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Israeli mental health services for Palestinian women in East Jerusalem: availability and barriers to care

Vered Chen Yossef Keasar

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Israeli mental health services for Palestinian women in East Jerusalem: availability and barriers to care

Prepared by:
Vered Chen Yossef Keasar

B.A.: Arabic Language and Literature, Hebrew University, Palestine

Supervisor: Dr. Eyad Hallak

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Thesis Approval

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Prepared By: Vered Chen Yossef Keasar
Registration No: 21811666

Supervisor: Dr. Eyad Hallak

Master thesis submitted, and accepted, Date: May 28, 2024
The names and signatures of the examining committee members are as follows:

1. Head of Committee: Dr. Eyad Hallak Signature:
2. Internal Examiner: Dr. Ola Hussein Signature:
3. External examiner: Dr. Taisir Abdallah Signature:

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Dedication

To my interviewees

Vered Chen Yossef Keasar

Declaration:

I certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed: 

Vered Chen Yossef Keasar

Date: July 5, 2024

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Abstract

Israeli mental health services for Palestinian women in East Jerusalem: availability and barriers to care

Little is known about the mental health services available to Palestinian women in East Jerusalem. This study aims to address this gap in the research, focusing on Israeli ambulatory and rehabilitation mental health services.

The first part of the research uses a descriptive methodology, based on research reports, publicly available data, and interviews, to present a picture of the available services.

The second part of the research employs a qualitative methodology to explore the perceptions of professionals and Palestinian laywomen regarding mental health services in the city. The research instrument for this part was semi-structured interviews. The sample included eight professionals connected to the field, and five Palestinian Jerusalemite laywomen. Data analysis was done using thematic analysis.

The results of the study show that ambulatory mental health treatment in East Jerusalem is provided primarily by the four Israeli *Kupot Cholim* (KCs). The numbers of psychiatrists and psychotherapists are low compared to the size of the population, and the spatial distribution of the services is limited. Arabic-speaking rehabilitation services in East Jerusalem include: a hostel, an assisted living service, an employment club, an education service, a mentoring service, several social clubs, and a center for the families of people with mental health disabilities. There are no services that are geared specifically towards women, or for treatment of survivors of sexual assault.

The qualitative analysis resulted in four main themes: (a) Stressors, (b) Barriers to care, (c) Alternatives to the Israeli system, and (d) Openness to mental healthcare.

In light of the results, it is recommended to combine community grassroots action, such as awareness raising campaigns and bureaucratic assistance to people in realizing their rights, with pressure on Israeli bodies to improve the availability and accessibility of mental health services.

Keywords: Mental health services, Barriers to care, Women's mental health, East Jerusalem, Palestinian women

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Definitions

Mental health: Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (WHO, 2022a).

East Jerusalem: The term East Jerusalem in this study is used to refer to the J1 area, i.e., the area illegally annexed by Israel in 1980 and included within the Israeli municipality of Jerusalem (Eye on Palestine, 2018). The target population of this study includes only the Palestinian residents of the J1 area, and not the Jewish settlers or other residents.

Palestinian women of East Jerusalem: In this study this term is used to refer to Palestinian women over the age of 18 who reside in the J1 area (Eye on Palestine, 2018).

Israeli mental health services: Any mental health service provided or supervised by the Israeli government (usually the Mental Health Division of the Ministry of Health), or by NGOs registered in Israel, or by private practitioners holding an Israeli license. These services may include: psychiatric care, psychotherapy, psychiatric rehabilitation, hospitalization, emergency care, treatment for people with autism, and more (Israel, Ministry of Health, 2024b).

Barriers to care: Circumstances that impede an individual's access to health services. The barriers that prevent or delay people from accessing care are many and varied, and are affected by location, culture, socioeconomic situation, healthcare policy, etc. (Orji, 2018). Barriers to mental health care may include stigma, the cost of care, not knowing where to go for help, preference for self-reliance, and many more (Clement et al., 2012).

Abbreviations

Kupat Cholim: KC (Plural: KCs)

1 First chapter

Background of the study

1.1 Introduction

Mental health problems are a common cause of suffering and disability worldwide. Mental healthcare, which includes a variety of services such as psychiatric care, psychotherapy, and various forms of support, can alleviate much of the burden of mental illness. However, many people do not have access to services that could benefit them, with 35%-50% of people with severe mental health disorders in high-income countries, and 76%-85% of people with severe mental health disorders in low and middle-income countries receiving no treatment at all (The WHO World Mental Health Survey Consortium, 2004).

Various circumstances may hinder people with mental disorders from accessing mental health services that are suited to their needs. Barriers to care are different between different areas and communities. In order to improve any population's access to mental healthcare, it is crucial to understand what services are available, whether they fulfill the population's needs, and what barriers are making it difficult for the population to utilize them (Orji, 2018).

East Jerusalem is a unique place, both in terms of its political and social characteristics, and in terms of the challenges it presents to mental health and to provision of mental health services (Imam & Hamdan, 2021). Palestinian women living in East Jerusalem are an especially vulnerable population (Allabadi & Hardan, 2016; Juzoor, 2017; Shalhoub-Kevorkian, 2015; United Nations Population Fund, 2021), whose access to mental healthcare has almost never been researched. This study attempts to address part of this gap in the research.

1.2 Research justification

Research indicates that Palestinian are at high risk for mental health disorders (Koenen et al., 2017; Marie et al., 2020; Shukri et al., 2023). There is little research on the mental health of Palestinian women specifically, but studies do show that they are often targeted by both political and gender-based violence, both of which are risk factors for mental ill-health

(Baldi, 2018; Bdier, Veronese, et al., 2023; Gibbs et al., 2021). There is therefore great importance for Palestinian women to have access to high-quality mental health services and support. East Jerusalem is represents a unique situation in Palestine, with the Israeli state officially responsible for providing social services, including mental health services.

Currently, very little is known about the mental health services available to Palestinian women in East Jerusalem, their utilization of these services and their barriers to care. Gaining this information is the first step towards ensuring they get adequate mental health care.

Since the state of Israel is the main body responsible for providing mental healthcare in Jerusalem, this research focuses on the Israeli mental health services in the city.

Community-based services, rather than on inpatient services at hospitals, were chosen as the focus of the research because these are the services that should act as the first line of treatment and be the most accessible to the largest number of people.

1.3 Research problem

Mental health services are a crucial part of healthcare. Palestinian women living in East Jerusalem represent a vulnerable population, whose access to mental healthcare has almost never been researched. This research aims to find out what are the Israeli community-based mental health services available to women in East Jerusalem, how they are utilized and what are the barriers that hinder women's access to them.

1.4 Importance of the research

To the best of the researcher's knowledge, this is the first study to present a comprehensive picture of the mental health services available at *Kupat Cholim* (KC) clinics in East Jerusalem, and the Arabic-speaking *Sal Shikum* rehabilitation services in the city. This is also, as far as the researcher could discover, the first study to explore the perceptions of professionals and East Jerusalem women regarding mental health services in the city, and to try to learn from them what are the problems with the system.

On a practical level, the research provides significant conclusions regarding the need for mental health services and the barriers to their use, and also provides some practical recommendations for improving access to mental healthcare.

This is by no means an exhaustive research, but hopefully by initiating the exploration of this important topic, and providing same basic data, it may provide the groundwork for further studies of women's mental health and mental health services in East Jerusalem.

1.5 Limitations of the research

This study has several limitations that should be addressed. Firstly, the number of laywomen interviewed is small, and they are of different ages, neighborhoods, and backgrounds. The sample is therefore very limited and cannot be said to represent any group in the varied fabric of East Jerusalem society. Interviewees were recruited mainly through a Jewish-Palestinian women's group, and it is possible that this method introduced a bias into the data, as women who participate in such a group may have specific political and social characteristics. The sample of professional interviewees is also rather small, and does not include representatives of all relevant services and organizations. The size and composition of the samples is a result of the researcher's limited time, and also of the fact that the researcher is Jewish-Israeli,

making it more difficult to reach and engage Palestinian interviewees. Despite all this, the researcher believes that the interviews provided valuable insights, and that taken together, they provide a consistent and valid picture. However, more research should be done to confirm and expand on the information gathered in this study, using a larger sample and incorporating quantitative methods.

Being a Master's thesis, the scope of this study is also limited. It is focused on the Israeli public system, neglecting several important parts of the complex array of health services in East Jerusalem, such as Palestinian services and international NGOs. Moreover, this study does not cover the whole of the Israeli public system. One area that is not touched upon is hospitalization, even though general and psychiatric hospitals have a major (and controversial) role in Jerusalem's mental health system. The study also does not address emergency services, which are very important for providing a correct response at times of acute psychiatric crises.

Similarly, this study does not address family healthcare centers, which are clinics that provide healthcare services to pregnant women and to babies and their families. According to the Ministry of Health's website, there are 35 family healthcare centers currently active in Jerusalem, 8 of which are in Palestinian neighborhoods (Israel, Ministry of Health, 2024a). These centers may potentially have a significant role in screening and treatment for mental health problems in women, especially perinatal depression. Another related area which is not covered in this study is welfare services, which are mainly focused on prevention of mental health crises, but also have some healthcare and treatment functions, including treatment centers for victims of sexual assault that are operated by the Ministry of Welfare. There are also volunteer-operated NGOs that provide emotional support over the telephone or the internet, and have Arabic-speaking volunteers (see for example: Eran Arabic Helpline, n.d.; Jerusalem Rape Crisis Center, n.d.; Sahar Arabic Chat, n.d.). While these are not professional services and do not provide therapy or any other kind of treatment, they are still a resource that is available to women in crisis, and isn't touched upon in this research.

Research of all these different elements is needed to provide a comprehensive picture of the mental health services available to women in East Jerusalem. While this wasn't possible in the scope of an MA thesis research, this study does have value in exploring the KC and *Sal Shikum* services, two major categories of services that have potential to reach people on a very large scale. It is to be hoped that this study will pave the way to more comprehensive research in the future.

1.6 Research questions

a. What are the mental health ambulatory treatment and rehabilitation services provided by Israel to Palestinian women in East Jerusalem?

b. Are these services used, and are the available services sufficient for the needs of Palestinian women in East Jerusalem?

c. Are there barriers that hinder women's use of these services, and what are they?

1.7 Structure of the research

The following chapter will present the theoretical framework of the study and review the relevant literature. It will also provide some background on the structure of the Israeli mental health system.

The third chapter will address the study methodology, the study population, the sampling process, the research procedure, and the data analysis method, as well as the question of ethical considerations.

The fourth chapter is dedicated to the results of the study and their discussion. After an in-depth presentation of the results, the researcher presents a short summary of the answers to the three research questions. The chapter ends with a discussion of the results.

The fifth chapter includes a short conclusion, and recommendations.

2 Second chapter

Theoretical framework and literature review

2.1 Mental health

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". Correspondingly, a mental disorder is "a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning" (WHO, 2022a). The WHO further emphasizes that mental health is an integral part of health and well-being as a whole, or in other words: "there is no health without mental health" (WHO, 2021a).

Mental health conditions are highly prevalent in every part of the world. According to a 2022 report, one in eight people live with a mental health disorder (WHO, 2022b). The most common mental disorders are depression, affecting an estimated 5% of adults worldwide (WHO, 2023b), and anxiety disorders, affecting an estimated 4% of the global population (WHO, 2023a). Other common disorders include bipolar disorder, post-traumatic stress disorder, schizophrenia, eating disorders, and others (WHO, 2022a).

People with mental health disorders have a significantly lower life expectancy, with high levels of death from unnatural causes, in particular suicide (Chan et al., 2023). According to the WHO's data, more than 700,000 people die every year as a result of suicide, and many more attempt suicide (WHO, 2021b). Because of a global issue of under-reporting of suicide, it is probable that the actual death toll is much higher (Snowdon & Choi, 2020). Apart from suicide, people with serious mental health problems often die at a younger age because of accompanying physical diseases (WHO, 2021a). Mental disorders are also a major cause for disability. A recent study estimated that mental health disorders account for 16% of the global burden of disability (Arias et al., 2022). Mental health problems have a large economic impact, through both the direct cost of care, and the indirect cost of the losses in productivity as a result of disability (Arias et al., 2022).

Risk and protective factors for mental health disorders include not only genetic and individual attributes, but also cultural, economic, political, and environmental factors. Marginalized groups may be at significantly higher risk for developing mental health

problems (WHO, 2021a). At the same time, these vulnerable groups may have less access to mental health services, and especially to high-quality services suited to their specific needs. Moreover, mental health problems frequently lead individuals into poverty, thus deepening their marginalization and limiting their access to care even further (Dixon et al., 2016). This vicious cycle highlights the need for responses that go beyond the medical sphere to address social issues (WHO, 2022b).

2.2 Mental health services

Treatment for mental health disorders is a wide and variegated field. The two leading treatment approaches, which are often combined, are psychiatric care (medication) and psychotherapy (therapy through talk). These service can be provided on an inpatient basis in a hospital (which may be either a psychiatric hospital or a regular hospital with a psychiatric ward), or within the community in outpatient clinics (WHO, 2021a). The later approach to service provision is termed "ambulatory care".

The current policy of the WHO is to shift the focus of care away from long-term hospitalization towards ambulatory care and other community-based mental health services, which allow individuals to receive care without giving up their support systems and daily lives (WHO, 2021a). In large part, this policy is due to the growing awareness and acceptance of the "recovery approach" in mental health, which puts great emphasis on the right of people with mental disorders to live full and self-determined lives in the community (Ness et al., 2022). This approach has given rise to various rehabilitation services, which are mental health services that do not aim to cure mental illnesses per se, but rather aim to provide support to people with mental health conditions and help them achieve their goals and participate in society in the ways that are meaningful to them (Israel Psychiatric Rehabilitation Association, 2024).

