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Consortium

Mental health and psychosocial service provision for adolescent girls in post-conflict settings

The case of the Gaza Strip

Bassam Abu Hamad, Nicola Jones, Nadia Al Bayoumi and Fiona Samuels

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ReBUILD Country Report

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Abbreviations

ASCA	American School Counsellor Association
CABC	Children Affected by Armed Conflicts
CBOs	Community Based Organisations
CMHC	Community Mental Health Centre
COPE	Parents Education Programme
DFID	Department for International Development
DMS	Diagnostic and Statistical Manual of Mental Disorders
EEG	Electroencephalogram
FGDs	Focus Group Discussions
GBV	Gender-based Violence
GCMHP	Gaza Community Mental Health Programme
GDP	Gross Domestic Product
HR	Human Resources
ICD	International Classification of Diseases
IDIs	In-depth Interviews
IDPs	Internally Displaced Persons
IKIs	Key Informant Interviews
IASC	Inter-Agency Standing Committee
MAP	Medical Aid for Palestinians
MOE	Ministry of Education
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
NECC	Near East Council of Churches
NGOs	Non-governmental Organisations

NIS	New Israeli Shekel
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PNA	Palestinian National Authority
PTSD	Post-traumatic Stress Disorder
SDQ	Strengths and Difficulties Questionnaire
UK	United Kingdom
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

Executive summary

Aims of this study

The most recent Palestinian–Israeli conflict in July 2014 has worsened the multi-faceted psychosocial vulnerabilities and risks already facing people in Gaza. The siege imposed on the Gaza Strip since June 2006 and the 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, tens of thousands have been injured (many of them children and women), and houses and buildings have been totally destroyed. 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 help to allay 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 local cultural norms and practices.

This case study was supported by the REBUILD consortium, a research partnership funded by the UK Department for International Development (DFID) as part of a broader study that explores the linkages between mental health/psychosocial wellbeing and socio-cultural norms in post-conflict settings (in Gaza, Liberia and Sri Lanka). It looks in depth at the extent to which these services are sufficiently informed by a thorough understanding of the context, as well as how gender inequalities and dynamics and socio-cultural norms shape the experiences of adolescent girls.

Adolescence is an extremely influential period in the life cycle and is critical in determining life-course potential. The study therefore aims to better understand the common challenges facing adolescent girls in post-conflict settings, the coping strategies they and their caregivers use, and the availability and adequacy of psychosocial and mental health services that can meet their needs.

The Gazan context

The Gaza Strip is one of the most densely populated areas in the world, with more than 5,000 people per square kilometre. It is home to 1.71 million people – 66% of them refugees. The average family has 6.3 persons and nearly 20% of the population are aged 10-18. In the past 20 years, the Gaza Strip has been ‘autonomous’’, experiencing a partial transfer of authority from the Israelis to the Palestinian Authority. But Israel still has overall sovereignty, controlling borders, trade, movement of goods and people, the commercial market, water, the main sources of energy, the means of communications and security. This lack of control over its own affairs is compounded by the fact that for decades, Israel has followed a de-development policy in the territory, which has resulted in widespread poverty and economic collapse.

Compared to other countries at a similar level of economic development, 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 about the health status of adolescents as a specific group; they are usually integrated in broader analyses of health issues affecting children and youth. However, findings of a 2010 survey indicated that 16% of young people had a health problem during the two weeks preceding data collection, while 3% of respondents were living with at least one chronic disease (Palestinian Central Bureau of Statistics-PCBS, 2010).

In terms of psychosocial and mental health, adolescents in the Gaza Strip are exposed to multiple psychosocial vulnerabilities resulting from over-population, political turbulence, chronic exposure to conflict, and strict conservative social norms – not least long-term economic hardship.

Study site and methodology

The study site

Shajaia neighbourhood, located at the eastern border between the Gaza Strip and Israel, was selected as the study site. It is the largest neighbourhood in Gaza City, with more than 120,000 residents. Average family size is 5.8 and most families (more than 61%) have children or adolescents. Shajaia is a conservative community, characterised by strict adherence to traditional cultural norms and practices.

Shajaia has four government-run primary health care centres, three centres run by non-government organisations (NGOs), and the only rehabilitation hospital in the Gaza Strip. Residents can also access services at the United Nations Relief and Works Agency (UNRWA), NGOs and governmental premises.

On 20 July 2014, around 120 Palestinians were killed in shelling in and around Shajaia, with hundreds injured and thousands of houses demolished. Many people were forcefully evicted from their houses with nowhere to go.

Study methodology

The research team used a mix of qualitative tools to capture different types of information from different groups and individuals, including focus group discussions with adolescent beneficiaries and service users (particularly girls) (6), semi-structured in-depth interviews with adolescents (12), and complementary interviews with some of their caregivers or friends (6). A large number of key informant interviews (21) were conducted at the policy-making/management and implementation levels, and there was also a focus group discussion with female counsellors. In addition, five facility checklists were administered at organisations providing psychosocial services to Shajaia residents.

The selected sample of interviewees was diverse and included conflict-affected families, mental health service users, beneficiaries of mental health and psychosocial programmes, and people with disabilities. Adolescent girls and boys were interviewed, but we over-sampled girls given the study's focus. Interviewees included users of regular psychosocial/mental health services and beneficiaries of specific outreach programmes, including those targeted at internally displaced persons (IDPs).

The research team consisted of one senior expert in the role of principal investigator and one female research assistant who focused on data collection and participated in analysis and report writing. A research fellow from the Overseas Development Institute (ODI) also provided oversight supervision and technical guidance. Data collection took place in November to December 2014 – two to four months after a ceasefire had been agreed. An open coding thematic technique was used in data analysis, with the team unpacking each transcript to extract key issues, remarks and quotes for each thematic area of the study: adolescent girls' vulnerabilities, coping mechanisms, service provision and quality of services. The research team was careful to ensure that the principles of research ethics were respected and maintained, including meeting child protection standards.

Study limitations

The absence of baseline data prior to conflict episodes, including that of the July 2014 conflict, made it difficult to attribute the study findings to the consequences of the conflict and/or to confirm the outcomes of the mental health and psychosocial services provided to adolescent girls. In addition, it was challenging to recruit service users of mental health institutions because of confidentiality requirements and their psychological status, which restricted their ability to interact with data collectors.

Mental health status and key stressors

The magnitude of the mental health problems experienced by people in the Gaza Strip is not fully known due to the lack of baseline information. The siege and repeated military operations have traumatised many people; 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 show that adolescents in the Gaza Strip suffer from PTSD and other forms of anxiety, depression, attention deficit disorder, conduct disorders, increased

violence, loss of hope, bad memories, nightmares and bed-wetting (Colliard and Hamad, 2010; Ministry of Health, 2014b).

Although many families end up living in collective centres (temporary shelters) when their homes are destroyed during bombing, the conditions in these centres can contribute to people's deteriorating psychological and mental wellbeing. Women and girls in particular face many constraints and become more vulnerable during daily life in these collective centres (Ma'an Development Centre, 2014). A key informant from an international organisation said: *'A girl told me that her father prevented her from going to the toilet because there were men in the area...'* The girl added, *"I stayed hours till they moved away from the area then I used the toilet".* Also, many women and girls suffer bladder-related health problems because of lack of access to separate toilets in the collective centres (Ma'an Development Centre, 2014).

Although mental health illnesses often start to develop during adolescence, people typically only approach specialist care later on in life – usually when the severity of their illness increases. Adolescent boys and girls can suffer from these illnesses, although numerous studies conclude that girls are affected more severely because of their exposure to other socio-cultural stressors including restriction of movement, which further complicate their situation (El Kahlout, 2008). The literature consistently indicates that physical and emotional symptoms experienced by adolescents (especially boys) are associated with being exposed to or witnessing violence (UNICEF, 2012). Substance abuse and violence among boys are also reported to be increasing.

For the post-conflict period (since August 2014), our findings suggest that chronic vulnerabilities had increased and the conflict was an additional factor that increased people's exposure to stressors. Families had often become separated, with some living in relatives' houses and others in shelters or communal centres. Many adolescents found themselves living in unfamiliar surroundings and/or with strangers, lacking adequate attention from 'safe' adults and therefore feeling unsafe on a day-to-day basis. This appeared to be a particular problem for adolescent girls – especially the lack of privacy afforded them. While boys may go outside or sleep in a living room, girls cannot do so due to cultural norms; they have to keep their hair and body covered at all times (usually from the age of 12 upwards) in case cousins, relatives or strangers might 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.

With regard to the compound vulnerabilities facing adolescents, economic hardships have the greatest influence on adolescents' deteriorating psychological status. Respondents linked many problems to the economic situation: 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 do not possess clothes or other items that their better-off peers have.

Lack 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; girls also often have less time to study or engage in leisure activities when there are power cuts). 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, girls do not have similar opportunities for play or recreation due to cultural norms. Generally, in the Gaza Strip, there is only modest understanding of the different stages of a child's development (including adolescence); families seldom create the space adolescent children need to express themselves, and seldom try to understand their special needs, concerns or capabilities.

Violence was a major concern among adolescent boys and girls in the study site. At school, boys were more likely to experience violence than girls, while in the home and in shelters, girls were more exposed to gender-based violence (GBV); some girls reported being punished when they arrived at their temporary residence late. Fear of being exposed to sexual harassment is also a stressor for girls, especially those living in remote areas and close to borders. Sexual harassment can not only affect the immediate reputation of the girl or young woman, but may also affect her future chances, especially when subject to strong social norms within a conservative community. Conforming to expectations of 'family honour' is a source of considerable stress for older adolescent girls, especially as violations (or perceived violations) of that honour can result in death.

Overall, the study concluded that some categories of adolescents are more vulnerable to psychosocial stressors. These adolescents include: girls; girls and boys over 15 years old; adolescents who have been directly affected by the war; those who have lost their homes; those who have lost the main breadwinner or member/s of their family or friends; those who have been orphaned; adolescents in child-headed families; adolescents who have missed out on education; those who are economically disadvantaged; adolescents with disabilities; those living in shelters; those who have previously been exposed to trauma; and those living in culturally conservative and physically isolated areas.

Coping strategies

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 challenge they face. During the acute stage of the conflict, most people (including adolescents) turned to religion, reading the Quran and saying prayers to protect them and their families. This was common practice, especially among women and girls. When there was an electricity supply, people watched the news, which usually served to increase their fears. Men and women coped by listening to radios and sleeping during the daytime; however, adolescent girls did housekeeping work while boys socialised with friends and relatives during the daytime, when shelling abated. While staying in temporary communal shelters, some adolescent girls participated in psychosocial debriefing sessions carried out there.

Boys and girls use different coping strategies

Post-conflict coping strategies differed significantly along gender lines. Young girls in particular sought support from social networks such as family members, friends and relatives, with girls also turning more to religion and seeking support from traditional healers. There was also a tendency among girls to cope by day-dreaming, imagining a different reality, imitation, drawing, writing, and using social media. Boys 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. Adolescent boys, however, found this hard to do, as they did not want to admit 'weakness'. Some boys and girls (especially younger girls) developed psychosomatic symptoms such as a stammer or convulsions as a way of reducing their exposure to physical violence from their parents, who are also heavily affected by stress. Interestingly, most of the coping strategies used by girls were positive, while boys tended to use negative coping strategies, including violence, choosing to be isolated, or using painkillers such as Tramadol. While adolescent girls have sought to cope by investing more time in their studies, boys have typically tried to cope with their poor economic situation by working, with or without dropping out of school.

Service provision

Little coordination and poor regulation

Currently, there are more than 162 organisations providing psychosocial and related services in Gaza, but only two – the Ministry of Health (MoH) and the Gaza Community Mental Health Programme (GCMHP) – provide specialist services. The services these organisations provide are characterised by poor coordination and regulation.

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 (PHC) centres, within the non-communicable disease (NCD) departments. In addition, the Ministry operates six community mental health centres (CMHCs) and provides inpatient mental health care (psychiatry) for severely affected people at the only mental health hospital in Gaza (30-bed capacity).

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 focuses on counselling and debriefing rather than providing consolidated case management for individuals. Both UNRWA and the Ministry of Education (MoE) run a large-scale school counselling programme, with more than 500 counsellors. In addition, there are many NGOs in Gaza that provide psychosocial awareness and support through counsellors and social workers; these are generally concerned with stress management techniques and recreational activities. The exception is the GCMHP, which provides mental health services through three CMHCs.

Lack of targeting

In 'normal' and crisis situations alike, adolescent girls in Gaza are not proactively targeted by service providers; in fact, adolescents tend to be overlooked by these programmes, which often focus on younger children. Also, there are few preventive activities targeting adolescents or activities to identify vulnerable groups who are at greater risk of mental health problems.

During and immediately after the most recent conflict (July 2014), routine mental health care services were substantially affected. Services provided by PHC centres were suspended, with the focus shifting to life-saving interventions. Post-conflict, 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 aid, awareness raising, debriefings, and fun days.

One feature reflecting the fragmentation and poor quality of psychosocial and mental health services in Gaza is the lack of nationally endorsed protocols or technical guidelines, except at PHC centres run by the MoH. There is no clearly defined therapeutic model to guide clinical practice, and no structured 'continuum of care'. Moreover, there is no strategic direction for psychosocial and mental health services in the Gaza Strip.

Availability of health personnel

The distribution of personnel (across most health professions) is fairly reasonable in Gaza; however, specialty and subspecialty areas such as mental health and child/adolescent psychiatry are greatly disadvantaged. Findings confirm critical gaps in HR management, including an absence of strategic direction, lack of clarity of roles and responsibilities, a weak supervisory system, and few incentives to improve performance.

Coordination

Findings indicate that there is little coordination (and therefore unnecessary duplication) among psychosocial and mental health programmes. This could be because the government does not play a sufficient coordination role with the various service providers. Although referral forms are usually available at service sites, these are not appropriately managed or utilised. Most organisations involved in this study reported referring service users to other institutions; but most referrals originate from NGOs who point 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.

Moreover, findings reveal gaps in training for mental health personnel, including improving technical performance, developing skills in assessment and diagnosis, use of case management, therapeutic modalities, psychiatric emergencies and child/adolescent psychiatry. Other areas identified as priorities include psychotherapy, cognitive behavioural therapy (CBT), family therapy, team case management, case management, managerial and leadership skills, supervision skills, occupational and rehabilitation approaches, substance abuse, forensic psychiatry, crisis intervention and community-based interventions.

Research on mental health is practically non-existent in the service sector, except in universities. MoH mental health facilities were reported to be less well-equipped and less spacious than facilities run by NGOs or UNRWA. Other constraints that were frequently mentioned by research participants include shortages of drugs and lack of modern equipment. The mental health hospital (and particularly its seclusion units) was described as a particularly outdated facility.

Accessing psychosocial services

Barriers to adolescents accessing services

Our findings indicate that despite there being many psychosocial and mental health service providers in Gaza, organisational, cultural and psychological barriers often prevent young people accessing those services. Donors often provide reactive psychosocial programmes as part of their emergency response immediately after a period of intensified fighting. These services do not tend to meet people's needs and are generally not proactive in screening, identifying and supporting those most in need. These programmes tend to be more accessible to children, women and adolescents, reaching a higher proportion of adolescent girls than boys. Surprisingly, of the programmes implemented during the most recent post-conflict period, only 0.9% targeted young people (aged 15-29 years). Generally speaking, adolescent girls tend to have less access to mental health services because of prevailing psychological and cultural norms, which act as barriers to service uptake. The older the girl is, the less

likely she is to receive mental health services because the stigma that comes with doing so could affect her reputation and her chances of marrying.

Health-seeking behaviour

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. Families are also involved in the treatment given by service providers, typically ensuring compliance with prescribed medication and follow-up visits.

Although patient satisfaction is not systematically measured, respondents generally seemed moderately satisfied with the quality of services provided in the Gaza Strip, particularly around accessibility; but there were missed opportunities for adequate counselling and providing information to service users. The main drivers encouraging people to seek mental health services included experiencing atypical physical symptoms (such as epileptic fits and bed-wetting), excessive nightmares, and feelings of isolation. In many cases, parents of girls who were suffering from bed-wetting sought support from psychosocial services in order to ready the girl for marriage. Typically, families would only seek formal mental health services late on and after consulting traditional healers.

Obtaining a medical report to get financial assistance from the Ministry of Social Affairs (MoSA) was often mentioned by health providers as a barrier to service uptake, but interestingly was not mentioned by service users or programme beneficiaries. Positive drivers of health-seeking behaviour included the perceived positive outcomes of interventions based at health facilities and schools. Teachers gave numerous reasons for referring adolescents to school counsellors, including poor academic performance, behavioural problems (including violence and aggression), family problems, engaging in culturally unacceptable behaviours, and mixing with members of the opposite sex.

It should be noted, though, that it is often very difficult for families (or mothers) to approach services. During the fieldwork for this study, for example, a mother of a 17-year-old adolescent girl was contacted to invite her daughter to participate in a focus group discussion. The mother was afraid of being beaten if she agreed to this request or allowed a researcher (even a female one) to visit their house. This is illustrative of the numerous obstacles preventing adolescent girls accessing psychosocial or mental health care.

Our research produced mixed findings about the attitudes of health care providers. On the one hand, most were found to be enthusiastic, caring and motivated to help their service users. On the other hand, particularly at the service delivery level, providers are neither age- nor gender-sensitive. Verbatim comments indicate that some providers had projected their own personal issues and problems onto service users. In some cases, it would appear that prevailing cultural norms have influenced providers' perspectives, with many adopting judgemental attitudes towards adolescents in general and gender issues in particular.

Stigma attached to accessing mental health and psychosocial services

Most study participants felt there is still stigma attached to psychosocial and mental ill-health, although it is declining over time (this is truer for psychosocial than mental health services). Responses indicate that stigma is evident among the broader community, among general health service providers, mental health providers, and the media. In general, our findings suggested that women seemed more likely to be stigmatised and affected by stigma when seeking help for mental health problems. It is clear that conflict-related trauma, given the high level of need, has helped people (especially adolescent boys) to disclose and address their mental health issues. Multiple strategies developed by development agencies in coordination with the Ministry of Health have been formulated to reduce the stigma attached to mental health problems, including changing the names of health facilities (e.g. from 'mental health hospital' to 'community mental health rehabilitation centre') and integrating mental health with other health care services. But they have largely proved ineffective.

Mental health outcomes

Recovery from mental illness does not necessarily mean a complete cure; rather, it means that service users are regaining their ability to function on a day-to-day level and their quality of life. Our findings reveal a lack of evidence-based practice that could maximise the impact of mental health interventions in the Gaza Strip. Also, it is difficult to measure impact on beneficiaries or service users due to an absence of baseline data. Most of the

organisations involved in the study did not use assessment tools, for adolescents or other groups. However, a number of participants did report positive impressions of the services they received, which delivered outcomes in helping them to cope and increase their wellbeing.

Evidence-based policy and programme recommendations

The findings of this study are instructive in many respects and have important implications for policy-makers, programme implementers, donors, and the broader international community. The report concludes by presenting recommendations and options going forward across five key themes:

- Strategies and policies
- Challenges and coping
- Coverage, utilisation, approach and outcomes
- HR
- Management systems

Together, these recommendations (see below) could significantly improve the psychosocial wellbeing of adolescents in the Gaza Strip and enhance the positive outcomes of formal and informal psychosocial support.

