been expensed are provided.

Figure 4: Financial breakdown of PSS/CWB project expenditures according to categories



Analysing how the funds have been spent, the evaluation found that the major bulk of the budget (54%) was utilised for the trainers and consultants who were commissioned to conduct the workshops. 15% of the funds went into salaries for the psychosocial advisor (and towards the end of the project coordinator) and 17% were direct costs associated with the workshops (facilitation, rent, accommodation). Seven per cent went into the joint office in Gaza that the advisor was sharing with DanChurchAid and Christian Aid and five and two per cent respectively went into miscellaneous administrative costs associated with the project and the fee to ACT International in Geneva.

Table 3: Financial breakdown of project expenditures 2009-11 (in USD)

	2009	2010	2011	total
Capacity-building				
- Workshops	15872	44773	9377	70022
- Consultants/trainers	175004	20771	33377	229152
Advisor Salary	6300	27982	27199	61481
Coordination: Gaza office	6563	4206	21084	31853
Coordination: ACT Intl		3227	3748	6975
Misc. audit, admin (NCA)		9099	13230	22329
Total (in USD)	**203 739**	**110 058**	**108 015**	**421 812**

4. Psychosocial project

As seen in the previous chapter, the main element in the ACT Psychosocial wellbeing project has been capacity-building of a core group of health and social work professionals that have been trained in psychosocial support. Apart from the training and capacity-building, funds have been invested into strengthening the coordination and cooperation between the APF partners working in oPt including the establishment of a joint actalliance office in the Gaza strip.

4.1 Capacity-development

During the year 2009-2011 international national and international trainers conducted 23 training sessions for 18-22 participants selected by APF (Ahli Arab Hospital, MECC, YEC and YMCA east Jerusalem). Number, type of training, themes and name of trainers are described in table 2 below. National local trainers conduct Nine (9) sessions out of 23, while internationals trainers conduct 14 training sessions; table 4 describes training activities conducted by local and international trainers.

Observational comments from the field: The Ahli Arab Hospital (AAH) has no psychosocial unit at the hospital; however, a social unit is available for admitted patients who are not able to pay their extra bills. Ahli Arab hospital's psychosocial team composed of senior nurses who have high degrees in nursing, long working experience and at least one has postgraduate studies in mental health. Their level of communication in English is better than the rest of the APF participants selected from other organizations.

The team works in psychosocial interventions as part time/paid for their extra working hours in the psychosocial project. Overall purpose of training as perceived by Ahli "psychosocial team" is to build their capacities to train others who are working at local community organizations. As indicated by the team members, they are hospital based and not community based organization, as community interventions are not part of hospital priority. The hospital started their psychosocial interventions after the war because of increasing numbers of people who needed help and availability of funds by the ACT-Alliance.

The team trained 20 people holding diploma and BAs in Nursing, social work etc. selected from different local community-based organizations (CBOs) and mainly working with women and children as they had been taught by the international trainers. They were trained in areas such as bedwetting, anxieties, violence against women and family health and other topics. Each trainee is asked to bring 30-40 women and children for training under the supervision of Ahli team and finally each trainee is asked to run training sessions in their respective

organisations.[19] This step was not completed yet. The trainees hoped to be involved in a paid work the hospital may arrange in the future, as all participants are not working and they voluntarily participating in the psychosocial team activities. The participants also expressed their wishes to have more training courses with new topics more than bedwetting, anxieties etc. The Ahli Arab hospital sees itself as "teaching facility" not implementing psychosocial activities at the community level.

The team indicated that they provide psychosocial support for women with cancer, which is part of their nursing care plan. There are neither records for the number of sessions nor files for clients describing the psychosocial activities conducted in each session. There is neither clear referral nor collaboration between the team and doctors working in the hospital. No increase in the number of patients coming to the hospital because of the new psychosocial project

Middle East Council of Churches has three health centres in various places cross the Gaza strip; in addition it has vocational training centres in Gaza City and Qarara (Khan Younis City). At Al-shajaya health centre, the psychosocial team has a clean, well-organized and decorated room that provides privacy to beneficiaries. A female social worker that was described by beneficiaries' as cooperative and supportive has reasonable experience in the field of psychosocial support and was exposed to various training activities before joining the MECC. The evaluation team observed one the sessions with a group of 6 women who heard about the services from their neighbours and relatives. They came because of their kids who have bedwetting.

We interviewed group of women who came for debriefing session, they heard about the psychosocial services from the psychosocial worker. In the discussion one of the beneficiaries said, "Words heal more than pills". The women were happy to join the group session and would encourage other women to come forward.

The evaluation team also visited Al-Daraj health centre, where a group of children (more than 20 children) participated in drawing and recreational activities. Children are placed in the main hall of the centre, with man distractions and no privacy. The psychosocial worker (a social worker) has no room in case she needs to see a child or a mother. Rafah

Rafah health clinic is the same as Daraj, no private room for the psychosocial worker, but they rent a room from a kindergarten adjacent to the clinic for children activities.

The team visited vocational training centre in both Gaza and Qarah where youngster (below the age of 18 years) are trained in carpentry and electricity. A psychosocial worker visits each centre twice a week to set with those who pass through difficulties. Participants interviewed were very enthusiastic about the new psychosocial interventions.

In the health clinics although there is no referral system between health personnel and the psychosocial project, health personnel are supportive and sensitive to psychosocial intervention. They accept having psychosocial intervention in the health clinic. Ad hoc cases, sometimes, are

[19] This component sprang out of the PSS/CWB project, but in the 2011 and 2012 ACT Appeal it was financed as a seperate component under the NCA/AAH target.

referred to psychosocial project mainly form the midwife and gynecologist who are interested in mental health issues.

The evaluation team also had a group discussion with the MECC psychosocial team who showed interest in psychosocial work. Some major points were raised about training (summarized in the training section), supervision and follow up; and systematic, culturally appropriate and structured training is highly needed in the future.

Youth empowerment Centre (YEC)
Youth empowerment Centre is a relatively new community based imitative. They provide recreation, educational and supportive activities to children living in the Northern Part of the Gaza Stip. YEC is not an ACT member, however, it is supported by the DCA and their team members participated in training activities organized by ACT. The evaluation team was not mandated to look at YEC activities, the aim of visit was to discuss and get their feedback about training sessions they were attended. The evaluation team noticed children participating in educational sessions and recreational activities. The participants who have BAs in social work, counselling and psychology, some of have reasonable training and experience in the field of psychosocial interventions perceived training by both local and internationals as useful and they acquired theoretical knowledge. However, needs assessment in advance before conducting any training activities are very important and have to be pre-request for any future training activities. They also expressed their concerns about different educational and experience levels in training; it is not useful to have unified training themes for participants who have different educational levels.

The team also interviewed two participants in the trainings from YMCA EJ (formerly supported by IOCC under the MEPL-81 Appeal). Based on the inputs from YMCA EJ, there were few tangible outcomes registered in the organization due to the ACT PSS trainings. YMCA EJ reported that due to lack of funding they had little activities whereby the PSS could be integrated.

The main points raised by the participants in the interviews were the following:

- Unified training sessions were organized to all professionals regardless of their background and practical experiences in the field (MECC, Ahli Arab hospital and YEC and YMCA East Jerusalem). Training was organized for psychosocial workers' to improve their capacity to intervene at the community and family level as psychosocial workers and to refer cases that need specialized services. Training was designed to a large extent by international trainers, with contributions from both local consultants and participants.

- The training sessions are rather more big headings than giving specific practical intervention guidelines for example drawing kids are asked to draw a picture describing his/her feelings, the psychosocial worker doesn't know what to do after the kids drew the picture. Group and family counseling is a big heading, but no guidelines on how to apply group or family counseling ("training topics were like picked from different areas")

- In all training sessions there was no focus on psychosocial components philosophy, interventions, difference between psychosocial intervention and psychiatric intervention, theory based with less emphasis on skill-based training, something that participants to

the focus groups and interviews conducted by the evaluation team expressed as highly needed. The mechanisms of integrating psychosocial activities in their work are missing in training and major part of the implementation.

- Community-based psychosocial interventions are newly introduced activities in both health and vocational training centres and Ahli Arab hospital. There was no clear mechanisms of enforcing psychosocial activities to be adopted by different departments

- The participants indicated that the idea of community wellbeing is a concept imported from abroad without clear activities. The evaluation team got different understandings and interpretations of the wellbeing project.

- The "Men in disasters" workshop, although participants acknowledged the need for such a course, it was not as effective as it should have been. According to 99% of the focus group participants interviewed the selection of experts recruited for training was not adequate, and the design of the training itself was too academic in nature, as it attempted to use very academic language that were not understood by the interpreter used who was not able to convey the trainers idea. There was also inadequacy between the type of messages and teaching methodology, to some extent, and the context to which they were placated. The participants did no see the course "men in disasters" as a useful course because the trainer was not able to deliver the appropriate message, interpretation was not appropriate and training methodology was not understandable by the participants.

- Training materials and handouts in Arabic language were very scarce and the limited English handouts distributed after training sessions were not very fruitful because of English language barrier among most of trainees

- The translated textbook "new mental health" claims cultural appropriate and adapted to the Palestinian context. In the one page introduction, nothing is mentioned about the mental health situation in Gaza or oPt. It is culturally inappropriate, nothing about meaning and social representation of health and illness, no mention of local idioms of distress to express painful experiences. The translated version does not acknowledge the original author of the book. It is available in Arabic. However, most of the participants in the FGD shared that they did not find it useful and of added value. For the PSS working group who did the translation and the work, it was a valuable and good learning experience. They undoubtedly benefitted a lot from the exercise.

- Although participants were officially approved by their organizations to participate in training and implement the project, there was no systematic follow up and professional supervision.

- Some of the international trainers are not culturally and politically aware of the context of Palestinians, some of them come for the first time to the oPt and to the Middle East. Another problem faced by international trainers was the language barrier; English as the language of instruction. As indicated by participants, the lack of good translation hindered the transmission of technical and conceptual material.