High-quality mental health services are crucial for lessening the burden of mental illness, minimizing suffering, and improving the quality of life of people affected by mental health disorders and their families. Despite the widespread recognition of the importance of mental healthcare, mental health conditions remain severely underserved (Moitra et al., 2022). According to the WHO mental health action plan, updated in 2021, in high-income countries 35%-50% of people with severe mental health disorders receive no treatment. The situation in low-income and middle-income countries is even more dire, with 76%-85% of people with severe mental health disorders receiving no treatment (WHO, 2021a).

One of the main reasons for the treatment gap in mental health is the insufficient investment of resources in mental healthcare, leading to a shortage of services and mental health professionals (WHO, 2021a). Yet even when services are theoretically available, often a high percentage of people who could benefit from mental health services never reach them (Clement et al., 2012; Orji, 2018). Circumstances and attitudes that impede people's access to health services are termed "barriers to care". Examples of barriers to mental healthcare include may include stigma, the cost of care, not knowing where to go for help, preference for self-reliance, and many more (Clement et al., 2012).

Barriers to care often vary greatly between different geographic, political, and social contexts. The first step to improving access to services is to understand what are the obstacles that make it difficult for people to engage with these services. Once the barriers to care are understood, it is possible to begin searching for ways to mitigate them. For this reason, there are many studies that investigate barriers to mental healthcare in various regions and

populations (see for example: Byrow et al., 2020; Moroz et al., 2020; Shea et al., 2019; Shi et al., 2020; Snow et al., 2019).

2.3 Women and mental health

Globally, women are a vulnerable population, both in political and economic terms, and (probably relatedly), in terms of mental health. Women present higher rates of depression and anxiety disorders than men, as well as higher rates of eating and borderline personality disorders (Niaz & Tariq, 2020; Viana & Corassa, 2020). According to the WHO's 2017 estimate, 5.1% of females worldwide suffer from depression compared to 3.6% of men, and 4.6% of females suffer from anxiety disorders compared to 2.6% of men (WHO, 2017). Women are also significantly more likely to develop PTSD following traumatic events (Tolin & Foa, 2006).

It seems that women are especially vulnerable to depression during the perinatal period. According to a recent systematic review of systematic reviews regarding perinatal depression, the estimated prevalence of antenatal depression globally is 28.5%, and the estimated prevalence of postnatal depression is 27.6% (Al-abri et al., 2023). The perinatal period is also associated with higher risk for anxiety, suicidality, and new or recurrent episodes of severe mental illnesses (Howard & Khalifeh, 2020). Perinatal mental health problems can have serious and long-lasting consequences for the health of both women and their offspring (Dagher et al., 2021; Howard & Khalifeh, 2020).

It has often been suggested that the higher prevalence of depression and anxiety in women may be partly explained by the discriminatory conditions under which many women live (Niaz & Tariq, 2020; Viana & Corassa, 2020; Williams & Watson, 2016). Women are often concentrated in lower-skilled jobs than men and receive lower pay (Bishu & Alkadry, 2017; Blau & Kahn, 2017; Said et al., 2022; Williams & Watson, 2016). Almost 1 in 3 women worldwide have experienced physical and/or sexual violence. About 26% have been subjected to physical and/or sexual violence from an intimate partner (WHO, 2018). Even when they are not under any direct threat, many women live in discriminatory environments, where they have less access to resources than men, their needs are perceived as less important, and their choices are more limited. All these factors affect women's mental health (Williams & Watson, 2016).

Conflict situations compound women's vulnerability. Gender-based violence is often exacerbated in conflict situations, and although more men than women are killed and injured in armed conflict, women are disproportionately affected by consequences of conflict such as displacement, loss of livelihood, and poverty, which are themselves risk factors for mental ill-health (Niaz & Tariq, 2020).

2.4 Mental health services for women

Mental health services for women are services that address needs that are specific to women or have a significant gendered aspect. An important example of one such issue is sexual assault. While sexual assault against people of all genders is not uncommon, women are at significantly higher risk than men (Khan et al., 2020). Female survivors of sexual assault exhibit high prevalence of PTSD, depression, substance abuse, and suicidality (Parcesepe et al., 2015). In a 2015 systematic review, Parcesepe et al. reviewed the scientific evidence for mental health interventions targeting adult female survivors of sexual assault. They found evidence to support the effectiveness of cognitive-behavioral interventions, exposure

interventions, and eye movement desensitization and reprocessing interventions. However, they emphasized that the number of studies on this topic is low, and that given the prevalence of mental health disorders associated with sexual assault, there is great need for a larger evidence base on the effectiveness of these interventions (Parcesepe et al., 2015).

Another area of mental health that is highly gendered is eating disorders, with an estimated 8.4% of women suffering from eating disorders at some point in their lives in comparison to 2.2% of men, according to a 2019 systematic review (Galmiche et al., 2019). Treatment of eating disorders is mainly done using psycho-behavioral therapies. There are several forms of therapy, such as Cognitive Behavioural Therapy – Enhanced (CBT-E), which are evidence-based and are specifically designed for treating eating disorders. Eating disorders are complex conditions, which are often accompanied by nutritional and physical health problems, and may be co-morbid with other mental health disorders. For this reason, treatment should be provided by a multidisciplinary team. In most cases treatment can be provided on an outpatient basis, though some cases require hospitalization (Hay, 2020).

As discussed in the previous chapter, the perinatal period is an especially vulnerable time for women's mental health. There is robust evidence for the effectiveness and cost-effectiveness of psychological and psychosocial interventions for postpartum depression (Howard & Khalifeh, 2020). While most of the research was done in high-income Western countries, there have also been some randomized controlled trials done in low-resource settings, providing indications for the effectiveness of CBT-based interventions delivered by trained community mental health workers or peers (Howard & Khalifeh, 2020).

Despite the growing awareness to perinatal mental health problems, there are still many women who are not diagnosed early enough, or do not have access to timely care. This, together with the high prevalence of perinatal mental health problems, has led to calls for routine screening of pregnant women and young mothers in primary healthcare services (Howard & Khalifeh, 2020). A recent systematic review of screening for perinatal depression and anxiety in community settings (Bhat et al., 2022) has found that most countries have community-based maternal-child health services, which provide an opportunity to integrate screening for perinatal mental health problems into routine maternal care. The study found that many of these services do carry out routine screening, however there is a lack of guidelines for best-practice screening procedures. Moreover, most screening efforts are invested in post-partum depression, with not enough attention given to anxiety disorders and to disorders occurring during pregnancy (Bhat et al., 2022).

Perinatal mental healthcare is especially important because a child's relationship with its primary caretakers in the first months and years of its life is critical to its development. Postpartum depression, and other mental health disorders affecting women with young children, can put a strain on mother-child relationships, and thus endanger not only the health of the mother but also that of the child (Julian & Muzik, 2020). Julian and Muzik's 2020 paper reviews the literature on interventions that aim to improve mother-infant relationships, targeting mothers who may be at higher risk for mental ill-health. Some of these are psycho-educational interventions, providing women with support and training with regard to attachment skills. Other interventions are based on dyadic psychotherapy, providing psychotherapy treatment to the mother and the child together. There is a growing evidence base supporting these interventions and linking them to improvements in parents' mindsets about caregiving, and in children's affect and behaviors (Julian & Muzik, 2020).

Menopause represents another period of vulnerability in women's life cycle. As explained in a thorough 2020 review by Riecher-Rossler, the hormonal changes associated with menopause, often coupled with various midlife stressors, may greatly impact mental health. Menopause is associated with increased risk for depressive symptoms and may also be associated with greater risk for severe mental disorders. The issue of menopause has important implications for treatment. For example hormonal treatment, replacing the estrogen whose levels in women's bodies greatly decreases after menopause, may have significant benefits (Riecher-Rossler, 2020).

Answering women's needs in mental health services doesn't necessarily, or only, require provision of specialized services. It may also mean making sure that the system as a whole is sensitive and responsive to women's needs. For example, a recent paper by the Lancet Psychiatry Commission has focused on intimate partner violence and mental health. This type of violence is highly gendered, and is mostly committed by men against women. Intimate partner violence is associated with higher risk for mental health problems and substance abuse in women and at the same time, women with mental health problems are at higher risk for being exposed to this kind of violence (Oram et al., 2022). Rather than advocating any specific service or therapy, the writers argue for the need for transforming the whole mental health system to put greater focus on "respectful care and good communication skills based on gender-sensitive and trauma-informed approaches to addressing intimate partner violence" (Oram et al., 2022). This includes inquiring about experiences of violence as part of all mental health assessments, and training staff to respond helpfully and empathetically to disclosures of intimate partner violence. It also includes educating everyone who comes into contact with service users, including non-clinical staff, on the signs and signals of intimate partner violence, and on how to sensitively interact with survivors (Oram et al., 2022).

A review of studies on mental healthcare for women veterans in the US and the UK (Godier-McBard et al., 2023) represents another poignant example of the importance of women-friendly mental healthcare. Woman veterans reported that the predominantly male environment of the veteran treatment-setting was unwelcoming, made them feel uncomfortable, and was insensitive to gender-related trauma. In some cases women were discriminated against in these settings. The studies included in the review suggested various solutions that would make it easier for women to access mental health services for veterans, such as more female service providers, women veteran peer-support groups, women-only treatment programs, and separate waiting rooms for women (Godier-McBard et al., 2023).

It seems that worldwide, there is still a long way to go to ensure that mental health services answer women's needs. In a 2019 study by Chandra et al., a survey on gender-sensitive mental healthcare for women was sent to 150 experts in women's mental health all over the world, and 73 of them responded (P. S. Chandra et al., 2019). The experts attached great importance to many items on the survey, among them "training of mental health professionals in gender sensitivity, having private spaces for examination, using a life course approach to service planning and delivery, and assisting women who find it difficult to navigate the system and mother-baby units". However, when the experts were asked to rate their satisfaction with the availability of these items in their own place of work, satisfaction rates were low overall, and especially low among experts from low-income countries (P. S. Chandra et al., 2019).

In order to be beneficial, mental health services must provide women with a safe space. Yet, this is often not the case. Perhaps the most prominent example of this are the disturbing

accounts of sexual assaults in psychiatric hospitals and other inpatient psychiatric settings (Betterly et al., 2023). It is extremely difficult to find out the exact extent of this phenomenon: according to a recent review, between 5% to 45% of mental health inpatients have experienced sexual violence during an inpatient admission (Betterly et al., 2023). This is a very wide range, but even the most conservative estimates still indicate an unacceptable risk to inpatients, and especially women. Sexual assault in inpatient psychiatric settings may cause a wide range of physical and mental health problems, as well as diminishing patients' trust in the system (Betterly et al., 2023).

For this reason, some researchers are advocating for women-only mental health services, as a way to provide a safe space for recovery. So far, there is surprisingly little research on the effects of providing services in a women-only environment. In a qualitative study of a women-only residential treatment service in Australia, the participants said that being in a women-only environment allowed them to feel safe and comfortable and helped them communicate (Abas et al., 2016). In a study carried out in a day clinic in Germany providing group-based treatment for trauma-related disorders, mixed-gender therapy groups were compared to women-only groups (Philipps et al., 2022). Patients treated in women-only groups had a higher increase in perceived social support, but apart from that the results showed no difference in treatment outcomes between women in the mixed-gender groups and in the women-only group. However, group relationships were reported to be significantly more pleasant in the women-only groups (Philipps et al., 2022). The researchers observed that the difference between mixed-gender and women-only groups had different meanings for different women:

> "Some women were relieved to be with their own gender and highlighted the positive effect of feeling safe and understood, others emphasized receiving esteem and respect when being treated with men because they often experienced this for the first time in their life. For the latter, this was often an important healing effect that they would have missed if being treated in a women-only group."

The researchers concluded that: "Women should have the possibility to choose between a women-only or a mixed-gender group and should be approached about their needs and requests proactively by therapists" (Philipps et al., 2022).

Women may have unique barriers to care, which services need to address even if they are not directly connected to mental health. For example, evidence is accumulating that since women are often the primary caretakers of children, lack of childcare can pose a significant barrier for women to accessing health services. In a survey conducted among women attending outpatient clinics at a hospital in Texas, lack of childcare was the most frequently cited reason for missing care. 52.7% of the participants reported forgoing healthcare for lack of childcare in the year preceding the survey (Gaur et al., 2020). In response to this finding, the hospital partnered with a civil society organization to develop a hospital-based no-cost childcare center for patients to use during appointments. Over the first year of the program, 119 patients used the services. Ninety seven percent of the patients who enrolled into the program were women (Alvarez et al., 2022).

Interest in childcare as a barrier to care is relatively new in research, and most studies of this topic have focused on physical health services rather than mental health services. However, in a survey among sixty-seven women receiving treatment for substance use disorders, 48.8% reported that at some point in their lives they wanted to attend a substance use disorder treatment program but did not do so because there was no one to care for their children. Moreover, 65.9% reported fearing that attending a treatment program would result in them losing their children (Brogly et al., 2018). The authors recommended developing programs

that respond to women's childcare needs (Brogly et al., 2018). As research and awareness of this topic advance, it is probable that we will see more and more calls for childcare to be integrated into physical and mental health services in order to enable more women to access them.

2.5 Mental health in Palestine

Research about mental health in occupied Palestine shows an extremely high prevalence of depression and PTSD. A 2023 literature review has found that approximately 40% of Palestinians are suffering from depression, and approximately 68.9% of Palestinians are suffering from PTSD, (Shukri et al., 2023) rates that are much higher than the global average (Koenen et al., 2017; WHO, 2023b). Another literature review has found that Palestine is also characterized by a high prevalence of anxiety disorders (Marie et al., 2020).