Strategies and policies

- Strategies and policies should address the determinants of mental wellbeing such as peace, social justice, gender equity, secure livelihoods, good health, education and employment – particularly for adolescent girls, who are more vulnerable to psychosocial problems than other groups. Advocacy focused on addressing gender and age inequalities should target (but not be restricted to) community leaders, policy-makers, politicians, relevant ministries and agencies, and the international community.
- 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.
- Effective planning and emergency preparedness within mental health services is essential to ensure efficient and effective performance, even in the most challenging circumstances. 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.
- It is important to advocate for national policies to protect adolescents and to ensure that those policies are implemented effectively. Potential areas for policy development include mental health practices (including a code of conduct for service providers), child/adolescent protection, gender, human rights, and combating gender-based violence.
- 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. 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.
- There is a need to strengthen coordination, networking and advocacy activities, possibly through the National Steering Committee for Mental Health, which provides a forum for all key stakeholders.
- There should be a mapping process and database established for psychosocial and mental health services, which could contribute to identifying gaps and challenges in terms of facilities, services and personnel.

Challenges and coping

- Tackling adolescents' vulnerabilities requires setting comprehensive multi-sectoral interventions and policies. These should include: drawing up an emergency preparedness plan; designing and implementing protection policies; ensuring that people's livelihoods are supported during crises by providing a safety net; improving living conditions at communal shelters; increasing understanding (among parents and the wider community) of adolescents' needs and perspectives through community awareness and mobilisation initiatives involving the media and community leaders;

introducing legislation and policies to enhance gender mainstreaming at all levels; and mapping the most vulnerable groups, especially adolescent girls, so that they can be purposively targeted by interventions. People with disabilities are also more prone to psychosocial vulnerabilities and should be given special consideration for measures to improve their wellbeing.

- 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 protection networks.

Coverage, utilisation, approach and outcomes

- 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. The Ministry of Health should better regulate and coordinate service provision, including promoting licensing and accreditation measures to ensure that provider organisations at least do no harm.
- It is essential to provide care according to an individualised management plan with clear baseline data and subsequent monitoring and follow-up. Providers need to monitor the effectiveness of their programmes, paying particular attention to outcomes by gender and age group.
- There is a need to strengthen the capacity of mental health service providers to respond to increased demand through provision of resources, focusing on hardware and software investments.
- Policy-makers should implement more programmes designed specifically to meet adolescents' needs, and direct greater effort to encouraging caregivers to increase uptake of services and programmes. Moreover, to standardise mental health and psychosocial interventions, it is important to collaboratively formulate technical protocols that are endorsed nationally. Service providers should adopt a strategy for promoting compliance with the protocols around three main pillars: ensuring that providers can access the protocols; providing training and follow-up; and formulating managerial and supportive policies to safeguard their implementation.
- Women and young girls need greater access to mental health services. 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 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 the school counselling programmes in prevention, early detection and management of mental illness. Gaps in service quality should be addressed, focusing on gender and developing technical standards.

Human resources

- Shortages of health personnel need to be bridged to ensure that there are sufficient specialist providers to deliver culturally sensitive and appropriate mental health services, particularly for young girls.
- There need to be further investments in training/capacity building in all areas, although priorities include: adolescent and child mental health and psychiatry; treatment modalities (especially case management); assessment and measurement of impacts; emergency preparedness and emergency psychosocial support. Moreover, training for mental health personnel on gender mainstreaming, gender-based violence and child/adolescent protection protocols and approaches is essential. In addition, there is a need for training to strengthen administrative and managerial systems, including: management skills, morale and motivation; monitoring (and use of indicators); supervision; and basic HR functions such as planning, equal opportunity policies, managing diversity, and leadership.
- Problems rooted in the attitudes of staff working for mental health service providers could be addressed by adopting standards for service provision, organising training on health ethics, improving interactions among providers, and adopting professional codes of conduct.

Management systems

- Stakeholders need to be mindful that robust administrative and managerial systems are essential to support technical interventions and service improvements. Therefore, future psychosocial and mental health projects need to give greater attention to these issues, managing human and non-human resources much more efficiently, improving quality of services, developing managerial guidelines and supervision, developing strategic thinking and policies, engaging in advocacy, promoting evidence-based practice, networking, and promoting sustainability.
- There is a pressing need to set performance indicators for psychosocial and mental health services. This would require upgrading medical records, improving documentation practices and creating a culture whereby information is used to inform decision-making. More attention should be paid to reporting and sharing information among stakeholders.
- It is essential to systematically monitor service users' satisfaction and respond to their views. Mechanisms to solicit feedback need to be put in place.
- Drug shortages should be systematically monitored so that they can be avoided, securing adequate stock for at least six months in all facilities. Essential equipment (including life-saving equipment) needs to be provided in all facilities.

Finally, our research 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 adequately respond to these, has exacerbated the already dire mental health status of the entire population, although adolescents (particularly girls) are disproportionately affected. It can be inferred that improving people's mental health and wellbeing is closely linked to positive change in the overall context, involving economic growth, community empowerment, cultural change and political resolution of the Palestinian case. Any kind of recovery is impossible while the Israeli blockade remains in place and the protracted conflict remains unresolved. Even if the conflict ended tomorrow, it would take many years to rebuild people's lives and communities.

1 Introduction and background

This report describes fieldwork from the Gaza component of a multi-country study undertaken by the Overseas Development Institute (UK), Al-Quds University (Gaza), The Good Practice Group (Sri Lanka) and The Carter Center (Liberia) with the support from the ReBUILD Consortium, a research partnership funded by the UK Department for International Development.

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) has described the situation in the Gaza Strip as a chronic emergency and a protracted human dignity crisis. In the most recent escalation of violence, on 7 July 2014, Israel launched a large-scale military operation against the Gaza Strip. According to an OCHA report in August 2014, the 51-day conflict wreaked an unprecedented scale of destruction, devastation and displacement.

The July 2014 military operation exacerbated the enormous problems and vulnerabilities already facing the people of Gaza – the combined result of a long-term embargo, recurrent military conflicts, occupation, and economic deprivation. The security situation in Gaza puts an enormous strain on people; there are no safe spaces, no bomb shelters, no alarm/warning system, and no place to flee as all borders are sealed. In just five years (2009-2014), there have been more than 4,000 Palestinian fatalities, tens of thousands of people have been injured, and there has been large-scale destruction of homes and buildings (Ministry of Health-MoH, 2014a). Nearly 30% of the population have been displaced from their homes and are living in temporary shelters or communal centres.

The siege imposed on the Gaza Strip since June 2006, compounded by the deaths, injuries and displacement caused by repeated outbreaks of intensified fighting, have taken a huge psychological toll on families and children. Escalation of fighting triggers acute levels of psychosocial distress, especially among women and children. Children have not been able to be sheltered from the effects of the conflict and, as their parents were focused on survival, they were often not able to take care of their children adequately. In addition, when the fighting was at its peak, incidents of violence against children and child abuse increased, and many families became separated, leaving children even more vulnerable.

An OCHA report (2014) suggests that hundreds of thousands of children are in need of psychosocial support, adding to the burden on already-stretched service providers – many of whom have themselves experienced acute personal trauma. The inter-agency Child Protection Rapid Assessment conducted in October 2014 also found a large increase in the number of children with acute stress-related symptoms such as bed-wetting, eating and sleeping disorders, extreme fear and violent behaviour. This has led to a drastic increase in demand for psychosocial services, which cannot be met through existing services and resources.

Appropriate psychosocial and mental health services can mitigate the effects of war and conflict and meet children's needs by helping them to return to normal life and promote their wellbeing. Evidence shows that psychosocial services can strengthen the capacity of parents and their siblings to positively cope with stressors and seek appropriate services when needed (Miller and Rasmussen, 2010; Gupta and Zimmer, 2008). As such, they can contribute to better quality of life and positive life outcomes.

When developing post-conflict psychosocial responses, and in order to ensure that interventions are culturally sensitive, it is critical to understand local social norms and practices to reach those most in need.

The impact of conflict on people's psychosocial and mental status will differ significantly according to a range of factors, including context, community resilience, previous experiences with trauma, socio-cultural norms, the extent and duration of the trauma, and the individual's age and gender (Allwood et al., 2002).

Adolescents are a distinct social group living through an extremely influential period in the life-cycle, which is critical in determining later life chances and outcomes. Although there are some variations in definitions and meanings, the UN defines adolescence as the period between 10 and 19 years of age (UNICEF, 2011). During adolescence, girls and boys start experiencing physical and neurological changes as well as social changes reflecting their transition from childhood to adulthood and new roles as spouses, parents, workers or citizens (Levine et al., 2009; Jones et al., 2010). Adolescence is also a critical period because it is a time when individuals can gain positive health, social behaviours and attitudes as well as social, educational and work skills that are all pivotal for personal development and learning (UNICEF, 2011).

This DFID-funded study therefore explores the linkages between mental health/psychosocial wellbeing and socio-cultural norms in post-conflict settings (Gaza, Liberia and Sri Lanka). It focuses on the extent to which psychosocial and mental health services are sufficiently informed by a thorough understanding of the context, as well as gender inequalities and dynamics and prevailing socio-cultural norms. It also explores the different coping strategies (positive and negative) that adolescents use to cope with psychosocial stress. Given the focus of the study, it pays particular attention to the experiences of adolescent girls.

1.1 Why the Gaza Strip?

The Gaza Strip is unique in that it has been experiencing protracted conflict with episodes of acute exacerbations that are associated with chronic exposure to psychological traumas. As well as the siege, which affects all aspects of people's lives, three Israeli military operations in less than five years have taken a huge toll on Gaza's population: there are high levels of post-traumatic stress disorder (PTSD) and anxiety, with people often displaying psychosomatic symptoms. Children and adolescents are among those most affected by the conflict and the siege; children display various symptoms, including enuresis (bed-wetting), stuttering, hyperactivity and nightmares (MoH, 2014a). Their increased exposure to violence at the communal level also triggers aggressive behaviours in school and at home.

The literature indicates that poverty among vulnerable households and communities in Gaza is both a cause and an outcome of an array of complex interactions of political, economic, health, psychological, and social deprivations (Jones and Shaheen, 2012). Members of poor households often suffer from physical, psychosocial and mental disabilities or chronic disease; they may also experience gender-based violence (GBV), stigma, discrimination, child labour and child abuse and domestic violence. Young people are also more likely to drop out of school and engage in high-risk behaviours (Hamad and Pavanello, 2012).

Gaza is also interesting from a gender perspective; its culture is a very conservative one, with strict tribal and patriarchal norms controlling the roles ascribed to women and girls, which typically exclude them from participating in public activities and the labour force. Cultural norms and traditions largely determine a person's psychosocial status and outlook. The vulnerability of women and young girls in Gaza is also linked to the prevailing socio-cultural norms that profoundly constrain their ability to move freely, engage in productive activities outside the home, and more generally exercise their agency to choose the course of their lives and those of their children (Hamad and Pavanello, 2012).

1.2 Study aim and objectives

The study explores how the conflict in Gaza has affected the psychosocial and mental health status of adolescents, and particularly adolescent girls. It looks in depth at the coping strategies adolescents use at the individual, household and community levels, the current level of service provision (including the role

of health workers in shaping adolescent service provision), and adolescents access to and uptake of available psychosocial and mental health services. The study's conclusions and recommendations are designed to help stakeholders develop strategies and interventions that are appropriate and responsive to adolescents' mental health and psychosocial needs, in normalised as well as post-conflict situations. The study also adds to the body of literature on this relatively neglected area.

Research objectives included the following:

- To assess the mental health and psychosocial problems experienced by adolescents in post-conflict settings.
- To identify existing formal responses (including levels of staffing, capacity building approaches and modalities for staff) for dealing with mental health and psychosocial problems.
- To explore how social norms and family and community structures in post-conflict contexts affect the gendered wellbeing and vulnerability of adolescents.
- To appraise formal and informal coping mechanisms among adolescents and their communities for dealing with psychosocial problems (especially those resulting from sexual and gender-based violence and the impacts of conflict).
- To provide recommendations on culturally and gender-appropriate approaches for responding to adolescents' mental health and psychosocial needs, focusing on the needs of girls in post-conflict settings and on human resource (HR) capacities.

1.3 Research questions

The main research question was this: are current services and other responses for dealing with mental health and psychosocial problems experienced by adolescent girls in post-conflict settings sufficiently informed by context, gender and socio-cultural norms? Several sub-questions stemmed from this main research question, as follows.

1. What formal approaches/responses are available for dealing with mental health and psychosocial stresses and what paradigms do practitioners working in these services adopt?
 - a To what extent are they informed by a gender perspective, and by socio-cultural specificities?
 - b How does the supply of mental health/psychosocial services in post-conflict contexts (and the low priority afforded them) affect the experiences of adolescents in dealing with psychosocial problems?
2. What informal coping strategies are adolescents and their communities adopting to deal with mental health and psychosocial problems?
 - a Which are promising/ adaptive?
 - b Which are potentially negative/ risky?
3. To what extent have service providers and practitioners been kept abreast of such changes? What sorts of capacity building opportunities have they been offered, if any? What are the key gaps in their training and approaches?
4. How could formal approaches for providing support or promoting wellbeing be strengthened and tailored to take into account longer-term psychosocial needs of adolescent girls in post-conflict settings and the human resource gaps that need to be bridged within current services?

This report is structured as follows. Having set out the background and aims of the study, Section 1 goes on to give a contextual overview of the situation in Palestine, focusing on issues relevant to adolescents' psychosocial and mental health. Section 2 describes the methodology used, including study design, description of the study site, data collection methods and tools, description of participants, sample, and method of analysis. Section 3 discusses some of the common mental health conditions among adolescents in Gaza, covering stressors that have emerged post-conflict as well as previous stressors and challenges. It

also describes some of the coping strategies adolescents use (particularly girls and their families). Section 4 provides an overview of the mental health and psychosocial services available in Gaza, focusing on HR capacities, availability of functional management systems, infrastructure and resources. Section 5 presents findings in relation to access, service uptake, outcomes, and service users' perspectives on the quality of services provided. Finally, Section 6 presents the study's conclusions about gaps in psychosocial and mental health services, with policy and programme recommendations about how services and programmes can be made more age- and gender-appropriate and responsive.

1.4 Context

1.4.1 The demographic context

The Gaza Strip is one of the most densely populated areas in the world, with more than 5,000 people per square kilometre (MoH, 2014b). The population is estimated at 1.71 million, 66% of whom (1.2 million) are refugees. Most families were forcibly displaced following the Arab–Israeli conflict of 1948. In common with many developing countries, Gaza's population is predominantly young. Nearly half of the population are under 15 years of age (the corresponding figure for the United Kingdom, by way of comparison, is 20%) (PCBS, 2012a). Moreover, the 'youth bulge' – the ratio of youth (aged 15-29) to the total over-15 population – is exceptionally high in Gaza, at 53% (UNFPA, 2013).

The proportion of young people has risen considerably in just five years; in 2010, children and young people aged 10-17 accounted for 20.4% of Gaza's population. The Labour Force Survey of the same year showed that 3.7% of young people (10-17) were employed, although substantially more boys than girls (6.3% compared with 1.1%). Youth unemployment in the occupied Palestinian territory totals 35.7%, which is much higher than the unemployment rate among the general population (21% in the second quarter of 2012) (Hamad and Pavanello, 2012).

Most households in the Gaza Strip are nuclear families (81%), and average family size is 6.3 persons (PCBS, 2012a). Life expectancy is 71 years on average (70 years for men, 73 years for women) (MoH, 2014b). According to the Palestinian Central Bureau of Statistics (PCBS, 2012a), the literacy rate among Palestinians (including women) is very high, above 95%. This no doubt reflects the high value Palestinian people have traditionally placed on education, regarding it as a durable and movable asset, 'contrary to land and houses that can be and were lost'; therefore, they have instilled this value in their children (Hamad and Shalabi, 2013). The inevitable increase in the young population will put further strain on access to livelihoods and basic services, including housing, employment and health care.

1.4.2 The political context

The expectations of the Palestinian people about what 'autonomy' would deliver, politically and economically, have not been met (the 1993 peace agreement provided for a partial transfer of authority from Israel to the Palestinian National Authority). Despite 'autonomy', Israel still has overall sovereignty of the Gaza Strip, controlling borders, movement of goods and people, electricity, communications, and security – and thus the key aspects of Palestinian people's lives.

In late 2007, Israel declared the Gaza Strip a 'hostile entity' after Hamas had gained control following heavy factional fighting with Fatah, establishing its own de facto government in Gaza. Since then, a tight air, sea and land blockade has been imposed, with Israeli policy seeking to ensure '*no development, no prosperity and no humanitarian crisis*'. The blockade has severely constrained sectors such as health, education, social services, industry, agriculture and construction, which were already struggling before these events.

Despite the partial lifting of import bans in 2010, together with other measures aimed at relaxing restrictions, the blockade is still in force today, permeating every aspect of people's daily lives and affording them little control over their affairs (MoH, 2014b).

As mentioned earlier, the United Nations and international agencies have repeatedly called the blockade a ‘protracted human dignity crisis’ and a ‘collective punishment’, citing that it is a clear violation of international humanitarian law (OCHA, 2009).

1.4.3 Health context

Palestinians in Gaza suffer from poverty-related illnesses such as malnutrition, anaemia and diseases linked to unsafe drinking water and poor sanitation – all conditions that are exacerbated by the blockade.

Compared to other countries at a similar level of economic development, the Palestinian population’s overall health outcomes are relatively good, partly due to strong performance of most basic public health and primary health care (PHC) functions (MoH, 2014b). Gaza performs better than many countries in the Middle East and North Africa (MENA) region on key indicators: the infant mortality rate is low, at less than 20 per 1,000 live births; the maternal mortality rate is less than 35 per 100,000 live births; and immunisation coverage is high, at more than 95% for most vaccines (MoH, 2014b).

While people are generally able to access health services under ordinary conditions, access becomes very challenging during conflicts and emergencies. Most basic services are satisfactory in terms of coverage and accessibility¹; however, there are issues surrounding the quality of care due to lack of appropriate standards and weak implementation of existing guidance. Access to advanced services, however, remains a real challenge facing the health care system in Gaza.

The health status of adolescents

Unlike young children and youth (15-29 years), little is known about the specific health status of adolescents (age 10-19) as a distinct social group; issues around adolescent health are usually subsumed within child or youth health. According to a recent UNFPA study (2013), 16% of youth had a health problem in the two weeks preceding household data collection, while 3% had at least one chronic disease. However, when asked how they assess their health status, 84% of youth indicated that it is good, 14% said average, and 3% said poor.

Adolescent girls face specific health risks due to socio-cultural norms surrounding marriage and childbearing. For example, 53% of young women were aged 18 or younger when they married, and 43% were 18 or younger at the time of their first pregnancy (ibid.). Many adolescent girls report feeling unprepared for this key stage in their physical and emotional growth and development, with 28% stating that this phase of their development process caused them problems (UNFPA, 2013). For instance, 22% reported that had no idea about menstruation and monthly periods; 40% were afraid when they first experienced a period, and 19% felt embarrassed; and 43% taught themselves how to clean their bodies during a period (UNFPA, 2013). When asked who they would approach for more information about how their bodies were changing (with more than one response possible), 7% would ask no one, 82% would ask the father, 43% would ask the mother, 9% would ask an older sister, 7% would ask the uncle/aunt/grandparent, 38% would ask other relatives, 29% would ask friends, 42% would ask their teacher, and 3% would read a book (UNFPA, 2013).

Regarding adolescents’ health-seeking behaviours, PCBS data indicate that more than two-thirds will tell parents when they feel sick and will seek medical services. When they experienced an illness, 70% saw someone about the problem: 54% visited a doctor’s clinic, 21% visited a hospital, 34% visited a health centre, 14% a pharmacy, 3% a traditional healer, and 5% opted to self-treat. Adolescent girls who did not seek treatment cited the following reasons: the condition did not require treatment (61%); financial constraints (27%); difficulty accessing services (11%); social factors hindering their receiving services (5%); and being busy/having no time (21%). The barriers that prevented young women seeking health

¹ According to OCHA and the World Health Organization (WHO) (2009), only 5-10% of the 150 water wells that are available to the population in Gaza meet international specifications for safe drinking water. Around 23 areas are connected to the public sewage system and 29 are still using alternative methods such as septic tanks (PCBS, 2012a).

services included: not knowing where to go (11%); not being able to get permission (17%); not being able to get money (36%); not being willing to go alone (39%); and lack of female health workers (32%) (PCBS, 2010).