Table 4: Overview of trainings conducted in PSS/CWB project

Timeline/date	Training	Consultant
2009		
23-26 March 2009	Al Ahli hospital staff care workshop (4 hours) 102 staff AAH	Päivi Muma, from FinChurchAid Emergency Roster.
26 March 2009	MECC staff care (4 hours training)	Päivi Muma (trainer). 16 participants from MECC
28 April 2009	Staff Care Workshop at IOCC school (3 hours)	Päivi Muma (trainer). 13 participants from IOCC.
29 April	Staff Care Workshop at YEC/ DCA (8 hours)	Päivi Muma (trainer). 15 participants.
1st Module: 1 -3 June 2009 2nd Module: 16 – 18.6. 2009 3rd Module: 15.7.2009 4th Module: 21 – 23.7. 2009 5th Module: 28. – 30.7.2009 at Al Ahli:	**Training of TOT 1** **Module 1**: at Al Ahli (Concept of Health, Participatory Methods e.g. learning by doing, problem solving & Debriefing), **Module 2**: Signs of mental disorders. **Module 3**: Counselling as a method, and Family and Group Counselling. **Module 4:** Different methods, life spans, family tree. Demonstration of debriefing with 40 community leaders. Drawing and puppets as a method. Gymnasium and games. **Module 5:** Child Normal Development (physical, mental and social), Story crafting method.	17 trainers from Ahli Arab, MECC and DCA/YMCA. Päivi Muma Anwar Al-Banna Jamil Abdel-Attiye Päivi Muma, Fadel Abu Hein
14+16+23 November 2009	Community based psychosocial support	Christin Nylund Bergan
17-19th December 2009	Conflict resolution & Anger control	Christin Nylund Bergan (CNB), NCA recruited
2010		
9th January 12th January 14 +16 January 17-21st January 28-29th January	**Training of Trainers 2:** 1. Child Development, AAH 2. Communication, Marna House 3. Teaching Practice only MECC staff; work shop for IOCC school teachers. 4. Drama Training 5. Group/Family Counselling	1. Jamil / Paivi 2. Päivi (Jamil.) 3. Jamil 4. TDP 5. Jaser Abu Jamea (GCMHP)
11th January	Staff Care for MECC	Paivi Muma.
8 + 10th March 2010	1. Program design 2. Role of UN in emergencies, clusters, UN, IASC	Christin Bergan Nylund (NCA)

Timeline/date	Training	Consultant
October 2010	*Planned workshop 3-21.10 cancelled due to late permit.*	*CNB*
30th November – 1st December 2010	Community well-being Seminar (Roots restaurant)	Ian Dickson Lauritsen (seconded from Church of Sweden)
3rd Phase 2011		
8 – 10 March 2011	"Men in Disasters" – place: Ahli hospital Library	**Kjell Reidar Jonassen** (NCA), 18 participants, AAH, YEC, MECC, YMCA.
27 -30 July 2011	**Training of Trainers 4:** IASC Guidelines MHPSS Life skills	Jasem Hmeid. 21 local professionals
13-19 September 2011	**Training of Trainers 5 (6 days):** -Results Based Management Components: Assessment, Project design, Implementing, Monitoring and Evaluation. -Participatory Approach in Program Planning.	**Christin Nylund Bergan**, Maher Wahbe (co-facilitator). 23 Participants from Al Ahli Arab Hospital, MECC, YEC, YMCA, and Culture and Free Thought Association (CFTA)
3,10,17 December 2011	IASC Guidelines on MHPSS (follow-up of September training)	Jasem Hmeid Mathaf hotel. 18 participants, AAH, YEC, MECC, YMCA.

(Complied by research team based on ACT training reports and interviews with consultants).

4.2 Cooperation and coordination

The institutional positioning of the psychosocial both at Ahli Arab Hospital and MECC, which is unclear, especially as regards its relationship to other departments, slows the intra-sectoral collaboration process between other partners. The health professionals in their settings are left without any notification about the project, and the coordination between the partners working in the same project after training is not clear. In the same line, training component also failed to design a follow up, collaboration and formal referral systems among partners participated in the training sessions and within the same institution.

The project was not able to utilize and strengthens the collaboration between the ACT partners and international members and other local stakeholders to discuss certain issues such as professionals' standards and psychosocial guidelines in UNICEF cluster meetings. The project was not able to collaborate with other psychosocial organizations and discuss referral system as a way of collaboration between psychosocial organizations.

There is no plan to establish and strengthen the collaboration between the psychosocial teams at both Ahli Arab hospital and MECC and other local institutions as well as no plans to disseminate knowledge to public and other health and psychosocial service providers and professionals; there is mandate of the how psychosocial to be integrated as part of daily activities.

4.3 Advocacy

In the actalliance Strategic Plan 2011-14, the third aim is **Advocacy for justice:** "to leverage the knowledge, experience and relationships of ACT members and communities to promote and advocate for just laws, policies, and practices". ACT's added value is defined as being able to link concrete experience in grass-roots community work to national, regional, and global policy debates. Despite the importance attached to advocacy in the ACT Strategy, the Forum in Palestine was the first one to develop a separate advocacy strategy, according to the secretariat in Geneva. There were mixed reactions to APF being active and issuing statements such as the one referred to below regarding UN Statehood in September 2011.

Although advocacy was not a component in the psychosocial project, rather it was a separate component handled by DanChurchAid in the Appeals. However, in the inception workshop[20] the evaluation team was asked to make a brief assessment of the relevant advocacy initiatives that could be explored for joint APF work. The team therefore included questions related to advocacy with all the APF members and studied the key documents such as the Advocacy Strategy, minutes from the annual meetings 2010 and 2011 and written comments from some of the partners to the Strategy.

During an advocacy workshop in 2010, the APF members made progress toward the formulation of an advocacy strategy. The APF agreed that its main role would be that of an advocacy *facilitator* rather than that of an advocacy *organizer*. This implies that the forum will provide opportunities for Palestinian communities to speak out for themselves, assist and encourage churches and organisations to raise awareness. The APF Advocacy Strategy stated that it had two overall goals:

1. To contribute towards a global discourse on the Israeli-Palestinian conflict that addresses the consequences of occupation, to promotes access of individuals to resources, and ultimately to bring an end to the occupation.
2. To spread awareness of the humanitarian consequences of the Israeli occupation and the Israeli-Palestinian conflict and to promote humanitarian access for goods, personnel and services.

APF has discussed and tried to agree on certain advocacy issues. There seems to be an agreement about APF advocates both **with** the people and **for** the people. "When advocating with the people, the APF will cooperate with community groups that are already part of individual church-based partners' work in Gaza and on the West Bank and where processes of empowerment takes place already. Examples include the YMCA Youth Groups, the ELCJHL education programs and community groups facilitated through the work of DSPR" (Strategy: 22).

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[20] Inception start-up workshop for the Evaluation of the ACT psychosocial project, 21 May 2012, videoconference between Gaza and West Bank APF partners.

The Strategy also planned to have a separate website, through which local communities can express how occupation affects their lives and tell about their situation. ACT will further facilitate that representatives from the constituencies represent their own views when speaking to journalists and policy makers. Finally, local constituencies with whom ACT cooperates will be invited to provide recommendations to APF's advocacy strategy.

Despite some points of agreements, the APF partners also have their disagreements which were illustrated in the September 2011 APF statement regarding the Palestinians' bid for UN Statehood. The discussions around this statement were, reportedly from the APF partners, so heavy that other partners opted to stay out of it. However, again the APF decided to stay engaged and continue until they found a consensus. When the statement finally was agreed upon it was very "watered" down. Still, the APF managed to have a joint statement. For some of the partners this was more important than the contents of the statement. This approach seems to also be present when analysing the PSS project; the joint work between the APF partners was more important than the quality of the psychosocial work.

Apart from the UN statehood there have been few joint statements in the period after the war. The reasons for that are related to:

- Diverging views of type of advocacy that APF should be conducting: i.e. should the advocacy be "rooted" in the partners' work on the ground or should APF also engage in overt advocacy on larger, political issues (UN statehood, divestment and boycott of Israeli products and services etc.).

- APF partners have different "red lines" of what their governing bodies, donors and constituencies would accept. The largely US-funded IOCC has different red lines as compared to the Church of Sweden, which is funded either by Sida or the church itself. And the red lines for the local churches based in Jerusalem, under Israeli (illegal) jurisdiction are quite different from those of the churches operating under PA rule in the West Bank and Gaza.

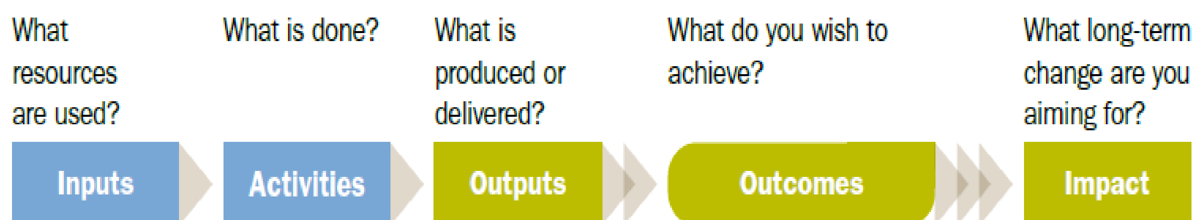
Despite disagreements, among the APF partners there was an almost close to unison agreement that there **are** opportunities for joint advocacy if the advocacy is rooted in the practical work of the partners (health, education, food security, employment etc.). Issues that are all within what we can define as right to development, and thus non-political. Among the issues mentioned by the partners were:

- Right to health (access, medicine)
- Rights of psychosocial workers (license, standards, protocols)
- Research on psychosocial determinants.
- Right to survival (arnona, housing, poverty)
- Right to food, work and an income.

4.4 Outcomes

In the above section, the evaluation has described specific measurable outputs that the PSS/ CWB project was able to deliver and not deliver. In the below section, the team has identified results on a higher level, outcomes – the changes that the project is likely to produce if successful.

As seen in the below results chain, the main focus of the evaluation was on the two boxes from the right; outcomes (medium term changes and effects) and impact (long-term changes that will be sustained to some extent even after the program has been phased out).



source: Norad Handbook of Results-Based Management, 2009

In the project plans and documents linked to the ACT appeals, there were no indicators for measuring potential outcomes. The research team therefore tried to reconstruct indicators, table 5, in order to measure the changes that would take place/not take place. It should be kept in mind that when discussing outcomes, these could be positive and negative, intended and unintended. In the last part of this chapter we have "reconstructed" the result chain for this project.

Table 5: Proposed outcome indicators for the PSS project

a.	**Extent of integration of PSS into the ordinary services (hospital, clinics, VTC, recreational etc).**
b.	**Ability and capacity of PSS team to practise skills obtained through PSS trainings.**
c.	**Existence of a staff care system in the organizations**
d.	**Rights holders' ability to access PSS.**
e.	**Access to high-quality PSS.**
f.	**Extent of community-based interventions among partners.**

A. Extent of integration of PSS into the ordinary services (hospital, clinics, VTC, recreational).
The project represents a unique and comprehensive approach to the psychosocial problems within the Gaza Strip. Each setting has its own multidisciplinary team that consists mostly of nurses, doctors, psychologists, and social workers. At the MECC there is also vocational

training centres and YEC has access to children in the Northern part of the Strip. The project has aimed at meeting the increasing and overwhelming psychosocial needs of Palestinians residing in the Gaza Strip by providing these services through health centres that are geographically accessible to beneficiaries. Considering the scarcity of qualified mental health professionals and psychosocial specialists the project has also a great potential to integrate psychosocial services into regular health services.

B. Ability and capacity of PSS team to practice PSS trainings

The training sessions are good in raising professionals' awareness about psychosocial issues, but come short to really enable psychosocial workers to probably intervene and conduct at the community and family levels. The training sessions do enable workers, however, to provide some support to clients and their families. The training sessions missed a key issue, which is the capacity for psychosocial workers to communicate to families about resources available in the community that can provide further help for clients and their families. The training was deemed too general and theoretical as reported by training participants. In addition, some modules are not culturally appropriate, especially those related to "men in disasters", the translated textbook "new mental health" There are some other technical limitations of the project in regard to training themes such as the lack of comprehensive skills-based intervention training such as a special course in counseling skills, family health etc. There also is a lack of clear mechanisms of follow-up and supervision of those who completed training. The follow-up and supervision mechanism is both the local partners and international and local consultants responsibilities to help or contribute to the design.

C. Existence of a staff care system in the organizations

The creation and establishing psychosocial interventions have allowed the availability of a more diversified staffing at both MECC and YEC has helped growing trust between the beneficiaries and the families on the one hand and their care takers in health centres The staff of these newly created services, looks and sounds quite happy and enthusiastic to be working there. Satisfied staff is certainly an important and positive factor for the quality of the services delivered to the beneficiaries. Though we do not have clients' take on their experience in those health centres, there also seems to be a good level of satisfaction among them particularly at YEC and Shajaya health centre. An indicator of this is the fact that a significant number of children are self-referrals based on mouth-to-ear information spreading around in the communities, from families of patients receiving services in those centres.