Researchers agree that the high levels of mental disorders are tightly connected to the political situation in Palestine, where almost every aspect of life is influenced by the Israeli occupation and oppression, and the ongoing violent conflict (Bdier, Veronese, et al., 2023; Dabbagh et al., 2023; Marie et al., 2020; Shukri et al., 2023). The war in Gaza, which began in October 2023 and is still ongoing, is of course a disaster of unimaginable proportions to, among other things, the mental health of the people of Gaza (Jabr & Berger, 2024). The effects of the current surge in violence on Palestinians living in the West Bank and Jerusalem is yet to be researched.

2.6 Women in Palestine – mental health challenges

Women in Palestine are affected by many intersecting risk factors, as they are often exposed to political violence and oppression as well as gender-based violence and social marginalization (Baldi, 2018). According to the Palestinian Central Bureau of Statistics' 2019 survey, 37% of Palestinian wives were exposed to violence from their husbands, 58.6% were reported to be psychologically abused, and 55.1% were subjected to economic violence (Palestinian Central Bureau of Statistics, 2019, as cited in Veronese et al., 2023. The website of the Palestinian Central Bureau of Statistics is unavailable, and therefore the original survey could not be reached). Research shows that gender-based violence is associated with stress, anxiety, and depression in Palestinian women (Bdier & Mahamid, 2021; Thabet et al., 2015).

At the same time, many women in Palestine have been affected, often repeatedly, by violence from Israeli occupation forces and settlers (Baldi, 2018). In a 2017 survey among 534 Palestinian women in the West Bank and Gaza, 41% reported that one of their family members was arrested by Israeli forces, 36.5% reported having their house broken into, 29.6% reported having a family member injured, and 16.1% reported witnessing the death of a family member. 1 in 20 women reported being directly injured, and 1 in 20 reported being arrested by Israeli forces (Gibbs et al., 2021). It is important to reiterate that these data predate the 2023 war, and that the war has caused a drastic increase in these numbers.

Interestingly, several studies indicate that exposure to political violence by the Israeli occupation is associated with increased gender-based violence (Clark et al., 2010; Foqahaa, 2018; Gibbs et al., 2021) and negative attitudes towards women's rights in Palestinian society (Foqahaa, 2018). The authors of one such study hypothesize that "occupation policies and interactions with occupation forces entail continuous humiliation for men and renders them

unable to protect and provide for their families, potentially leading to frustration and violence against people with less power – namely, women and children" (Clark et al., 2010).

On the other hand, in a study that focused on Palestinian women's (often astonishing) resilience in the face of political violence, social support from family and friends was identified as a major factor that helps women to maintain their psychological health (Veronese et al., 2023). Thus, it seems that the family can be both an added risk factor and an important protective factor for Palestinian women living under occupation.

2.7 The case of East Jerusalem

Jerusalem represents a unique situation in Palestine. Although East Jerusalem is occupied territory under international law (Resolution 476, 1980), Israel has unilaterally annexed it, and considers the city an inseparable part of Israel (Basic Law: Jerusalem the Capital of Israel, 1980). Therefore, the city operates under Israeli law, and there are extensive limitations on the Palestinian Authority's ability to act in it. The overwhelming majority of the city's 375,000 Palestinian residents hold a residency status but are not Israeli citizens and have no political power (the number of residents is based on an estimation of the population size of Jerusalem in 2021, in Yaniv et al., 2024. It is unclear from the report whether this number includes the many Palestinians living in Jerusalem without official residency status. Since the Israeli law does not allow family unification for Palestinians, many spouses are living in Jerusalem on the strength of short-term permits that must be periodically renewed).

According to Israeli law, East Jerusalem's residents are legally entitled to all Israeli civil services. However, in practice the city's infrastructure and services are chronically neglected by Israel (Israel, State Comptroller, 2019). Poverty is widespread in East Jerusalem, and the Palestinian population is subject to political oppression through a wide range of methods, from police brutality, through road closures, to home demolitions and revocations of residency status. The 2023 war has brought with it an economic crisis and escalation in police violence and attacks from Jewish residents of the city (Ir Amim, 2024).

Palestinian women living in Jerusalem face an array of hardships and challenges (United Nations Population Fund, 2021), some of which correspond to the conditions in other parts of Palestine, while others are unique to the city. For example, Israeli restrictions on movement between East Jerusalem and the West Bank, coupled with racist laws that prohibit family unification and allow Israel to revoke residency, mean that many women are in constant danger of being separated from their families or losing their residency status (Allabadi & Hardan, 2016). In her important 2015 paper, Nadera Shalhoub-Kevorkian exposes the devastating effects of Israeli policies and Israeli political violence on pregnant and birthing Palestinian women in Jerusalem (Shalhoub-Kevorkian, 2015). In a 2017 study by Juzoor organization, 953 women from six areas in East Jerusalem were interviewed. Three out of four of these women indicated that settler violence was a problem in their neighborhood, causing them to worry about their safety and the safety of their families (Juzoor, 2017).

Women in East Jerusalem are also dealing with a patriarchal and discriminatory society. Over 40% of the women interviewed for Juzoor organization's study needed permission to visit a relative or friend, or go to a health center or shopping area; over a third of them got married before the age of 18; 40% lacked access to recreational activities and/or public areas for recreation; 26% could not decide upon household issues by themselves; 85% did not have access to income and resources; and 94% said that there is discrimination against women

participating in public life. (Juzoor, 2017) Both the Juzoor study and a 2021 study by the United Nations Population Fund found high levels of gender-based violence (i.e., physical, sexual, psychological, social, and economic violence against women and girls) in East Jerusalem. In most cases the violence takes place inside the home, often committed by a husband or father, and sometimes a son (Juzoor, 2017; United Nations Population Fund, 2021). The UNFPA study also found that the conditions during the Covid-19 pandemic, such as lockdowns, obstruction of movement, increased poverty, and reduced services, caused an increase in the rates of gender-based violence (United Nations Population Fund, 2021).

East Jerusalem exists in a kind of "service vacuum", since Israel systematically neglects the city, while also forbidding Palestinian institutions from officially providing services. This situation promotes an increase in gender-based violence and causes a dire shortage in services for women who are exposed to violence (such as shelters, psychological support, legal and economic assistance, etc.) (United Nations Population Fund, 2021). Legally, women with legal status in East Jerusalem can resort to the police and the Israeli legal system. However, there is widespread distrust of Israeli authorities in general, and the police in particular, and therefor seeking this kind of help is highly stigmatized (United Nations Population Fund, 2021). In this reality, women's main sources of protection and support in the face of violence are their families, community-based initiatives, and NGOs. Despite impressive work being done by these actors, it is not nearly enough to answer the needs, especially since there is a low awareness of the services offered by Palestinian NGOs (United Nations Population Fund, 2021).

Despite the unique circumstances in which the women of East Jerusalem live, and the many stressors with which they are faced, there is very little research on the mental health of women in East Jerusalem, and on how their mental health needs can be met.

The health system in East Jerusalem is a mixture of Israeli and Palestinian institutions, as well as NGOs and international organizations such as UNRWA (Imam & Hamdan, 2021). Several studies have been dedicated to the health system of East Jerusalem (Imam & Hamdan, 2021; Zugair, 2022), but as far as could be ascertained none of them have focused on the field of mental health. This study aims to address some of these gaps in the research.

2.8 The Israeli mental health system

Unlike the Gaza Strip and the West Bank, Palestinian residents of East Jerusalem are entitled to Israeli healthcare. The Israeli system is a major actor in the healthcare of East Jerusalem in general, and mental health services in particular (Imam & Hamdan, 2021). Since this study focuses on Israeli services, it would be useful to provide a short overview of the Israeli mental health system.

The senior body in charge of the field of mental health in Israel is the Ministry of Health. The Ministry of Health's main roles are those of a regulator: determining and implementing mental health policy, setting professional standards, monitoring service providers, coordinating between service providers and organizations, etc (Israel, Ministry of Health, 2024b). At the same time there are certain services that are provided directly by the Ministry of Health, such as mental health rehabilitation services.

Inside the Ministry of Health, the faction responsible for mental health is the Mental Health Division. The Mental Health Division in the Ministry of Health has four main departments:

- The clinical bloc – Dealing with treatment of mental health disorders. This category includes ambulatory services, hospitalization services, a legal department, and an autism department
- The rehabilitation department
- The department for treatment of addiction
- The research and planning department (Israel, Ministry of Health, 2024b)

It is worth noting that *prevention* of mental health disorders isn't defined as part of the Ministry of Health's role, but rather is considered to be under the responsibility of the Ministry of Welfare and Social Affairs. The Ministry of Welfare's formal goals do not explicitly mention mental health, but they do include "detection and prevention among individuals, families, and communities at risk" and "provision of welfare services that are varied, flexible, and suited to different populations and needs" in order to prevent crises (Israel, Ministry of Welfare and Social Affairs, 2020).

This research will focus on the ambulatory treatment (e.g., treatment that does not include hospitalization) and rehabilitation services monitored by the Mental Health Division of the Ministry of Health.

2.8.1. Ambulatory services:

The term "ambulatory services" refers to healthcare that is provided on an outpatient basis, where patients visit a clinic or health center without being admitted to a hospital or a residential facility. In mental health, ambulatory care allows patients to receive assessment, treatment, and support in a familiar environment, while maintaining support networks, relationships, and employment (WHO, 2022b).

In accordance with the 1994 Israeli Health Insurance Law, most ambulatory health services in Israel are provided by four large organizations, known as *Kupot Cholim* (KCs). By law, every resident of Israel must be a member of one of the KCs and is entitled to a diverse "basket" of health services. The law states that the services must be provided "according to medical judgement, at a reasonable quality, in reasonable time, and at a reasonable distance from the insured person's place of residence" (National Health Insurance Law, 1994; Sabbah, 2019).

Historically, ambulatory mental health services were not included in the KCs' areas of responsibility. However, in a 2012 order initiated by the Minister of Health, the Israeli government transferred insurance responsibility in the field of mental health from the state to the KCs (Aviram & Azary-viesel, 2015; Decision 4611: Transferring Full Insurance Responsibility in the Area of Mental Health from the State to the Health Funds, 2012). The goals of this reform, implemented in 2015, were to position the Israeli Ministry of Health as a regulator rather than a service provider, to improve the quality and accessibility of mental health services, to make them more equally available to all, to promote community-based care and to decrease stigma (Aviram & Azary-viesel, 2015; Haran & Bachar, 2022).

Since 2015, the KCs provide psychotherapy and psychiatric ambulatory services. These services are provided for free, or for low fees, as part of citizens' mandatory health insurance. In addition to the KC services, there are about 70 governmental clinics that are operated directly by the Ministry of Health and provide mental health services (Blank, 2021, 2023;

Israel, Ministry of Health, 2022). There are also many psychiatrists and psychotherapists working in the private sector in Israel. Because of the high prices of private treatment, there are some non-governmental organizations that provide therapy for subsidized prices (Shekel, 2018).

Israel's public ambulatory services are often criticized for unreasonably long waiting times, which may take up to a year or even more. There is a great shortage of psychiatrists and psychotherapists in the KCs, and consequently many people do not receive the care they need. To cope with this problem, the KCs subsidize treatment by "independent" therapists who are not employed by the KCs. However, this solution still requires the patients to pay substantial sums of money that not all of them can afford (Elroy & Samuel, 2019; Israel, State Comptroller, 2020; Israel, Subcommittee on Gaps in Community Services in the Mental Health Reform, 2019). There is also a shortage of specialized services, such as services for children and teenagers, services for autism, post-trauma, eating disorders, etc. (Israel, Subcommittee on Gaps in Community Services in the Mental Health Reform, 2019). A recent report by the Knesset's research center has concluded that it is currently impossible to provide an estimation of the scope of psychotherapy services provided by the KCs, or of the number of people who receive these services (Blank, 2023).

The availability of mental health services in Palestinian towns is lower than in Jewish towns, and there is an extreme shortage of Arabic-speaking mental health professionals (Israel, State Comptroller, 2020; Israel, Subcommittee on Gaps in Community Services in the Mental Health Reform, 2019). Over 20% of the population of Israel is Palestinian, yet as of 2018 only 1.9% of psychiatrists, and 1.4 % of clinical psychologists in Israel were Palestinian (Elroy et al., 2018). The result is that many patients don't have the option of receiving therapy in their mother language (Israel, State Comptroller, 2020; Israel, Subcommittee on Gaps in Community Services in the Mental Health Reform, 2019). In a 2020 report, the Israeli State Comptroller lists all towns in Israel where the percentage of adults receiving mental health care is less than 3%. The overwhelming majority of these are Arab villages, indicating that the Palestinian population in Israel is severely underserved (Israel, State Comptroller, 2020).

2.8.2. Rehabilitation services:

In addition to psychotherapy and psychiatry, which are provided by the KCs, the Israeli system offers people with serious and persistent psychiatric disabilities another set of community-based services. These services are not focused on treatment of mental disorders, but rather on rehabilitation, i.e., promoting "recovery, community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives" (Psychiatric Rehabilitation Association, 2018). The Community Rehabilitation of Persons with Mental Health Disability Law, legislated in 2000 and implemented in 2001, defines a "basket" of rehabilitation services that respond to rehabilitation needs in a range of areas: employment, housing, education, social and leisure activity, dental treatment, case management, and assistance for the family members of the disabled person (Aviram et al., 2023; The Community Rehabilitation of Persons with Mental Health Disability Law, 2000). The law decrees that these services, called *Sal Shikum* ("rehabilitation basket") should be allocated by a professional committee, according to an individual rehabilitation plan based on each person's needs and wishes. To be eligible to apply for *Sal Shikum*, an individual needs to be above 18 years old, and must first undergo an evaluation and be determined by the Israeli National Insurance Institute to have a disability level of at least 40% due to a mental health disorder

(Aviram et al., 2023; The Community Rehabilitation of Persons with Mental Health Disability Law, 2000).

