



Briefing

The hidden costs of the 2014 Gaza– Israeli conflict

Adolescent girls' psychosocial wellbeing

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Cover photo: Anas al Baba/Oxfam: 11 year old Manar and her friends at their damaged school in Gaza

1 Introduction

The most recent Palestinian–Israeli conflict in July 2014 exacerbated the complex psychosocial vulnerabilities and risks already faced by the Gazan population. The siege imposed on the Gaza Strip since June 2006, and the accumulated consequences of repeated conflicts, have taken an enormous psychological toll on children and families. In the past five years alone, more than 4,000 Palestinians have died, and tens of thousands have been injured (many of them children and women). There has been large-scale destruction of houses and buildings have been destroyed, with the 2014 conflict leaving more than 30% of the population displaced and living in temporary shelters (Ministry of Health, 2014). The protracted conflict has triggered acute levels of psychosocial distress, especially among children and adolescents. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) has repeatedly described the situation as a chronic emergency and a protracted human dignity crisis.

Psychosocial and mental health services that are appropriately designed and resourced can alleviate the effects of war and conflict and respond to the needs of the affected population, helping people to return to normal life. However, when developing post-conflict psychosocial responses, it is crucial to understand not only existing support service infrastructure and gaps, but also local cultural norms and practices underpinning demand and the likelihood of service uptake. The Overseas Development Institute (ODI), together with local experts, undertook an in-depth qualitative research assessment of the experiences of adolescent girls and their families in the immediate post-conflict context in Gaza. This considered the effects on their psychosocial wellbeing, the coping strategies at their disposal and the extent to which existing support services were adequately informed by context-specific gendered norms and practices. The research is part of a broader project supported by the ReBUILD Consortium, which is funded by the UK Department for International Development (DFID), to look at the linkages between mental health/psychosocial wellbeing and gendered socio-cultural norms in post-conflict settings in Gaza, Liberia and Sri Lanka.

The Gazan context and study site

The Gaza Strip is often referred to as one of the most densely populated areas in the world – home to 1.71 million people, it has an exceptionally high ‘youth bulge’, with 53% of the population aged 15–29 (UNFPA, 2013).. In the past 20 years, the Gaza Strip has been ‘autonomous’, experiencing a partial transfer of authority from Israel to the Palestinian Authority, but with Israel still retaining overall sovereignty, including controlling borders, trade, movement of goods and people, the commercial

market, the main sources of energy, and the means of communication and security. The State of Palestine’s lack of control over its own affairs is compounded by the fact that for decades Israel has followed a de-development policy¹ in the territory, which has resulted in economic collapse and widespread poverty.

Compared to other countries at a similar level of economic development, basic health outcomes for the Palestinian population overall are relatively good, partly due to strong performance on most basic public health and primary health care (PHC) functions. Little is known, however, about the health status of adolescents as a specific group, and even less is known about the psychosocial wellbeing, in terms of psychosocial and mental health, of adolescents in the Gaza Strip. What is clear, however, is that they are exposed to multiple psychosocial vulnerabilities resulting from overpopulation, political turbulence, chronic exposure to conflict, strict conservative social norms and long-term economic hardship. Moreover, while adolescent boys and girls can suffer from psychosocial ill-being, a number of studies have concluded that girls are affected more severely because of their exposure to other socio-cultural stressors including restriction of movement, which can further complicate their situation (e.g. El Kahlout, 2008).

Our qualitative research focused on the Shajaia neighbourhood in Gaza City, an area with more than 120,000 residents that was particularly affected by the 2014 conflict. On 20 July 2014, approximately 120 Palestinians were killed in shelling in and around Shajaia, with hundreds injured and thousands of houses demolished. Many people were forcibly evicted from their houses and left with nowhere to go.

2 Mental health status and key stressors among adolescent girls

The magnitude of the psychosocial problems in the Gaza Strip is not fully known due to the lack of baseline information. However, it is evident that repeated military operations have traumatised many people and that there are high levels of post-traumatic stress disorder (PTSD), with chronic symptoms including high levels of anxiety and psychosomatic reactions (Colliard and Hamad, 2010). Studies also show that adolescents in the Gaza Strip suffer from PTSD and other forms of anxiety, depression, attention deficit disorder, conduct disorders, increased violence and loss of hope (Colliard and Hamad, 2010; Ministry of Health, 2014b).