Domestic violence and family honour killings

Women face high levels of domestic violence. According to the PCBS (2012b), 51% of women who had ever been married reported experiencing violence at the hands of their husband in the 12 months preceding data collection. Of these women, 76.4% had been exposed to psychological violence 'at least for one time'; 78.9% had been exposed to violence in their wider community, 34.8% exposed to physical violence, 14.9% exposed to sexual violence and 88.3% exposed to economic violence (such as disposing of the property of others, destroying livelihood assets).

Based on statistics from the Al-Muntada Coalition, four cases of femicide on the pretext of so-called 'family honour killing' were documented in Gaza in 2009; a similar number were reported in 2010 (Al-Muntada, 2010). Despite the lack of official statistics, family honour killings seem to have increased significantly in recent years, rising to 27 in 2013 (Women's Human Rights and Justice, 2014; Palestinian Media Watch, 2014). Lack of protective legislation, laws and policies seem to contribute to this phenomenon. For instance, a longstanding law provides leniency in sentencing for men if the motive for murdering a female family member is to preserve family honour.

Nutrition and food security

Due to rising prices and declining incomes, many Palestinians are increasingly food insecure. Various food items are becoming prohibitively expensive, particularly for urban residents who rely on cash purchases. Many families have resorted to negative coping strategies to maintain their level of food consumption, such as reducing the number of meals, eating smaller quantities, selling disposable assets, taking on more debt, taking children out of school, and even marrying their daughters earlier (O'Callaghan et al., 2009).

A recent Family Survey found that increasing levels of food insecurity had contributed to a significant rise in stunting (PCBS, 2010). Abudayya et al. (2011) reported that among children aged 12-15, 5.4% were underweight and 18.5% were overweight/obese. They also indicated that the prevalence of stunting, which reflects chronic exposure to malnutrition, was 9.5%. Prevalence of iron deficiency (which causes anaemia) among younger adolescents at preparatory schools was 23.6%, with the rate for girls almost double that for boys (31.4% and 15.9% respectively) (Abu Nada, 2010). The prevalence of anaemia among pregnant women reached 75% (NECC, 2014; Elmadfa and Meyer, 2014).

The mental wellbeing of adolescent boys and girls affects their eating patterns and practices, and vice versa. Adolescents with psychosocial problems are more prone to malnutrition (World Vision, 2009). According to the 2010 PCBS survey, 72% of youth aged (15-29 years) think their weight matches their height, while 19% think they weigh more than they should.

People with disabilities

Over the past 15 years, the proportion of Palestinians with some form of disability has increased significantly, to about 7% (PCBS, 2013). Just over one in every 100 Palestinian children in Gaza (1.4%) have a disability (1.8% of boys and 1.3% of girls). Just under half of all disabilities are mobility-related while a quarter are learning-related. Illness is the most common reason for disability, followed by congenital causes. However, a substantial proportion of disabilities are caused by armed conflict. Israeli military operations have left many Gazan children with amputated limbs or permanent disabilities (MoH, 2014b).

Children with disabilities face numerous barriers to accessing public services (Perezniето et al., 2014), and they are often stigmatised within their communities and by service providers. Further, children with disabilities are at greater risk of violence, exploitation and abuse, sometimes even within their family (UNRWA, 2013). In some households, disability is regarded as a divine punishment, which brings shame

on the family. It is common for parents to keep a disabled child at home. This stigma then translates into self-exclusion in adulthood (PCBS, 2013). In other words, disability creates additional layers of complexity for households, including economic pressures due to additional costs of caring for a disabled family member, the impact of social stigma, and more.

The impact of chronic stress

The unique circumstances of Gaza mean that the population experience high levels of chronic stress, which affects people's lifestyle choices. For example, around 40% of men in Gaza smoke (compared to an average of 25.9% in OECD (Organisation for Economic Co-operation and Development) countries; and more than 30% of adolescents smoke (MoH, 2014b). This increases their vulnerabilities and exposure to other health hazards.

Reflecting the chronic stress that people in the Gaza Strip face, the area is experiencing an 'epidemiological transition', whereby non-communicable diseases linked to lifestyle and stress, (including heart disease, cancer, hypertension and cardiovascular diseases, and diabetes) are gradually replacing infectious diseases as the leading cause of death. In 2013, for example, the leading causes of death were heart disease (25.1%), cancer (13%), cerebrovascular disease (8.8%), perinatal conditions (7.3%) and accidents (6.4%) (MoH, 2014b).

Mental health service provision

In Gaza, mental health services are an integral component of general health services. The four major providers are the Ministry of Health (MoH), UNRWA, NGOs, and private for-profit operators (MoH, 2014b). The MoH is responsible for a significant portion of primary, secondary, and some tertiary health care (providing more than 50% of services) (MoH, 2014b). It runs 54 PHC centres and 13 hospitals, including the only psychiatric hospital in Gaza. The Ministry buys tertiary services from other providers, locally and abroad (MoH, 2014b).

UNRWA plays an important role in the sector, delivering free PHC services through 22 centres and buying secondary and tertiary services for registered Palestinian refugees (UNRWA, 2014). It also contracts NGOs to provide certain services, mainly specialties in secondary and tertiary care (MoH, 2014b).

The NGO sector also plays a vital role, complementing the work of the MoH in providing (often costly) tertiary services that the Ministry is unable to provide. NGOs do a great deal of work to make health care accessible to vulnerable and marginalised groups, running more than 50 centres providing health and health-related services. They also contribute to bridging the gaps and perceived inequalities in the health system. In particular, NGOs are an important provider of psychosocial and mental health and rehabilitative services in Gaza (Yaghi, 2009).

The private sector is largely unregulated, and tends to focus on obstetrics and surgical intervention (MoH, 2014b).

Public spending on health

The PNA typically devotes an unusually large share of its scarce resources to the health sector. Over the past five years, health spending ranged from 13%-16% of gross domestic product (GDP), which is more than most middle-income countries (4%-5%) and higher than the OECD average (9.5%) (MoH and PCBS, 2014). Annual per capita health expenditure has increased from \$120 in 1994 to \$311 in 2012, in contrast with neighbouring countries, which spend much less (Egypt, for example, spends \$30 per capita on health) (MoH, 2014b). However, around 80% of Palestinians' contributions to health expenses are out-of-pocket payments (43% of total spending on health). By comparison, the average out-of-pocket (OOP) expenditure on health among OECD countries as a percentage of total expenditure on health was 19.5% (MoH and PCBS, 2014). The fact that households carry such a large burden of costs for meeting family health needs suggests a serious system failure.

Coverage of the health workforce

Generally, the distribution of health personnel per population in Gaza is reasonable. The labour market is flooded by physicians, pharmacists, dentists, paramedics and technicians who trained in a wide range of countries (more than 120). However, specialty and subspecialty areas, including in mental health, are greatly under-represented (in mental health less than 0.25 per 10,000, compared with a figure of 1.5 per 10,000 in OECD countries).

There is a reasonable gender balance among health personnel, and women are more likely to participate in the health workforce in future as they are currently participating in training programmes in higher numbers than their male counterparts (WHO, 2010). However, more efforts are needed to ensure that women are appointed to senior positions in the health system.

1.4.4 Legacy of the siege and three Israeli military operations

The impact of the blockade and three devastating Israeli military operations against the Gaza Strip since 2008 cannot be underestimated. Each offensive not only resulted in thousands of deaths and injuries and population displacement, but also caused major disruption to basic services (education, health, water and sanitation, and power supplies) and compromised people's livelihoods and food security. The mental health and wellbeing of Gaza's population, already compromised, has worsened further with each offensive, manifested in higher levels of stress and anxiety, violence against children, gender-based violence, and family separation, putting children in particular at further risk of harm (Ma'an Development Centre, 2014).

Israel's three-week military operation in 2008/2009 (Operation Cast Lead) resulted in 1,455 Palestinian deaths, almost 40% of whom were children and women. Around 5,380 people were injured, almost half of them children and women, and there was massive damage to thousands of homes, businesses, and other community infrastructure (Ministry of Justice, 2010). There was widespread disruption to basic services, and people's livelihoods were badly affected. It was reported that the offensive increased pressure on families' ability to provide nutritious food, with 80.9% of families reporting food shortages during the operation and 10% continuing to do so six months after (Save the Children and Medical Aid for Palestinians, 2012).

In November 2012, 'Israel' launched another military operation, striking more than 1,500 sites (including government buildings and houses) and killing 186 Palestinians (MoH, 2012) and causing more injuries and displacement. Research subsequently found that children's exposure to trauma during this offensive was an important predictor of PTSD and neuroticism (Khamis, 2013).

In July 2014, the most recent Israeli military operation against Gaza (which lasted 51 days) caused widespread damage to electricity and water infrastructure. At least 2,133 Palestinians were killed (including 187 girls and 313 boys) (MoH, 2014a). Many families suffered multiple losses; at least 142 lost three or more members in the same incident. According to the MoH, more than 11,433 Palestinians (including 3,374 children) were injured in the 2014 offensive. Preliminary estimates suggest that around 1,000 children have permanent disabilities as a result of their injuries, and up to 1,500 orphaned children will need sustained support from child protection and welfare sectors (Health Cluster, 2014).

Fifteen hospitals and 45 PHC centres were damaged during the offensive (Health Cluster, 2014), and an estimated 500,000 people were directly affected by damage to water facilities (OCHA, 2014). Education services were also severely disrupted by the latest offensive. Twenty-six schools were completely destroyed and 122 were damaged, affecting more than half a million children who had been due to start the new school year in September 2014 (UN, 2014). The education sector – already overstretched prior to the 2014 offensive – is now under even more strain. In some schools, overcrowding and under-resourcing mean that classes are running triple shifts, with pupils having to start at 6am.

During the acute stage of the military operation, an estimated 500,000 people – 28% of the population – were internally displaced, staying in UNRWA schools designated as emergency shelters (293,000),

government schools (49,000), or in empty buildings, churches or mosques, and sometimes with host families (170,000) (OCHA, 2014). The number of displaced people staying in these communal centres was much higher than had been anticipated in contingency plans; the result was major overcrowding, lack of privacy, inadequate sanitation and hygiene, insufficient access to water, and a lack of electricity. Health concerns included spread of communicable diseases, limited access to health care (including for chronic conditions) and lack of medicines.

Women at these centres reported having very limited privacy, which they found degrading. There were also instances of sexual abuse and gender-based violence (GBV) reported at some UNRWA collective centres (Ma'an Development Centre, 2014). Displaced people staying with host families also put a significant strain on their already depleted resources. At the time of the field research for this study (November 2014), around 25,000 people were still being hosted at 19 UNRWA collective centres (mostly schools).

2 Methodology

2.1 Study design

The study mainly used qualitative research methods, complemented by secondary data review and analysis. Empirical data were collected during eight weeks of fieldwork between November and December 2014. A mix of qualitative tools was used to capture different types of information from different groups and individuals. These included focus group discussions (FGDs) with adolescents (particularly girls), semi-structured in-depth interviews with a selection of adolescents, and separate interviews with participants' caregivers or friends. A large number of key informant interviews were conducted with government, UNRWA and NGO health service providers, mainly at the policy-making/management and implementation levels. Qualitative instruments were piloted and revised before being used in the fieldwork. The number and range of interviews, using a variety of different techniques and approaches, was sufficient to reach full engagement and provide an in-depth understanding of the issues being investigated.

The research team consisted of: a senior expert who performed the role of principal investigator, responsible for designing research tools, planning, coordinating activities, participating in data collection analysis and report writing; and a female research assistant (to facilitate interviews with girls only) who focused on data collection and participated in analysis and report writing. In addition, a research fellow from ODI provided oversight and technical guidance.

To ensure reliability and validity of the data, two training sessions were provided to the research team to review, understand and finalise the study tools and guidelines. There was a standardised approach to interviewing participants to ensure accuracy and credibility of the information generated.

2.2 Study site

After reviewing the main events and consequences of the most recent conflict in 2014 alongside the demographic, geopolitical and socioeconomic characteristics of Gaza's population, Shajaia was selected as the study site. The area came under heavy shelling in July 2014, with around 120 Palestinians killed in one day alone.

The neighbourhood of Shajaia, with more than 120,000 residents, is located at the eastern border between the Gaza Strip and Israel. Its strategic location makes it more exposed to Israeli incursions. A total of 21,736 households live in 9,273 crowded buildings (Gaza Municipality database 2014); refugees represent less than 25% of Shajaia's population (NECC, 2014). Average family size is 5.8, and most families (more than 61%) have children or adolescents (NECC, 2014). Shajaia is also known as a conservative community with strict socio-cultural norms and traditions. Most women marry at a young age (the median marriage age for women is under 20) and most women do not participate in the labour force.

There is widespread unemployment in Shajaia, especially among women. In 2008, around one-third of people were receiving social assistance, mostly through MoSA (non-refugees) and UNRWA (refugees); today, more than half of Shajaia's residents receive social assistance (NECC, 2014). Shajaia was not traditionally a poor area; historically, the main sources of income were trading of clothes, working in Israel

and agriculture. But since the blockade, the main source of income is employment with government social services.

Almost all households are connected to electricity, water and sewage networks (NECC, 2014), and have basic assets such as refrigerators, cooking gas and furniture. Shajaia is served by Gaza municipality. The area has four government-run PHC centres, three NGO-run clinics, and the only rehabilitation hospital in the Gaza Strip (MoH, 2014b). One PHC centre and the hospital were totally demolished during the 2014 conflict. In addition, residents receive services from nearby UNRWA, NGO and government premises. There are 42 regular schools in Shajaia for basic education, mostly owned and managed by the Ministry of Education (MoE).

2.3 Research participants and instruments

Guided by the original study proposal and after thorough discussion among the research team, the final research approach and questions were agreed. The team approached the Research Ethics Clearance Committee in Gaza to secure approval to conduct the study, and then approached relevant organisations to gain their support, including providing access to the information, database, and also to programme beneficiaries and service users.

Care was exercised to ensure that the principles of research ethics were respected and maintained, including child protection standards. The 1975 International Code of Ethics Principles (known as the Declaration of Helsinki and adopted by the World Medical Assembly) was adhered to and an official letter of approval obtained from the Helsinki Committee in Gaza.

Prior to taking part in the fieldwork, all participants were given a comprehensive explanation of the research objectives and outcomes, and were assured of anonymity and confidentiality. Researchers sought participants' verbal consent to carry out fieldwork discussions, as well as take notes and make audio recordings.

Because of the wide range of psychosocial and mental health programmes in Gaza, the selected sample of interviewees was also diverse, including service users from families affected by the conflict, beneficiaries of mental health and psychosocial programmes, and people with disabilities. Adolescent girls and boys were interviewed, though the focus was on the experiences of girls. Participants also included beneficiaries of regular psychosocial and mental health services and beneficiaries of outreach programmes (including programmes targeting IDPs hosted at collective centres). Pilot interviews were conducted prior to the actual data collection.

Table 1: Research tools used in this study

Type of instrument	Purpose	Number of tools and participants	Descriptive details
Mapping of mental health and psychosocial services	To identify facilities and participants to be included in the study and to get an overview of available services	Mapping exercise was done after meeting the Coordination Cluster committee and UNICEF	List of the main psychosocial and mental health services serving Shajaia area
Facility checklists	To assess the appropriateness of the mental health and psychosocial services provided at facilities To get statistics about the services provided at mental health services To identify gaps in human resources, equipment, and	<ul style="list-style-type: none"> 5 checklists were administered 3-5 key informants from each facility participated (medical director, nursing director and administrative director) 	<ul style="list-style-type: none"> Shajaia clinic (NECC) - NGO Gaza Community Mental Health Programme (GCMHP) - NGO Sorani Community Mental Health Centre (MoH)

	resources at the designated facilities		<ul style="list-style-type: none"> • Gaza Town Health Centre - UNRWA • Mental Health Hospital - MoH
Focus group discussions (FGDs)	To get in-depth understanding of stressors facing adolescents (especially girls) and their coping mechanisms Also, to assess service uptake, accessibility and users' evaluation of quality of psychosocial and mental health services	<ul style="list-style-type: none"> • 6 FGDs conducted • 44 participants in total (30 adolescent girls and 14 adolescent boys) 	<ul style="list-style-type: none"> • Two FGDs (one with women, one with men) held with IDPs at collective centres • Two FGDs (one with women, one with men) held for beneficiaries of outreach psychosocial programme • Two FGDs held exclusively with female service users
Key informant interviews (KIIs)	To explore perspectives of policy-makers, service providers (implementers), doctors, nurses, psychologists, from different programmes	<ul style="list-style-type: none"> • 21 KIIs were conducted (12 men, 9 women) 	<ul style="list-style-type: none"> • 5 interviews with policy makers from UNRWA, NGOs, UN agencies and MOH. • 16 interviews with implementers, from different disciplines and organisations
FGDs with counsellors	To explore the perspectives of counsellors about services provided, gaps and potentials	<ul style="list-style-type: none"> • One FGD was held with 6 female counsellors 	1 FGDs with female counsellors
In-depth interviews (IDIs) with service users	To explore service users' in-depth personal experiences, access and affordability of services, and users' perspectives about services	<ul style="list-style-type: none"> • 12 IDIs were conducted (4 adolescent boys, 8 adolescent girls) 	<ul style="list-style-type: none"> • IDIs with 4 adolescent boys (service users) • IDIs with 8 adolescent girls (service users)
IDIs with caregivers, friends and family members of service users	To ascertain access, uptake of services and the role of the family, as well as the outcome of services	<ul style="list-style-type: none"> • 6 IDIs with caregivers/family member or friends (2 men, 4 women) 	<ul style="list-style-type: none"> • Fathers of 2 mental health service users • Sister of 1 mental health service user • Mothers of 3 mental health service users

The data collection process entailed the following:

- The research team conducted a mapping exercise for psychosocial and mental health services available in Shajaia by reviewing the available literature and meeting relevant stakeholders.
- Researchers visited five health facilities that were identified through the mapping exercise and applied a semi-structured facility checklist at each. The five comprised: one community mental health centre run by the MoH and providing specialist mental health services; one NGO facility providing psychosocial services; one NGO facility providing specialist mental health services; one UNRWA clinic providing psychosocial services; and the MoH's only psychiatric hospital in Gaza. At each facility, at least three senior staff were involved in filling out the facility checklist.
- Six focus group discussions (FGDs) were held, four with female service users and two with male service users, based on a semi-structured interview schedule. Two FGDs involved IDPs (one with adolescent boys aged 13-16, the other with adolescent girls aged 10-14). At the time of data collection, these IDPs were living at a UNRWA collective centre (school) and had received psychosocial support services there. Two FGDs involved beneficiaries of outreach programmes implemented by NGOs as part of their

response to the crisis (one with adolescent girls aged 12-16, the other with adolescent boys aged 13-16); and two FGDs were held with female mental health service users aged 12-17.

- Recruiting people with mental health disorders to participate in the focus group discussions was a real challenge. People (especially women) with mental illnesses were reluctant to be interviewed in a group setting because of the stigma associated with mental health disorders. Therefore, the research team increased the number of in-depth interviews to compensate for any gaps. However, on average, seven people attended each focus group and the average duration was 60 minutes.
- 12 in-depth interviews were held (four with adolescent boys and eight with adolescent girls aged 10-17 – all beneficiaries of psychosocial and mental health services in Shajaia). Interviewees' ages were diverse and ranged from 10-17 years. The average duration of interviews was 45 minutes.
- One FGD was held with six female counsellors serving adolescents benefiting from different psychosocial and mental health programmes. This included a counsellor supporting people with disabilities, and counsellors based in schools.
- 21 key informant interviews were conducted (five at the policy-making and management level and 16 at the implementation level) with a wide range of stakeholders, including government agency officials, NGO representatives, UN agencies and UNRWA. The duration of the interviews varied from one to two hours.