A major issue with *Sal Shikum* services is that many people do not access their rights. In 2020, 95,691 people in Israel were recognized by the National Insurance Institute to have a psychiatric disability at a level of 40% or higher. However, in practice only 30,988 of them, about 32%, received rehabilitation services. Moreover, many people with psychiatric disabilities do not apply to have their eligibility evaluated at all, whether because they are unaware of their rights or for other reasons. It is estimated that there are tens of thousands of people with serious psychiatric disabilities who are not recognized by the National Insurance Institute and have no access to the *Sal Shikum* basket of services (Aviram et al., 2023).

As in the case of ambulatory services, Palestinian citizens of Israel use *Sal Shikum* services less than the Jewish citizens do. According to the Mental Health Division's statistical yearbook, between 2012-2022 the rate of Jews who received rehabilitation services was about three times higher than the rate of Arabs (Israel, Mental Health Division, 2023b).

3 Third chapter

Methodology and procedures

The first research question is: "What are the mental health ambulatory treatment and rehabilitation services provided by Israel to Palestinian women in East Jerusalem?"

This question was answered using a descriptive methodology, integrating information from reports, data available on governmental and KC websites, and interviews to provide an overview of existing services.

The next two research questions are: "Are these services used, and are the available services sufficient for the needs of Palestinian women in East Jerusalem?" and "Are there barriers that hinder women's use of these services, and what are they?". To answer these questions, a qualitative approach was adopted, based on thematic analysis of interviews.

3.1 Study population

This study targeted two distinct populations: people who work in East Jerusalem and have a professional connection to the field of mental health (from now on referred to as "professionals"), and Palestinian women over the age of 18 and under the age of 60 (from now on referred to as "laywomen").

3.2 Sampling

Professionals were reached using a snowball approach: the researcher used some initial contacts to reach people working in the field of mental health in East Jerusalem. Following their interviews, they were asked to refer the researcher to other relevant professionals. The researcher attempted to reach people who represent as many different parts of the system, and as many different viewpoints as possible.

All in all, eight professionals were interviewed: two therapists, a social worker, an administrator at one of the KCs, a rehabilitation worker, a researcher, and two people who work at civil society organizations in Jerusalem. All the interviewees live in Jerusalem, three of them are men and five are women, one of them is Jewish and the rest Palestinian (Table 3.1). Seven of the interviews were conducted in Hebrew, since the interviewees were fluent in Hebrew, and one in Arabic.

Recruitment of laywomen for participation in the study was done using convenience and snowball sampling: An open call for interviewees was published through a Jewish-Palestinian women's group, and interviewees were asked if they could refer the researcher to other interviewees.

Five laywomen were interviewed. All the interviewees were Palestinian (Table 3.1). Their ages were as follows: one was in her twenties, two were in their thirties, one was in her forties, and one in her fifties. The interviewees live in various parts of the city, and their experiences with mental health problems represent a varied spectrum between isolated crises that passed without formal treatment, to chronic and severe mental illnesses. Four of the interviews were conducted in Arabic, and one in Hebrew since the interviewee speaks excellent Hebrew.

The small sample sizes, and the sampling process, constitute a limitation of this research, and may have introduced bias which it is important to take into consideration. However the research group believes that despite the limitations the results are still valid and useful (see "limitations" section for a discussion of this issue).

Table 3.1: Sample summary

	Professional interviewees	**Laywomen interviewees**
Number of Interviewees	8	5
Gender	3 men, 5 women	5 women
Nationality	7 Palestinian, 1 Jewish	5 Palestinian

3.3 Research procedure

The research began with a search for online data on the mental health services available in East Jerusalem. In addition to searching for relevant studies and reports, the researcher reviewed the listings of mental health service providers available on the websites of the four KCs, and the list of rehabilitation services on the website of the Israeli Ministry of Health. This data was later integrated with information received from interviews with professionals working in the services.

Interviews were conducted using semi-structured interview guides. The interview guides included pre-prepared main questions, to which the researcher added spontaneous follow-up questions to expand on interesting data points which came up during the interviews (Kallio et al., 2016). The interview guide was developed by the researcher, in consultation with the supervisor Dr. Eyad Hallak and with Dr. Taisir Abdallah.

For interviews with professionals, the main questions were:

- Could you tell me about your work? (When the participant was not working directly in mental health, a variation of this question was used: "Can you tell me about your work and its connection to mental health?")

- What mental health services are you aware of in East Jerusalem?
- Are these services being used?
- Are you satisfied with the services?
- Do you see any problems with the services? (If this did not come up on its own, a follow-up question was asked: "Are there barriers that make it harder for people to use the services?")
- My research is focused specifically on women in East Jerusalem. How do you think women experience the services? (Again, if the topic of barriers did not come up, it was specifically asked about in a follow-up question).
- Are there services that specifically target women?
- Is there anything you would like to add?

In some cases, the professional Palestinian women who were interviewed also volunteered information of their personal experiences with mental health difficulties and services. When this happened, their stories were added to the analysis.

For interviews with laywomen, the main questions were:

- Have you ever gone through a crisis, or a time of sadness or difficulty?
- Could you tell me about it?
- How did you deal with this crisis? (Or, if the difficulty is still ongoing: "How are you dealing with this?")
- Was there someone who helped you and supported you? (Or, if the difficulty is still ongoing: Is there anyone you can go to for help and support?")
- Have you considered seeing a professional, like a doctor, or a psychiatrist or a therapist? (If the answer was "no", the researcher followed up by asking as gently as possible why the interviewee didn't consider it. If the answer was "yes", the researcher asked the interviewee about her experience).
- Is there anything you would like to add?

Of the thirteen semi-structured interview, twelve were conducted between June and September 2023, and one other interview in March 2024. In addition to the interviews, the researcher also returned to two of the professional interviewees, a rehabilitation worker and a KC worker, for two shorter follow-up conversations in March 2024 in order to ask about the war's impact on the services.

3.4 Analysis of the qualitative data

All interviews were recorded and transcribed. The first stage of transcription was done automatically using Express Scribe transcription software. The researcher then went over all the transcriptions while listening to the recordings, and carefully corrected the transcriptions.

The data was then analyzed using the method of thematic analysis described by Braun and Clarke (Braun & Clarke, 2006), which is a much-used and well accepted approach that facilitates the identification of patterns or themes in a given data set (Byrne, 2022). The method involves six phases: repeated reading of the data; generating initial codes; searching for themes and reflecting on the connections between them; reviewing and refining themes; defining and naming themes; and producing the final report (Braun & Clarke, 2006).

In accordance with Braun and Clark's approach, the analysis was conducted as a recursive, rather than linear, process. The researcher first familiarized herself with the data through the transcription, and then by reading and rereading the data. The researcher generated first a table of initial codes and then an initial "theme map", which was refined and reorganized until reaching a result that offered a detailed and complex account of the data, while also organizing it coherently (see figure 1). As advised by Braun and Clarke, in the final write-up of the report, the results of the thematic analysis are presented with quotes from the data. Quotes have been translated to English and slightly edited for brevity in a way that does not affect their meaning. Details that might lead to identification of the participants have been altered.

Qualitative research in general, and thematic analysis in particular, is not compatible with a positivist-empiricist model of a search for objective truth.

> "The aim of coding and theme development in reflexive thematic analysis is not to “accurately” summarize the data, nor to minimize the influence of researcher subjectivity on the analytic process, because neither is seen as possible nor indeed desirable. The aim is to provide a coherent and compelling *interpretation* of the data, grounded in the data. The researcher is a *storyteller*, actively engaged in interpreting data through the lens of their own cultural membership and social positionings, their theoretical assumptions and ideological commitments, as well as their scholarly knowledge." (Braun et al., 2019, pp. 848-849)

Keeping this theoretical principle in mind, the researcher took pains to maintain a reflexive position throughout the whole process of the analysis, and to make sure that the interpretation is well grounded in the data.

3.5 Ethical considerations

All participants in the study signed an informed consent form (appendix A). The participants are anonymous and identifying details have been altered. Interview recordings and transcripts, and all other identifying files, are stored on a password-protected drive.

4 Fourth chapter

Results and discussion

4.1 Description of mental health services in East Jerusalem

All the services identified in this study are meant both for men and for women. No services that are specifically targeted at women were identified.

However, as will be seen in the results of the thematic analysis, women have specific risk factors and barriers to care that are different from those of men.

4.1.1. Ambulatory services:

4.1.1.1. Public sector:

As in other parts of Israel, ambulatory health services in East Jerusalem, including mental health treatment, are under the responsibility of the KCs (*Kupot Cholim*). However, East Jerusalem is unique in that it is the only place where the Israeli Ministry of Health allows the KCs to outsource their work to private service providers, or "franchisees". Only about 15% of the clinics in East Jerusalem are operated directly by the KCs. The rest are operated by franchisees, who provide the physical space, the equipment, and the staff, in return for a monthly payment from the KCs. The payment is calculated according to the number of people insured with the franchisee (Nas Research and Consulting, 2023; Zugair, 2022).

The "franchisee model" has far-reaching consequences for the health system of East Jerusalem. The franchisees are inevitably influenced by financial considerations that often impact the quality of services. The KCs' supervision over the franchisee clinics is insufficient, especially in the neighborhoods outside the separation wall (Nas Research and Consulting, 2023). In a recent study of health services in East Jerusalem, patients, doctors, and franchisees testified to the low quality of services provided by the franchisee clinics (Zugair, 2022). The medical staff working in these clinics have a greater workload, and receive worse pay, than the staff in regular clinics operated directly by the KCs. The franchisee clinics often employ doctors who are inexperienced or don't have an Israeli license. Among other problems, most doctors working at the franchisee clinics are general practitioners, and there is a shortage of other specialties (Zugair, 2022). Theoretically, patients can receive services at Hebrew-language clinics in West Jerusalem. However, as

several of the interviewees in this study have pointed out, language and accessibility barriers cause many patients, and especially women, to avoid coming to West Jerusalem for medical treatment.

Crucially, mental health is one of the fields where the shortage of ambulatory services in East Jerusalem is most severe (Zugair, 2022). In a survey where residents of East Jerusalem were asked "what services are lacking in your clinic?", mental health services were among the most common answers to this question, together with child psychologists and behavior analysts, social workers, paramedical services related to child development, and emergency services (Zugair, 2022).

The largest KC in Israel is Clalit (Israel, National Insurance Institute, 2023). According to the National Insurance Institute's data, about 404,000 of the residents of Jerusalem (both Jews and Palestinians) are insured by KC Clalit (Israel, National Insurance Institute, 2023). Clalit is also by far the largest KC in East Jerusalem. According to the Jerusalem Institute for Policy Research, 63% (about 236,000 people, see Yaniv et al., 2024) of the insured residents of East Jerusalem are members of Clalit (Zugair, 2022). This means that Clalit has roughly the same number of Palestinian and Jewish members in Jerusalem (even though, as explained earlier, most of Clalit's Palestinian members do not receive services directly from Clalit, but rather through a franchisee). Yet, the number of mental health practitioners available to the Palestinian population is much lower. Clalit's website lists only four psychologists and five psychiatrists working in Palestinian East Jerusalem. All but one of them work at Clalit's mental health clinic in Beit Hanina neighborhood (which isn't a franchisee clinic and is operated directly by Clalit) (Clalit Health Services, 2023). In comparison, the website lists 23 psychologists and 12 psychiatrists working in the Jewish neighborhoods of Jerusalem. Spatially, they are spread over several clinics in different neighborhoods, making the service more accessible to a larger population. Moreover, none of the professionals working in the Jewish parts of the city is listed as providing services in Arabic (Clalit Health Services, 2023).

The second largest KC in East Jerusalem is Meuchedet, with 21% (Zugair, 2022) (about 78,000) of the insured residents. According to the interviews, Meuchedet's East Jerusalem mental health team consists of three psychotherapists, one social worker, one psychiatrist and one psychology intern. Unlike KC Clalit, KC Meuchedet does not have a dedicated mental health clinic, so the mental health team operates from one of the franchisee clinics in Sheikh Jarrah neighborhood. The lack of a dedicated workspace and administrative staff impacts the quantity and the quality of mental healthcare that the team is able to provide.

KC Maccabi, with 7.5% of the insured residents of East Jerusalem, lists two Arabic-speaking psychiatrists in East Jerusalem (one in Beit Safafa and the other in the area of Salah al-Din street), and no psychotherapists (Maccabi, 2024).

KC Leumit, also with 7.5% of insured residents, lists three Arabic-speaking psychiatrists in East Jerusalem, and two psychotherapists, all at a franchisee-operated clinic in Beit Hanina (Kupat Cholim Leumit, 2024).

As far as could be ascertained, none of these organizations have Jerusalem-based Arabic-speaking services that specifically target women and girls or address gendered needs such as eating disorders and sexual abuse-related trauma.

4.1.1.2. Private sector:

There is one private mental health clinic in East Jerusalem, called *Ma'atzama Bakehila*. The clinic is in Sheikh Jarrah, and its staff includes three psychiatrists, a clinical psychologist, and four social workers, of whom some are therapists and one works on helping patients to get their legal rights. *Ma'atzama Bakehila* has financial agreements with the KCs, so that when the KCs cannot provide the needed services to their patients, they can refer them to *Ma'atzama Bakehila.* For this reason, despite being a private clinic, most of the patients do not pay for treatment out of pocket.

There are also therapists who accept patients at private clinics in East Jerusalem, but they are beyond the scope of this study.

4.1.1.3. Third sector:

While there are Palestinian and International NGOs that provide mental health services in East Jerusalem, as far as could be ascertained there are no Israeli NGOs that do this.

4.1.2. Rehabilitation services:

The Israeli Ministry of Health's website lists 69 mental health rehabilitation (*Sal Shikum*) services in the Jerusalem district, which besides the city of Jerusalem includes several Jewish towns and villages, and several Palestinian villages (Israel, Mental Health Division, 2023a). After eliminating double listings, 69 services remain on the list. Of these services, only five are located in Palestinian areas, one in Abu Gosh and the rest in East Jerusalem.