A large number of patients actually come to the services are self-referred. They heard about the services either from others who benefited from that service, or because of their being users of the services such as vocational centres or they heard about the service when they come health centre for regular check-ups and care. In fact, according the information gathered, only 2-3 cases were referred by health professionals like the case in Shajayia.

There still are no real psychosocial services offered at the both Ahli Arab hospital and MECC apart from recreational activities. This is definitely not offered in Ahli Arab hospital, Daraj Centre and Kherbat al-Adas at this time. They just don't have the place that provides privacy on a regular basis, except at Shajayah.

D. Access to high-quality PSS.

There is a sense, from all interviews and focus groups with practitioners and local trainers, that if understanding of psychosocial interventions, their variety, their complexity and of the variety of responses available to meet them, has increased, the training has only superficially scratch the depth of each subject and, therefore, has not been sufficient to build strong intervention competences. “People know the chapters’ title” as one interviewee put it, “but they don’t really know their content”.

The lack of psychosocial services at both Ahli Arab and MECC is due to the lack of time (Ahli Arab team are full-time professionals at the hospital), but also to the fact that training provided did not really cover techniques and procedures covered by psychosocial interventions.

Participants interviewed reported positively staff care and debriefing training sessions, IASC guidelines training and project management cycle and community planning and assessment. Although the local trainer has not practical experience as psychosocial professionals, participants appreciated his theoretical knowledge.

Accessibility is related to three main issues; first geographical accessibility that is referred to whether services are reachable by beneficiaries. The MECC have different health clinics distributed in different geographical locations. YEC has two branches in the Northern part of the Strip. Second cognitive accessibility that is referred to whether beneficiates know about the existence of the services and third is acceptability, which is referred to people acceptance of the services.

E. Extent of community-based interventions among partners

The existing APF implementing partners in Gaza (especially AAH and DSPR/MECC) are not community-based organisations[21] in the sense that their constituencies and target group are represented in their decision-making bodies. AAH and DSPR are traditional service-delivery organisations within health, education and vocational training. There is no representation of users or patients’ groups in the decision-making bodies. In that sense, the concept of the community-wellbeing project was not adapted or tailored to the existing partners.

Community-based organisations – as the name indicate – spring out of their communities in order to meet a certain need (infrastructure, water, health, education etc.). People organise in order to advocate and claim their needs. The APF wanted to transform the existing partners into becoming more responsive and accountable to their communities – in line with existing ACT and international standards for transparency and accountability. However the local partners work within completely different frameworks and available resources, for them, changing the way they work (by installing a new modality of close consultation with the communities) would imply a completely new way of working and was thus perceived as being risky.

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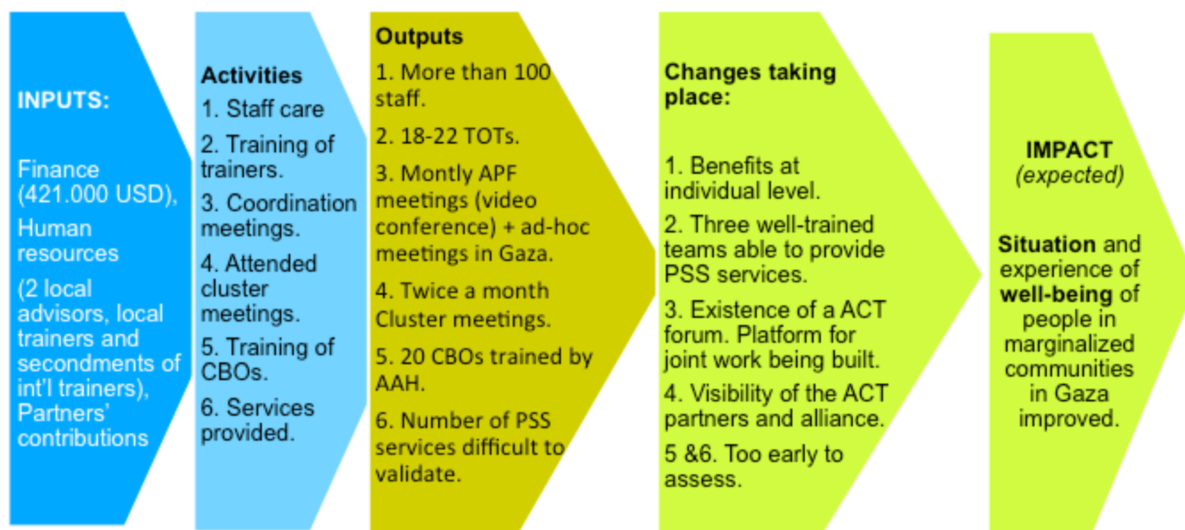
[21] Community-based organizations are civil society non-profits that operate within a single local community. They are essentially a subset of the wider group of non-profits. Like other non-profits they are often run on a voluntary basis and are self funded. Within community organizations there are many variations in terms of size and organizational structure. Some are formally incorporated, with a written constitution and a board of directors (also known as a committee), while others are much smaller and are more informal. The recent evolution of community organizations, especially in developing countries, has strengthened the view that these "bottom-up" organizations are more effective addressing local needs than larger charitable organizations["NGOs and the New Democracy". Harvard International Review] Wikipedia.

The fact that AAH has started to train a group of volunteers from neighbouring and local CBOs could potentially be a sign that AAH wants to have a closer contact with their communities. The project is still ongoing and the CBOs are waiting for AAH to come and monitor their work in the community. Thus it is too early to assess if this initiative could create positive spin-off effects in the sense that local communities be empowered to assist themselves in claiming their rights.

MECC has also not fully integrated community based interventions in their regular work, but via their unique entry points (clinics, VTCs) the MECC has a great potential for starting community based psychosocial interventions.

Summing up the findings from the different result levels, the evaluation team reconstructed the result chain below (figure 6 below).

Figure 5: Result Chain of the Psychosocial Wellbeing Project



(Source: Evaluation team based on project documents and information from partners and APF)

5 Assessment

In this chapter the evaluation assess the findings described in the previous chapter along the OECD/DAC and ALNAP criteria for evaluating development and humanitarian work: relevance/appropriateness, connectedness, efficiency, effectiveness, impact and sustainability. Gender and conflict sensitivity are analysed across the board.

5.1 Relevance/appropriateness

Relevance refers to which extent is project in line with local needs/priorities, i.e. does the project objectives reflect key priorities; does it receive support from key partners, and responds to the needs of target group?

Appropriateness refers to which extent has the humanitarian project contributed to strengthening long-term goals and objectives (local ownership, partnership).

The project has been an important part of the overall effort to develop a Palestinian psychosocial system to address the high and growing prevalence of social and psychological challenges in the Palestinian population. It has tried to address the need to increase the number and the qualification of psychosocial workers in the Gaza Strip, which still fall short of meeting the demand for services. This was particularly the case for services to children and adolescents, an area where little had been done until then, even when half of the population in the Gaza Strip is under 18 years of age.

The first phase of the PSS project (staff care) was perceived as highly relevant to the needs of the implementing partners. Following the devastating war in Gaza, staff in all the organisations reported on exhaustion, weariness and general signs of psychological overload. Because the requests for staff care came from the partners themselves they were perceived as appropriate to their needs. The training enhanced the knowledge of the staff in the four partner organisations (MECC, AAH, YEC and YMCA). Since the staff care trainings were demand-driven, there was also a high degree of local ownership towards the trainings, especially among the staff in the Ahli Hospital and MECC.

In the second and third phase of the project, when the immediate needs for staff care had been met and the partners decided to try and utilise their newly gained psychosocial skills into developing community-based interventions, the relevance was found to be weaker. Working in a community-based way in order to strengthen the resilience of people in Gaza **was** identified as a need, but the partners found it difficult to agree on the practical modalities for implementing

such a project. Once the implementing partners were about to start implementing a community-based approach there were resistance due to different reasons: the partners were afraid of raising expectations in the communities that MECC and AAH would for example start providing services that came along with the well-being program (which would be according to the defined needs of the communities: food security, livelihoods, water etc.). Both partners, but especially the AAH, being heavily burdened and underfunded already were hesitant to take on such commitments due to the long-term implications this might have. Practical issues such as staff employment in the wellbeing project; where would they be employed, who would guarantee for them after the project was finished etc., were unresolved. The psychosocial advisor who was contracted by the APF for support the project throughout the period warned about the lack of ownership and the different financial and administrative problems that had to be solved before continuing with the wellbeing project.[22]

Analysing and trying to learn from the experience of the wellbeing project, one key question raised is: how could the wellbeing project develop so far, raise funds from the ACT Appeal 2011, make plans and a budget when the concept was not “rooted” and “owned” by the implementing partners?

There are different explanations and narratives as to what happened and the research team has tried to listen to all stakeholders, triangulate and come up with its own analysis.

A major explanation seems to be a lack of a strong context analysis of the situation that the project would operate in: the design of the project was not detailed and the “problem” statement was built on a number of assumptions that were not deeply analysed. None of the documents developed by APF[23] gave a proper problem statement of what the wellbeing project would solve and how the partners’ existing abilities would be able to meet the needs. The concept paper made assumptions of the situation in Gaza without underpinning it with solid facts or research; for example, the target group was defined as “marginalised communities in Gaza within geographically defined areas with a population of maximum 10 000”. However, there was no context analysis researching the catchment area and if these communities really **wanted** to have the intervention of the ACT partners; had they requested any of the APF partners for assistance? Had the ACT partners closely consulted with the communities before making plans? It seems that the project **assumed** that the communities wanted such a project without really researching it properly.

Also, it seems that the APF partners did not listen or take the perspectives of the advisor fully on-board. The steering group in the APF that wrote the Appeal 2011 in which funds for the wellbeing project was applied for was keen on accessing the funds from the Appeal.

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[22] The community wellbeing seminar in Gaza, 30.11-1-12.2010, report written by Maher Wahbe.
[23] APF, Final Draft Concept Paper, Wellbeing Project, undated, or Log-Frame, The Community Well-Being Programme Gaza 2011.

Summing up, the research team concludes that the first phase of the project – psychosocial staff care was both relevant and appropriate and based on the needs of the partners. A weakness however was that it led to some extent of confusion regarding the role of the PSS teams in the partner organisations; should they conduct therapeutic briefings with clients or should their role be to support and build local communities' resilience?

The second/third phase was highly relevant from a theoretical perspective - the wellbeing project aimed at making the implementing partners more accountable and responsive towards their constituencies, however the well-being is a concept that was not clearly defined and formulated therefore, partners were incapable of embracing such a change within the frames and structures of the project designed. Thus, the wellbeing project did not succeed in implementation due to lack of clarity and ownership from the partners.

5.2 Connectedness and sustainability

*Connectedness refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account. Connectedness has been adapted from the concept of sustainability – the idea that interventions **should support longer-term goals**, and eventually be managed without donor input. (ALNAP Guide 2006).*

Sustainability refers to the extent to which a project has been successful in creating surviving/dynamics towards the implemented activities and programs strategies, and to which extent it would continue after funds have been phased out.

Although it is generally accepted that there is always a link between humanitarian action, recovery and development, there is currently no consensus concerning the *extent* to which humanitarian action should support longer-term needs (ALNAP discussion).