2.4 Observations of participants' willingness to engage

Generally, participants were open, dynamic and expressive, and required little probing. Despite the sensitivities and stigma attached to psychosocial and mental health issues, almost all participants agreed to be interviewed. Coordination with key informants to set up interviews proved very time-consuming. The research team noticed that programme beneficiaries – especially girls with mental health disorders – were reluctant to participate in focus groups, instead preferring the in-depth interview approach. So the research team conducted more in-depth interviews than originally planned.

Service providers rarely conceptualised an individual's psychosocial status in a holistic way – for instance, rarely did they mention domestic violence, even though service users frequently did. Generally, service users were more candid in speaking about psychosocial issues compared than providers were. It was noticeable that providers talked more about pathologies associated with traumatic events due to political reasons. There appears to be a wide gulf between service users and providers in relation to case management plans, the approach to care, activities, and even appointments; providers think they engage service users well, but service users' responses indicate otherwise. Clearly, there is at least a communication gap in this regard. Also, male programme beneficiaries tended to use the conflict as an excuse to approach psychosocial services whereas they needed those services before the recent conflicts. Women tended to be more vulnerable, to present with psychosocial issues, were more open in their discussions, and were generally more aware of their need for psycho-social support than their male counterparts.

However, some participants were less willing or able to freely express their response to the study questions. Service users with mental health disorders talked less, and their tone reflected a sort of depression or frustration. By contrast, psychosocial service users and programme beneficiaries were more expressive and open, almost welcoming an audience for their complaints and suffering. Generally, beneficiaries of psychosocial programmes yielded more information than mental health service users. It could be argued that participants' desire to be heard and to talk about the problems they face in their lives motivated them to participate and to give their opinions.

Key informants (particularly counsellors) were also expressive and open in their responses. At times it was a challenge to keep them focused, and to control their tendency to express themselves very explicitly. Although confidentiality and anonymity were assured, some scepticism must still remain about the credibility of the responses. This assumption is related to political, cultural and social influences in the area.

The research team noticed that respondents' opinions and perspectives were influenced by their political affiliation or that of their peers who were available during the interview, especially while administering the health facility checklist. For instance, respondents who are politically affiliated to the ruling party gave more positive responses than those who are affiliated to the opposition, and vice versa. Moreover, it was noticed that mental health teams from different organisations and programmes tended to undermine the experiences and qualifications of their peers from other organisations.

There were clear variations in participants' understanding of some of the basic concepts raised in discussions. Issues pertaining to the nature of psychosocial services, levels and classifications of psychosocial services and mental health, integration of people with disabilities, case management, and division of roles and responsibilities were not adequately conceptualised by participants, despite the probing skills of the moderators.

2.5 Data processing and analysis

As well as taking written notes, all research tools were audio-recorded (except for two key informants, who did not give their consent). Together, these enabled the research team to prepare detailed minutes/notes in English and check them for accuracy. Two people attended most of the interviews, which enabled better debriefing and reflection. Debriefing notes contained the most important themes, differences among those themes, important quotes, interactions, memos, major ideas and concepts, verbal and non-verbal messages, and summaries of discussion.

Upon completion of primary data collection, in January, 2014, the research team took part in a two-day debrief meeting to conduct a preliminary analysis of the fieldwork findings. The approach used was based on 'adequate immersion', 'manipulation' and then 'categorisation'. Open coding techniques were used, in which the research team formed initial categories about the issue being studied by segmenting information. The categorisation approach was a mixture of hierarchical and relational categorisation. The tools on hand during the analysis included study objectives, moderators' notes, daily reports, audio-recorded materials, transcripts of the sessions, demographic information about respondents, and interactional observation remarks. Subsequently, the research team unpacked each minute/transcript to extract key issues, remarks and quotes for each thematic area of the study, which were then collated in an Excel sheet, which has been used as a key reference in the report writing.

2.6 Limitations and challenges

Despite the research team's background, experience, familiarity with the local context, and good local connections, the study still encountered some important challenges as follows.

- In common with other cross-sectional studies, assessing the situation at a particular point in time may not capture all perspectives about psychosocial and mental health issues and services, as the situation may differ over time. Chronological monitoring (longitudinal designs) of the psychosocial status of service users and beneficiaries, their perspectives and views, is essential.
- A lack of baseline data prior to the conflicts made it difficult to precisely attribute findings to the consequences of the conflict. As will be discussed in section 3, there are no baseline data on the prevalence of psychosocial and mental health issues in Shajajaia, or indeed in Gaza more generally.
- Recruitment of participants from mental health institutions was complicated for various reasons, including issues of confidentiality, communication (reflecting social stigma attached to mental illness), and the effect of ingested drugs, which affected service users' ability to communicate.
- Lack of clear standards and definitions, and a clear conceptual/regulatory framework, affected the credibility of interviewees' responses. For instance, respondents gave very different responses when defining even basic concepts such as psychosocial versus mental health.

- Limitations pertaining to the realities of daily life in Gaza (such as frequent electricity cuts, poor communications infrastructure), and limited time and resources, proved to be significant constraints.

3 Overview of mental health challenges and coping strategies

While several key informants believe that exposure to the wide range of stressors outlined in Section 1 have fostered people's resilience and increased the threshold of psychological collapse, many others highlighted the fragile psychosocial status of children and adolescents in the Gaza Strip. This is manifested in increased violence, trauma, loss of hope, lower levels of concentration, bad memories, nightmares and bed-wetting.

Most individuals who use specialist mental health services are adults, yet experts noted that mental illnesses often start to develop during adolescence. People typically approach specialist care late – usually when the severity of the illness increases. The first part of this section provides an overview of the common mental health illnesses (prior to and following the most recent period of conflict) based on our literature review and issues emerging from the interviews. The second part of the section discusses common coping mechanisms.

3.1 Main drivers for seeking psychosocial services

The main drivers behind people seeking psychosocial support or treatment for mental health problems are: physical symptoms (such as epileptic fits or bed-wetting), nightmares and isolation; children behaving very badly or violently. Seeking treatment for bed-wetting was often mentioned in the context of preparing adolescent girls for marriage. Some adolescents sought counselling themselves due to feeling anxious and afraid after watching TV news reports. As one 15-year-old girl said, *'I was afraid when I watched injured and killed people on the TV; therefore I approached the counsellor.'*

Other drivers (which motivated teachers to refer their adolescent pupils to school counsellors) included poor academic performance, aggressive or culturally unacceptable behaviour, violence, and engaging in relationships with the opposite sex. Teachers also reported referring children with signs of emotional or psychological disorders such as anxiety or depression, and those who showed signs of physical abuse.

3.2 Commonly reported mental health issues

3.2.1 Prior to the 2014 conflict

Daily frustrations due to the worsening of people's living conditions, and the lack of hope that the situation will ever end, have combined to give rise to psychological problems and domestic tensions, reflected in the sharp increase in domestic violence in recent years (Colliard and Hamad, 2010). Husbands (typically the family breadwinner) report feeling powerless and hopeless, only able to offer their children a model of failure, which increases their level of stress and negatively affects the household.

The full magnitude of people's psychosocial and mental health problems in Gaza is not known (MoH, 2014c). A review of the most robust epidemiological surveys (those using random samples and diagnostic

interviews) in conflict-affected populations around the world showed an average prevalence of 15.4% (30 studies) for PTSD and 17.3 % (26 studies) for depression (Steel et al., 2009).

After Operation Cast Lead (2008/2009), local studies showed that 61% of Gazan children (aged 6-17) had reported signs of post-traumatic stress disorder (PTSD). A 2009 study of young people in Gaza and Nablus indicated that 17.9% had anxiety other than PTSD, and 15.3% showed signs of depression (MoH, 2010). Another study found that the most common traumatic events experienced by adolescents in Gaza are ‘‘Watching mutilated bodies on TV’’ (90.4%), and hearing shootings and bombardments (87.1%) (El Kahlout, 2008). The prevalence of anxiety, depression, and PTSD among participants was 20.8%, 31.0% and 12.7% respectively (El Kahlout, 2008). The study found that adolescent girls are more affected than boys.

A study by UNICEF (2012) showed that physical and emotional symptoms experienced by children and young people (especially among boys) were associated with being exposed to or witnessing violence. Of the children interviewed: 94% reported sleeping with their parents; 91% reported having increased sleep disturbances; 85% reported an appetite change (increase or decrease); 84% looked stunned or dazed; 77% reported crying more; 80% reported fear of loud sounds; 63% reported fearing death; 62% reported fear of being alone; 59% reported fear of injury; and 57% reported fear of leaving their house.

During data collection, the research team consulted service providers’ databases (including those of the Ministry of Health, Gaza Community Mental Health Programme, UNICEF), and records to analyse available information about adolescents’ illnesses. Table 2 (below) shows the most common mental health problems reported by young people (aged 10-19) according to the Ministry of Health’s 2013 database, noting that the number of new cases that year was 1,551.

Table 2: Distribution of beneficiaries served at MoH mental health institutions by type of illness and gender

Type of illness	Female	Male
Organic disease	0	8
Drug addiction	3	3
Schizophrenia	7	12
Affective disorders	10	5
Neurosis	15	15
Personality disorder	4	8
Mental retardation	31	52
Epilepsy	17	14
Others	8	11
Total	95	128

As a consequence of chronic exposure to stress, it is reported that 4.4% of children (as rated by parents) and 9.8% (as rated by teachers) were suffering from ‘attention deficit hyperactivity disorder’ (ADHD) (Elumour, 2008); 15.7% (as rated by parents) and 17.5% (as rated by teachers) also exhibited conduct disorders, with higher prevalence among boys. In another study, Abu Sneada (2009) found that 29.5% of surveyed adolescents in Gaza had experienced some form of psychosomatic disorder such as digestive disorders (53.7%), other psychological disorders (35.6%), metabolic disorders (32.4%), skeletal (30.9%) and cardiovascular disorders (28.1%). The study concluded that there were significant positive correlations

between exposure to traumatic events and the development of psychosomatic disorders, with females being disproportionately affected (see also Box 1).

New problems and categories of mental illness are continuing to emerge. Substance abuse, for example, is increasing, with a MoH report (2014c) indicating that 32,000-45,000 people are taking substances, 20% of whom are addicts. Another study conducted by the United Nations Population Fund (UNFPA) found that 98% of young men were having difficulty sleeping and problems with aggression, while 4 out of 10 took the prescription drug Tramadol to help them sleep and reduce anxiety (UNICEF, 2011).

Box 1: Adolescent resilience

To assess how resilient adolescents are in facing the psychosocial vulnerabilities they are experiencing, the Strengths and Difficulties Questionnaire (SDQ) is a useful measure. In 2014 the authors in another study with adolescents from poor families that most adolescents in Gaza scored 'normal' 82%. Gender differences were not statistically significant either, though more girls scored 'normal'. Contrarily, the same source showed that a substantial proportion exhibited low hope scores (40%) which reflect gaps in adolescents' belief in their ability to complete tasks and reach goals. On the self-esteem index, adolescents scored 70% in Gaza (ibid.) with 66.2% of them feeling ashamed of their clothes.

Source: Perezniето et al., 2014

3.2.2 Post-conflict

The most recent conflict in 2014 poses serious threats to the mental health and psychological and social wellbeing of adults and children in Gaza. A UN report released in September 2014 (immediately after the ceasefire) estimated that 360,000 people will require some form of mental health or psychosocial intervention in the future, in addition to those affected by the previous two conflicts (OCHA, 2014). The World Health Organization (WHO) projected that as a result of the conflict, the percentage of people with mental disorders has increased by 5%-10% above the baseline (Health Cluster, 2014). According to one of our key informants, around 80% of people recover after a period of intense conflict and are able to resume normal life, while 20% need support to do so.

Statistics from the Gaza Community Mental Health Programme (GCMHP) for 2014 (including the post-conflict period) show that the most frequently reported chronic illnesses were epilepsy, paranoid schizophrenia, and psychotic and delusional diseases. The programme classified some cases that presented as linked to human rights violations mainly resulting from conflicts; among these, depression was most common, followed by PTSD, obsessive compulsive neurosis, anxiety, conversion disorders and substance abuse. Epilepsy, PTSD, anxiety, enuresis and schizophrenia were the most commonly reported disorders affecting children (up to the age of 17). It was not possible to get specific statistics on adolescents, as the programme's database does not disaggregate by age. In general, 54% of people presenting at the GCMHP were men, 46% women.

The study findings suggest that the magnitude of psychosocial issues increased following the conflict in 2014; almost all organisations reported that the number of service users approaching them had increased noticeably after the most recent conflict. Some providers (such as GCMHP) indicated that they have an unusually long waiting list. This is particularly true for psychosocial services that are integrated with other services such as PHC and education.

To give an example, the MoH community mental health centre (Sorani) serving Shajaia saw an increase in the number of cases it dealt with (new and follow-up), from 1,267 in October 2014 to 1,419 and 1,516 in November and December respectively. On average, the centre sees 40 new cases each month. School

counsellors also noticed a marked increase in the number of mothers approaching them to get advice or support for their children. As one school counsellor (at the MoE school in Shajaia) said: *'Last year, I hardly received one or two mothers in one month. After the war, I may see three mothers on average every day. They come to ask for my help and to discuss their daughters' problems.*

3.3 Stressors

This subsection summarises the main factors that negatively affect adolescents' psychological status in Shajaia. It is largely based on interviews with stakeholders, particularly focus group discussions and in-depth interviews with adolescents.

3.3.1 Conflict-related

The key stressors in adolescents' lives are often related to the impacts of conflict. One protection specialist noted that the *'...level of stress is increasing; hope and aspiration are decreasing. People are now more depressed, more desperate than before.'* During the acute stage of the conflict, women had to take on many roles previously carried out by male family members, and were in charge of sustaining the household's livelihood resources, especially at collective centres. A new category of child-headed households has also appeared. Families have become separated; some members of displaced families now live with relatives or in collective centres. Adolescents have found themselves living with strangers, and often feel unsafe. There is also a loss of hope about the future amid the constant uncertainty and threat of war. Nesma, an 11-year-old girl, said, *'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...'*

Displacement

Adolescents frequently cited losing their homes and having to live in a collective centre as major sources of stress. It is not merely the material loss of the house; rather, it is the loss of the protective space that homes represent for children, as well as loss of the family's entire assets. As one girl at a UNRWA collective centre said during a focus group discussion: *'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.'*

Losing loved ones or neighbours also constitutes a catastrophic situation for a family, but particularly so for adolescents. The loss is even greater when the deceased was the breadwinner or sole son of the family.

Experience of injury and death

The terror children and adolescents have lived through during the fighting – having to quickly evacuate houses under continuous fire from Israeli rockets, airplanes, tanks and canons – has left many with traumatised, with difficult and unforgettable memories. As one 14-year-old girl from Shajaia said: *'What happened during the war is indescribable. You will not be able to imagine it. It was unbearably terrifying – fear, dismay, death, and horror!'* The girl's full story is described in Box 2.

Box 2: Surviving under rockets' fire

A few days before the massacre in Shajaia, my mother and I were standing at the kitchen preparing food (it was Ramadan). The Israelis throw one rocket which hit our next door neighbours. I was in the front of the window and saw injured people, everyone was screaming, girls were crying, and we were also covered in dust and stones but I was able to see the injured people until the second bomb came in a few minutes. I stepped back and attached my body to the fridge and took my mother's hand. She also was watching silently. My mother told me, 'come on, we have to go and see your little brothers, they must be scared from the sound now'. I told her, no, I am not moving. In fact, I was shaking and unable to move or to let her go.

In a few minutes, while I am still shocked, a third rocket exploded and this was so big. My mother left me and went to see the kids, and then we heard voices asking us to go out of the house because it is burning. My uncle's wife saw the fire in the top of the building, and we left the house in a rush. I can't describe how I left the house. We moved to our neighbour's house... in the other street and stayed there for a week, then my father decided that we should return back to our home. While there, we were suffocating because they received their relatives who were displaced from the eastern part of the town, we were about 140 people in one house.

At the night of the massacre, all of us and my uncle's family who live in the third floor came down and we all sat together in our home. All the children were in one room, bombing was everywhere, and one rocket partially damaged one side of the house, so we all came in one room, and didn't move. My father brought a bucket and the one of us who needs the bathroom was using the bucket inside the room. Around 4am, one ambulance came to rescue some injured persons and didn't reach them but refused to pick us, I don't know why. After that, my father said we have to move between the houses.

I called the ambulance when we were inside the house... The ambulance didn't reach us. I called for a second time and they said they will try to come but didn't. I knew then when we were walking that they will not send another ambulance because I saw two ambulances bombed. Almost all houses were partially destroyed and we started to run from one house to the other, we wanted to see people and to try to leave the area with them.

My mother and us were reading Quran while running, she said don't stop reading Quran and we were also repeating the Shehada [words Muslims say immediately before dying] because we expected death at any moment. We kept running and running. We saw burned houses, pieces of bodies, a hand over the tree, and a stomach/intestine of a man. We saw all that and we were shaking but kept running. We were running as if dogs are running after us. While running, my sister, my mother and I saw a dead body so similar to my sister, same size and length of hair but the body was completely burned and the hair was white. We didn't recognize her but tried to keep moving. My mother then wasn't able to walk and fell down fainting on the ground.

I didn't know what to do, I had my little sister holding my hand and my mother on the ground. I just caught my sister stronger and ran faster until I reached my father and told him. I saw my sister with him and he was carrying my three-year-old brother. My sisters stood together, while my father and I returned to bring my mother. I carried her from one side and my father from the other side until we became all together again. We kept walking to nowhere. No one knew where to go. Finally, we reached close to my grandfather's house and he said we have to go to the hospital. At the hospital, many dead bodies were there!

Source: 14-year-old girl, Shajaia

Internally displaced people and people whose houses were destroyed had almost no information about when they might be able to return to their homes. Unclear and unreliable information about reconstruction plans contributed to people's feelings of instability and loss of hope.

Lack of privacy

Lack of privacy (particularly an issue for girls) was already a problem before the conflict and only increased after it, especially for those living in collective centres or being hosted by relatives. In Palestine, girls traditionally sit together in one room of the house while boys sit in another room. During and after the most recent conflict, boys and girls (and sometimes parents too) all use the same room, leaving no privacy for girls. Boys may go outside or sleep in the living room but girls cannot. Also, after reaching a certain age (usually 12), girls have to keep their hair and body covered at all times in case cousins or relatives visit (even in very hot weather).

Lack of privacy and access to toilets in their temporary living arrangements has caused problems for many young girls in particular. As one key informant explained: 'A girl told me that her father prevented her from going to the toilet because there were men in the area... The girl added: "I stayed suffering for hours till they moved away from the area then I used the toilet".' A 2014 report from the Ma'an Development Centre indicates that many girls (especially adolescents) suffer from bladder-related problems because they lack privacy and access to convenient toilet facilities at shelters. The same report suggests that some girls ended up bed-wetting because they were unable to access toilet facilities.

More generally, our findings highlighted that internally displaced people, many of them living in collective centres, face specific problems including overcrowding and lack of basic facilities to which they are generally accustomed (sufficient bathrooms and separate sleeping areas).

3.3.2 Compounding vulnerabilities

Economic hardships

Economic hardships seem to play the biggest role in adolescents' deteriorating psychological status. Key informants linked the bleak economic situation to a rise in domestic violence and to dysfunctional relationships between adolescents and their parents. Parents feel helpless given the general political and economic situation, and to avoid being blamed by their children, they respond either with violence or by neglecting their children.

Adolescents cited lack of money and sources of income as one of their biggest stressors. This is true for all families, but particularly for those living in rented houses, as they are at greater risk of losing their home if their parents cannot afford the rent. Being unable to afford certain things like clothes or other possessions also had a detrimental effect on many adolescents. Adolescent girls reported feeling despair when they did not possess clothes or other items that their better-off peers had.