It seems that the list on the Ministry of Health's website is not up to date, since the interviews resulted in a more extensive list of Arabic-speaking *Sal Shikum* services in East Jerusalem:

- A hostel providing housing for people with mental health disabilities, together with other therapeutic services
- An "assisted living" service, in which people living at home receive regular visits from rehabilitation staff
- An employment club, meant to help people develop employment-related skills
- An education service, helping people to complete or supplement their education
- A "mentoring" service, meant to help people develop social and everyday skills
- Several social clubs
- A center for families of people with mental health disabilities

All these services are mixed-gender, targeting both men and women.

According to the interviews, there are also several services that are not meant specifically for the Palestinian population of Jerusalem but do have Arab employees. This allows residents of East Jerusalem to use these services. These include three "supported employment" services, and a case management service. Moreover, some East Jerusalem residents opt to use services that are geared towards the Jewish population and have no

Arabic speaking staff, but this option is of course is irrelevant for the many Palestinians who do not speak Hebrew.

In the context of women and mental health, it is important to note that in Jerusalem there are no Arabic-speaking rehabilitation services for people who went through sexual assault or for people suffering from eating disorders.

According to the interviews, the number of Palestinians using *Sal Shikum* services is very low. Out of about 5400 people who use *Sal Shikum* services in the Jerusalem district, less than 400 (7.4%) are Palestinian.

4.1.3. Mental healthcare during the war:

Israel's war with Gaza, which broke out in October 2023 and is still ongoing with devastating consequences, had a profound impact on East Jerusalem (see for example: Ben-Kalifa & Mordekovitch, 2023). While most of the interviews were conducted before the beginning of the war, the researcher returned to two of the professional interviewees, a rehabilitation worker and a KC worker, for follow-up conversations aiming to find out how the mental health services were impacted by the war.

According to the rehabilitation worker, during the first few weeks of the war all rehabilitation services in Jerusalem were suspended in accordance with the Israeli military guidelines. Even after services were formally allowed to operate, it took time for the rehabilitation services in East Jerusalem to reopen and return to normal activity. One problem was that not all services could comply with security requirements, such as a secure space that allows evacuation in case of bombing. Another problem was that during the first three months of the war or so, it was extremely difficult for Palestinians to move around the city because of roadblocks and checkpoints, coupled with frequent violence from Israeli armed forces. Under these circumstances, service users were often unable to reach the services, and staff members often could not reach their workplaces or their clients' homes. There were cases of both staff and service users being exposed to violence from armed forces. The only service that continued operating throughout the whole period was the hostel. Gradually, however, the services began to reopen, and the service users started to come back. Currently, all rehabilitation services are back to routine activity.

According to the KC worker, ambulatory mental health services continued as usual throughout the war, with the staff making great efforts to continue working despite the stress and the limitations on movement.

4.2 Thematic analysis of interviews

The results of the thematic analysis are organized into four main themes (Fig. 4.1.): Stressors; Barriers to care; Alternatives to the Israeli system; Openness to mental health care. Some of these overarching themes include several sub-themes, as can be seen in Figure 1. In this section each of the themes will be presented with examples from the data, in order to provide a detailed picture of the accumulated information that arises from the interviews.

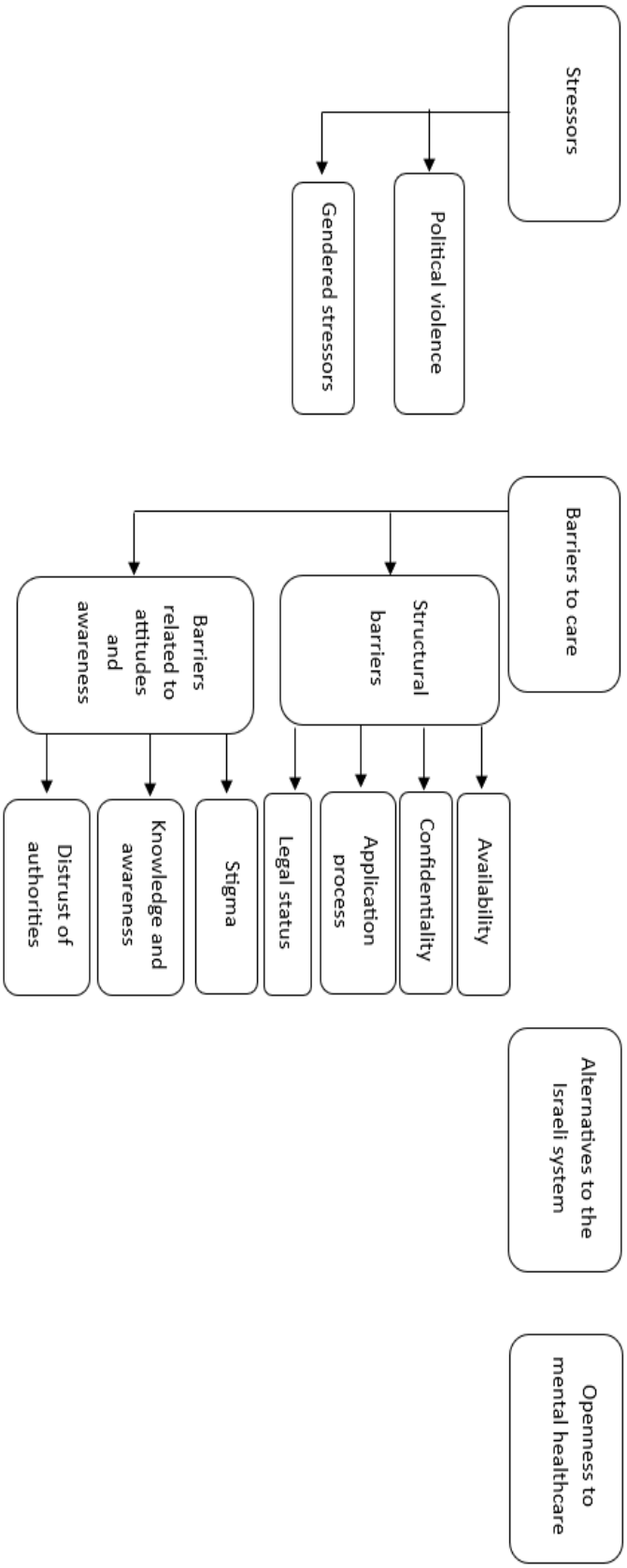

Figure 4.1: Theme map

4.2.1. Stressors:

One of the most prominent themes that emerged from the interviews was the stressors women in East Jerusalem are forced to deal with in their everyday lives, and the effects of these stressors on their mental health. This was not part of the original focus of the study, which is centered around mental health services rather than the causes of mental disorders, but the recurrence of this theme convinced the researcher of its relevance and importance. Mental health services must be informed by the population's needs, and this may be especially true in the case of East Jerusalem. Several of the interviewees made a point of emphasizing that mental health in East Jerusalem cannot be viewed separately from the context of external reality.

In an interview with a KC worker, he said: "There is always a connection between the circumstances of life and the state of mental health, but I think in East Jerusalem, and specifically in the case of women, the reality of life is very very difficult and in many cases it's hard to separate it."

In another interview, a therapist with long experience with the East Jerusalem population spoke even more bluntly: "I see women who are having normal reactions to an abnormal situation. It is the environment that is disordered, not the woman."

As will be seen in the study, the extreme circumstances of life in East Jerusalem not only affect women's mental health, but are also connected to the barriers that make it difficult for them to receive adequate care.

The theme of stressors can be separated into two sub-themes, which represent two types of stressors that came up in the interviews: political violence and gendered stressors.

4.2.1.1. Political violence:

The theme of political violence – the use of force against the East Jerusalem population, either by Israeli armed forces or by Israeli settlers – came up in many of the interviews, both with professionals and laywomen. Different interviewees mentioned different forms of violence: arrests, breaking into houses, shootings, tear gas, restriction of movement, home demolitions, etc. Some interviewees spoke of such things as regular, everyday occurrences, and emphasized their impact on mental health in creating constant feelings of fear, tension, and lack of safety.

For example, among many other stories, one woman said:

> "Every day, we might be sleeping, and find police and a search inside our house! If you come to us at the Old City, [you'll find that] all the women and even the children are mentally ill, all of them. Once I was sleeping, I woke up and found a soldier aiming a… at my head! It was three in the morning, what do you want? She wants the neighbor's son. But how did she enter while we're sleeping? This is insane."

Another interviewee said:

> "We are constantly feeling tension and pressure, we're very emotional. We are scared for our children. I for example fear for my son when he goes out to work, that he might not come back, one of the Jewish settlers might shoot him for no reason, just like that, I don't know why. All this creates an internal fear, we live with this fear every day"

The issue of children being targeted, or casually exposed to violence, came up several times. For example:

> "My son was exactly 13 years old. They suspected him of wanting to carry out an attack, that he said he wanted to do a stabbing. We were going to buy shoes, when the whole state came, the whole police, I found them waiting there, they want to take a thirteen-year-old child."

4.2.1.2. Gendered stressors:

When asked about a period of crisis in their lives, four out of the five laywomen interviewees spoke of highly gendered circumstances as a major factor in the crisis they went through.

One woman spoke of a period of marital crisis, which was caused by her husband's reaction to her working and making money:

> "Well, it was at the time I started working. Then I began to notice that the relationship is beginning to be not good, because he began to feel threatened, and… when I'm working in a good job, bringing in money, let's say the [balance of] powers at home changes. So the relationship started to become weaker, and that also affected [my] mental state."

The interviewee was certain that her husband's reaction arose from a sexist viewpoint, and that it represented a wider social phenomenon:

> "I feel that it's a result of education and culture. That… if the woman starts working at a job that is, let's say, more important than the man's, it's hard for him to accept it. And then he begins to diminish the woman and make her feel bad with herself."

In another interview, the interviewee spoke of how, as a divorced woman, her family felt they had the right to make decisions for her, and how this affected her:

> "When I divorced, I faced something in my society. In Arab societies, marriage and divorce is a family decision, not a personal decision. That is, if Vered [here she used the researcher's name as an example] wants to get married, the whole family has to see, to agree, I don't know what. As if they are going to get married, not you. If Vered wants to get divorced, ok, they all need to come, the uncles and the grandfather and the grandmother and so on, to approve. This creates a big problem because everyone has an opinion. In the end they don't give the girl her opinion. […] This causes a crisis, it makes me feel that I'm wronged in this society, persecuted. That I don't have the right to express my opinion, to speak."

In this case too, the interviewee made it clear that her family's attitude and actions were connected to gender: "The Arab society still thinks that a divorced woman is a rejected woman, who is coming from the devil. The devil is riding her and controlling her."

In two other interviews, the gendered stressors took on a much more extreme form, since both women had experienced different forms of gender-based violence and abuse. Both women are living with serious mental disorders and believe that the abuse they went through had a significant role in their mental health state. To bring only a few poignant quotes from their stories:

- "I was exposed to many shocks in my life, my mother died when I was five years old, she was killed. Her brother killed her. After that, when I was nine my father's wife threw me from the balcony. After that I lived with my grandmother and in unsafe places, I was exposed to sexual harassment. It wasn't easy, I married at an early age, I didn't understand… I was fourteen, I didn't understand what marriage means, what sexual relations between a woman and her husband mean."

- "My husband was an addict. He was addicted to drugs, he used to take drugs and so on. He used to beat me all the time, he was violent towards me and my children, so the solution was that I leave him. When I left him it wasn't easy, I mean he tried to kill me."

- "And then my husband married another woman over me. He wanted to marry another woman, and because he was like this I became ill, I became mentally ill. He used to treat me badly, and beat me, and insult me, and wrong me, and upset me […] he would try to diminish my abilities, because I studied at university and he studied at university, and so on. He made me feel that I'm not like him, that I don't understand."

Similarly, some of the professionals who were interviewed spoke of many of the women they work with as being "very marginalized" and "abused", and considered that a significant factor in their mental health.

As a sidenote, it is rather surprising that living conditions in East Jerusalem, such as poverty and inadequate infrastructure, did not emerge as a stressor from the interviews, or at least not significantly enough to count as a theme. Only one woman, who lives in Shouafat refugee camp, spoke of the adverse effects of the camp's high population density on residents' mental wellbeing. Despite not coming up as a theme in the interviews, living conditions in East Jerusalem may have significant impact on mental health, and this should be explored further in future studies.

4.2.2. Barriers to care:

This is an overarching theme that includes several sub-themes, all related to factors that make it harder for women in East Jerusalem to access mental health care. Sub-themes are divided into two categories: 1. Structural barriers; 2. Barriers related to attitudes and awareness (see figure 1).

4.2.2.1. Structural barriers:

4.2.2.1.1. Availability:

The first condition for receiving any kind of care is the availability of caregivers. Many of the professionals interviewees said that the KC*s* do not have enough Arabic-speaking therapists and psychiatrists to fulfill the needs of the population, even with the added capacity of the private *Ma'atzama Bakehila* clinic. This causes extremely long waiting times. For example, one of the KC workers said: "There's a lack of professionals, there's a lack of job opportunities, and there are no clinics. This is the only clinic [this KC has] in Jerusalem. Right now we have 169 people on the waiting list, which means [a waiting time of] 1.5-2 years."

A laywoman interviewee said, somewhat hyperbolically: "To be honest, the Kupat Cholim [mental health] services are very bad, because they take a very long time to give people these services, and the appointments are very far off. A person can die by the time his appointment happens."

The professional interviewees acknowledged that long waiting times is a general problem in Israel, but emphasized that it is even more severe for Arabic speakers in Jerusalem. Two interviewees mentioned that the shortage of therapists and psychiatrists is partly due to discrimination against Palestinians students in the Israeli system:

> "There are fields that the hospitals and the Israeli health system don't give to Arabs. […] There are certain fields that Arab doctors get accepted to more easily, so they prefer to go there, and there are fields that [they get accepted to] less. Mental health, I guess that's one of the fields that Arabs are less accepted to."