Our findings suggest that chronic vulnerabilities have increased since the ceasefire in August 2014, with the conflict being an additional factor that has exacerbated people’s exposure to stressors. Many families have become

1 This de-development policy has included controlling trade, destroying factories and business institutions, along with the denial of entry of raw materials, advanced equipment and machines, among other measures.

separated, with some living in relatives' houses and others in shelters or communal centres. Many adolescents have found themselves living in unfamiliar surroundings and/or with strangers, lacking adequate attention from 'safe' adults [close family members and relatives] and therefore feeling unsafe on a day-to-day basis. This appeared to be a particular problem for adolescent girls, and was articulated often through the lack of privacy afforded them. While boys can go outside or sleep in a living room, girls cannot do so due to strictly imposed gendered cultural norms whereby they have to keep their hair and body covered at all times (usually from the age of 12) in case relatives or strangers come to the house. During the research, adolescents repeatedly mentioned losing their homes, losing a loved family member or friend, and living in crowded and dirty shelters or other communal centres as the main sources of stress. A key informant from an international organisation gave an example: 'A girl told me that her father prevented her from going to the toilet for hours because there were men in the area...' As a result, many women and girls suffer bladder-related health problems due to lack of access to separate toilets in the collective centres (Ma'an Development Centre, 2014). There were also fears of sexual harassment and gender-based violence within the shelter environment. As a consequence of concerns about such risks, some girls reported being punished by their family for late arrival at their temporary residence.

Among the compounding vulnerabilities facing adolescents, economic hardship has the greatest influence on adolescents' deteriorating psychological status. Respondents linked many problems to the economic situation, including domestic violence, low educational attainment, inadequate socialisation, insufficient recreational activities, and dysfunctional relationships between adolescents and their parents. Female adolescents in particular reported negative feelings when they lack clothes or other items that their better-off peers have.

Frequent absence of electricity and other basic services or infrastructure also created many stressors among the community, affecting girls in specific ways. For example, power cuts may affect adolescents because they tend to increase the level of domestic stress in general as completing ordinary day-to-day tasks becomes more challenging; girls also often have less time to study or engage in leisure activities when there are power cuts, due to increased domestic chores which need to be carried out manually. Indeed, adolescent boys and girls felt stressed when they did not have places to go for recreation; while boys can spend time with friends in the streets playing traditional games, due to cultural norms girls do not have similar opportunities for play or recreation.

3 Gendered coping strategies

Post-conflict coping strategies differed significantly along gender lines. Overall, our findings indicated that people tend to rely on emotion-focused coping strategies rather than problem-solving strategies, because adolescents and their parents can do little to address the root causes of the main challenges they face. Younger girls (12-14 years old) in particular sought support from social networks such as family members, friends and relatives, also turning to religion and support from traditional healers. There was also a tendency among girls to cope by day-dreaming, imagining a different reality, drawing, writing and using social media. Boys, on the other hand, tended to seek out recreational activities such as gathering with friends on the streets, or sport activities, as a way of coping.

Adolescent girls sometimes approached psychosocial support available in schools and PHC clinics, and tended to engage in psychosocial activities – e.g. group debriefings – where these were available. Adolescent boys, however, found this harder to do, as they did not want to admit 'weakness' as they wanted to uphold local norms about appropriate 'masculinities'. As a result, most of the coping strategies used by girls were more constructive (including investing more time in their education, undertaking additional household chores), while boys tended to use negative coping strategies, including violence, choosing to be isolated, or using painkillers such as Tramadol.