The stress caused by lack of money was mentioned by girls and boys alike but from different perspectives; boys seemed to think more about how they could support the family breadwinner but did not give any thought to how to reduce household spending. Girls, however, did not think about how they could support the family breadwinner but do think of ways to curb spending and try to make fewer demands when they feel their parents are not able to provide them with what they need. (The next subsection goes into more detail on gender differences in the mental health and psychosocial problems facing adolescents in Gaza.)

Adolescents in households where the breadwinner has a serious health problem are worst affected, because unlike others, they have no hope that things will improve in future (for instance, if their father were to get a better job).

Maintaining some level of normality by continuing to go to school is not always possible. Transport to and from school is not always easy or affordable, with some young people feeling unsafe (especially those in collective centres) and wanting to go to schools where they used to live rather than where they are staying temporarily.

Relationships between parents and their adolescent children

Cultural factors can either act as a source of strength for adolescents, or a source of stress. Generally, communities in Gaza have very limited understanding of the different stages of children's development, including adolescence. This means families seldom create the space needed for adolescent children to express themselves, and seldom pay attention to understanding their unique needs and concerns. This was frequently reported by adolescents, psychosocial and mental health service practitioners, and policy-makers. As one female counsellor working for an NGO noted: *'Parents don't listen to their children. They don't think about how harmful this could be. When I talk to mothers, they say we have never thought about this before and we are thankful to you to open our eyes on that.'* Another key informant (social protection specialist) pointed to the obvious gaps between adolescents and their parents, saying *'Adolescents (both) feel that they are not adequately valued by the family and the community, they are not adequately recognised or valued by people and parents. Families don't understand the needs of adolescents. There are many communication gaps between adolescents and their families, adolescents don't understand parents' concerns and worries about them and also parents don't understand needs, aspirations and desires adolescents have. It's a mutual misunderstanding.'*

Girls are more likely than boys to feel that they are not heard or understood by their parents, and by fathers in particular. One 14-year-old girl said: *'If I share my problem with mother, the problem could become bigger because I know mom will inform my dad of it.'* Girls and boys reported stressful moments when they are unable to decide on their own private issues such as wearing the scarf (Hejab), especially when going to school. Issues related to dressing can be confusing; some families may object to their daughters wearing Hejab (scarf to cover the hair) while the daughters want to wear it. Still, generally speaking, it is much easier to get the family's consent to wear the Hejab, as this is in line with the dominant culture and religious norms. After reaching a certain age (typically 12), girls in most areas of Gaza are expected to adhere to a certain outlook and appearance, reflecting greater commitment to cultural/religious norms and preferences. This is cause for some concern, given that a recent study has suggested that independent decision-making can be one of the predictors of wellbeing in adolescence; the less choices adolescents can make about their lives, the lower their level of wellbeing (Al Bayoumi, 2014).

Other social and cultural stressors include separation from parents. In many cases, children (aged 9 and over) do not see their mothers regularly following divorce as the father tends to retain custody of the children. Living with a stepmother creates additional stresses, especially when fathers treat their children from different wives unequally. Two children (boys aged 11 and 13 from Shajaia, both of whom had a stammer) interviewed at one of the government-run clinics said: *'Even when we play without speaking but if we move anything, she, the stepmother, tells my father that we are misbehaving and he beats us. When her daughters make a big noise, she says: 'come on mama, good girls have to be calm', and that's all!'*

Exposure to violence at home and at school

Children and adolescents are also at high risk of violence. Around 43% of children (aged 12-17) had been exposed to physical violence within the household, while 75% had been exposed to psychological violence (PCBS, 2012b). In addition to economic hardships, cultural and geographic factors also contribute to creating or normalising violence within the family. One key informant shared his observation: *'We use physical violence against children at schools and houses because we misinterpret their behaviours such as attention deficit syndrome or hyperactivities. We think it is a discipline problem while simply the adolescent is sick.'* Interviews with policy-makers, psychologists and adolescents themselves indicated that the level of education is not necessarily connected to the level of violence. There were several examples of highly educated people behaving violently towards their children and families.

Violence in schools was another concern raised by FGD participants. Policy-makers are aware of the problem; the most recent national data show that more than one-fifth of students in Gaza aged 12-17 were exposed to psychological violence from their teachers or peers, and 21% were exposed to physical violence (PCBS, 2012b). The same data show that boys were more likely to be exposed to violence than girls (28% compared with 16%).

Some adolescent girls (IDPs living in UNRWA collective centres) described how they are punished when they arrive late at school. The lack of understanding on the part of the school administration may be causing some children not to attend classes. One 11-year-old girl from Shajaia, who now lives in a UNRWA collective centre, said: *'I go to school walking as transportation is expensive for me. When I arrive to school late, I am punished; they instruct me to sweep the classroom!'* Another girl of a similar age added: *'My school is good but when I don't have money for school transportation, I don't go to school. I do not like to arrive to school late and get beaten by the headmaster.'*

Fear of sexual harassment

The focus group discussions revealed that fear of sexual harassment is a stressor for girls and young women, especially those living in remote areas and close to borders, where there is an added fear of military actions. Some adolescent girls reported feeling scared when they travel to school because of the risk of sexual harassment. One male FGD participant said: *'Girls may not be safe if they go outside alone. People are not trustworthy.'* He added, *'If my sister would like to go out, I, my brother or father go with her because we*

care for her safety. She may be exposed to harassment in the street. Anyone can annoy her or ask her to give him her phone number for example.'

Protecting family honour

Family honour is a source of stress for many girls, especially those living in the most conservative communities (not necessarily the poorest or the least educated families). The issue is particularly pressing for girls aged 13 and older. According to one 17-year-old young woman from Shajaia, her family forced her to stop going to school when they knew she was talking to a male colleague and she had special feelings towards him. She was beaten by her cousins, and she is now watched by everyone in the family when she goes out. She lamented: *'I don't know what to do with myself, they don't want me to do anything in life. My brother stops me and looks at what I wear before I go out. I feel uncertain about what should I do with myself so they are okay with me.'* It can be concluded that many families simply do not understand the emotions and behaviours that adolescents have to deal with. In turn, striving to behave in accordance with strict social and religious norms inevitably means that adolescent girls have to contend with unmet personal emotional needs.

Interestingly, key informants revealed that family expectations of daughters are always higher than their expectations of sons. This puts girls under a great deal of pressure, to behave properly and never make mistakes. Also, it partly explains why mistakes made by sons are treated more leniently. This point was made by most of the experts and counsellors interviewed. Additionally, adolescent girls themselves reported worrying when they fail to meet family expectations, explaining that *'we don't want to fail our families and score lower grades than what we used to do'*.

No safe spaces to play

Adolescent boys and girls reported feeling stressed by not having safe places to go for recreation. This is particularly the case for girls, as boys are at least allowed to spend time with friends in the streets playing traditional games. Adolescent boys, however, feel disadvantaged compared to older youths (for instance, they cannot afford to rent a playground for football, whereas older youths can do).

Lack of access to information and support

Lack of access to information is a challenge facing many adolescents, who do not know where to go for certain services. Counsellors in girls' schools reported that pupils often do not know they are available to help, or what kind of support they can offer. The situation is even worse in boys' schools. In focus group discussions, adolescent boys expressed their need for guidance, but were not aware where they could obtain it from without being accused of being immature.

Some adolescents also mentioned that they had previously had negative experiences with health care providers, which made them less likely to seek care and treatment in future.

Child labour

Key informants reported that child labour was an issue before the most recent conflict, and continues to be a major problem, as many boys are having to take on the role of main breadwinner because their father has been killed or badly injured. A 15-year-old boy said: *'The father of my friend died. The dad has a car; my friend will get a driving licence to work instead of his dad.'* Also, the violence children experience in school can lead to them dropping out, and boys who drop out of school usually have to find work, often in low-paid jobs.

During focus group discussions in UNRWA collective centres with displaced young boys, three participants out of nine did not attend school classes, two of them saying they did not intend to go back to school. The third participant (18 years old) hoped he would: *'I hope to go back to school. When we dropped out from school, we thought we are men.'* He added, *'Three years after dropping out from school, I sometimes question why I dropped out from school and question what I should do now. I worked for five years in metal*

works and now I am jobless. There is also no work after the tunnels [between Gaza and Egypt] were destroyed.'

Other reports indicate that child labour is not just a violation of children's right to protection, but also exposes them to additional harm and feelings of deprivation. During an NGO needs assessment carried out in January 2015, children participated in discussions about creating child-friendly spaces (Catholic Relief Services, 2015), and one 13-year-old boy poignantly noted: *'Please consider the children who work when you plan your activity timetable. We cannot join these activities if they are early in the morning because we have to work while we want to but we cannot'* (Catholic Relief Services, 2015).

Fear, worry, and dismay: these three stressors are part of daily life for people in the Gaza Strip, but particularly for children and adolescents. Almost every person interviewed as part of this study shared concerns about safety and uncertainty. For children and adolescents, these emotions may lead to somatic (bodily) stress symptoms. Mental health experts and ordinary parents confirmed that their children are exhibiting anxieties that could lead to mental health problems. One mother said, *'Since war my son was talking during his sleep... He covered all his body and his face under his blanket. He wants to feel protected and safe.'* Many other examples illustrate that continuous trauma shapes the lives of children and adolescents in Gaza, influencing their future health and wellbeing.

3.3.3 Gender and age differences in the psychosocial and mental health issues facing adolescents

Boys are more vulnerable to political violence and bombardments as they spend more time outside, on the streets, which is not a social space open to adolescent girls.

Girls at the later adolescence stage (15-19 years) reported feeling less valued than boys of the same age when it comes to sharing opinions and thoughts. One 15-year-old girl who seemed to be wise and open-minded said: *'My grandfather, when we want to speak, he says, 'you shut up, what do you think you know? You keep yourself out of things that aren't your business'.'* She explained that her grandfather holds similar attitudes towards boys but shows more understanding and is willing to listen to them.

Older adolescent girls (those aged 13 and above) felt unhappy with the way they were thought of among their families and communities. There are contradictory attitudes towards girls: their families and community have high expectations of their behaviour and regards them as wiser than boys of the same age; yet girls are not trusted by their families, believing they need to be under male supervision. It is not easy to explain these contradictions – why a family feels comfortable sending a daughter out with a brother close in age to protect her, while believing that the daughter is wiser than the son. It may be that families find it easier to adhere to prevailing socio-cultural norms rather than defend any behaviour that confronts cultural taboos.

Lack of access to formal and informal education decreases people's resilience. Adolescent girls invest more time on education and hence have higher levels of attainment. However, with scarce resources, families often prefer to invest in sending their sons to university. Also, early marriage (which is more prominent in certain areas in Gaza, including Shajaia), restricts girls' access to university education.

With regard to sexual abuse, the society's reaction to incidents of sexual abuse that female are exposed to exacerbates the situation; in most cases, female victims are blamed and can be further punished by the community and by her family members as well. In many cases of sexual abuse or violence, the fate was killing the victim 'honour killing'-Sometimes with the participation of the abuser himself in cases of 'incest'. Indeed, tribal honour was a source of stress for females. Under the justification/excuse of protecting her, the family puts additional pressure and restriction on how females get dressed, when and with whom they go outside the house, and in some cases, they are forced to drop out their schools. The

community, on the other hand, shows more flexibility in handling behaviours from males and believes that male's honour is maintained whatever they do.

While families tend to approach specialist mental health services late on when their son or daughter has a problem, they are likely to delay seeking specialist help for longer when it comes to a daughter. Some study participants shared very painful experiences; families would approach all traditional healers in an area or try to hide/deny the problem for a long time before approaching specialist mental health services to treat their daughters. 'One of the main reasons why families seek mental health services is so they can ensure their daughter is ready for marriage. It is common for families to approach services when a daughter is around 13 years old, with symptoms that include bed-wetting. As one key informant (NGO staff member) recounted: *'A friend of mine, who is a doctor, has his 16-year-old daughter engaged to a good young man. When she showed symptoms of mental issues, he brought her to me and his first question was, would we be able to assure her fiancé that she will be okay?!'*

Among the most vulnerable groups of adolescents are:

- Children under 12: although they tend to present to clinics with other health issues, which constitute a gateway to accessing mental health services, and despite almost half of existing psychosocial and mental health services targeting children under 12, stakeholders rarely considered the impact of stressors on this group.
- Children in the middle adolescence period (no longer a child but not yet an adult – that is, aged between 13 and 18), with girls most vulnerable. Contradictions between young people's evolving capacities during these years and the social restrictions placed on them (particularly girls) is the main source of age/gender-specific challenges.
- Orphaned girls (especially from the age of 14 upwards).
- Those who come from conservative areas with strict socio-cultural norms, such as Shajaia, as well as those from poor and uneducated families.
- Girls who are the oldest of their siblings: there is a heavier burden on the oldest girl in a family (from around 15) as she is expected to take on the role of mother to her younger siblings, especially in big families. These girls even perceive themselves as adults, illustrated by this comment from Israa, a 14-year-old girl and the oldest daughter in her family: 'During the war, we women were sitting together in one room and children were in the other room'.
- Those from remote or marginalised areas.
- Those who are internally displaced and still living in temporary shelters or collective centres.
- Those directly affected by the war, having lost their homes, family members or friends.
- A newly emerging group – child-headed households who, according to respondents, are receiving little support from government or NGOs.
- Those with disabilities, particularly those living in collective centres.
- Girls who are culturally deemed to be especially attractive tend to be overprotected and more restricted, and in turn often exposed to more fear and stress.

3.4 Coping strategies

Coping strategies refer to the specific efforts, behavioural and psychological, that people employ to master, tolerate, reduce or minimise stressful events. Our study respondents reported using two broad categories of coping strategies: namely (1) problem-solving strategies aiming to actively alleviate the cause of the stressful circumstances, and (2) strategies designed to regulate the emotional consequences of stressful events. However, most responses fell within the second category, because adolescents and their families can do little to address the reasons behind the conflict, given its political nature.

The population of Gaza have employed a wide range of coping mechanisms to deal with the prevailing chronic stressors. Using international standardised assessment scales, one study by Abu Sultan (2012) examined the impact of traumatic experiences resulting from the war on self-esteem and resilience among university students; it found that the mean of total resilience scores (which reflected tenacity and personal accomplishment, trust in one's instincts, tolerance, acceptance of change, relationships and spiritual factors) was 64.5% (a relatively low score). Abu Sultan (2012) concluded that there is an inverse correlation between anxiety status and level of personal resilience; as resilience increases, anxiety levels decrease.

Another study explored psychological effects and coping strategies among Palestinian adolescents exposed to conflict (El-Buhaisi, 2010) revealed that the most frequent coping strategies involved trying to improve self-image (get body in shape, get better grades, etc.), developing 'social support', avoiding problems, investing in close friends, seeking professional support, solving family problems, and showing a sense of humour. Moreover, on the self-efficacy scale (which is used to predict ability to cope with daily stresses as well as adaptation), among poor adolescents in Gaza, after experiencing all kinds of traumatic life events, the overall score was 70.5% (Pereznieta et al., 2014). Adolescent girls in Gaza scored higher than their male counterparts, with a statistically significant difference (72% and 69% respectively).

Responses from interviewees suggest that many families with adolescents use similar coping strategies during acute stages of the conflict; families remained inside their houses for long periods of time, often without electricity and water. When there was electricity, people watched the news on TV, which tended to increase their fears. Many people (including adolescents and particularly adolescent girls) coped by praying repeatedly, reading Quran and praying for protection for themselves and their families.

Adolescent girls aged 13 and above tended to share housekeeping responsibilities with their mother, as well as taking care of younger siblings. They typically spent all of their time with neighbours, friends and/or relatives they were staying with temporarily, having fled their homes. Adolescent boys coped by spending time together as well, listening to radios, and sleeping during the day time. When taking shelter, some young children and adolescents participated in psychosocial activities carried out inside collective centres (organised either by UNRWA or NGOs). In a departure from their normal social role, many adult women were involved in activities outside the collective centre, providing families with food and non-food items.

Generally, adolescents, caregivers and experts covered similar thoughts when they described adolescents' coping strategies post-conflict. The most common strategies involved: (1) getting support from social networks such as family members, friends and relatives; (2) finding comfort through their faith in God's power; (3) seeking support from traditional healers; (4) seeking recreational activities such as hanging out, visiting other family members, sport activities, or celebrating birthdays of relatives and friends; (5) daydreams, imaginations, drawing, writing, and using social media; (6) getting support from school or clinic counsellors and taking part in psychosocial activities; (7) developing somatic symptoms such as a stammer or convulsions to decrease the level of physical violence they are exposed to in the home (reported by a few adolescents). Negative coping strategies that were reported included adolescents behaving turn violently, choosing to become isolated, or using addictive substances. To cope with economic hardships, some adolescents chose to drop out of school and find work.

Differences in how adolescent girls and boys of different ages and social groups cope with adversity and stressors are described in more detail below. Besides gender, cultural and economic backgrounds also affect how adolescents cope. For instance, the prevailing culture may influence how families decide where to seek support from; during focus group discussions with counsellors, an example was given about two mothers who were sisters, and had the same level of education and economic status. The only difference was that the sister who lives in Shajaia (a relatively poor area) took her daughter to a traditional healer when the girl had convulsions after the war, while the other sister, living in Al Nasser (a relatively advantaged area) sent her daughter, who had similar problems, to a counsellor, who she saw for six weeks.

Some adolescents who are from better-off households have access to computers and other new technologies and can cope by using social media, and joining relatively expensive recreational activities. However, these adolescents represent a tiny percentage of the adolescent population in the Gaza Strip. Economic status may also determine whether a family is eligible for free services or can approach private care providers. Some families choose to travel outside the Gaza Strip to access mental health care for their children to avoid the stigma attached with doing so, although poor households do not have this option.

3.4.1 Age and gender differences in coping strategies

Ability to socialise

Unlike adolescent boys, girls are not allowed to hang around outside their home or visit others, or even go to friends' birthday parties unless those friends are among nearby relatives. Almost every interviewee and respondent reported this and presented it as very 'matter of fact' – something that young people just have to cope with.

Adolescents tend to engage in recreational activities or hobbies such as folk dancing (Dabkka), which is more accessible to adolescent boys or younger girls (under 12). When older girls want to dance, as reported during focus groups, they have to use a closed room inside the house and seldom let anyone know what they are doing. One of the girls, aged 14, said: *'When we gather, we feel it is boring and want to create some fun, so we close the room and dance without anyone except my mother knowing. We keep the music low...'* She added, *'During war, we did not have chances to do this because of crowdedness and fear, of course.'*

Generally speaking, girls are better able to express themselves verbally, and therefore find it easier to share their emotions. Girls who were interviewed reported that when they go through difficult times, they talk to their aunts who are close to them in age, or, less so, to their mothers. Some chose to talk to close friends but many girls (especially those aged 13-17) said they felt more comfortable talking to aunts. Their reasons for this include trust (unlike a friend, an aunt shares the same family name and will not betray the girl while a friend may be tempted to if the friendship becomes strained). Also, aunts (given that they are closer in age to the girl) may be more understanding of the issues she is facing and give kind advice, whereas the girl's mother may react violently if the issue is sensitive. For boys, friends and brothers were the safest and most convenient source of support. They also feel comfortable talking to their mothers, although as one 15-year-old noted, *'I don't share problems with my mother, for one reason, she tells my father and the problem turns larger!'*

Religion, faith and traditional healers

Adults and adolescents (boys and girls alike) referred to spiritual values and ideologies that help them cope with the main stressors in their lives. For instance, religion can compensate their grief at losing a loved one by attributing the loss to a noble cause such as 'martyrs for freedom', with martyrs going to an eternal 'paradise'. Also, mindfulness and association with omnipotent power is a widely used coping method. Adolescent girls have strong notions of God as a superpower and frequently use the services of traditional healers, including those practising Ruqia (specific religious-oriented practices like reading the Quran and saying specific words). Despite this being common practice, few interviewees or respondents explicitly mentioned seeking support from traditional healers as a coping strategy. Interestingly, some traditional healers earn four times more than medical doctors, with people paying around 200 New Israeli shekels (NIS) per visit. It may be that women and girls find it easier and more culturally acceptable to turn to their faith to support them through traumatic times. This argument is consistent with notions of religion and religious practices having a greater influence on women's wellbeing compared with men (Al Bayoumi, 2014).