Several of the professional interviewees expressed the opinion that the KCs are not doing enough to improve the availability of mental health services, whether because of disinterest or for political reasons: "The KCs aren't in a hurry to solve this problem, they are improving it slowly, and so [the available services] never reach the level of the demand on the ground in the area of Jerusalem."

In the case of *Sal Shikum* services, it seems that there are enough places in the existing rehabilitation programs to meet the demand, so there is no problem of long waiting times. On the other hand, one of the professional interviewees identified a different availability issue. She explained that while services for Arabic speakers do exist in the different areas of rehabilitation (housing, employment, education, etc.), options are much more limited than those available to the Hebrew-speaking population. This impacts service-users' ability to choose, and also means that there are no specialized services that can answer specific needs:

> "If there are several services, the patient can choose where he wants to get his rehabilitation, his accompaniment. When there is only one service that does it, it limits the person's options, and often when the person is unhappy with the service and wants to choose a different place he doesn't have the option […] In the Jewish sector in Jerusalem there are more services… many more assisted living services, many more hostel services, there's a very wide range, with specific populations. For older people, for girls with eating disorders […]"

This problem was echoed by an interviewee who uses the Sal Shikum "employment club" service, who complained: "The club we're in is mixed, with all kinds of mental illnesses […] What does [someone who went through] sexual assault have to do with a patient who has schizophrenia? Why put them together?"

All in all, however, the professional's opinion was that the *Sal Shikum* services have the capacity to grow and develop, and that there is a bi-directional connection between the number of service users and the availability of services: "My personal belief is that when there are more services more people will come to receive them, and when there are more people coming the services also [grow]."

4.2.2.1.2. Confidentiality:

An inherent problem of the franchisee model is that it compromises medical privacy and confidentiality. The franchisees are mostly locals, and clinics are often small and neighborhood-based. This means that patients or their families are often acquainted with the franchisee or the staff. A recent study found that this close-knit structure brings with it concerns about violations of privacy and medical confidentiality (Zugair, 2022). The interviews demonstrated that in a field as stigmatized as mental health, patient concerns about privacy have a critical importance, and might prevent people in need from seeking out care. One interviewee said:

> "How can I see a psychologist in Jerusalem, I would have to go to a doctor at our… to the family doctor so he would give me a referral to a psychologist, to be honest it's difficult for me to do that. Because the family doctor is a friend of my father's, he sits with him at the café in the evening, and I don't want anyone to know about this subject, I felt… a bit of shame about this thing, I mean I don't want my family to know the reason, because they were also a factor in the subject. So I didn't want any of them to know."

An NGO worker who works with many women in East Jerusalem also emphasized in her interview that the lack of confidentiality is a significant barrier to women from accessing mental health care. She gave herself as an example, saying that she cannot go to therapy at the KC, because her father knows the franchisee.

Another interviewee pointed out that the issue of confidentiality is also connected to gender, and is more severe for women than it is for men:

> "Any illness you have, the family would find out about it. As a woman it's much worse because in our society it's like… I don't know how to say it [in Hebrew], it's Musallam bihi [مسلم به]. You know some Arabic, right? Musallam bihi means your man, your partner can know everything that's in your medical file. If you're not married, then it's your father."

4.2.2.1.3. Application process:

To be eligible to apply for Sal Shikum rehabilitation services, an individual must first undergo an evaluation and be determined by the Israeli National Insurance Institute to have a disability level of at least 40% due to a mental health disorder (Aviram et al., 2023; The Community Rehabilitation of Persons with Mental Health Disability Law, 2000). After that, they may apply to the Regional Rehabilitation Committee to receive *Sal Shikum* services (Israel, Ministry of Health, n.d.). A number of the professional interviewees spoke of the application process as a serious barrier to accessing *Sal Shikum* services for residents of East Jerusalem:

> "Getting recognized by the National Insurance takes a lot of resources and time from people in the Arab society in Jerusalem, because they have to prove residency, since they are not citizens, they are residents. So they need to prove residency, and that is a process that takes more time than it does for people who are citizens and living in Jerusalem, who apply to the National Insurance. So the process gets delayed and takes a lot of time, energy. I don't know if you know but the National Insurance committees are something very difficult, very threatening, a lot of people are very afraid of it, concerned about it, come out of it with very unpleasant experiences."

In another interview, an NGO worker specializing in social rights explained that even after getting the disability evaluation from the National Insurance Institute, the application to the Regional Rehabilitation Committee to get *Sal Shikum* services is still a central barrier:

> "It's a form of I think 15 pages, 16 pages that you have to fill in. Lot of details of course, and you need to bring data, from a family doctor who needs to fill some of it, a psychologist needs to fill some of it, a social worker. I mean, a person with mental health difficulties who is struggling to manage daily life anyway, he needs to collect all these people, go to them one by one, ask them to fill in the relevant part of the form and then submit it."

Some of the forms that the applicants must fill are only available in Hebrew. This in itself poses a serious difficulty for many East Jerusalem residents. As the interviewee pointed out:

> "This [i.e., the difficulty of completing the application] is not something that is limited to East Jerusalem, it's a country wide problem. But in East Jerusalem, because of the issue of language and the issue of culture it's even more difficult."

He explained that the application process is so difficult that most people who need rehabilitation services don't manage to complete it on their own. Therefore, most people only get rehabilitation services if they have a family member, social worker, or doctor who is willing to work on the application for them. According to this interviewee, about 80% of people in East Jerusalem who are eligible for rehabilitation services do not apply to receive them.

4.2.2.1.4. Legal status:

The precarious legal status of the Palestinian residents of Jerusalem, and the ease with which the state revokes their rights (Stein, 1998), affects every area of life in East Jerusalem. As quoted in the previous section, one of the professional interviewees considered the need to "prove residency" to the National Insurance Institute a significant barrier to getting access to rehabilitation services. Even more painful was the story of one of the laywomen, who was the most vulnerable of all the women who participated in the study: a single mother with severe mental illness and very little support from her family. Her story demonstrates how an uncertain legal status endangers not only medical care but also financial and other kinds of support from the state, which are so crucial to the rehabilitation of people dealing with mental illness:

> "I have great difficulty in getting the correct treatment, first of all because I'm Arab. The National Insurance currently doesn't recognize me as an Israeli resident and doesn't recognize that I'm in the country, because according to their claims I'm not in the country or I'm living I don't know where, [even though] my home is here. I've been dealing with this issue for a year now, it has prevented me from continuing treatment, it has prevented me from taking my medicines, caused me to have relapses that are not right. There is also no income. I can't work at all, and I have no income for myself or for my children. I have many relapses and crises, because I have a sick child, and when I'm cut off from my rights from the state I can't [word unclear] my children. I can't get our medicines, I can't get them food or drink or anything."

She said that she is currently in a legal battle over her residency status. In the meanwhile, her medical insurance is frequently cut off. In periods when she is uninsured, she cannot buy medication for state-subsidized rates, and is forced to buy medicine for the full price or go without:

> "Sometimes I can't buy all my medicine because sometimes there's no money for medicine […] I can't do without the medicine, so whenever there's money or whenever I get money from someone, I must buy medicine, even if it means we won't have electricity or gas or food or anything, because the medicine is very important. The medicine allows me to be stable, to get up, sit, go places, to eat and take care of my children. Without the medicine I can't do anything."

4.2.2.2. Barriers related to attitudes and awareness:

4.2.2.2.1. Stigma:

The issue of mental health stigma came up again and again, in different forms, in many of the interviews. Social stigma compounds the difficulties faced by people with mental health problems: "It's not easy, it's very hard, especially since the people around us don't accept our illness."

Interviewees spoke of social stigma as a significant barrier to care:

> "People have a negative idea about psychiatrists. I mean, a psychiatrist means that you're crazy. That's the common and dominant attitude in our society. If they see that I went to a psychiatrist – crazy. That's it, you're crazy, you're name is 'crazy', that's it. That's why no one goes to a psychiatrist. Maybe one in a hundred would go, and it would be very secret."

Another interviewee spoke of her mother, who was going through a difficult time in terms of mental health: "I told her: 'Go see a psychiatrist, I'll pay for it', and she laughed it off, like it's a joke: 'Do you want people to say I'm crazy?'"

One woman said that going to therapy would have damaged her self-image, and that this is connected to social stigma:

> "In our society, going to a doctor, a psychologist… it isn't seen as a good thing. It means you're in a bad state. I understand that it's a contradiction, but people really think like that… You're in a crisis, but it's difficult for you to go to a psychiatrist for example because it's not accepted, it isn't seen as something normal. […] If I had gone no one would know, but the problem is how I would feel with myself […] that I couldn't solve my problems and had to go to a psychologist."

One of the professional interviewees recounted a story of a woman who refuses to apply to the National Insurance Institute to be recognized as having a mental health disability, even though it would make her eligible for *Sal Shikum* services and perhaps also a disability pension:

> "She does get treatment, she goes to a psychologist and a neurologist, and she pays for it from her own pocket, but she won't notify the state. I really beg her to do it, but she refuses because of the stereotype. She refuses to be called a disabled person."

Sadly, it seems that mental health stigma doesn't only exist among the general public, but also among health and welfare staff, who have an important role in referring people who need it to therapy and other mental health services. A professional interviewee who had worked on raising awareness in municipal organizations said: "We quickly found out that social workers inside the welfare offices know nothing about mental health, and have a strong stereotype regarding mental health."

Another interviewee said:

> "After I had my second child, at one of my visits to the family healthcare center the nurse asked me to fill in a questionnaire that detects whether there's a concern of postpartum depression or not. So I filled the questionnaire, and apparently the result was that I do have some kind of postpartum depression, and then she said to me 'look, according to the family healthcare center's rule, your answers mean that I need to send you to a social worker, but I don't want to do that. I want to give you another week's opportunity. Try to rest, and come back and do the questionnaire again, and we'll see how you are'."

The interviewee attributed the nurse's stance to stigma:

> "She probably assumed that the woman in front of her wouldn't accept it if she told her 'you have depression' or 'you need to get treatment or support or help'. So she gave me another chance to rest another week and then come and do the questionnaire again. […] She found out that I have a problem, using a professional questionnaire for detection of postpartum depression, and she didn't deal with that from a professional perspective, but rather from a social perspective."

The nurse's assumption that a mental health diagnosis is a negative outcome that should be avoided if possible not only perpetuates negative attitudes towards mental health, but may also cause patients to miss important opportunities to receive the treatment they need.

Two of the professional interviewees commented that for women, social stigma is an especially strong barrier. One of them said:

> "I do see women who come, but it's definitely easier for men to come and get the service. When you're sick [as a man] you go directly to get everything you're entitled to, and when you're a woman you have to sit at home and hide it so people won't know. […] There are men who are also in this loop, but much less than women."

The other spoke of how stigma, coupled with women's lower level of autonomy, can prevent women from getting treatment or force them to do so in secret:

> "I'm sorry to say that because of stigma and stereotype, a woman coming to get therapy – what would the family say? What would the children say, the husband, I don't know what. I've had women patients who came, had three or four meetings, and some of them were feeling good and it started helping them, but they stopped because of pressure from the family. […] There are also some who come, and their family doesn't know that they are going to therapy. Or maybe her husband doesn't know, he thinks she's going to a physical therapist or a family doctor […]"

4.2.2.2.2. Knowledge and awareness:

Several of the professionals emphasized that many people have very little knowledge and awareness regarding the field of mental health. This theme is strongly tied to the theme of stigma, since the social taboo and shame associated with mental health make it difficult to ask and gain knowledge.

An NGO worker said that many of the women she works with "don't have a name for what they are going through". Even when they know that they need help, people often don't know what their rights are, or don't feel comfortable demanding them: "In the field of health, people don't demand their rights. They don't even know what they are entitled to, and even if they do know their rights they don't want to get into this mess of… crazy, not crazy, 'they have mental illness, don't go near them'."

Another professional interviewee said:

> "There's a lack of awareness, people don't know what Sal Shikum is. People don't even know that they are entitled to services from the state, without paying, without losing their right to National Insurance [disability] pension. A lot of women are scared of that in the Arab society."

A few of the women who were interviewed said that they didn't know what their options for treatment were: "Honestly, I don't know. There is no one to guide me. I don't know, I don't have experience with these places, I never went to a psychologist […]"

It seems that even the staff at the franchisee clinics lack knowledge regarding the services provided by mental health clinics. Two mental health workers said that people referred to them by the franchisee clinics often have needs that are not part of the mental health clinics' services, for example developmental assessments for children: "Sometimes they [the patients] waste months, they come, they bring a referral and all that headache, and they get to you and in the end you're not the right address."

4.2.2.2.3. Distrust of authorities:

The state of Israel is the body responsible for providing services to the residents of the city. At the same time it is an occupying power that employs a plethora of methods to oppress, marginalize, and drive out the Palestinian residents of Jerusalem. It is therefore unsurprising that many of the city's residents view the authorities with deep distrust on several levels. This often leaves the residents with no official address to turn to in times of trouble and limits their access to services that are vital for mental health.

Turning to the police, for example, is very problematic and often impossible. In this situation, girls and women have no protection from gender-based violence. One interviewee spoke of the issue of sexual abuse of children:

> "This [problem] is world-wide, country-wide, it's not something that is unique to East Jerusalem, but… Imagine if you, as a child, don't only have to deal with your father or your brother or your uncle or I don't know who, you also have to complain to the police who is your occupier. It's two or three times as hard to get to the point of filing such a complaint. A child like that might not actually be mentally ill, but she won't get anywhere in life because of what she's been through. She can't concentrate on her studies, she can't get along in society […]"

Another interviewee said:

> "If there's a case of abuse we're supposed to go to the police, right? A woman is supposed to… but would she go to the police, the same police who took her other son to prison, so that the same police would protect her daughter from the attempted rape she went through?!"