The Appeals of the ACT alliance, however, even if they were initiated as humanitarian appeals (around the second Intifada in year 2000), are trying to bridge the gap between humanitarian and development work. A key challenge for the ACT Appeals is that the implementing partners are mainly local development organisations that are neither set-up or equipped for responding in emergency situations. As noted in the Evaluation of the MEPL-81 Appeal, "[the ACT partners] are struggling with finding the appropriate programming as well as funding, as many appeals, including the ACT/APL appeals, favour an either/or approach. Additionally, emergency appeals usually have a shorter time frame for funding and implementation, though in a chronic environment the relief-development overlap requires longer-term funding and planning." (2010:38).

The psychosocial project was to some extent gradually integrated into some of the partners' regular work, especially the MECC and YEC. For the AAH the psychosocial support was for

reasons described in the previous chapter not integrated into the hospital's regular counselling done by the nurses towards for example the cancer patients. Instead, the PSS team decided to train a group of young people from a number of CBOs. From that angle, the research team found that the immediate staff care was not connected to the longer-term goals of the hospital. However the well-trained staff at the Ahli hospital has demanded time and opportunities from the leadership at the hospital to exercise their knowledge obtained via the PSS trainings. This is therefore an indicator of conceptual sustainability; the fact that people have become convinced that integrating psychosocial services would strengthen and enhance the outcomes of the regular hospital services.

For the DSPR/MECC, there are many indicators that the leadership is gradually becoming committed to integrating PSS into the clinics, the vocational trainings and the education: the social workers are conducting counselling sessions with groups of mothers, children and young boys training at the VTCs; there are referrals between the medical doctors and the social workers (although not fully explored yet). These are indicators of connectedness. To which extent the PSS services will be sustained after the funding (via the current Appeal under DSPR) remains to be seen. The research team recommends that DSPR include PSS as a project or theme in the DSPR Strategy[24] with separate resources and objectives, working across all the sectors and programs of the DSPR, but to ensure that a lasting change takes place in the way that DSPR works with its rights holders.

As seen in the previous chapter, the referral systems and cooperation between the trained PSS team and other psychosocial and mental health facilities in Gaza was found to be weak. Contact is however established between DSPR/MECC and the UN Cluster working group on psychosocial support, so for DSPR the opportunities of further developing lasting and sustainable referral systems are definitely in place.

The research team also explored[25] to which extent the PSS project helped to empower the local communities or support groups. Part of the outputs in the second and third phase of the project was to train the local community groups and associations in order to enable them to assist and identify their own communities. The team found a number of individuals that had been trained and were ready to start working, but in the AAH they were waiting for the last phase to start – namely implementing projects in the communities. It was thus too early for this evaluation to assess the potential sustainability of this approach.

5.3 Effectiveness, including gender

Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. (ALNAP Guide 2006).

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[24] Currently, psychosocial wellbeing is mentioned under the first Strategic Objective of Health. *Department of Service for Palestinian Refugees, Strategic Plan, (Final Draft), December 2011*

[25] A full list of indicators of sustainability is listed in the NCG Inception report submitted to the actalliance on 30.04.12

The three different phases of the project had three different goals and objectives[26], assessing effectiveness would therefore imply assessing to which extent the objectives of the three different phases have been met.

For the first phase (2009) the specific objective was "introduce Psycho-Social mechanisms that would tend to the traumas and stresses of families and children who come to the clinics." Via the clinics of the DSPR/MECC it seems that this objective was partly fulfilled as the partner has reported that it has conducted sessions for an unknown number of women and children annually[27] since 2009. For the Ahli hospital, the PSS staff has conducted between 25-34 training sessions for the communities that they trained (TOT), but there is no internal referral system regarding the patients. For the IOCC and EJ-YMCA staff that was trained there were no reports of them utilising their skills in the regular work.

For the second phase, there were two objectives:
1. Women, men, youth, and children have access to and benefit from psychosocial support services provided by ACT members.
2. The quality of psychosocial support services provided to targeted communities and groups has been improved.

For both of the objectives the integration of the PSS into the regular services would be a prerequisite and since this was only partially done the goals were not fully achieved.

The objective of the third phase was "the community well being program has built the capacities of the psychosocial staff of members to provide high quality psychosocial services". As discussed earlier in the report, this objective was too ambitious and was not achieved due to different interpretations and understandings between the APF partners of who would do what. There were different interpretations about the CWB concept, which was revised in August 2011 and included only capacity building component to partners. The trainings and workshops were conducted according the revised plan.

The project has led to the creation of well-trained psychosocial teams in MECC, YEC and part time team at the Ahli Arab hospital. A total number of 18-20 people participated in the training sessions through the phases of the project to provide psychosocial activities in their respective institutions. However the teams have not succeeded in providing psychosocial services for the community and to patients inside the hospital

There are still important areas of psychosocial interventions that are not well dealt with, despite the completion of the project three phases. This includes practical skills on community and family support and the non-specialized supports and interventions in addition to how to use the

[26] See inception workshop presentation.
[27] According their own reporting there were 12.000 women and children receiving counselling sessions from the PSS team, but we were unable to validate it. DSPR/NECC Gaza Area, Annual Report 2011.

IASC guidelines. And no professional supervision system has been applied and specific professionals guidelines

When assessing the effectiveness of the PSS project from a gender perspective, a gender gap was noticed among the staff trained from Ahli hospital. From the beginning, the Ahli hospital decided that the psychosocial training would be based on staff doing it outside the regular working hours. This meant that only senior staff at the hospital that did not have obligations outside their work could attend the training. Out of the six trainees, only one was a woman, but also she was unable to be taking part due to work obligations.[28] The selection criteria therefore unintentionally excluded female staff. The criteria also discriminated against younger staff at the hospital as only senior management staff was selected to attend the training. This meant that AAH encountered a problem with the staff utilised their skills in counselling with Ahli patients; for example, the hospital performs more than 10 mastectomies (i.e. removal of breasts to treat women with breast cancer) per month. According to information from AAH, all breast cancer patients at AAH received counselling from the PSS team but this is not documented in their charts.[29] From the research team's point of view and keeping the cultural codex in Gaza in mind, it would most likely be easier for a female patient trying to cope with the trauma of loosing a breast to receive counselling from a female nurse than a male. There is great need for AAH to be more realistic in their planning for how to utilise the skills trained in the future (see chapter 7 for specific recommendations to AAH).

5.4 Efficiency

Efficiency measures to which extent has the project been implemented in a timely and cost-effective manner.

The total funds expensed on the psychosocial project over the three years of the evaluation were USD421.000 (around 335.00Euro). This component constitutes less than 3% of the total ACT Appeals. For the distribution of funds, as seen in the previous chapter more than half of the funds have been spent on consultants and trainers and the remaining on the salaries and administrative costs of running the project.

In the 2010 Evaluation of the Act Appeal, the cost-efficiency of joint and single-donor monitoring missions (in 2009), was raised by a few APF members who questioned both the utility and timeliness of the reports. One member noted that the members of the joint monitoring mission (in July 2009) "didn't have enough time to do a proper job." However other members felt that the process of the joint monitoring mission was more important than the report and was useful for members. During the course of this Evaluation no such concerns were raised regarding the relatively high costs of the international consultants that have played a major role in the project. This might be due to the fact that a local Palestinian advisor/co-facilitator was in place throughout the period and the costs of international consultants were reduced in 2010 and 2011 as compared to the first year.

[28] Also during the Evaluation process she was not able to fully attend the focus group discussion with the staff due to the work load in the hospital.
[29] Information from AAH in email 28.05.2012

The choice of the project's implementing partners (MECC, Ahli Arab, YMCA-EJ, and YEC) was self-evident given the fact that these are faith-based organizations (except YEC) and are long-term partners of the ACT members. However, assessing the choice of partners from the angle of effectiveness and efficiency, in other words, which organisations in Gaza would be most likely to produce strong results on integrating psychosocial support in health and education services, the choice of partners was not given. The Ahli Arab hospital was not ready to administer such a project since it is mainly a general hospital; the MECC and YMCA-EJ had no or very limited experience in running psychosocial projects. This leads the research team to conclude that the selection of partners was not made out of a cost-effective analysis, but rather a motivation of trying to strengthen and enhance the capacities of existing partners. This is probably self-evident for the actalliance partners, but not clearly spelled out in the project documents and thus we find it useful for the sake of the analysis to highlight this (see also lessons learnt).

Another factor that impeded the efficiency of the project was the distance between Jerusalem and Gaza; most of the decision-makers in the APF were located in Jerusalem, while the implementing partners were in Gaza. In the beginning of the project (2009), the partners had their own "Gaza-forum" where plans were made according to the needs identified locally. In 2010-11 efforts were made to link Gaza and Jerusalem by video conference to ensure that all partners were informed about each others' work and progress in developing the wellbeing project.[30] A local advisory board, the "Core group" with its own TOR[31] was established for the wellbeing project and the Gaza-based APF members spent many meetings trying to agree on the structure of the project. The psychosocial advisor employed by APF in mid-2010 (via NCA) was facilitating the work. A Swedish consultant from CoS provided ideas for the organizational structure of the wellbeing project. Efforts were therefore clearly made to try and empower the Gaza implementing partners in taking the lead and run their own project. Despite these efforts, the APF members were not able to agree on key issues. In April 2011 NCA took a decision to appoint the advisor to become the coordinator of the wellbeing project in the hope that this would assist the partners in moving the work forward. However this decision did not help and the project continued to struggle. The lack of permits for international consultants and the monitoring visit from Church of Sweden further impeded the capacity-building project to move forward.

For the timeliness of the second and third phase of the project, there were clearly delays due to both i**nternal** in APF (lack of agreement among partners, decision being taken in Jerusalem related to Gaza) and **external** (lack of permits for international consultants and monitoring visit) challenges.

Although there were clearly frustrations among the APF partners and the coordinator/advisor with regards to the lack of progress, the research team is impressed with the persistence of the APF partners for staying engaged and not giving up the joint project. Through the lengthy negotiations the APF partners in Gaza started to know each other and built a potential foundation for future joint work.

[30] Email from NCA to APF partners in Gaza 18.04.2011 informing that NCA is taking the responsibility for the community wellbeing project on behalf of the APF and appointing the advisor to coordinate the work. This was not a jointly agreed-upon decision by the APF partners in Gaza.
[31] TOR for the Project Advisory Board, "The Core Group", draft 01.04.2011.

5.5 Impact

Impact refers to the contribution of the project to the overall goal in triggering positive changes in the social environment on individual, family, community levels that has occurred as a result of the project interventions.

The research team found it difficult to measure the impact of this project for a number of reasons; first of al there were not baselines or situational analysis of the psychosocial capacity of the implementing partners (although based on the reconstructive method we can assume that it was close to zero). Even if we assume that the PSS knowledge and competence in the organisation was zero before the start of the project, and that their knowledge have undoubtedly increased due to the trainings described in the previous chapter, the skills of the trainees were not verified, i.e. since the psychosocial project was not integrated into the regular work of the partners there were no beneficiaries that the research team could interact with in order to validate the skills of the PSS counsellors.

A second limitation for assessing the potential impact of the project is the large number of agencies and organisations conducting PSS interventions in the Gaza Strip, more than 162 agencies are working in providing such services (TDF/UNICEF Study). Even if we had found direct beneficiaries of the project, most likely they would have been counselled and supported by a number of other service-providers.