Children are taken as an excuse (bridge) for females to seek services as reported by the majority of interviewed counsellors and experts. Older adolescent girls (those above 16) are not typically allowed or

willing to seek psychosocial support services for themselves; most interviewees reported that families take younger children along as a pretext for seeking support for older siblings. After the war, some older adolescents accompanied their young brother or sister to counselling sessions and started to share their own emotions and stressors with the counsellors.

Interestingly, females have higher ability to demonstrate their psychosocial and mental health needs. Despite adolescent girls being more able to express their psychosocial and mental health needs, access to services is higher for adolescent boys, while access to psychosocial services is higher for girls. Boys' egos restrict their participation in psychosocial activities, which they see as targeted towards children, while regarding themselves as men. However, there is no baseline data in Gaza to determine the prevalence of mental health illnesses among women/men, boys and girls of different ages.

Differences in economic status

Some adolescents from poor families may opt for isolation, cutting themselves off from others, especially family members. This creates additional stress for women within the family. It is not clear whether adolescent boys and girls choose isolation in equal numbers, or whether one sex is more likely to choose this coping strategy. By contrast, adolescent girls from better-off families living in are with more relaxed social norms often cope by exchanging gifts and celebrating birthdays. Attending family celebrations such as weddings or welcoming a new baby was mentioned quite often by respondents. One senior key informant said: *'Rich people have more access to coping approaches than poor.'* He continued, *'Coping reflects the norms and when the norms are terrible, then the coping is also terrible.'*

Leisure activities

Reading, painting and writing stories is more common among adolescent girls, while boys tend to do exercise, sport and free play. Counsellors explained that girls often write down their emotions or create stories that reflect their realities. They always keep their notebooks private. Some adolescents go on recreational and cultural trips, usually one-day activity where they travel to other places in Gaza and take part in group activities. These trips are typically organised by mosques, which may have religious/political objectives, or NGOs, which may also have their own agendas. Recreational trips organised by mosques tend to involve more boys than girls.

Use of social media

Mental health experts and counsellors mentioned that adolescents (of both sexes) are increasingly using social media, but girls tend to use it for longer because they spend more time inside the house than boys. Some counsellors explained that girls use social media and computers at home during the day because men and boys in the family use it at night, and it is frowned upon for girls to use computers and have internet access at a late hour.

Seeking help from formal sources of support

Many adolescents (particularly girls) became involved in psychosocial support programmes, especially after Operation Cast Lead in 2008/2009. Girl pupils tend to make more use of school counsellors more than boys, who find it difficult to approach school counsellors for various reasons, including stigma and perceptions of weakness.

Negative coping strategies

According to our respondents (including counsellors and mental health experts), boys seem more likely to become addicted to substances or painkillers such as Tramadol. They are also more likely to get involved in political parties at a young age, suffer from depression and anxiety and/ or commit suicide. Focus group discussions with boys confirmed that some of their friends do try taking substances to help them feel better. There is little concrete data on the prevalence of substance abuse among adolescent boys in Gaza, although experts confirmed that it is an issue. One key informant said: *'I saw few females who use drugs; but saw males equal to the number of my hair.'* He added, *'Females' coping strategies are constructive, they focus*

on education – females spend more time studying.’ Another key informant (a service provider) said: *‘Females are predestined to cope well by ‘Allah’.*’ He added: *‘Negative coping is common among males more than females.’*

Some adolescents, particularly those from poorer families, look to work as a coping strategy, to bring more income into the household. This is more common among boys but some adolescent girls take on work too. One girl, Najwa, aged 16, from a border area in Shajaja, had sought support from a counselling service herself. She said: *‘My father is a poor labourer, he asked me once to sit in the small grocery he opened. I was doing that after school, but while there, I cannot get my meal; I feel shy too eat in front of others. Also, I was feeling nervous all the time imagining that one can hurt me... [referring to harassment].’*

Daydreaming was also mentioned frequently by counsellors and even some adolescents (who described it in different terms, of imagining what life could be like and imagining actually living that life). Counsellors explained that some girls may live inside their imagination and create privacy in their minds as the only place where they can. While this is not necessarily negative, if there is an over-reliance on such imaginary worlds, it risks degenerating into mental ill-being.

Other negative coping strategies include children behaving violently and hitting other family members, particularly younger siblings. Tensions could also generate violence among peers, reinforcing one aspect of Palestinian social culture that sees physically strong males as being able to manage better than others.

It seems some children have developed a stammer or other physical symptom as a kind of coping strategy, particularly in the context of greater tensions at home and increased domestic violence. Some of the young adolescents interviewed suggested that fathers beat/punish their children less if they exhibit a stammer or some kind of fit or attack. So some children had come to use this as a way of avoiding exposure to violence.

Box 3 gives a rich picture of the type of challenges and difficulties experienced by one family during and after the July 2014 fighting, including the kinds of coping strategies they used and the nature of the support they were able to access.

Box 3: Life in a shelter: psychosocial challenges, coping strategies and access to basic services

Hassna, aged 41, has seven children (three daughters, four sons). The family live close to the border between Gaza and Israel in a reasonably well-established house. Two of her daughters married before the age of 16, and she is now a grandmother. After joining a literacy course, Hassna got a job and worked for five years as a cleaner at the offices of a community-based organisation working on women’s rights issues. The group closed after fighting between Fatah and Hamas, leaving Hassna without a job.

Hassna’s neighbourhood was heavily bombed during the war in July 2014. Her house was severely damaged and the small business (breeding animals) to which she turned after she become unemployed was completely destroyed. During the fighting, Hassna and her family fled to a UNRWA collective centre and stayed there for a week. Although supposedly a safe place, it too was bombed and many people were killed. Three of Hassna’s sons (aged 20, 16 and 4) were injured. The 16-year-old boy had a hearing impairment before the conflict, which has now become much worse.

UNRWA moved people to a different shelter. Hassna described this as a new ‘tragedy’, saying: ‘I had lived the worst 45 days in my life at the shelter’. She and her family, including her three injured sons, lived with 128 people (‘mostly strangers’) in a small classroom at a UNRWA school; Hassna’s family were given 2m sq to stay and sleep. All of her family were crying when they first arrived there.

Around 12,000 people were living at the school, a place that was not designed as a shelter. There was not enough tinned food or bread, and the goods that were provided did not uphold people’s dignity. There was no soap or other items for personal hygiene at the beginning, so Hassna had to buy these items. She said: ‘Three times I bought anti-lice shampoo because my children had been infected with lice due to the bad hygienic situation... Later on, UNRWA provided it.’

Hassna continued: ‘Many times my children had experienced vomiting and diarrhoea. Health was completely lacking at the shelter, but later on, NGOs and UNRWA started to treat us when needed.’ When Hassna’s daughter had a fever while transferring to the second shelter, the team at the hospital didn’t pay any attention to her as they were prioritising people with more severe injuries and wounds.

Also, the nights were very cold and Hassna’s family didn’t have enough blankets. She explained: ‘In the shelter they used to give only one blanket for each six family members. They gave us only one blanket! Hassna believes distribution of the limited support available inside the shelter was not fair because of overcrowding and lack of organisation. Also, she felt that influential families, who moved to the shelter earlier when it was less crowded, were privileged in comparison to the late-comers such as Hassna.

Hygiene and sanitary conditions at the shelter were also far from adequate, with no clean water. Hassna described the situation: ‘You have to wait at a long queue, at least for around one hour to use the toilet. It is very dirty and disgusting.’ Using the toilet was a source of frequent clashes between people and Hassna reported volunteering many times to act as a mediator to stop women fighting with each other. She explains: ‘I also had a clash for the first time in my life with another woman who hit my 12-year-old daughter because she wanted to use the toilet before her and my daughter refused. I was standing nearby to protect my daughter and I become very angry when I heard my daughter crying.’ She went on, ‘My mother-in-law has been urged to urinate in a bucket because access to the toilet [on the ground floor, while the family were on the third floor] was difficult for her. Lack of privacy inside the shelter was very distressing experience especially for girls, women and especially breastfeeding mothers.’

When asked how her adolescent daughter (age 12) coped, Hassna mentioned that she slept most of the time, she hardly communicated or interacted with others. Also, she refused to eat, preferring to sleep. Up until the time of the interview (two months after leaving the shelter), her daughter still refuses to talk about what happened during their stay at the shelter.

After 45 difficult days in the shelter, Hassna’s family decided to leave and went back to live in their badly damaged house. They felt that living in the shelter was degrading, and they had lost their dignity. At the time of the interview, five months after the ceasefire, the area they were living in still had no water, electricity or communications. The building they were in was leaking water through the roof.

Hassna reported that her family had not received any psychosocial support or services, except for the youngest son (aged 4) who took part in some activities inside the shelter organised by a local community-based organisation. A team of two counsellors (from the same organisation) provided three sessions of five minutes each, using drawings and balloons. They were supposed to provide support for all the injured people in the shelter in just two hours, according to Hassna. Clearly, this was not sufficient, and Hassna bemoaned: ‘My son did not recover and I feel that he will keep memorising all the terrible images he saw.’

She added: ‘My 16-year-old son was injured too, but he didn’t receive any psychosocial support and my daughter who is in a bad condition didn’t receive any support either till now.’ She continued, ‘Despite

being injured, and suffering from hearing impairment, no one has provided any kind of care to him. I am particularly worried about him because he currently shows bad behaviours'. By this, she means he has started mixing with 'bad friends... he started to smoke, become more aggressive and misbehaves..'. He doesn't go to school regularly and misses many classes and returns back to the house very late at night.'

Hassna is not sure how her adolescent daughter is coping. She thinks that she is not okay but her problems are not manifesting themselves in the same way as her brother. For now, at least, Hassna's priority is her son.

Hassna ended by saying: 'I feel very sad about what happened to us, all our life aspects have been distorted. Our family was okay and always we used to be together. But not anymore. My children are outside the house most of the time. Our experience in the shelters is unforgettable tragedy. We all need psychosocial support.'

4 Psychosocial and mental health service provision

4.1 Availability, coverage and targeting

In situations of war or conflict, emergency assistance tends to prioritise the physical needs of the affected population at the expense of their psychosocial needs. The same is true of the Palestinian health system, which has been unable to protect the population's psychosocial wellbeing given the more pressing needs that arise from repeated military offensives.

There is also considerable fragmentation among mental health and psychosocial service providers in Gaza (Colliard and Hamad, 2010). According to the Palestinian Public Health Law (2004), the Ministry of Health (MoH) is not only responsible for the provision of basic health services but also for regulating, supervising, licensing and accreditation of health services provided by other actors. Similar to other Palestinian ministries, the MoH inevitably focuses more on its service provision role than its regulatory role, mainly due to weak coordination mechanisms (MoH, 2014b).

4.1.1 Diversity of providers

There are large numbers of diverse organisations providing largely unregulated psychosocial and mental health services in Gaza. In 2010, Terre des Hommes (TdH) and the MoH mapped all mental health and psychosocial resources and identified 162 NGOs that were involved, mostly implementing psychosocial programmes. In terms of mental health and psychiatry, the only institutions offering any specialist services are the Ministry and the Gaza Community Mental Health Programme (GCMHP) (TdH, 2010). Since the mapping was carried out, little has changed.

The Ministry of Health

The Ministry is the main provider of mental health services and (in theory at least) responsible for regulating the sector. In 2013, with support from the World Health Organization (WHO), the Ministry started a process of integrating mental health services into all of its 54 primary health care (PHC) centres, within the non-communicable disease (NCD) departments. So far, the 'stepped care' model (facility-based rather than community-based) has been applied in 38 centres in the north of Gaza, Gaza governorate and Rafah districts. The model provides basic training in mental health and psychosocial issues for general practitioners and nurses at PHC centres so that they can identify and manage common problems such as depression and anxiety, or refer individuals in need of specialist care to one of six community mental health centres (CMHCs) in Gaza. The aim is to be able to identify mental disorders earlier on, among people attending PHC centres for other problems. It also aims to help reduce the social stigma around mental health by dealing with common problems as an integral part of primary health care.

In Rafah and the north of Gaza, where the model was first applied in 2013, 462 new cases were detected and 1,723 follow-up sessions provided to PHC patients suffering from common mental health disorders (MoH, 2014c). Records show that to date, there have been 590 cases of people with depression who needed further specialist intervention, 121 with anxiety, and 361 with anxiety and depression (1,072 in total). One key informant from the MoH remarked, *'The issue of stigma is severe in Gaza. We at the health system*

stigmatise mental illnesses and also the staff working on this field... This integrated model helps to reduce stigma and to sustain HR for basic-level mental health services. We will expand that approach to all our clinics. At Shajaia, the study site, health care providers from two MoH clinics were trained to use the model. However, the programme focuses on people attending for treatment of NCDs, who are usually older; relatively few adolescents seek NCD services so may not be reached by the facility-based approach.

As already mentioned, the MoH operates six CMHCs across the five districts of the Gaza Strip (two in Gaza governorate, home to 35% of the population of the Gaza Strip). Four of the six centres are located in PHC centres, while two are standalone. (One requires renovations as it was damaged during the July 2014 conflict.) Each CMHC serves 200,000-350,000 people. As well as caring for patients with more complex mental health issues (including prescribing psychotropic medicines), the CMHCs serve as training and supervision hubs for basic services such as the PHC centres and school mental health services (MoH, 2014c). The six CMHCs registered a total of 1,551 new cases in 2013 and provided 72,858 follow-up sessions to patients with various mental disorders (MoH, 2014c).

Utilisation of CMHCs has significantly increased over the past three years. In 2012, there were 1,242 new cases, compared with only 591 in 2011 (MoH, 2014c). People typically self-refer (80%) or are referred from PHC centres or schools. CMHCs focus more on therapeutic aspects of care rather than psychosocial wellbeing and addressing the root causes of psychosocial vulnerabilities.

The MoH also provides inpatient care (psychiatry) through the only mental health hospital in Gaza, which was built in 1982. There is a lack of consensus among stakeholders about what to call this centre; some call it a hospital (Ramallah affiliated MoH); others call it a rehabilitation centre. The facility has a capacity of 30 beds and provides rehabilitation programmes, daycare activities, 24-hour emergency and admission services, and a programme to combat addiction. A plan to close the facility some years ago and hospitalise some patients in medical wards of general hospitals was strongly resisted.

In 2013, the facility received 676 new admissions, with an average length of stay of 8.7 days –much lower than other psychiatric hospitals in the region. In 2014 there were 1,553 admissions, including 53 girls/young women and 155 boys/young men (aged 10-18). This gender differential in admissions may reflect a tendency to avoid admitting adolescent girls; it seems at odds with the prevalence of mental health illnesses among adolescent girls, with MoH records for 2014 showing that nearly 43% of cases with mental health issues were female. The occupancy rate of the hospital at the time of data collection was around 80%, with more men than women. Generally, the hospital provides direct services to around 2,000 people. More than 80% of cases are self-referred or family-referred. This raises important questions around active targeting and early discovery of cases. Usually, in the Gaza context, families will only seek support from psychosocial services when a case reaches critical levels and after trying all other options (including traditional healers), described in more detail later.

Targeting of the Ministry's mental health programmes is generally not proactive, and there is no specific purposive targeting of adolescent girls. Hospital admission protocols require the approval of an adolescent's parents prior to offering services. The stepped care model opens up new horizons for early discovery of cases; however, it is in its infancy and is currently only accessible to older service users presenting with NCDs. There are minimal efforts on prevention or identification of the most vulnerable 'at-risk' groups.

UNRWA

UNRWA is the second major provider of mental health and psychosocial services, with psychosocial working at UNRWA schools, health and relief centres. Its Community Mental Health Programme (CMHP) started in 2002 and has continuously evolved, helping refugees in the Gaza Strip cope with the deteriorating conditions characterised by high levels of violence and economic decline. UNRWA claims that its CMHP encourages people to develop constructive coping strategies and promotes mental wellbeing. Despite its

name, the programme “focuses on preventive services, largely through counselling and debriefing rather than providing integrated case management for individuals.

Counsellors at UNRWA schools help children to learn basic life skills such as appropriate forms of communication, as well as to develop coping mechanisms for stress and build their self-confidence through a range of exercises. According to the Ministry of Education (MoE), 56% of UNRWA-managed schools are covered by counselling services (MoE, 2014). The MoE also employs school counsellors, covering 82% of MoE. Despite good coverage, key informants from both UNRWA and the Ministry admitted there are several weaknesses in the counselling services they provide. One said: *‘The school counselling is helpful to pupils. However, it is far from achieving its goals... Now it focuses on behavioural issues and academic achievements... We intensified training on counselling through support from international organisations.’* Many key informants referred to schools as the best place in which to address adolescents’ psychosocial vulnerabilities (boys and girls alike). One policy-maker reported: *‘There is a missed opportunity to improve the psychosocial status of adolescent girls through school counselling. To target adolescents, you need to go at the places they are naturally available – the schools. It is the place that is not associated with stigma and the place at which early discovery of problems could take place.’*

Counsellors working in UNRWA health centres provide education about psychological issues and help chronically-ill patients manage their condition through making lifestyle changes. Beneficiaries receive educational sessions, counselling services and debriefing activities. At one UNRWA facility, 80% of cases are referred to the counsellor by health staff working with patients seeking non-mental health services; 10% by UNRWA school counsellors; and the rest are family- or self-referrals. UNRWA reports indicate that its CMHP programme contributes to training health staff to be more aware of issues surrounding gender-based violence (UNRWA, 2015). As mentioned earlier, there are several UNRWA and MoE schools in Shajaia, as well as a UNRWA health centre (Al Darraj). UNRWA school counsellors tend to target pupils with low academic achievement or behavioural issues as well as those experiencing emotional problems. However, given its current structure and the number of counsellors at UNRWA schools, it is impossible for the CMHP to proactively identify and address the needs of the most vulnerable adolescents.

NGO providers

There are many NGOs in Gaza that provide psychosocial awareness and support and non-specialist mental health services through counsellors and social workers; these typically involve recreational activities rather than professional, individualised services. The exception is the GCMHP, which is the largest NGO mental health services provider in Gaza (Colliard and Hamad, 2010). The programme was established in 1990 with the aim of improving the psychosocial and mental status of the population through promoting access to standardised community mental health services. Reports indicate that it has partially met essential psychosocial needs at a time when government services were unable to do so (MoH, 2014c; Colliard and Hamad, 2010).

The GCMHP operates through three community mental health centres throughout the Gaza Strip. The Gaza centre is the largest and serves all of Gaza and North Gaza governorates, including Shajaia. In 2013, the programme registered 979 new cases and provided 3,383 follow-up sessions (MoH, 2014c). These figures represent a big increase on 2012, when there were 514 new cases and 2,553 follow-up sessions (GCMHP, 2012). Analysis of 2012 and 2013 data reveals that in one year, there was an increase in new cases by at least 90% and by 33% in follow-up sessions. The programme provides various services, including training, research studies, supporting a schools mediation programme, and supporting victims of human rights violations (GCMHP, 2014). Again, most cases are self-referrals; however, in post-conflict periods, more cases are referred by other service providers.