A social worker who works for the city's welfare office said that women often have difficulty trusting welfare workers for fear that they would take away their children. And indeed, this issue came up with one of the laywomen interviewees: "The welfare [worker], when she comes the first thing is she wants to take our children to boarding schools. The first thing she thinks about is: you are mentally ill – you are a danger to your children."

Another aspect of the distrust of authorities is that people are afraid that having a record of mental health treatment in their medical files might hurt them. A KC worker said:

> "The women who come to Kupat Cholim are usually very worried about what would be written in their files, that's why there are a lot of people who go to [Palestinian] NGOs if they know them. It feels more anonymous, that things are not being recorded. Of course there's a file and everything is written down. But it's not the authorities."

One of the laywomen said: "I heard that it would be recorded in my file that I went to a psychiatrist, and that it would impact my work as a teacher in the future, when they ask for a health certificate or something like that."

4.2.3. Alternatives to the Israeli system:

In light of the various barriers to receiving care from the Israeli public mental health system, it is not surprising that several of the professional interviewees mentioned that many people find other options for getting treatment.

There are some alternative options for care in Jerusalem itself. There are some therapists who have private clinics in Jerusalem, and there is also the Palestinian Counseling Center, an NGO that provides therapy for very low prices. None of the people interviewed for this study used these options, but two of them did chose to get treatment privately in the West Bank, and a third took her mother to receive treatment there.

Private sector treatment in the West Bank has some important advantages, since there is less danger of the patient's social circle finding out about it, information isn't passed on to the Israeli authorities and there is no need to go through an application process. On the other hand there are significant disadvantages: higher cost, long distances and the need to go through checkpoints, and according to some of the interviewees, the quality of services is not always good enough. Several quotes from interviews demonstrate this dilemma:

- In the end people go to get treatment in all kinds of places that are… I don't know. Some places are good, and some are much less good, places that I think should have been closed the day before yesterday […] There are places I appreciate very much, they provide good treatment, but people pay out of their pocket. One of the challenges is getting there and back, getting in and getting out, checkpoints and so on. In the end these are people with mental illnesses who

have to deal [with this]. The way is pretty long and sometimes, especially in Qalandiya, they might decide to close the checkpoint for an hour because the soldiers are changing shifts. So there's a queue, and people get stuck there."

- "In the end I decided to go to a doctor in Beit Lahem. He asked for a lot of money. One session, 45 minutes, cost 200-300 shekel, while if you go in Jerusalem using the insurance, you get a referral [and it costs] 30 shekels. […] It would have been much easier to get treatment here in Jerusalem, but I was very afraid of it. I didn't want anyone to know, I didn't trust my family doctor who would give me the referral not to tell my father."

- "My mother went to a psychiatrist in Ramallah. He gave her medicine for nerves and so on. Of course, the treatment was physical, with medicine, not sitting and talking with you, nothing like that. The doctor doesn't have time to talk with you. He hasn't got time to sit and talk, because in the waiting room he has 30, 40, or 50 patients."

4.2.4. Openness to mental healthcare:

Despite the widespread negative attitudes towards mental health disorders and mental health treatment, there are indications that the East Jerusalem society does in fact have a degree of openness to this subject. The first indication is the fact that according to people working in mental health, the demand for mental health services far outstrips the supply:

> "There's a stereotype that people in the Arab society don't go to psychologists and don't go to therapy. This stereotype is really incorrect. The Palestinian Counseling Center has an endless waiting list. Any psychologist you'll meet in the Arab society, working privately or otherwise, would tell you he has no capacity for new patients at the clinic […] [at the KC clinic] we have a hundred and forty new referrals every week."

Moreover, several of the professional interviewees expressed the opinion that increased capacity and quality of the services would bring about an increase in demand:

> "One of the good things is the more you expand the service, people smell it, it's like they know there's someone there. And the other way around, you can see that when you don't answer people give up. So the better the service you give, more people come."

Another sign that the Palestinian society in East Jerusalem is interested in mental healthcare is that, as two professional interviewees recounted, awareness-raising events have been enthusiastically received:

> "We started a series of awareness-raising workshops, and I was surprised. I expected a meeting of 30-40 people, but there were 50-60 people. Talking about mental health, right? I didn't expect these numbers. Really. And the amazing thing is that in one neighborhood for example, after we finished the first meeting, the women especially asked for another meeting and we did it, and now we're planning a third meeting."

The accumulated evidence suggests that there are many in East Jerusalem who are interested in better access to mental health services and information, and that removal of structural barriers would result in a surge of people accessing care.

4.3. Answers to the research questions

This is a summary of the answers to the research questions, as they arise from the results of the study:

4.3.1. First research question:

What are the mental health ambulatory treatment and rehabilitation services provided by Israel to Palestinian women in East Jerusalem?

Ambulatory treatment, provided primarily by the KCs and to a lesser extent by private-sector parties, includes psychiatric care and psychotherapy.

Rehabilitation services are provided by the Israeli Ministry of Health through the *Sal Shikum* program. To be eligible for rehabilitation services, an individual must be recognized by the Israeli National Insurance Institute to have a mental health disability of 40% or more. Arabic-speaking rehabilitation services in Jerusalem include: a hostel, an assisted living service, an employment club, an education service, a mentoring service, several social clubs, and a center for the families of people with mental health disabilities. Moreover, there are a few other services that are not specifically geared toward Palestinians but do have Arabic-speaking employees, allowing Palestinians to use the service if they wish to.

All services were meant for both men and women, and no services were found that specialize in gendered needs, such as treatment for sexual trauma of eating disorders.

4.3.2. Second research question:

Are these services used, and are the available services sufficient for the needs of Palestinian women in East Jerusalem?

Ambulatory services are used, both by women and by men, and are not sufficient for the needs of Palestinian women in East Jerusalem. The numbers of psychiatrists and psychotherapists listed on the KCs' websites are low compared to the size of the population, and the spatial distribution of the services is limited. The need and demand for psychiatric care and psychotherapy is much higher than the services are able to provide, resulting in extremely long waiting times.

Rehabilitation services, on the other hand, are used by a relatively small number of Palestinians: out of about 5400 service users in the Jerusalem district, less than 400 (7.4%) are Palestinian. According to the people interviewed in this study, there does not seem to be high demand for these services. This, however, does not necessarily mean that the available services are sufficient. There are very many people with mental health disabilities who may have been able to benefit from these services if they had been more accessible, and if there had been higher awareness regarding them.

4.3.3. Third research question:

Are there barriers that hinder women's use of these services, and what are they?

The barriers that Palestinian women in East Jerusalem face when considering using mental health services are many, and may be divided into structural barriers which are imposed by the Israeli system, and barriers related to attitudes and awareness within the Palestinian

society of East Jerusalem. Structural barriers include the low availability of mental health services; the lack of confidentiality which is a consequence of outsourcing the KCs' responsibilities to private franchisees; the difficult process of applying for Sal Shikum services; and the uncertain legal status of East Jerusalem' residents, which means that their right to receive social services from the state can be challenged at any point. The attitudinal barriers include stigma regarding mental disorders and mental healthcare; a lack of knowledge and awareness regarding mental health and the options for mental healthcare; and a strong distrust of authorities that, however justified, may leave people with no place to turn to in times of crisis.

4.4. Discussion

This study attempts to map the Israeli community-based mental health services that exist in East Jerusalem and are available to Palestinian women. Two categories of services are described: ambulatory treatment (i.e., treatment that does not include hospitalization), and rehabilitation services for people who are recognized as suffering from a mental health disability. Beyond that, the study endeavors to qualitatively explore how professionals and Palestinian laywomen perceive mental health services in the city, focusing especially on barriers that make it difficult for Palestinian women to receive mental health care.

All the services identified in this research are meant for both men and women, with no services geared specifically towards women. This is problematic, because women have specific mental health needs, such as treatment for perinatal mental health disorders (Al-abri et al., 2023), and some conditions, such as eating disorders, affect women more than men (Galmiche et al., 2019). Moreover, there is great importance in providing women with a gender-sensitive, trauma-informed environment to promote recovery (P. S. Chandra et al., 2019; Godier-McBard et al., 2023; Oram et al., 2022). The lack of women-centered services may indicate that not enough attention is directed toward making sure that the available services answer women's needs.

Gender-sensitive care is of course even more important when treating people who went through sexual trauma, which is why it is especially worrying that the KCs and *Sal Shikum* seem to have no Jerusalem-based, Arabic-speaking mental health service that specializes in sexual trauma. However, it is important to mention that the Ministry of Welfare and Social Services does operate three centers for treatment of survivors of sexual assault (one for adults, two for children). These centers are all located in Jewish-majority parts of the city, but the researcher was informed that they do provide services in Arabic as well as Hebrew. These centers are outside the scope of this study, but future research should investigate whether they indeed provide Arabic-language treatment, whether they are accessible and helpful to the East Jerusalem population, and whether their capacity is enough for the population's needs.

The descriptive part of the study showed that the KCs offer Arabic-language psychotherapy and psychiatric care, but that the number of practitioners is very low compared to the size of the population and to the number of Hebrew-speaking practitioners. The testimonies of many of the interviewees, both professionals and laywomen, show that the number of practitioners is far from enough for the needs of the population. This is not surprising, given the general neglect of East Jerusalem by the Israeli establishment (Israel State Comptroller, 2019). Moreover, it seems that the "franchisee model" makes it easier for the state to wash its hands of its responsibilities regarding healthcare in East Jerusalem.

The case of rehabilitation services seems to be different. The number of Arabic-language services in the city is limited, meaning that service users have little choice between rehabilitation options. However, it seems that the shortage of services is felt less acutely than in the case of ambulatory treatment, because the demand for rehabilitation services among Palestinian Jerusalemites is low. This is probably the result of low awareness on the one hand, and the difficult process involved in getting the services on the other hand. At the same time, it is possible that there is relatively high willingness within the Sal Shikum administration to expand services.

The qualitative analysis resulted in four main themes. The first theme is "stressors", referring to factors that contribute to psychological distress and mental disorders in women living in East Jerusalem. While this theme is not directly connected to mental health services, it came up very strongly in interviews with both professionals and laywomen, with several interviewees stressing that discussion of mental health in Jerusalem cannot be separated from the realities of life in the city. For this reason, it was decided to include this theme in the results. The interviewees described a constant feeling of fear, a sense of living in a hostile and unsafe environment because of violence and oppression either from the Israeli state or from Jewish settlers. At the same time they also described many situations where as women, they were subject to abuse or had to fight for their agency and for recognition of their worth within their own family and society. These findings are compatible with many studies that show the adverse effects of the occupation on Palestinians' mental health (Bdier, Veronese, et al., 2023; Dabbagh et al., 2023; Marie et al., 2020; Shukri et al., 2023), as well as studies on gender inequality and the high prevalence of gender-based violence in Palestine (Baldi, 2018; Bdier, Mahamid, et al., 2023) and East Jerusalem (Juzoor, 2017; United Nations Population Fund, 2021). These findings are relevant to this study because they strengthen the hypothesis that Palestinian women living in East Jerusalem exist at the intersection of several risk factors for mental ill-health, indicating that there is a special importance in ensuring that they have access to adequate mental healthcare.

On a reflexive note, it is important to acknowledge that this hypothesis was part of the underpinning of the study from the beginning (see section 1.2. "Research justification). This may have introduced a bias into the research, since the researcher expected to find various risk factors affecting the interviewees. However the researcher took pains to work reflexively throughout the data collection and analysis process, to be aware of assumptions and to make sure that the results are grounded in the data.

The second theme identified in the analysis was "barriers to care". This theme is especially important, because understanding the issues that make it difficult for people to receive care is crucial for improving any kind of health services. The analysis resulted in a list of seven barriers, both structural and attitudinal. All these barriers exist together, creating a cumulative effect. Moreover, it is probable that many of them intersect, strengthening and increasing each other. For example, low availability of care, low awareness, and stigma are all connected: since the options for mental healthcare are so limited, only a small minority of the population can receive treatment, while most people are hardly aware that treatment can be beneficial and is part of their rights. In this state of affairs, it is hardly surprising that therapy and psychiatric care are not viewed as a normal part of life. As long as people suffering from psychological distress, and their families, don't have access to information, support, and treatment, mental illness remains a baffling and highly burdensome phenomenon, and stigmatization is almost unavoidable. On the other hand, as long as stigma remains high and mental health awareness remains low, people don't demand more mental health services and there is no pressure on the Israeli mental health system to improve the

availability of services and remove structural barriers. As one of the interviewees said: "Where a population doesn't demand its rights, the establishment can avoid commitment."

Similarly, the compromised patient confidentiality in KC clinics in East Jerusalem is, of course, a serious problem all on its own. However, the stigma surrounding mental health means that anyone, and especially a woman, who seeks mental healthcare may find themselves "socially punished" if their family or social circles find out about it. This makes the issue of confidentiality even more critical as a barrier to care.

While the barriers identified in this study affect people of all genders, some of them may have a special significance in the case of women. Several interviewees said that because of patriarchal attitudes, women are more exposed to pressures from their spouses or their families when making decisions about their own health. Because of stigma, families may discourage or even forbid women from seeking mental healthcare. Moreover, one interviewee said that women are more in danger of having their patient confidentiality breached, because of the belief that a woman's father or husband is entitled to information about her medical condition. Women are also often those who act as single parents or primary caretakers, and therefore they may be more affected by the fear that asking the authorities for help could lead to their children being taken away.

These findings underline the importance of raising awareness and changing stigmas, both with regard to mental health and with regard to the role of women in society, if we are to improve women's access to mental healthcare.