5.6 Gender

Gender equality refers to the equal enjoyment by women, girls, boys, and men of rights, opportunities, resources and rewards. The ACT Alliance considers gender equality as a cross cutting issue and over the years members have endeavoured to promote gender sensitive approaches to development and humanitarian assistance.

The term gender is often used as if it is synonymous and interchangeable with the word women. This is not the case. The reason why gender approaches often address women and girls is because of the acknowledged discrimination and exclusion which most women and girls still face in a great number of countries. While the ultimate goal of the ACT Alliance is gender equality, it sees gender equity (fairness) as the means to achieving that result. ACT recognizes that women cannot achieve gender equality by themselves. Men need to be involved if gender equality is to be achieved for all.

ACT has separate Gender Guidelines and recently issued a report collecting Best Gender Practices (Clapping with both hands). In the previous Evaluation of the MEPL-81 Appeal, gender was found to be “fair” and most partners referred to the number of women in the decision-making processes and women are present at various levels of their organisations in project and/or programme positions. The understanding of gender among many members is that of “women’s issues”. The awareness and knowledge about how to integrate an analysis of

how project can best benefit men and women from different perspectives, was missing with some of the partners. NCA who was handling the project has gender high on its agenda, and has taken steps to integrate gender across the projects.

One example is that based on the findings from the MHPSS Mapping conducted by TDF/ UNICEF in 2010, one of the gaps pointed out was the lack of projects targeting men and young boys. NCA and the APF partners discussed how men and boys' needs could be better taken care of in emergencies. The partners requested training on this issue and an external consultant from Norway was commissioned to train them on "men in disasters".[32] Based on the feedback from the focus group discussions with the training participants, there was a unanimous agreement that the training did not meet their expectations; the topic was relevant, but the training was too theoretical and "lecture-based", and the trainer was unable to make the example practical and relevant for the Gaza setting.

The research team tried to explore if the topic "men in disasters" would have been handled more openly if men and women had attended separately and if a male Arabic-speaking trainer had conducted the training. The participants claimed that they did not want to have the trainings separate between males/females ("the rest of Gaza is already segregated enough, so we should at least be able to train together!"). Still, the evaluation would challenge the ACT alliance into trying to identify Arabic-speaking male gender trainers.

Gender concerns were also integrated in the trainings of the life skills and IASC Guidelines, for examples when designing and caring for shelter and sanitation needs for men/women.

[32] Kjell Reidar Jonassen, Centre for adaptive Education, "Men in Disasters". 3 Days Workshop in Gaza, 7th – 10th March 2011.

6 Lessons learnt

If you were to start the project or joint APF work all over again today – keeping in mind the knowledge and experience you have gained over the last three years – what would you have done differently?

This was the question that the research team posed to each one of the stakeholders involved in the APF since 2009. Some of the individuals had left Palestine – and thus had been able to reflect more deeply with the distance of time, while others were still in the “midst” of the challenges of trying to get the Forum to work together. Below is a small selection[33] of the many statements we heard:

- Different experts from abroad brought with them different ideas and concepts. While this was very good for me personally - I really gained a lot – I can see that for making a joint program between the APF partners, it was probably not very good as the participants in the training could not agree on one joint direction of work. There was no real ownership to the community-wellbeing project.

- Do not impose on the local partners anything! In ACT we had an excellent theory [the community-based well-being program] but when the reality didn’t match, we tried to change the reality. We didn’t recognise the strengths and weaknesses of each organisation – we pushed them to do things that they didn’t have the capacity for.

- ACT members are doing bilateral agreements with their partners to do psychosocial support activities. The idea of incorporating psychosocial component in the ACT appeal is to work together to maximize our impact on the communities. If we will continue to do ad-hoc activities among members individually, then I wonder about the added value of APF. Why should some of the psychosocial activities be inside the appeal, while others are outside?

- To have collective work is an empowerment of the local churches, the advantage of aid, not only subsiding Christian institutions also Muslim institutions is very good. The role of the Church is to alleviate suffering and poverty. ACT partners should go into every poor house in Gaza. This is our duty as a church.

- The main lesson learnt for me is that in order to develop a project we need to be very specific about where we are going – setting clear objectives and goals. This was difficult for the APF when developing the wellbeing project, because each organisation had a different understanding of what is meant by community-based support and community-wellbeing. So every time we came to concrete action the whole process stopped.

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[33] All interviews were transcribed and copies are held with the research team.

*- The role of the coordinator was very difficult. He was given a task without the necessary authority and backing from a joint APF. A key lesson learnt is that in order to have a coordinator of a forum this needs to be **joint** decision by the forum, not a decision taken by one of the partners.*

Based on the above statements and other reflections there are a few generic lessons learnt that can be derived from this:

By engaging outside "drivers of change" in the form of consultants, trainers, ACT partners or prospects of funding, there is a risk of **disempowering the nationals** and weakening local ownership of projects and programs.

Although the intention of introducing the community-based wellbeing program was the exact opposite, namely **empowering** the nationals, an unintended result was that the local implementing partners felt disempowered. They were not convinced about the concept of wellbeing, which was introduced by the consultants seconded from the Nordic churches, but went along with it for different reasons elaborated below. The availability of funds and local APF partners did not want to upset their international ones were among the factors that influenced this development.

Analysing the causes of the disempowerment, the research team found several interlinked reasons; one was that the gap between the **concepts introduced** and the **regular work** of the partners was too wide; i.e. the concept of community-based wellbeing implied that the partners would go into the communities and identify the poorest of the poor, mobilise and train them into helping themselves, while for partners like the Arab Ahli Hospital this was too far away from the work at the hospital. AAH feared it would create expectations towards the hospital that it could not meet in the future.

Closely linked to the above is the fact that the existing APF implementing partners in Gaza (especially AAH and DSPR/MECC) are not community-based organisations[34] in the sense that their constituencies and target group are represented in their decision-making bodies. AAH and DSPR are traditional service-delivery organisations within health, education and vocational training. There is no representation of users or patients' groups in the decision-making bodies. In that sense, the concept of the community-wellbeing project was not adapted or tailored to the existing partners.

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[34] Community-based organizations are civil society non-profits that operate within a single local community. They are essentially a subset of the wider group of nonprofits. Like other nonprofits they are often run on a voluntary basis and are self funded. Within community organizations there are many variations in terms of size and organizational structure. Some are formally incorporated, with a written constitution and a board of directors (also known as a committee), while others are much smaller and are more informal. The recent evolution of community organizations, especially in developing countries, has strengthened the view that these "bottom-up" organizations are more effective addressing local needs than larger charitable organizations["NGOs and the New Democracy". Harvard International Review] Wikipedia.

Community-based organisations – as the name indicate – spring out of their communities in order to meet a certain need (infrastructure, water, health, education etc.). People organise in order to advocate and claim their needs. The APF wanted to transform the existing partners into becoming more responsive and accountable to their communities – in line with existing ACT and international standards for transparency and accountability. However the local partners work within completely different frameworks and available resources, for them, changing the way they work (by installing a new modality of close consultation with the communities) would imply a completely new way of working and was thus perceived as being risky.

Different messages; the first consultant seconded from FinChurchAid was an experienced psychologist and crisis therapist that provided much needed staff care for the ACT partners; the ACT lead on psychosocial support from Church of Sweden focused much on the need for PSS to be community-based; and the third consultant seconded from Norwegian Church Aid focused on problem solving, analysing community needs etc. All of the trainings were perceived more of less useful for the trainees on individual levels, however the trainings were not designed to systematically build-up the capacity of people working on one project with clear objectives and goals.

All issues mentioned above, the gap between the concept and the type of partners, were part of what the team identified as the main weakness of the wellbeing project, the lack of a proper **context analysis.** None of the documents developed by APF[35] gave a proper problem statement of what the wellbeing project would solve and how the partners' existing abilities would be able to meet the needs. The concept paper made assumptions of the situation in Gaza without underpinning it with solid facts or research; for example, the target group was defined as "marginalised communities in Gaza within geographically defined areas with a population of maximum 10 000". However, there was no context analysis researching if these communities really **wanted** to have the intervention of the ACT partners; had they requested any of the APF partners for assistance? It seems that the project **assumed** that the communities wanted such a project without really researching it properly.

A key lesson learnt could therefore be that before initiating any community-based initiatives, there has to be a solid situational/context analysis to ensure that there is a **local ownership** towards any initiative. Ideally, initiatives for assistance should come from the communities themselves, but knowing that some communities are located in remote areas or in other ways unable to access services, the implementing partners can approach them. Careful do no harm analysis is also necessary when approaching communities; i.e. an analysis of who would benefit from a project and who would not, while at the same time trying to support activities that would bring communities closer together rather than split them apart.

[35] APF, Final Draft Concept Paper, Wellbeing Project, undated, or Log-Frame, The Community Well-Being Programme Gaza 2011.

The ACT secretariat in Geneva recognised that local partners in the actalliance forums around the world risk being "overrun" by the internationals in the quest for securing new funds. This links us to the issue of internal power relations in the forums; as discussed in the previous chapter since some of the ACT members have double and sometimes triple roles (donor, partner, implementer etc.) this is often perceived by the local partners as the donors having more power in decision making processes than the locals.

In order to make the discussion on **power relations** more nuanced, the ACT Geneva encouraged the forums to analyse their **strengths and weaknesses** by distinguishing between those that have power and those that have the funds (and often takes decisions). For example, a Palestinian religious leader has a lot of power by the mandate he has been given by the Church and the constituencies. The local ACT members are also powerful due to the fact that they are the ones implementing projects on the ground, and thus have credibility among people. Without the local members to implement, the ACT members would have little value-added to highlight in the international fora and advocacy work, while the international ACT partners have the strongest funding base. In-built in these fora there is a need for a mutual recognition and respect for each others' strengths and weaknesses.

The selection of the local partners to implement a community-based psychosocial project was not based on an analysis of their skills, competencies, identifies etc. but was motivated by the ACT alliance wish to support existing (church-based) partners in strengthening and enhancing their capacities. Recognising this dynamic has implications on how such a project is monitored and evaluated; rather than evaluating this project in line with MHPSS guidelines or SPHERE and ACT alliance guidelines for CBPS, the project needs to be evaluated as a capacity-building project aimed at these specific organisations and based on an situational analysis of their strengths and weaknesses.

7 Conclusions and recommendations

The psychosocial wellbeing project in Gaza was the first concerted effort of the ACT Palestine Forum to develop a joint project: in many ways we can say that the project became an **instrument** for APF practical cooperation. As it often happens when something is an instrument in order to achieve a higher goal, the quality of the instrument often suffers. The instrumentality of the joint project (making the partners work together) became more important than the quality of the psychosocial work; the partners' staff were trained in psychosocial work, but the quality of the services being provided to the end-users was found to vary greatly. In one of the partner organisations, the staff was even unable to practise what they had learnt.

Despite the fact that psychosocial project did not fully succeed in producing the expected results, the evaluation team found that a foundation had been built for future joint projects. There is no need to rush into new joint projects. The Evaluation team recommends the ACT partners to take one step back and critically reflect on what they could have done differently. By analysing connectors (”what binds us together”) and dividers (”what splits us”) joint interests among partners can be identified. Potential new projects need to be driven by joint and mutual interests, not availability of funding.

Closely linked to the above, the evaluation also recommends that research (participatory research) should form the basis for further programming. In addition the ACT Forum is advised to keep awareness-raising and training in working with rights-based advocacy, either jointly or individually. APF or partners are recommended to commission at least one participatory research annually that can be utilised to rights-based advocacy.