Many NGOs have begun implementing psychosocial programmes in response to the impact of Operation Cast Lead (in 2008/2009). Their interventions are mostly reactive and subject to the availability of external funding. Many offer outreach stress relief programmes – for example, the Near East Council of Churches

(NECC) has run a PHC centre in Shajaia since 1952. After the 2008/2009 conflict, it began to implement psychosocial interventions integrated within its PHC centres.

NECC provides psychosocial support directed at children, women, adolescents and even staff, through individual and group counselling, group sessions, open days and recreational trips. Table 3 (below) summarises the psychosocial activities implemented by NECC in 2014. When NECC began its psychosocial interventions, the programme was donor-driven; the organisation had very limited experience in psychosocial support and issues. Seven years on, it is still struggling to develop a robust and professional psychosocial support programme. Other organisations have also become involved in providing psychosocial services without being fully equipped to do so.

Table 3: NECC psychosocial activities, 2014

Activities and target groups	Achieved
School children (6-15) years targeted through Children Affected by Armed Conflict approach	641
Kindergarten children served through cognitive behavioural therapy	1,164
Participants of stress management sessions for mothers	6,054
Individual counselling for women or mothers/ children with psychosocial problems	375
Individual counselling sessions	962
General psychosocial consultations	563
Psychosocial awareness sessions for PHC beneficiaries	248
Home visits for selected cases	163

The 2010 mapping exercise conducted by Terre des Hommes and the MoH found significant disparities in psychosocial activities (2,310 in total) delivered by NGOs in Gaza, and in the geographical distribution of services provided by the 162 organisations identified (TdH, 2010). Surprisingly, of the programmes being implemented at that time, only 0.9% targeted youth.

Routine mental health care services were substantially affected during the July 2014 conflict, with many services at PHC centres suspended, partly due to damage to facilities and partly because they had to shift to providing life-saving services. The Health Cluster report (2014) indicates that two out of the six CMHCs remained open, but the others were closed due to damage (particularly the West Gaza centre) or staff being unable to reach their place of work. The mental health hospital facility remained open (in theory); but only 30% of staff reported to work during the acute phase of the conflict. One key informant claims that three mental health emergency teams were deployed at general hospitals to provide psychological and psychosocial support to injured people and their families. But there are no details about the services provided by these teams. Since the ceasefire, most essential mental health services have resumed operations, except those centres that require renovations. However, the demand for mental health services is much greater, according to service provider key informants.

Service provision in Shajaia

During the data collection, the research team attended several meetings organised by the UN-led Community Mental Health Cluster and visited UNCIEF, which holds a database on organisations providing psychosocial services. It listed 59 psychosocial and mental health-related programmes implemented in the study area, Shajaia. (Table 4 provides an example of the psychosocial services provided there during the post-conflict period. There is more detailed information on these programmes in Annexes 1 and 2.) Around 16 local and international NGOs reported serving more than 25,600 children from Shajaia through their psychosocial programmes immediately after the 2014 crisis. Other organisations not included in UNICEF's database such as NECC and the MoH reported providing services to around 2,200 children. UNRWA assumes coverage of 80% of Palestinian refugees in all areas of the Gaza Strip, which amounts to 12,000 children.

As with the previous outbreaks of intense conflict, many national and international organisations incorporated provision of psychosocial and mental health services in their emergency response. Some had little experience in implementing such interventions. Many projects were set up as a result of a large influx of funding for mental health and psychosocial interventions, and there were reports that some organisations recruited staff with no relevant experience. Some organisations implemented up to 17 projects in a short period (less than three months and some even lasting only one month), which raises important questions about the quality of the services provided. Twelve international organisations had directly implemented psychosocial services (20%) and the rest were implemented by local NGOs and the International Red Cross and Red Crescent Movement. Direct provision of services by international organisations can undermine efforts to build local capacities and sustainability. Most of the interventions had ended by December 2014, just four months after the crisis, which is not an adequate period for effective psychological support. At a minimum, such interventions should last at least six months after the crisis (Inter-Agency Standing Committee, 2007).

One of the most notable observations is the considerable fragmentation among mental health and psychosocial service providers in Gaza, with no clear vision or strategy for responding to people's mental health needs during a crisis, in the short and the long term. Study participants also expressed concerns and contradictory views about the quality of services provided during the most recent post-conflict period.

Table 4: Service mapping of mental health/psycho-social services in Shajaja area/Gaza City

Programme name	Objectives	Implementation	Implementing agency	Geographic coverage	Service uptake	Approach	Implementation strategy	Target group	Programme orientation	Staffing level	Linkages	Results
Structured sessions with caregivers	To enhance children's resilience	Jan-Dec 2014 Sep 2014-Feb 2015	Local NGO: Palestinian Center for Democracy and Conflict Resolution	Al Shajaja	Target: 90 parents	Level one strengthening resilience and stress management	Stand-alone interventions	Parents	Child focused activity but the target is parents	Information not available (N/A)	N/A	N/A
Community-based session for children	Support sessions for caregivers	Sep 2014 Oct 2014	International NGO: Qattan Center for the Child	Al Shajaja	1,845 children	Strengthen community and family support	The center offers education and recreation services to children	Children	Not clear if target is adolescents or children in general	Organization has good capacities	N/A	N/A
Responding to mental disorders	Psycho-social first aid and detection of cases	Aug-Dec 2014	National NGO: GCMHP	Al Shajaja	118	(Person-focused) Psychological first aid	Stand-alone interventions from a specialist center	Children and adults	Not purposive intended targeting for adolescents	High	Yes	Not systematic
Provision of specialist mental health services	Specialist mental health services	2005 to date	Government: Sorani PHC centre	Al Shajaja	1,516 cases (Dec 2014)	Clinical management of mental disorders	Physically integrated within PHC centre Functionally stand-alone	No data on number of children in adolescence age	Not purposive intended targeting for adolescents	At least 8 staff, not all of them adequately trained	Referral exists but not organised	Not systematically available
Psycho-social services at NECC	Provision of PSS services through group activities and individual counselling	2009 to date	International NGO: NECC	Al Shajaja	800 children (Sep- Dec 2014)	Strengthen community and family support (group activities)	Integrated services in PHC centre	General population with focus on children and adolescents	Most group activities and recreational services are designed for adolescents	Only one counsellor	Not systematic. Referral	Not standardised
CMHP at UNRWA clinics	Provision of mental health/	2005 to date	UNRWA	Al Shajaja	N/A	Awareness, individual and group	Integrated services in PHC centre	General population	No adolescent intended targeting or	2 full-time counsellors and 1	Referral is available	Some application of post-test and

Mental health services at a hospital	psychosocial services through individual and group activities	1982 to date	MoH	All of Gaza Strip	Around 2,163 every year No info on number of adolescents	sessions and debriefing	Stand-alone service	222 persons/ 3 months	tailored activities	part-time counsellor	pre-test but not for all cases
	Provide advanced mental health care					Clinical management of mental disorders		General population	No tailored services to adolescents	70 staff, not all of them trained	No impact measurement based on national indicators
										Referral available	

Of the organisations that incorporated psychosocial interventions in their emergency response, only one-third had any experience of providing such services. In the early stages after a crisis, many affected people are likely to need psychological support rather than mental health services; mental health expertise is more likely to be required later on, to address chronic trauma through longer-term mental health services, which are not always readily available.

To conclude, the coverage of psychosocial programmes is less of an issue. There are however significant concerns about the quality of psychosocial support services and their long-term sustainability. Although support services reached large numbers of people, most involved NGOs activities and involved people self-presenting, which are not necessarily the people most in need. There should be a more proactive approach to screening, identifying and providing appropriate services for the worst-affected population groups.

In terms of mental health services, there are serious gaps in coverage and quality, with only two organisations providing comprehensive services – and those two unable to meet demand. Adolescents have generally been targeted as part of the community or household rather than as a specific vulnerable group, with tailored approaches to targeting. Not one of the service providers had organised specific programmes for adolescent boys or girls. Even organisations providing specialist mental health services (such as GCMHP and MoH) have no specific programmes targeting adolescents, although their activities include adolescents among a larger pool of beneficiaries. Another issue is that many organisations do not collect or disaggregate data by age, with most grouping all children into one category (0-18). Similarly, few organisations disaggregate data on beneficiaries by gender.

4.2 Principles guiding the provision of psychosocial and mental health services

The Inter-Agency Standing Committee (IASC) principles for psychosocial and mental health services (2007) guide the classification of services in this study. The first level concerns the provision of basic services, livelihood and security, which, as we have seen, were not adequately provided for the affected population of Shajaja, which was badly damaged. Key informants pointed out that the livelihood safety network in the Gaza Strip was not effective during the crisis. As one said: *'How there will be mental wellbeing if people die on streets and bombed at their home, schools or collective centres? You can imagine how life would be stressful without security, water, hygiene and electricity.'*

Most psychosocial services provided by NGOs in Shajaja and elsewhere in the Gaza Strip are regarded as level two: namely, community and family support. These services are vital to sustain and promote the mental health and psychosocial wellbeing of affected families (IASC, 2012). Despite concerns about their effectiveness, the school counselling services offered by MoH and UNRWA are mostly preventive in nature and target children, including adolescents. Immediately after the 2014 crisis, in one four-week period (September), UNRWA and MoH provided psychosocial support to children (including adolescent girls) through non-curricular activities.

Level three services involve focused, non-specialist support for people who need more intensive individualised support such as first aid and basic mental health services. Although these services were provided by experienced organisations such as GCMHP, MoH and, to some extent, UNRWA health centres, they were regarded as inadequate in coverage and quality. One key informant stated: *'What has been done is not sufficient and is not effective. These emergency reactive programmes are dangerous; there should be longer-term development-oriented programmes.'*

The fourth level involves the provision of specialist psychosocial and mental health services. The six specialist CMHCs run by MoH, the three GCMHP centres and the psychiatric hospital are the only sites offering these services. Clearly, there is an acute shortage of these services, confirmed by the interviews and the local literature (Colliard and Hamad, 2010). Although most people recover from serious trauma within a six-month period, some (5%-10%) will develop serious illnesses that require this fourth level of services (MoH, 2010). Because of the chronic nature of the conflict in Gaza and the frequent exposure to trauma, providers reported that some people showed manifestations of more severe mental illnesses soon after the conflict.

The most common activities implemented after the crisis were structured group activities, psychosocial first aid, awareness raising, debriefings and open fun days. Few organisations provide individualised care, case management and individual counselling. Using data from the UNICEF database, the most common activities implemented after the most recent conflict (July 2014) are as follows:

- Basic psychosocial support sessions
- Sport, recreational and stress-relieving activities
- Activities to encourage self-expression (painting, drawings, writings, storytelling, stand-up comedy, acting, singing...).
- Theatre shows to represent pain and trauma through creativity and humour
- Group counselling sessions for traumatised children
- Age-appropriate recreational activities for children in designated child-friendly spaces within the community
- Training on common reactions to stressful events and how to offer comfort and support to children under stress
- Crisis interventions, including psychological first aid and case detection, operating a referral system and awareness raising
- Emergency visits by service providers for children affected by the war
- Sessions to promote children's resilience
- Awareness-raising sessions on community-based child protection mechanisms and referral systems
- Distribution of hygiene kits and recreational kits
- Counselling sessions using mind and body technique

Lack of standards, protocols or guidelines

There were no protocols or technical guidelines at the facilities assessed by the research team; nor are there any nationally agreed protocols for psychosocial and mental health services. Colliard and Hamad (2010) pointed out that these services are not standardised and do not follow accredited protocols or guidelines. Also, there is no clearly defined therapeutic model available and endorsed by mental health programmes. But good-quality care requires the availability and implementation of standards and protocols. The World Health Organization (WHO) defines quality as '*Proper performance, in accordance with standards/protocols, of interventions that are known to be safe, that are affordable to the society in question and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition*' (WHO, 2006). In addition, according to one senior key informant, field manuals, job aids and flow charts for key work processes are either not available or not implemented. Some providers reported having protocols available but when asked to provide copies what they presented was irrelevant. UNRWA technical instructions for health services do not include a component on mental health; however, there are certain guidelines for specific issues such as sexual violence and domestic violence. The research team has been informed by senior management at UNRWA and MoH that there are plans to develop protocols for school counselling.

On a positive note, MoH in collaboration with WHO and with European Union (EU) funding, has developed clear and user-friendly protocols for integrating mental health into PHC activities at NCD clinics, although there is still no national-level protocol. Reports suggest this protocol is being implemented reasonably well at the PHC centres. However, few NGOs were aware of the protocols and expressed interest in using them. One key informant, the manager of an NGO programme, stated: '*I don't know about the MoH protocols, no one disseminate it to us, we are ready to implement it.*' Regarding specialist mental health services run by the GCMHP, CMHCs and the hospital, the interviews and literature reinforce the conclusion that there are no standards or protocols in place (Hamad and Colliard, 2010).

Lack of strategic direction for psychosocial and mental health services

More importantly, the data suggest there is no agreed strategic direction for psychosocial and mental health services in the Gaza Strip. There is an urgent need for stakeholders to engage in a collaborative strategic thinking process to determine a conceptual model for psychosocial interventions. As one key informant

said: *'Few people understand what psychosocial means... The situation is a mess and very hectic where every organisation behaves on its own and, mostly, approaches are donor-driven.'* She added, *'Some organisations do harm people.'*

There were major disparities among providers on the basic concepts of psychosocial issues, roles and responsibilities, division of labour, referral levels and continuity of care. Providers were using different treatment models without any kind of complementarity. For instance, some used the mind and body technique, while others were strongly against it. Some organisations reported using randomised clinical trials (RCTs), others argued that the approach is not valid anymore. Some reported using the Community Parent Education Programme ('COPE') approach while others had adopted the CABAC (children affected by armed conflict) approach. Some organisations provide integrated mental health services within other regular services, while others oppose that approach.

In terms of documentation, the GCMHP reported using the Diagnostic and Statistical Manual of Mental Disorders (DMS4) for the classification of psychosocial and mental health conditions, while other providers use DMS5, and the MoH uses the International Classification of Diseases (ICD) 10. The use of different models/approaches could be attributed to the great diversity of training sites (with professionals undertaking courses in more than 120 countries), lack of strategic direction, and donors' influence and agendas.

Another vital yet absent feature is the lack of a 'continuum of care' for psychosocial and mental health services. There is no coordination, so beneficiaries are often 'lost' between providers, missing opportunities to connect service users/beneficiaries to other organisations or community resources that could help them continue their treatment journey. This is further complicated by the lack of referral systems, weak integration and fragmentation of services.

People with disabilities who are more prone to psychosocial vulnerabilities are also not being well served by the current system. On the one hand, mental health institutions assume that these people should be served by disability-related organisations; on the other hand, disability organisations claims that people with disabilities need to be served by specialist organisations.

4.3 Human resources

According to the WHO, securing adequate human resources (HR) is one of the six core building blocks of any health system (WHO, 2011); and the provision of mental health is no exception. Generally speaking, in Gaza, the distribution of health personnel per population for most professions is fairly acceptable; however, an MoH report indicates that HR in specialties and subspecialties in mental health and psychiatry are inadequate (less than 0.25 per 10,000 people for mental health, compared with 1.5 per 10,000 in OECD countries) (MoH, 2014c).

Records indicate that the total number of employees working on psychosocial and mental health services at MoH facilities is 162 (102 men, 60 women). There is a severe shortage of specialists in psychiatry, child psychiatry, clinical psychology, rehabilitation and occupational health, and there is not one female psychiatrist or clinical psychologist. A key informant from an NGO said: *'In the entire Gaza, I am sure that there is very limited number of good psychiatrist, if any, and almost no child or adolescent psychiatrist, no single female psychiatrist or clinical psychologist is available.'* The ratio of government mental health HR per population is 6.8 per 100,000 (including administrators) – much lower than in other areas of the region. For instance, there are 2.9 mental health nurses per 100,000 people in Gaza, compared with 10.7 per 100,000 in Jordan (MoH, 2014c). This HR gap also applies to other sub-specialties. There are also problems because all six senior psychiatrists employed by the MoH are either already retired or will retire this year. That leaves only four psychiatrists available to cover the entire population of the Gaza Strip. There are only two clinical psychologists, also due to retire soon.

Data show that all six CMHCs run by the MoH are staffed with at least one physician (usually not a psychiatrist), one psychologist, one social worker and one nurse. The mental health hospital facility has 70 staff, including 13 physicians, 23 nurses, 8 psychologists and 5 social workers. There are currently no rehabilitation specialists available within mental health services (MoH, 2014c). GCMHP centres are staffed with at least one psychiatrist/physician, one nurse, one social worker and one psychologist. There is gender

balance across all facilities, although there is a shortage of female nurses for the psychiatric department at the hospital.

Recently, Saymah et al. (2015) mapped the availability of HR in specialist mental health facilities, including private providers, finding a ratio of 11.9 per 100,000 people. This breaks down as: 0.25 psychiatrists per 100,000 people, 1.6 ‘other’ medical doctors (not specialised in psychiatry), 4.8 nurses, 2.2 psychologists, 2.5 social workers, 0.5 occupational therapists, and 36.4 ‘other’ health or mental health workers, including auxiliary staff, non-doctor/non-physician PHC workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors (Saymah et al., 2015). Table 5 below gives details of available resources.

Table 5: Number of mental health professionals by discipline working within mental health facilities and private practice in Gaza

Mental health discipline	Number of mental health professionals
Psychiatrists	4
Medical doctors	26
Psychologists	35
Social workers	40
Nurses	76
Occupational therapists	8
Other mental health workers	577

One key informant from the MoH said: *‘Serious gaps in the education system exist; there are around seven colleges that pump hundreds of social workers, educational counsellors, and counsellors while there are very few clinical psychologists.’* He continued: *‘Many providers practice without any sort of clinical background and act as clinical specialists. Related titles and roles are not clearly identified.’* The lack of qualified personnel undermines the provision of safe and appropriate mental health services, and presents a real risk to people seeking care and treatment.

These issues highlight the importance of the Ministry of Health’s role as a regulator and overall supervisor of service provision. The Ministry is also responsible for accreditation and licensing of personnel, education programmes and health facilities, which, if implemented properly, could provide quality assurance measures, which could improve standardisation and enhance overall quality of services. Several years ago, the MoH conducted a series of meetings to develop consensus about job titles and roles, but this process has not been completed. Study participants indicated that some organisations depend on volunteers and inexperienced graduates to implement their psychosocial programmes, lacking sufficiently well-trained staff capable of providing psychological services. One NGO key informant noted: *‘When some animators go beyond their roles and act as counsellors, their poor technical capacities may distort the community confidence and trust of the service in general.’* The informant added, *‘Animators, social workers and counsellor roles are mixed up.’*

Critical gaps in workforce and management

The study confirms that there are critical gaps in HR personnel and management in the psychosocial and mental health sector. There is a total absence of strategic workforce planning, evident by the retirement of all six MoH psychiatrists in the same year with no replacements in place. Similar to other services, induction/orientation programmes for newly recruited mental health personnel are rarely available. Nor is there any system for performance-related rewards or incentives. Instead, the prevailing culture is one of political/professional appointments based on personal connections/favours or political affiliation. Even basic management essentials such as staff job descriptions were not available at some facilities. Political differences also affect morale and job security among MoH employees.

Many staff currently employed by the Ministry were hired by the de facto government created by Hamas between 2007 and 2014. Those employees are regarded as ‘unofficial’ by the recently formed ‘Unity Government’ and up until now have not received salaries. A key informant from the Ministry mentioned

this, saying: *‘Health care providers are not adequate as the demand is high, also employees don’t get their salaries and this affects their motivation and productivity.’*

There are also issues with poor management of health personnel, which is linked to the absence of strategic planning. For example, only 35% of MoH facilities were found to have an HR strategy (Hamad and Shalabi, 2013; MoH, 2014c); few facilities have staff induction or appraisal systems in place, and there are no performance-based recruitment or promotion systems (Hamad, 2013).