The third theme that emerged from the qualitative analysis was "alternatives to the Israeli system". Because the Israeli system is so inadequate and poses so many daunting barriers to those who wish to access care, many people prefer to use mental health services provided by NGOs, or to get treatment in the private sector. This route does constitute a solution for many, but it has several disadvantages: private treatment is expensive, and not everyone can afford it; data from the interviews suggests that the NGOs providing services in Jerusalem have very long waiting lists; getting treatment in the West Bank involves long drives and requires passing through checkpoints; and the quality of the services is not always good enough. Moreover, none of the interviewees mentioned the existence of any rehabilitation services provided by the private sector or Palestinian NGOs, though it would require further research to find out whether rehabilitation services exist outside the Israeli public system.

In short, it is a good thing that people who need treatment find alternative ways to have at least some of their needs answered, but this does not mean that the flawed Israeli services are in any way acceptable. Israel is the occupying power in East Jerusalem (Resolution 478, 1980) and has also unilaterally and illegally annexed it and does not allow the Palestinian government to act within the city (Basic Law: Jerusalem the Capital of Israel, 1980). This means that both by international and Israeli law, Israel is responsible for providing social services to the residents of East Jerusalem. Among other things, the city's residents have a right to accessible, high-quality, public mental health services in their own city. They should not have to seek for alternatives in the private sector, especially since the occupation makes movement to and from the West Bank extremely difficult (Griffiths & Repo, 2021; Samman, 2021).

The fourth, and final, theme identified in the analysis is "openness to mental healthcare". Despite the widespread stigma, the demand for therapy and psychiatric care far outstrips what the services are able to provide, and people working in the field believe that improved

services would bring a further increase in demand. Awareness-raising events have been well attended and received good responses. This is an encouraging finding, suggesting that there is at least some space for change of negative attitudes towards mental illness in East Jerusalem society.

It seems likely that increased availability of services would result in a surge of utilization of mental health treatment. This, in turn, would help reduce stigma and raise awareness. Unfortunately, in the case of East Jerusalem structural barriers are imposed by a largely hostile state and may prove very difficult to combat.

5. Fifth chapter

Conclusion and recommendations

5.1 Conclusion

Accessible, high-quality mental health services are part of the basic right of the residents of East Jerusalem to healthcare, and it is Israel's responsibility to provide them. In a city where life is often extremely difficult, women are an especially vulnerable population and there is great importance in services that are fitted to their needs. However, the capacity of mental health ambulatory services in East Jerusalem is not nearly enough to meet the needs of the population, and many people who could benefit from rehabilitation services never reach them. Moreover, there are almost no services that aim to address women's specific needs.

Even the inadequate services that currently exist are inaccessible to many women because of a complex array of barriers to care. At the same time, there is great need and interest in better mental healthcare among the residents of East Jerusalem. In an occupied city, where the residents have no political power and the authorities are often hostile, it is very difficult to bring about systemic change. However consistent pressure on the KCs and the Israeli Ministry of Health, together with awareness-raising work within Palestinian society and support for individuals who need help in realizing their rights, may gradually lead to more people getting the help they need as well as reduction of the social stigma associated with mental illness.

Further research is needed to expand upon the results of this study, and to learn more about other parts of the Israeli health and welfare systems in Jerusalem, and their interactions with Palestinian and NGO-provided services.

5.2 Recommendations

- **Allowing direct access to a mental health practitioner** – Currently, people who wish to see a psychiatrist or a psychotherapist must first get a referral from their family doctor or their local KC clinic. The interviews indicate that this is the point where confidentiality is most likely to be breached, since many women fear that their doctor or someone from the clinic's staff would inform their families. This problem could be mitigated if patients were allowed to make appointments with mental health staff without going through their local clinic first. Achieving this would undoubtedly require exerting a lot of pressure on the KCs, as they would have to invest in staff to

screen the patients. However, it may be that this process is already beginning: in a follow-up conversation with an employee of one of the KCs, the researcher was told that as a result of the war, the KC is planning to open a phone hotline which people can call to make appointments for mental healthcare directly, without a referral from a family doctor. This hotline is planned to serve the whole Jerusalem district. According to the plan, the hotline should begin operating in a few weeks. It is important to follow up on this initiative to see if this hotline provides adequate service to Arabic speakers.

- **Awareness-raising campaigns** – Awareness-raising campaigns can fulfill two extremely important roles: to educate the public on mental health and mental disorders, and to provide them with information on their rights and options for care. From the results of the study, it seems that many people are open, and even eager, to receive this kind of information. Successful awareness raising campaigns may not only help people access needed services, but also help in mitigating stigma.

- **Help people to access their rights** – While the availability of psychotherapy and psychiatric services is severely limited by the resources allocated by the KCs, the results of the study suggest that the *Sal Shikum* rehabilitation system may have places for more service users and might even be willing to increase its capacity. It seems that currently the main barrier to accessing rehabilitation services is the difficult application process. This process demands time and energy and is difficult to navigate without Hebrew language skills and a familiarity with the Israeli system, and therefore many people are not able to complete it on their own. There are several organizations that help people in dealing with the bureaucratic challenges posed by the National Insurance Institute and *Sal Shikum*, but these initiatives are comparatively low scale. A concentrated effort by civil society organizations to reach people who are suffering from a mental health disability, inform them of their rights, and help them get *Sal Shikum* services could potentially greatly increase the numbers of people receiving needed services. It would also raise awareness to the existence of these services, which at present seems to be low.

- **Pressure the National Insurance Institute and the Regional Rehabilitation Committee to translate all forms and information regarding disability recognition and *Sal Shikum* into Arabic** – A relatively simple step which would immediately improve access to services.

- **Cancel the franchisee model** – The outsourcing of the operation of healthcare clinics to private parties is a deep structural flaw in the East Jerusalem health system, and it inevitably comes at a great cost to the quality of all health services, including mental health. The franchisee model should be canceled, and services provided directly by the KCs.

- **Further research** – This study is only an initial, and partial, exploration of a large and important topic. Further research should focus on hospital-based mental health services, mental health and prevention services provided by the Ministry of Welfare, and mental health services provided by NGOs and Palestinian authorities. Another important issue for research is the quality of the services and whether they answer women's needs, in particular with regard to gender sensitivity and trauma awareness.

6. Sixth chapter

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7 Seventh chapter

Appendix A: consent form (Arabic and Hebrew)

جامعة القدس
Al-Quds University

المشارك/ة العزيز/ة،

شكرا جزيلا لاستعدادك للمشاركة في هذا البحث بخصوص خدمات الصحة النفسية المتاحة للنساء المقدسيات والحواجز التي تعوق دون الحصول على الرعاية. أريد إجراء مقابلة معك باعتبارك امرأة مقدسية و/أو صاحب/ة خبرة في مجال الصحة النفسية في القدس.

المشاركة في البحث أمر اختياري ويمكن لك التوقف عن المشاركة في أي وقت.

ستبقى هويتك سرية في البحث، وسيتم حذف أو تغيير أي تفصيل قد يؤدي إلى التعرف عليك. سيتم الاحتفاظ بتفاصيلك في محرك أقراص محمي بكلمة مرور، وبصفتي الباحثة المسؤولة عن هذا البحث فأنا المخولة الوحيدة للوصول إلى هذه المعلومات. سيتم تخزين هذا النموذج بشكل منفصل عن المعطيات ولا يمكن الربط بينه وبين المعلومات التي ستتحدث/ين عنها.

ستنضم اليّ في المقابلة زميلتي ندى كتانة بصفتها مترجمة، وستحافظ هي أيضا على سرية هويتك وعلى سرية المقابلة.

سيتم تسجيل المقابلة من أجل تحليل المعلومات. بعد نهاية المقابلة سيتم نقل التسجيل إلى محرك أقراص محمي بكلمة مرور حيث سيتم محوه بعد ذلك من جهاز التسجيل. وسيُستخدم التسجيل لأغراض البحث فقط ولن يتم نقله لأي جهة أخرى. يمكنك رفض التسجيل الآن أو في أي وقت لاحق وفي هذه الحالة سيتم محوه بشكل نهائي.

في نهاية المقابلة، يمكن أن أطلب منك أن تنصحني/تنصحيني بأشخاص آخرين يفيدني أن أتحدث معهم. انت ليس ملزما/ة بإحالتي إلى أشخاص آخرين، وعلى أي حال لن اقوم بإبلاغ هذا الشخص بأنك من قمت بتزويدي بإسمه/ها إلا بإذن منك.

إن كان لديك أي استفسار يمكنك الاتصال بي على هذا الرقم – فيرد قيسر 052-6828860 أو التواصل عن طريق البريد الاكتروني vered.keasar@gmail.com.

توقيع المشارك/ة

الاسم	التوقيع	التاريخ
_____	_____	_____

توقيع الباحثة

الاسم	التوقيع	التاريخ
_____	_____	_____

توقيع د. يوسف النتشة، مدير مركز دراسات القدس في جامعة القدس

15.6.2023

جامعة القدس
Al-Quds University

משתתפ.ת יקר.ה,

תודה רבה על הסכמתך להשתתף במחקר זה, העוסק בשירותי בריאות הנפש הזמינים לנשים במזרח ירושלים ובחסמים המקשים על השימוש בהם. פניתי אלייך בבקשה להשתתף במחקר בשל היותך אישה מזרח ירושלמית ו/או בשל הקשר המקצועי שלך לתחום.

השתתפותך במחקר היא וולונטרית, ותוכל.י להפסיק את ההשתתפות בכל שלב.

זהותך כמרואיין.ת תישאר חסויה, וכל פרט העשוי לזהות אותך ישונה או שלא ייכלל במחקר. פרטייך יישמרו בכונן מוגן בסיסמה, שרק לי, החוקרת, יש גישה אליו. טופס הסכמה זה נשמר בנפרד מהנתונים ואינו מאפשר לקשר בינך לבין הנתונים שתספק.י.

הראיון יוקלט כדי לאפשר ניתוח מעמיק של המידע. לאחר סיום הראיון, ההקלטה תועבר לכונן מוגן בסיסמה ותימחק ממכשיר ההקלטה. ההקלטה תשמש למטרות מחקר בלבד ולא תועבר לאף אדם נוסף. ביכולתך להחליט כעת או בכל שלב בהמשך שאינך מסכים.ה להקלטה, ובמקרה זה ההקלטה תימחק.

בסיום הראיון, ייתכן שאבקש ממך להפנות אותי לאנשים נוספים הרלוונטיים למחקר. אינך מחוייב.ת להפנות אותי לאנשים נוספים, ובכל מקרה לא אומר להם שהגעתי דרכך אלא באישורך המפורש.

לכל שאלה בנוגע למחקר ניתן לפנות אליי בטלפון או באימייל – ורד קיסר 052-6828860, vered.keasar@gmail.com

חתימת המרואיין.ת

_____	_____	_____
שם	חתימה	תאריך

חתימת המראיינת

_____	_____	_____
שם	חתימה	תאריך

חתימת ד"ר יוסף אלנתשה, ראש המרכז ללימודי ירושלים באוניברסיטה אלקדס

_____
15.6.2023

خدمات الصّحّة النّفسيّة الإسرائيليّة المتاحة للنّساء الفلسطينيات في القدس الشرقيّة: مدى توفّر تلك الخدمات والحواجز الّتي تعوق الحصول على الرّعاية

اعداد: فيرد خين يوسف قيسر

اشراف: د. اياد الحلاق

ملخص:

لا يُعرف سوى القليل عن خدمات الصّحّة النّفسيّة المتاحة للنساء الفلسطينيات المقدسيّات. تهدف هذه الدراسة الى سد هذه الفجوة البحثية، مع التركيز على العلاج النفسي في العيادات المجتمعية الإسرائيلية، وعلى خدمات إعادة التأهيل الإسرائيلية.

في القسم الأوّل من البحث تم استخدام المنهجية الوصفيّة لتقديم عرضا عاما عن الخدمات المتوفّرة، وذلك اعتمادًا على التّقارير البحثيّة، والبيانات المتاحة للجمهور والمقابلات. اما في القسم الثّاني تم استخدام المنهجيّة النوعيّة، بهدف فهم نظرة العمّال المهنيّين والنّساء الفلسطينيّات غير المحترفات إلى خدمات الصّحّة النّفسيّة في المدينة. لقد كانت أداة البحث المقابلات شبه المنظمة، حيث تم مقابلة ثمانية أشخاص محترفين لديهم صلة مهنيّة بمجال الصحة النفسية، وخمس نساء مقدسيات غير محترفات. وتم تحليل المعلومات من خلال التّحليل الموضوعيّ (thematic analysis).

وتُظهر نتائج الدّراسة أنّ توفير العلاج النفسيّ في العيادات المجتمعيّة يتمّ بشكل أساسيّ من قبل "صناديق المرضى" أو "كوبوت حوليم" الإسرائيليّة الأربع، ولكنّ أعداد الأطباء والمعالجين النّفسيّين منخفضة، كما أنّ التّوزيع المكانيّ للخدمات هو محدود. أما خدمات إعادة التّأهيل النّاطقة باللّغة العربيّة في القدس الشرقيّة فتشمل: نُزُل (hostel)، خدمة مساعدة المعيشة، النّادي التّوظيفيّ، خدمة التّعليم، خدمة المرافقة والتّوجيه، عدّة نوادي اجتماعيّة، ومركز لعائلات الأشخاص ذوي الإعاقات النّفسيّة. يُشار إلى أنّه لا توجد خدمات تستهدف النّساء خصيصًا، وكذلك لا توجد خدمات لعلاج ضحايا الاعتداء الجنسيّ.

ظهرت أربعة مواضيع (themes) رئيسيّة من التّحليل النّوعيّ، وهي: "الضّغوطات"، "العوائق الّتي تحول دون الرّعاية"، "بدائل النّظام الإسرائيليّ"، و"الانفتاح على الرّعاية الصّحّيّة النّفسيّة".

في ضوء النتائج، يُوصى الجمع بين العمل على مستوى المجتمع (مثل حملات التوعية والمساعدة في الحصول على الحقوق)، وممارسة الضغط على المؤسسات الإسرائيلية لتحسين التوافر وإمكانية الوصول الى خدمات الصحة النفسية.