4 Fragmented and poorly coordinated support services

Currently, there are more than 162 organisations providing psychosocial and related services in Gaza. These suffer from weak coordination and regulation. Moreover, only two – the Ministry of Health (MoH) and the Gaza Community Mental Health Programme (GCMHP) – provide specialist services. The MoH is the main provider, supervisor and regulator of mental health services. It has recently begun a process of integrating mental health services into all its 54 primary health care centres, within the non-communicable disease departments. The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) is the second major provider, delivering mental health and psychosocial services through counsellors based at UNRWA health and relief centres. UNRWA focuses on preventive care and on counselling and debriefing rather than providing consolidated case management for individuals. Both UNRWA and the Ministry of Education run a large-scale school counselling programme, with more than 500 counsellors. In addition, there are many non-governmental organisations (NGOs) in Gaza that provide psychosocial awareness and support through counsellors and social workers, but much of the support is short-term – peaking immediately after a conflict episode but not oriented

Box 1: Conflict-related scars – testimonies from adolescent girls

For many adolescents, the experiences of the 2014 conflict, as well as the preceding conflicts, have deeply affected them:

‘What will happen? All years are alike, year after year, war attacks us, and every year, we don’t know if war is coming this year or the year after...’ 11-year-old girl
‘What happened during the war is indescribable. You will not be able to imagine it. It was unbearably terrifying – fear, dismay, death, and horror!’ 14-year-old girl

These negative effects have also reverberated post-conflict in a range of ways which are particularly trying for girls, given the strictly gender-segregated society under Hamas governance:

‘I stayed suffering for hours till they moved away from the area then I used the toilet.’ 15-year-old girl

‘We need to regain our respect and dignity, to be liberated and have freedom as others, not the same as we are now.’ She added: ‘I always say to my father, I would like to go back home, and he usually says the same answer, “we will”. Then he informed me that our home was destroyed, so I told him to make a tent for us on the rubbles of our home.’

‘The general physician stopped following up my daughters, especially the older one, and he asked me to stop treating her because she is now a young lady, and continuing receiving mental health services will affect her reputation and she will be stigmatised forever [in marriage]. He told me, “It is enough, don’t take her to any doctor. This will affect her if people know about her case.”’ Mother of an adolescent girl

towards developing a sustainable and comprehensive system of tailored support. In the post-conflict period, at least 59 psychosocial programmes had been implemented by local and international NGOs in the Shajaia area alone, serving more than 25,600 children. The most common interventions after the conflict were structured group activities, psychosocial first aid², awareness raising, debriefings, and fun days. Donors often provide reactive psychosocial programmes as part of their emergency response immediately after a period of intensified fighting. However, these services are generally not proactive in screening, identifying and supporting those most in need.

Moreover, there are few preventive activities targeting adolescents or activities to identify vulnerable groups at greater risk of mental health problems. Additionally, most organisations involved in this study reported referring service users to other institutions; but most referrals originate from NGOs pointing those in need in the direction of specialist services. There are few referrals in the opposite direction, which raises important questions about continuity of care. Systematic follow-up of referrals, feedback and exchange of information is rare.

5 Barriers to adolescents accessing services

Despite the presence of multiple psychosocial and mental health service providers in Gaza, organisational, cultural and psychological barriers often prevent young people accessing those services. Surprisingly, of the programmes

implemented during the most recent post-conflict period, only 0.9% targeted young people (categorised as being between the ages of 15 and 29). Generally speaking, adolescent girls also tend to have less access to mental health services because of prevailing psychological and cultural norms that act as barriers to service uptake. The older the girl, the less likely she is to accede to psychosocial and mental health services, because the stigma that comes with doing so could affect her reputation and her chances of marrying.

Due to the lack of proactive targeting by psychosocial and mental health service providers, families themselves usually decide when and how to seek services after recognising that a family member has psychosocial problems. Typically, families only seek formal mental health services late on and after consulting traditional healers. For the poorest households, obtaining a medical report to get financial assistance from the Ministry of Social Affairs was often mentioned by health providers as a barrier to psychosocial and mental health service uptake, but interestingly this was not mentioned by service users or programme beneficiaries. Fear of male partners’ reactions was also mentioned frequently by mothers of adolescent girls as being a deterrent to service uptake.

2 This has included measures provided at shelters and has involved helping people to feel safe, connecting them with others, and providing emotional and social support.