Another key recommendation is that before entering into any new joint projects, thorough context/situational analysis with measureable data and indicators (results-based frameworks), including do no harm and gender analysis need to be undertaking. Central in such analysis to ensure that there is a strong local ownership

Seconding international consultants should be demand-driven and based on written requests from the APF specifying types of competences required. To ensure that the seconded consultant is integrated into the project/program, TOR should be developed and monitored and the international consultants should work closely with the local counterparts.

In order to strengthen the APF in Gaza, a highly qualified coordinator with substantial work experience should be employed with a clear TOR and authority. Alternatively the APF coordinator can rotate between Gaza/West Bank.

In addition to the above more general recommendations for the APF, the evaluation team provides some specific recommendations for the implementing partners:

Recommendations for the MECC

The MECC has a strong potential to create a model of integrating psychosocial services into their general health care clinics. Through its heath care clinics, MECC can genuinely and systematically link between physical and psychosocial care providers to meet the needs of their beneficiaries. Integration occurs when psychosocial workers and health workers such as nurses and GPs work together to address both physical and psychosocial needs of their targeted population. Therefore the evaluation team recommends the following

- The MECC is to adopt the collaborative integration approach where both psychosocial and health professionals are working together in the same clinic/centre to assess those in need of health care.
- Disseminate the knowledge about the project to all health and vocational training departments/units.
- In a workshop for department heads designs mechanisms of cooperation between the psychosocial team and health professionals (nurse and doctors).
- Design a follow up mechanisms.
- Design referral system.
- Design mechanisms for supervision and types of supervision to be used.

Recommendations for Ahli Arab Hospital

Ahli Arab Hospital psychosocial team and manager clearly stated that hospital is not ready for community outreach services yet and it is not in their priorities. They clearly indicated that cancer among women is striking and probably is significantly increasing; almost every week a mastectomy is performed. In addition, many cancer patients from Gaza are referred to Augusta-Victoria hospital in West Bank for therapy. For many cancer patients "cancer equals death", they do not have any counselling sessions and support. Therefore, the evaluation team recommendation strongly recommend Ahli Arab hospital to integrate counselling for cancer patients (in-patients and those who are referred to West Bank for therapy) as part of the services provided, which very different form the reassurance that nurses provide to patients as part of their nursing care plans. To implement this recommendation the evaluation team recommends the following steps:

- Chose a group of nurses or health professionals who are interested in counselling.
- Invite national and international experts to run a course in counselling of cancer patients, the course has to be based on skills with little theory. The teaching methodology is different here.
- Give accreditation to this course and incentives to all those who pass the course successfully and integrate them into the hospital pay role.
- Design a follow up and supervision mechanisms.
- Disseminate the knowledge about this new cadre not only to hospital departments also to Ministry of Health and Social Welfare.

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ANNEXES

Annex I: Terms of Reference

Evaluation of the ACT Psychosocial Program, Gaza

1. Evaluation Purpose

Norwegian Church Aid (NCA) seeks to conduct an external evaluation of the psychosocial program implemented by NCA in cooperation with ACT alliance members and their partner organizations during 2009-2011 as a response to the war on Gaza in December-February 2009. The psychosocial programme was implemented by NCA in cooperation with resource persons in Church of Sweden (CoS) and FinChurchAid (FCA) and with ACT alliance partners.

The purpose of conducting and external evaluation is to document results, and if possible to assess the impact of more than three years of activities. We seek to learn from this experience and will use findings and recommendations in future programming.

The psychosocial project aimed to improve the situation and experience of well-being of people in marginalized communities in Gaza with high level of resilience and cooping. Central activities were training for staff in ACT alliance organizations and partner organizations. The total funds risen in ACT appeals for the project was USD 456 000.

The evaluation should be conducted by a team of two external consultants. These may be local or international consultants, or a combination of international and local. It is important to encourage participation of ACT members in Gaza and those ACT members that have been directly engaged such as Church of Sweden, FinChurchAid and NCA in the evaluations process to facilitate learning.

2. Background of the Project

The ACT Palestine Forum (APF) was established in 2008 and includes local and international ACT alliance members. The local ACT alliance members are Middle East Council of Churches/Department of Service to Palestinian Refugees (MECC/DSPR), East Jerusalem Young Men's Christian Association (EJ - YMCA) and Evangelical Lutheran Church in Jordan and the Holy Land (ELCJHL). The international ACT alliance members with local representatives in OPT are the Lutheran World Federation (LWF), International Orthodox Christian Charities (IOCC), DanChurchAid (DCA), Christian Aid (CA), FinChurchAid (FCA), Church of Sweden (CoS), Norwegian Church Aid (NCA), while Diakonia as a new member in 2012.

The ACT Alliance members working in Gaza with psychosocial programmes are Norwegian Church Aid with the Al Ahli Arab Hospital and the MECC/DSPR, DCA working with Youth Enhancement Center (YEC) and IOCC working with YMCA-East Jerusalem as well as Christian Aid participating in joint activities and FinChurch Aid and Church of Sweden supporting with resource persons and advice.

Since its inception, APF has worked for improving the coordination and cooperation between member organizations, and on conducting needs assessments, emergency preparedness planning, evaluations and strategic planning.

The main stages of the development of the psychosocial program were in three stages. First the immediate response phase to the war in 2009, then programme was implemented though ACT appeals and joint planning in 2010 and 2011.

The first phase was in the aftermath of the war on Gaza in 2008-09, ACT members worked in different ways to support their staff and beneficiaries of their humanitarian programs focusing on the following psychosocial objectives: 1) coordination of efforts and staff-care 2) building capacity of ACT member staff to provide staff care and training for others to ensure sustainability of the psychosocial activities 3) to develop relevant and effective psychosocial support programs for marginalized communities.
In order to assist the ACT members in achieving these objectives, two psychosocial consultants were seconded in February 2009 from FinChurchAid and the Church of Sweden. In August 2009 another consultant was seconded from NCA. The capacity of the ACT Forum members in Gaza was assessed and a need for psychosocial community-based work was identified. Workshops on staff-care were held for the staff of Ahli Arab Hospital and MECC/DSPR/MECC clinics. These were followed by workshops for the staff of YEC\DCA and YMCA/IOCC in Gaza. Staff-care sessions and Training of Trainers (ToT) were conducted throughout of 2009, and a mental health textbook was prepared by the Ahli Arab Hospital team in cooperation with the local advisor in English and Arabic.

In the second phase, at the end of the activities implemented during 2009, APF members decided to expand the psychosocial support program to include more coordination, direction, and cross-cutting psychosocial, educational and team-building activities and a plan of action was developed for 2010. The main objectives of the 2010 activities were to ensure access of women, men, youth, and children to the psychosocial support services provided by ACT members as well as to improve the quality of the these services.

In the third phase, during 2011, the APF members agreed to develop the psychosocial program in a new direction where the communities are more involved and active in identifying resources and defining needs through planning, implementing and monitoring the program. This turned out to be a challenging step. The plans were revised for continuing capacity building and networking among implementing ACT members and defer the plan for community based intervention for later. In 2011 the main objective was revised to include the building of the capacities of the psychosocial staff of members to provide high quality services while the main activities were; Training of Trainers (ToT) on various topics related to the psychosocial field ; i.e. participatory approach methodology, leadership skills, community mobilization and communication skills. Training workshops on project cycle, men in disaster and advanced MHPP ISAC guidelines were also conducted. Besides, there was an open day activity for children during Al Adha feast as well as peer group meetings.

Parallel to the joint ACT implemented psychosocial programme as described above and managed by NCA, individual ACT members and its partners continued to implement psychosocial activities in their own organizations.

Al Ahli Arab Hospital has through its social workers created relations with community based organizations in the Gaza Strip. The hospital provides psychosocial services for approximately 1 400 psychologically affected patients per year and it makes sure that they have access to psychosocial resources including counseling. The hospital provides group counseling to patients in need of psychosocial support emphasizing on life-skills, self-care and care for others. The psychosocial activities of the hospital include home visits, and when needed, the referral of individuals requiring specialized support.

MECC/DSPR/MECC has established social workers in all three clinics, these social workers serve around 14 000 beneficiaries per year. These social workers are available for counselling for parents and children who come to the clinics for follow up. They also hold awareness training in nutrition, family-planning children issues and other social issues. In addition, they arrange summer activities for children at available space in the clinics. Also the VTC has stated social work among the 200 pupils.

DCA has worked with the Youth Enhancement Centre (YEC) and implemented community based activities through two community centers. YEC offers psychosocial support to youth and fosters youth capacity building, youth empowerment and encourages youth participation in all aspects of daily life. It also undertakes scientific research and targeted studies related to children. They do provide services for around 7 000 youth per year.

IOCC/YMCA East Jerusalem have also implemented community based psychosocial activities in the Gaza Strip in the aftermath of the 2009 war on Gaza. They provide psychosocial services through the Network of EJ-YMCA centers, youth centers, community centers and other community-based partners of the EJ-YMCA in five districts in the Gaza Strip with an approximate 10 000 beneficiaries per year.

3. Stakeholder Involvement

Norwegian Church Aid (NCA) as the lead agency of the psychosocial program in Gaza will commission the evaluation. NCA will be responsible for hiring the consultant and following up the evaluation team and progress.

The ToR has been circulated for comments to the main ACT alliance partners that has been involved in the psychosocial programme such as CoS, FCA, MECC/MECC and Al Ahli Arab Hospital. The ToR has also been raised for discussion in February 2012 ACT Forum meeting in Jerusalem where ACT partners involved in the psychosocial well being programs in Gaza – DCA and ICCO/YMCA-EJ - agreed to participate in the evaluation both in terms of their participation in the joint ACT psychosocial activities but also that the evaluation will be looking into its effect on their staff and quality of work of partner organizations involved in the psychosocial well being programming.

The evaluation should include participatory involvement of the effect of the programme on the target group e.g. staff of organizations, patients and other beneficiaries in the targeted communities.
The psychosocial sector is large and many interventions were initiated after the 2008-2009 war when needs for such interventions were identified. It is important to situate the study of the ACT alliance psychosocial intervention in the context of other main players such as UN agencies, other INGOs and local NGOs programs. A UNICEF study from 2010 is essential point of reference to identify relevant stakeholders to approach.

Summary of stakeholders to be consulted:

ACT members and partners	UN, INGO and authorities
NCA staff in Jerusalem and Gaza	UNICEF
NCA HQ advisor on psychosocial programs	UNRWA
NCA consultant Christina Bergan	WHO
ACT ME officer Josef Pfattner	UNOCHA
FCA emergency coordinator OPT Antti Toivanen	AIDA members (approx 5)
FCA consultants Pavvi Mumma	PHGO members (approx 5)
CoS advisor Elsa Berglund	GCMHP (main pal resource centre)
MECC/DSPR/MECC staff and beneficiaries	Relevant authority
Diocese of Jerusalem/Ahli Arab Hospital staff and beneficiaries	
DCA Jerusalem and Gaza staff	
YEC staff and beneficiaries	
IOCC Gaza and Jerusalem staff and beneficiaries	
YMCA-EJ Gaza staff and beneficiaries	

4. Evaluation Methodology

The consultant will prepare an inception report prior to the commencement of the evaluation field work. The inception report will detail the evaluation protocols, methodologies and instruments that will be used for the purpose of data collection in the field.

The evaluation team will be working independently, but will be able to rely on APF members' staff in acting as focal point for the evaluation process and providing support during field visits. Rula Daghash will be the main contact person in NCA.