6 Evidence-based policy and programme entry-points

Given the close linkages between psychosocial wellbeing and effective human functioning – whether it be in the education arena, workplace or broader polity – it is critical that development actors pay greater attention to the psychosocial fallout of conflict and to the support services needed to enhance individual and community coping strategies and promote resilience in the context of large scale violence and trauma. In particular it is vital that a short-term, one-size-fits-all approach is not adopted, but rather that support services are developed with a clear understanding of local gendered socio-cultural norms and practices with regard to mental health, and are targeted and implemented in an age-appropriate manner. More specifically, our findings point to the need for a greater focus on five key areas that together could lead to a much more supportive environment for adolescent girls in post-conflict contexts in Gaza and beyond.

1. Develop an integrated psychosocial and mental health strategy

There is an urgent need to address chronic trauma alongside longer-term mental health strategies. Dealing with psychosocial conditions linked to conflict-related emergencies in Gaza should complement rather than compromise development interventions already being implemented. Many of the current gaps in psychosocial services could be circumvented if more efforts were dedicated to adequate planning and coordination prior to and during a crisis. To overcome fragmentation of mental health services in the Gaza Strip, stakeholders need to develop a conceptual model and standards for prevention, control, early identification, diagnosis and management of mental health and psychosocial issues. Moreover, there is an urgent need for standards to regulate targeting and service provision, designed in ways that consider gender- and age-specific needs and sensitivities.

2. Work to harness and enhance adolescent girls' positive coping strategies

Tackling adolescents' vulnerabilities requires comprehensive multi-sectoral interventions and policies, cutting across health, education, justice, sports and recreation, media and social work sectors, among others. In doing this, greater efforts need to be made to enhance positive coping strategies. These could include: building basic life skills among children and adolescents; promoting access to psychosocial support; strengthening ties and nurturing relationships between adolescents and their families (especially at an early age); and investing in education as a means of strengthening children and young people's self-esteem. At the same time, there should be greater efforts to monitor and address negative coping strategies through awareness raising, policy setting and

multi-sectoral interventions such as child protection networks which facilitate a coordinated continuum of care across a range of NGO and governmental agencies.

3. Actively promote service uptake and follow up

In order to promote greater uptake of support services, policy-makers and implementers need to set more appropriate criteria to proactively screen, identify and serve the groups most affected by psychosocial and mental health problems. In turn, the Ministry of Health should better regulate and coordinate service provision, including the promotion of licensing and accreditation measures to ensure that provider organisations, at a minimum, do no harm to the young people they are designed to serve. At the same time, there is a need to implement more programmes designed specifically to meet adolescents' needs, address shortages in specialist providers able to deliver culturally sensitive support services and to direct greater effort to encouraging caregivers to increase uptake of services and programmes. In the case of young women and girls, this could be achieved by removing some of the psychological barriers that hinder service uptake at community level, particularly reducing the stigma attached to seeking support for psychosocial and mental health issues. Efforts should focus on raising community awareness through media, education and community mobilisation, and to improving health workers' awareness of the challenges facing adolescents as they go through this very specific life-cycle stage. There is a need to strengthen the role of school counselling programmes in prevention, early detection and management of mental illness.

4. Move away from short-term time horizons and invest in robust management systems

Although low down on government and donor priority lists alike, investing in robust administrative and managerial systems is essential to support technical interventions and service improvements. Therefore, future psychosocial and mental health projects need to give greater attention to these issues, including managing human and non-human resources more effectively, promoting evidence-based practice, setting performance indicators for psychosocial and mental health services, tackling drug shortages, and engaging in networking to enhance sustainable solutions.

A year after the 2014 conflict, our research has highlighted the accumulated psychosocial toll exacted on young people, and especially adolescent girls. Our findings confirm that the prevailing combination of chronic economic, political, cultural and social vulnerabilities facing people in the Gaza Strip, and the inability of social services to respond to these adequately, has exacerbated the already dire psychosocial status of the population, and perhaps in particular that of adolescent girls, who would seem to be disproportionately affected. Given that there is

a robust evidence base to indicate that improving people's psychosocial wellbeing is closely linked to positive change in their overall context, any kind of recovery will remain highly challenging while the Israeli blockade remains in place and the protracted conflict remains unresolved. Future solutions need therefore to work in tandem at both levels – both strengthening adolescent girls' resilience in the face of severe psychosocial vulnerabilities, whilst simultaneously seeking a sustainable and peaceful political solution.

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