The evaluation should be carried out by multi-disciplinary team with experience in evaluation of psychosocial projects and the IASC Guidelines on Mental Health and Psychosocial support, management, and organization development. The evaluation team leader will be held responsible for the final output of the evaluation report, and for liaising with NCA.

The consultant will prepare a suggestion for participation in the evaluation that can ensure learning in the ACT Alliance organizations that have been involved in the cooperation.
This is a suggested time frame:

Weeks One: 5 days	Review of documents and prep of inception report
Week Two: 5 days	Presentation of inception report to ACT forum in Jerusalem and interview with ACT members in Jerusalem including NCA staff and UN and INGOs in Jerusalem.
Week Three: 5 days	Presentation of inception report to partners in Gaza and Interviews in Gaza with ACT members and partner org, Preparation for beneficiaries consultation
Week Four: 5 days	Participatory consultation with beneficiaries in Gaza
Week Five: 5 days	Preparation of report and analysis
Week Six: 5 days	Presentation of report to NCA in a workshop with ACT partners in Gaza, writing up of final report.

5. Evaluation Criteria

The evaluation will be conducted using the standards of OECD\DAC Evaluation criteria as described below:

1. **Relevance:** Assess whether the project is in line with local needs and priorities, i.e. the extent to which the objective of the project reflects key priorities and receives support from key partners, and responds to the needs of target group.
2. **Efficiency:** measure the qualitative and quantitative outputs achieved in relation to the inputs and compare alternative approaches to see whether the most efficient approaches were used.
3. **Effectiveness:** measure the extent to which the project activities achieve its intended objectives to improve the well-being of the inhabitants of the marginalized communities in Gaza.
4. **Impact:** The contribution of the project to the overall goal in triggering positive changes in the social environment on individual, family, community levels that has occurred as a result of the project interventions.
5. **Sustainability:** Assess the level to which the project has been successful in creating surviving/ dynamics towards the implemented activities and programs strategies.
6. **Gender:** Assess gender mainstreaming in the project activities, outputs and outcomes. In addition to examine the impact on women.
7. **Recommendations.** There should be formulated recommendations for the continuation of the work to international and local ACT alliance members.

Resource materials:

- The IASC Guidelines on Mental Health and Psychosocial support.
- ACT Appeal documents – plans and reports
- Local organizations plans and reports.
- http://www.ACT Alliance.org/resources/policies-and-guidelines/impact-assessment/IA-Guide-eng-v1.pdf to download the ACT Alliance impact assessment guideline
- UNICEF evaluation from 2010 (Mapping of Mental Health and Psychosocial support services in the Gaza Strip)

Annex II: List of people interviewed and consulted

	Name	Position	Institution
ACT Alliance partners			
1.	Dr Issa Tarazi	Executive director	Near East Council of Churches Committee for Refugee Work, MECC/DSPR Gaza Area
2.	Dr Wafa Yousef Kanaan	Program coordinator, health and social development	MECC/DSPR Gaza
3.	Nadine	Communication	MECC/DSPR Gaza
4.	Dr Iman Saad	Gynaecologist	MECC/DSPR clinics
5.	Dr Mustafa	Medical doctor/nutrition	MECC/DSPR clinics
6.	Dr Bernhard Sabella	Director	MECC/DSPR Central Office, Jerusalem
7.	George Stephen	Program coordinator and ACT Coordinator as of April 2012	MECC/DSPR Central Office, Jerusalem
8.	Bishara Al-Khouri	Board member	MECC/DSPR Gaza
9.	Elias Manneh	Chairman of Board	MECC/DSPR Gaza
10.	Suheil Tarazi	Member of Board	MECC/DSPR Gaza
11.	Araxi Waheed	Treasurer of Board	MECC/DSPR Gaza
12.	Elias Arteen	Member of Board	MECC/DSPR Gaza
13.	Mads Schack Lindegård	Regional representative, Middle East	Danish Church Aid (DCA)
14.	Omar Majdalawi	Gaza program coordinator	DCA
15.	Sam Coleman Dunlap	Country director	International Orthodox Christian Charities Inc. (IOCC)
16.	Dr George Malki	Deputy country director	IOCC
17.	Dimitrije Djukic	Gaza Program Director	IOCC
18.	Kathleen Bouzis	Intern	IOCC
19.	Gudrun Bertinussen	Regional representative, Middle East	Norwegian Church Aid (NCA) Jerusalem
20.	Liv Steinmoeggen	Former representative	NCA
21.	Ehab Barakat	Former ACT Palestine coordinator, program coordinator Health and Emergency	NCA
22.	Rula Daghash	Program Coordinator	NCA
23.	Else Berglund	Psychosocial Specialist	International Dept., Church of Sweden
24.	Ingrid Norrman	Acting Programme Officer, Humanitarian Response	Church of Sweden
25.	Antti Toivanen	Area Coordinator	Finn-Church Aid
26.	Azzam H. Alsaqqa	Emergency Consultant, Gaza	Christian Aid
27.	Dr. Tawfiq A. Nasser	The Chief Executive Officer	Augusta Victoria Hospital/ The Lutheran World Federation
28.	Andre Batarshe	General Secretary	YMCA East Jerusalem (EJ)

29.	Elham Salameh	Program manager	YMCA EJ
30.	Fauzi Wehaidi	Program director	YMCA EJ, Gaza program
31.	Renda Shweireh	Project coordinator, educational recreational project	YMCA EJ, Gaza program
32.	George Awad	Director	Evangelical Lutheran Church in the Holy Land
33.	Ramzi I. Zananiri	Executive director, West Bank/Jerusalem	Near East Council of Churches, International Christian Committee
Other members of ACT Palestine Forum			
34.	Soheila Tarazi	Director	Arab Ahli Hospital
35.		Medical Director	Arab Ahli Hospital
36.	Rania Dahwood	Coordinator	Youth Empowerment Centre
37.	Karita Laisi	Regional Director	FELM - Middle East
38.	Jamal Atamneh		Christian Aid
Consultants – advisors to the PSS project			
39.	Maher Wahbe	Psychosocial advisor 2010-11	
40.	Jamil Attiye	Psychosocial advisor 2009	Body and mind Institute, Gaza
41.	Paivi Muma	Psychosocial consultant	Seconded by FCA
42.	Christin Nylund Bergan	Community-based consultant	Seconded by NCA
43.	Ian Dickson Lauritzen	Organisational development	Seconded by CoS
44.	Jasem Hmeid	Trainer, IASC Guidelines, Life skills etc.	Independent
Focus Group Discussion - Participants in ACT Trainings			
45.	Said Abu Shawish	Nursing supervisor/PSS team	Arab Ahli Hospital
46.	Ismail Abu Tarabish	Nursing supervisor/PSS team	Arab Ahli Hospital
47.	Abdel-Aziz Abdallah	Senior Staff Nurse/PSS team	Arab Ahli Hospital
48.	Muhammed Al-Nagah	Social Worker/PSS team	Arab Ahli Hospital
49.	Wael Elian	Public Health Specialist/PSS Team	Arab Ahli Hospital
50.	Majeda Hejazy	Senior Staff Nurse/PSS Team	Arab Ahli Hospital
51.	Zhikriat Al-Arini,	Psychologist	Youth Empowerment Centre
52.	Fadwa Afana	Social Worker	Youth Empowerment Centre
53.	Nijoud Okasha	Social Worker	Youth Empowerment Centre
54.	Muhammed Abu Amirah	PS Supervisor/PSS Team	Youth Empowerment Centre
55.	Muhammed Saleh Ayesh	Social Worker	Youth Empowerment Centre
56.	Fatima Aziz	Psychologist	Youth Empowerment Centre
57.	Emad Jilde	Head of Vocational Training	MECC/DSPR Gaza
58.	Lubna	Head Nurse	MECC/DSPR Gaza
59.	Bodor Al-Helou	Counsellor, Shejaiye clinic	MECC/DSPR Gaza
60.	Wafa	Counsellor	MECC/DSPR Gaza
61.	Suha Zuroub	Counsellor, Rafah clinic	MECC/DSPR Gaza

62.	Heba Bakheet	Counsellor, children	MECC/DSPR Gaza
63.	Neveen Shaheen	Social Worker	MECC/DSPR Gaza
64.	Ramez Shahin	Vocational training Centre Counsellor	MECC/DSPR Gaza
65.	Yousef	Section of Social Research	MECC/DSPR Gaza
Key informants, resource persons			
66.	Dr Safa Z. Nasr	Child Protection Officer, head of Protection Cluster Gaza	UNICEF, Gaza office
67.	Dr Iyad Zaqout	Manager for Community Mental Health Programme	UNRWA, Gaza office
68.	Dr Adnan A. Al-Wahaidi	Executive Director	Ard Al-Insan, Palestine
69.	Dr I´tidal al-Khatib	Director	IRFAN Canada
70.	Dawoud Al-Massri	Access to justice Analyst	UNDP, Gaza Office
71.	Widad M. NAser	Project Officer	Norwegian People's Aid
72.	Mahmoud Hamada	Project Coordinator	Norwegian People's Aid
73.	Ketil Østnor	Country Director	Norwegian People's Aid
74.	Yousef Al-Nabaheen	Financial Manager	Norwegian People's Aid
Participants in Arab Ahli Trainings			
75.	Nirsrin		Nussirat/AAH
76.	Dalal		
77.	Raid	Tell Az-Zatar	Sahel Development Society/ AAH
78.	Shirin	Az-Azhar university graduate	Jabalia Society/AAH
79.	Raouf		Society of Rural Women Development/AAH partner
80.	Bilal	Al Quds university graduate	Dar As-Sabil al-Kahyri/AAH
Rightsholders consulted and observed in the field			
81.	5 doctors and nurses in Shejaiya clinic		
82.	8 women and one child in Shejaiya clinic		
83.	1 mother and husband in Shejaiya clinic coming for check-up		MECC/DSPR
84.	Father outside clinic waiting for wife and child		
85.	Dr Mustafa	Dental health doctor	MECC/DSPR clinics
86.	40 children taking part in children recreational, psychosocial activities in Daraj		MECC/DSPR Daraj clinic
87.	Family visiting clinic in Khirbet Adas		
88.	15-20 youth attending vocational training centres in Shejaiye and AL-Qararah Khan Younis		
89.	20 children taking part in children recreational, psychosocial activities in Khirbet Adas.		

Annex III: WORK PLAN

30.03.12	**Contract signing** between NCA and NCG in Jerusalem.
04.04-23.04	**Inception phase**: reviewing documents received from NCA/ACT Alliance, developing evaluation tools, interview guidelines, field schedule etc.
30.04.12	Submission of **draft Inception Report** to NCA/ACT Alliance for comments.
07.05.12	Comments to draft inception report from NCA/ACT Alliance
14.05.12	Revised inception report submitted by research team to NCA.

20.5-.2.06	**Field survey in Gaza and West Bank**.
21St May 22nd May 24th May	Start-up meeting and **presentation of inception report** for key stakeholders (NCA/ACT Alliance, partners) in **Jerusalem**. Interviews West Bank/Jerusalem Start-up meeting and **presentation of inception report** for key stakeholders (NCA/ACT Alliance, partners) in **Gaza.**
24-30th May	Field work, interviews with rightsholders and other stakeholders, focus group discussions etc.
30th May	Debrief and presentation of preliminary findings for NCA/ACT Alliance in oPt for validation and discussion in **Gaza**.
31st May or 1st June	Debrief and presentation of preliminary findings for NCA/ACT Alliance in oPt for validation and discussion in **Jerusalem.**

15.06.12	Submission of **Draft Evaluation report** to NCA/ACT Alliance.
26.06.12	Written comments to Draft Evaluation report from NCA/ACT Alliance and other key stakeholders to research team.
28.06.12	Present final report for ACT Alliance Annual Meeting in Sharm Al-Shaykh.
02.07.12	Revised **Final Evaluation report** submitted to NCA/ACT Alliance along with a response to how comments have been handled**.**

Annex IV: Interview guidelines

Respondents	Estimated numbers	Interview guideline
Participants in trainings	15-20	1
Consultants - trainers	4-6	2
Local partners (institutions) (Ahli hospital, YEC, MECC, IOCC, YMCA, etc.**)**	10	3
ACT partners (CA, NCA, DCA, EJ-YMCA, LWF, ELCJHL, FCA, CoS, MECC – DSPR)	8	4
Key informants - coordinating and cooperating partners/resource centres (GCMHP, GTCCM, PHGO, key people in community centres)	2-4	5
International UN agencies (UNRWA, UNICEF, OCHA, AIDA)	2-4	5
Indirect beneficiaries: communities in Rafah, Shejaiya, Qararah	10-15?	6

Interview guideline 1: Training participants

Evaluation of the training activities will be conducted in the form of focus group discussion. These are semi-structured interviews that are mainly open-ended questions. *(Make sure that the questions are asked in a gender-context sensitive way!)*

Background information.

1. Current professional background and experience in the field of psychosocial mental health field.
2. How many trainings organized via the ACT Psychosocial (PS) project have you taken part in? (According to your memory)? 1, 2-4, 5-7, 8-10?
3. Which trainings did you take part in? (month/year/trainer)?
4. Do you remember the name of the trainer?
5. How do you hear/know about the ACT Psychosocial training course?
6. How were you selected to take part in training?

Training

7. Do you think the training modules were appropriate to your practice/current job/post? If yes, how? If no, why not?
8. How did the training topics/themes meet your needs? (any examples?)
9. How training course helped you to modify my practice? (any examples)
10. What types of skills you acquired that enabled you to provide good quality services
11. Trainers competence and skills, did they:
    a. Have updated knowledge in the specific topic they were training?
    b. Give you examples on how to apply the knowledge? If yes, how?
    c. Gave you practical skills to help you deal with knowledge provided? If yes, how?
12. Were the trainings adapted to the different (gender) needs of men and women? (example, were the baby-sitting facilities for female trainees, was the training mixed male/female, separated etc.)

Follow-up - recommendations

13. Do the organization you belong to provide any form of follow up after the course?
14. Do you have any sort of supervision?
15. Describe some good points about the course and could be improved
16. Recommendations and suggestions for how to improve the impact of the trainings and capacity-building.

Interview guideline 2: Consultants – Trainers'

Interviews with the trainers and consultants will be semi-structured and mainly open-ended questions. Interviews with the local trainers will be conducted in Gaza, while interviews with the internationals (from Finland, Sweden, Norway) will most likely be conducted by phone, skype or emails (depending on their availability).

Background

1. Current professional background and years of experience as a psychosocial consultant in the field of psychosocial mental health field (publications in the field, language were published, type of clinical experiences etc.)

ACT PS project

2. How did you hear/know about the ACT PS project?
3. What was the process of recruitment as a consultant/trainer?
4. How were the topics and themes of the trainings decided? Share with us the process of designing the training materials?
5. Were the material distributed after/during the trainings? Did the trainees get any handouts? (in Arabic or English?)

Outcomes of trainings:

6. What were the main achievements of the trainings you conducted? (short-term – and if possible, any medium term results observed?)
7. Any impact of the program on the partners both local and international?
8. Any views of the supervision and follow-up are necessary for the organization/institution experience? (Were you able to promote that during your consultancy period?)
9. Describe main challenges experienced in your work (challenges related to logistics, visa etc is of less interest to this evaluation)
10. In your opinion, how did the PS project help in community development, empowerment and creation of self-help groups? Any examples that could be shared.
11. How was gender taken into consideration when developing the training material? (i.e. specific considerations to make sure that men/women would benefit according to their situation)

Referral/coordination

12. How does the referral system between the ACT partners in Gaza function?
13. How is the coordination and collaboration with organizations and between organizations in the mental health system?

Advocacy

14. Did you take part in any advocacy activities via the ACT alliance or APF during your work with the PS project? If yes, any examples.

15. In your view, what could be the main function or benefit of advocacy in such a PS project? How could it contribute to strengthen project outcomes in Gaza?

Lessons learnt – recommendations

16. After your experience with the PS project; what has been the main lessons learnt from your side?
17. Is there anything you would have done differently today with the knowledge that you have gained throughout the last years of implementation?
18. Recommendations and suggestions

Interview guideline 3: Local implementing partners (Ahli hospital, YEC, MECC, IOCC, YMCA, etc.)

Interviews with the local and international partners will be semi-structured and mainly open-ended questions.

1. Name of the institution, background and position of the person in-charge.
2. Please describe the types of services provided by your organization?

About the ACT Psychosocial (PS) project: in Gaza

3. What is the number of beneficiaries currently being dealt with in your organization?
    a. Out of those, how many approximately have benefited from the ACT psychosocial project?
    b. How many new beneficiaries benefited from the project?
4. How has the project enabled your organization to deal with vulnerable groups in the community?
5. What have been the main challenges in implementing the project?
6. How has your organization followed-up the recommendation from the **2010 Evaluation of the MEPL81 with special focus on?**
    a. Integrating **gender** perspective in the work.
    b. Increase information sharing between ACT partners.
    c. **Strengthen the Coordinator role** with clarified authority and full time position independent of single member

Empowerment – individual and community

7. In what ways your organization helped local communities to establish self-help groups?
8. How did your organization utilize the project resources to empower communities and establish help groups?
9. How has the project assisted in promoting individual empowerment for the beneficiaries?
10. How did the project target men/women, young/old different needs of the communities?

Referral/coordination

11. Tell us about the coordination you have established with local partners and international community?
12. What are the type/s of psychosocial interventions used to help clients and their families?
13. What are the activities that your organization/institution use in order to combat stigma attached to mental illness?
14. Do you have and implement psychosocial standards/guidelines?
15. In your opinion, did the training program contribute to the organization/institution development and if so, in which ways?
16. Please, describe the type of professional supervision in place, if available

17. Do you have follow-up mechanisms at the organizational and inter-organizational level?
18. Do you have a referral system? Would you say that the referral / counter-referral system in your specialty is adequate in the psychosocial mental health system, and if not, why?

ACT membership, coordination/cooperation and advocacy?

19. Are you a member of the ACT Palestinian forum? If yes, how did you become a member?
20. What are the benefits from being an APF partner?
21. What are the challenges or obstacles in the APF work?
22. Are you familiar with the ACT Advocacy Plan? If yes, have you taken part in any joint advocacy activities?

Lessons learnt – recommendations

23. After your experience with the PS project during the last three years; what has been the main lessons learnt from your side?
24. Is there anything you would have done differently today with the knowledge that you have gained throughout the last years of implementation?

25. Recommendations and suggestions.

Interview guideline 4: ACT members **(CA, NCA, DCA, EJ-YMCA, LWF, ELCJHL, FCA, CoS, MECC – DSPR)**

Interviews with the local and international partners will be semi-structured and mainly open-ended questions.

1. Name of the institution, background and position of the person in-charge.
2. Please describe the types of services provided by your organization?

ACT membership, coordination/cooperation and advocacy?

3. How long have you been members of the ACT alliance?
4. What are the main benefits of being an ACT alliance partner?
5. What are the main challenges or obstacles in the ACT alliance work?
6. Are you familiar with the ACT Advocacy Plan? If yes, have you taken part in any joint advocacy activities?

ACT PS Project in Gaza

7. What has been the contribution of your organization to the PS project in Gaza?
8. Main achievements of the project?
9. Main challenges?
10. How has your organization followed-up the recommendation from the 2010 Evaluation of the MEPL81?
    a. Integrating **gender** perspective in the work.
    b. Emergency Preparedness Plan
    c. Improve the knowledge **of ACT policies and guidelines**
    d. Improve **knowledge of and manner of applying minimum standards**
    e. Increase information sharing between ACT partners.

f. **Strengthen the Coordinator role** with clarified authority and full time position independent of single member

11. What are the main benefits of being an ACT alliance partner?
12. What are the main challenges or obstacles in the ACT alliance work?
13. Are you familiar with the ACT Advocacy Plan? If yes, have you taken part in any joint advocacy activities?

Lessons learnt – recommendations

14. After your experience with the PS project during the last three years; what has been the main lessons learnt from your side?
15. Is there anything you would have done differently today with the knowledge that you have gained throughout the last years of implementation?
16. Recommendations and suggestions.

Interview guideline 5: Key informants – cooperating or coordinating organizations and agencies, international UN agencies (UNRWA, UNICEF, OCHA, AIDA) (mainly in Gaza)

Interviews with the local partners will be semi-structured and mainly open-ended questions. If informants would like to be anonymous this should be noted.

1. Name of the institution, background and position of the person in-charge.
2. Please describe the types of services provided by your organization? Special focus on psycho-social and mental health services.

ACT alliance - APF

3. Have you heard about the ACT alliance and or ACT Palestine forum? If yes, what do you know?
4. Are you familiar with the ACT Psychosocial trainings and staff care that has been provided by Act alliance partners? If no, share the main implementing agencies in gaza (Ahli hospital, MECC, YEC, DCA etc.)
5. How has your organization cooperated or coordinated with the above-mentioned organisations and agencies?
6. Has any staff from your organization taken part in the trainings?
7. Has Staff from the above-mentioned organisations taken part in trainings or capacity-development efforts conducted by your organization?

Mental health and psychosocial situation in Gaza

8. Based on your knowledge and experience in the field, what are the needs in terms of psychosocial and mental health for the population in Gaza currently?
9. Would you have some recommendations or suggestions to improve the psychosocial services?
10. Recommendations and suggestions

Interview guideline 6: Indirect beneficiaries – communities in Rafah, Shejaiya and Qarah

Interviews with beneficiaries will be mainly open-ended questions. If informants would like to be anonymous this is their full right and should be noted in the interview to make sure that the information taken down can not be traced back to the informant.

Name, age, community, family situation (number of children/dependents).

1. In your opinion, what are the main psychosocial issues (mental health – explain) encountered by people in this specific geographic area (village, city)?[36]

2. Use of psychosocial services

1. Have you, or anyone in your family benefited from any **psychosocial** services in the last three (3) months?
2. If yes, which **psychosocial** service did you use? Have you used the same service before?

3. Choice of psychosocial services

If you (or anyone in your household) have used multiple services in the last three months, what has been the deciding factor in determining which service you use at any given moment?

4. Are you familiar with the ACT Psychosocial trainings and staff care that has been provided by Act alliance partners?
   a. If no, share the main implementing agencies in Gaza (Ahli hospital, MECC, YEC, DCA etc.).
   b. If yes, what types of services you have received?
   c. Did the services you received meet your needs and expectations?

6. How many times did you visit the organization or was visited by professionals from the organization?
7. What are the main weakness of the project or service received, if any?
9. Any recommendations or suggestions for improving the psychosocial project?

[36] By starting with this question the team would like to get the overview of the key challenges that the communities are facing before ”stearing” the informants towards the specific PS project.