UNRWA employs around 160 school counsellors, which works out at one counsellor for approximately 1,400 pupils (Perezniето et al., 2014; MoE, 2014). In addition, it employs 24 counsellors at health centres and 13 counsellors at social service centres. The Ministry of Education (MoE) also employs 359 counsellors with a student:counsellor ratio of 703:1. Both the UNRWA and MoE school counselling programmes have gaps in terms of the number of counsellors, their roles and competencies. The American School Counsellor Association (ASCA, 2005) recommends a ratio of 1 counsellor to 250 students. Mostly, UNRWA counsellors have completed a Bachelor of Arts (BA) in psychology or educational counselling. Among NGO providers, the NECC for example has just one female counsellor at each health facility, trained up to BA level (in psychology or social services).

4.4 Training

There are four universities and seven colleges that provide training at BA or diploma level in mental health-related specialties and a Master’s degree in psychiatric nursing, educational psychology, psychological counselling, and community mental health. These training programmes operate independently, and mainly target psychologists, nurses and doctors. There are no postgraduate medical training opportunities available in psychiatry within the Gaza Strip; students choosing psychiatry as their specialty must go to Egypt or elsewhere, and there is usually little in the way of follow-up after training has been completed.

UNRWA and the MoE implement intensive training programmes for school counsellors in collaboration with UN agencies and some NGOs. In 2002, the GCMHP supported the MoE to establish six counselling units at its schools, and this has been now rolled out to almost all schools. In addition, UNICEF and other donors supported NGOs to run several short-term training courses, mostly in psychosocial interventions, dealing with gender-based violence, and gender issues more broadly.

MoH officials indicated that the Ministry and WHO are currently implementing an ambitious training programme for PHC doctors and nurses working in NCD departments at primary health care (PHC) centres. So far, they have conducted 16 workshops, each lasting four days, benefiting 380 people (nurses and doctors), more than half of whom were women. Unlike other training courses, this training was dedicated to developing mental health protocols. The plan is to train all doctors and nurses working on NCDs at the Ministry’s 54 PHC centres.

Despite a range of training initiatives, most have been donor-driven rather than demand-based, with little follow-up (WHO, 2010; MoH, 2014b, 2014c) and staff shortages remain a major constraint to effective provision of services. As one hospital staff member said: *‘A lot of training is still needed, the training taking place is like one drop of water in a sea, we may need 100 year training to reach where we aspire to be.’* Key informants also emphasised that training programmes had failed to improve the quality of services and to motivate employees due to the disconnect “between these programmes and the organisational context in which services operate – that is, they are not part of an overall quality improvement plan. Very few of the facilities visited during the study had a clear training system or structured programmes for investment in HR to tackle workforce gaps. In addition, capacity building programmes rarely focused on improving performance at the managerial level, which has a major impact on technical performance and staff working at facility level.

Workforce planning

The MoH, in collaboration with WHO, has developed a 10-year HR development plan that identifies the number of staff needed in each professional group and the priority mental health training topics. The plan indicates a need to hire or train 18 medical doctors as psychiatrists. Longer-term needs for mental health

training include the activation of the psychiatric board training programme for doctors. Among other disciplines (social workers, psychologists and nurses) the capacity building strategy identifies priorities including psychotherapy, cognitive behavioural therapy, specialty training in different disciplines, family therapy, team case management, supervision skills, occupational therapy and rehabilitation skills, substance abuse, forensic psychiatry, crisis intervention, and community-based interventions.

Moreover, research on mental health is practically non-existent in the public sector, except in universities. A study conducted by UNRWA reported that among the training topics requested by counsellors were pronunciation problems and psychological testing. This raises questions as to exactly what counsellors expected themselves to be able to handle in their work, and whether these expectations are realistic (Terahata, 2009).

Generally speaking, the priority areas for training identified in the MoH plan and those reported by study participants were very similar. Key informants identified sexual violence, case identification and referral, gender, designing programmes specifically to meet adolescents' needs, post-conflict services, emergency preparedness, and management of mental health services as potential areas for future training courses.

4.5 Supervision

With support from international organisations, some government and NGO mental health services are currently endeavouring to develop supervision systems. Our research findings show that training is not always supported by intensive follow-up, field visits to service sites, and meetings to ensure that staff are applying what they have learnt. One key informant reported that *“Clinical supervisors visit each counsellor twice a month and the general supervisor conducts a visit once monthly.”* Respondents from the facilities assessed during the study reported that there are supervisory systems in place; but they did not always disclose its approach and/or strategies to the research team.

Weak or non-existent supervision systems and tools

Some interviewees explicitly referred to weaknesses in supervisory systems, whereas others said there were no such systems or regular supervisory visits. As one key informant noted: *“Supervision is not adequately performed. There are visits and follow-up but not necessarily congruent with clinical supervision approach.”* Another one stated, *“Management understanding of supervision is still poor, employees and directors should be trained on how to make performance appraisals.”* The method by which supervision was carried out, and/or the effects of “regular” supervision, were not clear within most organisations. Most supervisory activities were unplanned; they mainly consisted of unstructured visits with no use of supervisory tools such as checklists. One key informant said: *‘Tools for supervision are lacking; technical supervision is not endorsed yet by the system; the concept of supervision is not yet developed; it is evolving now.’*

Supervisory activities that were carried out tended to focus on administrative duties rather than professional coaching and support. It is interesting to note that two of the three assessed facilities recruited external consultants to provide supervision to their psychosocial and mental health teams, while the third established online supervision with facilities outside Palestine. Some organisations (two) have hired permanent members of staff whose sole responsibility is to provide supervision for frontline teams.

It is vital to formulate clinical supervision policies that clarify the roles of supervisors, the staff they are supervising, and the relationships between them. It is also important to enhance the capacity of supervisors to provide on-the-job training and support in order to improve service quality. The literature indicates that supervisory practices are generally lacking in health facilities in Gaza (only available in 27% of facilities); those that do exist seem mostly concerned with detecting errors and blaming employees rather than providing ongoing coaching, support and training (Palestinian Non-Governmental Organizations Network, 2009).

4.6 Infrastructure, equipment, systems and management

The physical environment in all mental health facilities was generally good (except for the hospital), with sufficient space, number of rooms, pharmacy, stores, ventilation, light and cleanliness. However, a few staff from the Ministry of Health, including one key informant, complained of not having enough space: *'The number of rooms is not adequate. In the clinics there are no computers, so we can't enter the data into the computers.'* To cope with the increasing demand for psychosocial services, some organisations have rented extra spaces and annexed them to health facilities belonging to other organisations such as NECC.

The quality of physical facilities

Staff at Gaza's only mental health hospital felt the number of rooms was not adequate, although they felt the pharmacy and warehouse were good. However, this did not correlate with the research team's observations. For instance, the hospital team believed the seclusion rooms (isolation rooms) for patients were of good quality, whereas the research team deemed them to be inappropriate and inhumane (for example, the toilet facilities were not separated from the sleeping space, and there is inadequate ventilation). There was also some misuse of equipment meant for patients, with nurses taking air conditioning units from the isolation rooms and using them for staff rooms. The monitor in the female isolation unit does not work, so patients are observed through a small window (reminiscent of a prison cell).

There are also problems with safety measures in most of the assessed facilities. For instance, there are no protective barriers on the windows in case of shelling, no exit signs and no fire extinguishers, while stairs are not well maintained to allow a hasty exit. The incinerator for medical waste is situated very close to the hospital's entrance; the area is also used as a temporary dumping site. The incinerator is also very old and therefore not functioning effectively.

Patient registration areas

There were contradictory findings about the quality of the patient registration area in the facilities assessed; some were judged to be good, with a computerised system, but others were poor. PHC centres providing psychosocial services alongside mainstream services often had no visible registration place for new visitors or service users, and there did not seem to be an organised process for how patients arrive and present themselves. Waiting areas, counselling spaces and examination rooms for psychosocial services were deemed good to very good at all facilities, although some lacked adequate furniture and therapeutic tools. The appointment system used by some facilities (including the GCMHP) is designed to protect patients' privacy; privacy is mostly well maintained across all facilities, except for some PHC centres. Psychosocial support teams generally maintain confidentiality and privacy during counselling sessions, but practice varies; some nurses lock the room and turn the telephone off, others do not.

Most facilities have access to water and electricity, with good hygiene and cleanliness (the latter was only an issue at one facility, which had no cleaners). Daily power cuts, often for several hours at a time, represent a major constraint to the provision of services. Although all facilities have generators, there is a severe shortage of fuel, which means some key services (e.g. lab services) are frequently suspended.

The research team observed that mental health facilities are generally not accessible to people with disabilities, with offices often located on the third or fourth floor in buildings with no elevator. Mudallal's (2012) patient satisfaction survey in Gaza indicated that only 33.3% of people attending Ministry of Health CMHCs reported that the facilities were accessible to disabled people.

The provision of psychosocial and mental health services does not generally require sophisticated medical equipment. Apart from MoH facilities, most others have adequate equipment. Key informants from the Ministry reported that they have all the resources and equipment they need to deliver services. But when the research team checked the availability of certain items such as emergency first aid equipment, it was often not available. Non-medical equipment such as computers (to facilitate electronic medical records), stationery, filing and other office equipment were scarce or very outdated. A key informant from the MoH said: *'I turn my office computer on when I arrive to work and wait long time while it starts opening... I cannot store data on my old computer.'* Other respondents referred to a lack of assessment tools to aid

diagnosis, including tools to diagnose autistic children, training tools for children with intellectual and learning disabilities.

Drug shortages

The most crucial shortages in mental health facilities are drug shortages, which affect NGO and government services (although shortages are more severe in the latter). Some drugs had been out of stock for almost a year at the time of the study. At least 40% of essential drugs were typically not available most of the time, including antipsychotic, anti-addictive drugs such as medicate and Assival/Diazepam -these are sedative drugs given to people to help them quit addiction. The Health Cluster report (2014) indicates that prior to the most recent conflict, 27 out of 42 essential psychotropic drugs were out of stock – some for more than six months. There is a need to create a mechanism for ensuring a minimum six-month buffer stock of essential drugs used to treat mental health patients to avoid jeopardising individuals' treatment plans.

Mudallal's (2012) study at the Ministry's six CMHCs found that most people attending the centres (85.1%) had visited to get pharmacotherapy. But a considerable percentage of service users (22.2%) reported having to buy medications from outside the MoH premises due to lack of availability.

Management capacity and other constraints in the MoH

Mental health services lack a defined structure with clearly delineated roles and responsibilities, which makes it difficult to regulate relationships among facilities and health providers. As stated earlier, the MoH focuses more on its service provision role than its regulatory role, mainly due to weak coordination mechanisms (MoH, 2014a). It rarely monitors services provided by NGOs and does not even know of all services that exist. Even within Ministry facilities, systems, management structures and clinical decision-making can vary significantly. Strong political influences also make effective coordination, team work, professionalism and standardisation difficult to achieve (Hamad, 2013). The Ministry of Health does not take a leading role, for example, in licensing of mental health professions, which cut across two other ministries (MoE and MoSA). Two years ago, mental health was a general directorate within the Ministry of Health, but it has been now degraded to a unit. No one knows what the next health minister will do. At present, the mental health unit is annexed to responsibilities of the Director General of the PHC Directorate.

One of the most serious issues is the nature of the health management workforce in Gaza. Managers (particularly in government but also among NGOs) are often chosen on account of being experienced clinicians and/or having the right political or tribal connections (Hamad, 2013). Upon taking such leadership positions, they generally do not undertake any special training in management or leadership, which considerably undermines provision of effective mental health services. Managerial positions are seen almost as 'rewards'; some individuals devote relatively little time and effort to managing the organisation, which often comes second to the individual's personal interests (MoH, 2014b). The research confirmed this; key managerial positions in mental health facilities are not generally held by qualified managers, but rather by mental health professionals who have had no training in management (Colliard and Hamad, 2010). In addition, there are no appraisal or performance management systems for staff as a means of improving the quality of patient care.

Most of the organisations that participated in this study reported having strategic plans (often a donor requirement); however, they were not always being operationalised (put into practice). One of the important characteristics of well-functioning systems is having written policies and procedures in place; yet these were only found in two of the five facilities assessed.

It was also clear that decision-making within mental health facilities does not tend to be data or evidence based. Information systems are lacking, with serious gaps in terms of data collection, processing, analysis, documentation and dissemination.

4.7 Coordination

General impressions indicate that there is little coordination among psychosocial and mental health programmes (although there are some limited coordination mechanisms for case referral and procurement).² Some beneficiaries received services from several providers; others received nothing. Coordination was mentioned by all stakeholders as one of the most challenging problems facing psychosocial and mental health services, which was confirmed by observations during field visits. It was clear that coordination is limited and the government does not play a sufficient role in coordinating services of different providers. One key informant said: *‘Indeed, the system is fragmented and the MoH doesn’t control the services, no comprehensive multi-disciplinary approach exists, no agreed approach, and people don’t have a shared vision.’* He added, *‘In fact, the sector is not managed by the MoH; rather by big NGOs who take the lead.’*

Because of the complexity of psychosocial and mental health services, coordination and cooperation is essential. In the health literature, the concept of ‘cooperation’ describes collective actions involving more than one specialist agency, performing different roles for a common purpose (Adeleye and Ofili, 2010).

In normal circumstances, providing mental health and psychosocial services requires cooperation not just with the mainstream health sector but also with social services, education and justice, among others. However, it was noted that there is also minimal coordination within each of these sectors; even within the same organisation, there is often little coordination between different departments. For instance, within each PHC centre, there is no coordination between regular services and the mental health services now available there. More broadly, there is little coordination and cooperation between service provision (implementing staff), training departments and health information systems within the same organisation (Colliard and Hamad, 2010).

In order to address these coordination gaps, during the acute stage of the conflict UN agencies (especially UNICEF) took on an umbrella role. It convened several meetings so that government and NGOs could exchange information about which organisations were carrying out which activities. The ‘Cluster’ initiative has no legal framework; participation is optional and the outcomes of these meetings are frequently debated. Some study respondents reported that they did not know about these coordination forums. Others noted that even UNRWA does not always coordinate its activities. As one key informant explained: *‘UNRWA has its own approach and usually doesn’t coordinate well with others.’* However, others mentioned that during the emergency period, some NGOs coordinated with UNRWA and provided psychosocial services inside UNRWA’s collective centres.

As reported earlier, UNICEF’s database of organisations providing psychosocial services does not include the MoH, UNRWA and NECC (because they are focused predominantly on NGO providers), although they are key providers in Shajaja and other areas of the Gaza Strip. Also, as a result of poor regulation, many organisations launched psychosocial programmes without informing or consulting the Ministry of Health. International organisations do not always coordinate their programmes with the MoH. In addition, competition and lack of coordination among donors further increases fragmentation and duplication. Key informants also reported that personal relationships among managers and providers largely determine the degree of coordination between facilities and organisations.

As already mentioned, lack of coordination has resulted in lack of strategic direction for mental health, with individual service providers carrying out their activities often in isolation, without having to adhere to national protocols or a national strategic plan, and there is no national emergency preparedness plan. Duplication of services has also resulted in service users and beneficiaries ‘shopping around’ among providers, which leads to wasted resources.

When asked to nominate with whom they coordinate, the hospital team mentioned WHO, MDM Spain, IRC, IMC and the GCMHP. Also, some coordination takes place with MOSA and the police for certain specific issues; with MOSA to issue medical reports for patients in order to be assisted through MOSA and with the police for criminal and aggressive behaviours committed by some people. GCMHP is more active

² In 2007, a National Mental Health Committee was established, which included almost all relevant actors, with the aim of coordinating the provision of mental health services. But this committee has not met for at least the past three years.

in coordinating with others including human rights organisations, MOSA, MOE and the health cluster. There is limited cooperation with UNRWA – primarily in the form of referrals, securing drugs and with universities. A key informant from the UNRWA PHC centre indicated that they coordinate with school counsellors, the women’s centre at UNRWA and with specialized MOH’s CMHC. A missed opportunity is coordinating with the university sector where the service provision and the education sector need to agree on the specialties needed, approach for the provision of services, integrating protocols into the curricula and launching out joint improvement initiatives. Currently, the collaboration between universities and mental health institutions is concentrated around the training of students at mental health institutions.

4.8 Referrals

To ensure the provision of comprehensive and integrated psychosocial services, it is essential to develop effective referral systems that can ensure continuity of care for service users. But in Gaza, psychosocial services are not classified into discrete levels and there is no functioning referral network (even though most facilities assessed claimed they had some kind of referral system). There is also no forum for exchange of information between those making referrals and the organisations they are referring service users to. One key informant from the MoH stated: *‘No clear national guidelines or referrals are available, we lack clear referral systems.’* In the few cases where there are formal Memoranda of Understanding between organisations, this is usually as a result of donor requirements.

In some facilities, referral forms are available; but the ‘system’ in place is not appropriately managed or effectively utilised. However, most organisations surveyed in this assessment reported referring service users to other institutions. The TdH mapping exercise (2010) shows that most referrals come from NGOs or CBOs, which refer users to specialist government mental health services; there are few referrals in the opposite direction (TdH, 2010).

The mental health hospital and the GCMHP are the main services that receive referrals, usually from the school counselling programme, PHC centres, CMHCs, police and other institutions. The referral process usually operates through personal contacts between staff of provider organisations rather than through formal systems. There are no referrals to community-based rehabilitation programmes. Sometimes PCH centres refer service users to UNRWA to receive free medications not available from the MoH, or they refer people with disabilities to disability organisations to receive specialist services.

The GCMHP receives many referrals; some organisations have signed agreements with the programme, but others have not. One key informant at GCMHP said: *‘Health providers from other programmes know about our programme and they send people without forms.’* He continued, *‘The programme receives all but we don’t prescribe drugs unless the client has a file in our programme... Before the crisis, self- and family referral were the highest sources of referred cases, but now, more cases are referred by other parties and also cases are recruited through the phone counselling programme... We receive people even if they come without documents or information and open new files for them.’* The programme refers complicated cases that require admission to the MoH hospital.

At UNRWA, referrals require approval from the PHC centre management. Previously, UNRWA clinics used to refer complicated cases to the GCMHP but now they refer them to the MoH. However, informal referrals still take place (according to UNRWA staff). Within the NECC, referrals for psychosocial care are informal. Despite the availability of an electronic information system, no records are kept for referred cases, so there is no follow-up.

Although the MoH has introduced a computerised system to link PHC centres and hospitals, there remain substantial gaps in the referral system for people with mental health and psychosocial support needs.

4.9 Financing and costing

Only around 2% of the MoH budget goes to mental health services, a remarkably low proportion. Many psychosocial support services in particular are funded (and implemented) by external organisations, which undermines the long-term sustainability of these services. Of total expenditure on mental health, 56% is

allocated to the mental health hospital and 44% to CMHCs (MoH and PCBS, 2014). In the past three years, WHO spent more than \$1 million on MoH psychosocial services in Gaza, including training, capacity building and logistics. NECC's psychosocial programme consumes around 3.5% of the organisation's total budget (almost exclusively from donors), although this percentage increased to 6.5% in 2014, reflecting the additional needs (and donated funds) post-conflict. There is limited information available about how much UNRWA spends on psychosocial services, which cut across different programmes. The GCMHP has a consortium of donors which funds around 70% of its budget.

A cost analysis study shows that mental health services are the most expensive services provided at PHC centres. The annual cost per mental health patient is around \$850, of which \$280 is spent on drugs (MoH, 2014b). All the facilities assessed as part of this study were running budget deficits, which had forced them to suspend some services (particularly government services). The director of the mental health hospital said, *'When there are no donated funds, usually we suspend training, home visits programme and rehabilitation programme.'* Lack of funds also affected service providers' ability to secure essential drugs. At the household level, high unemployment and the deteriorating economic situation have led to a sharp decrease in government revenues from health insurance and co-payments (MoH, 2014c). Health facilities participating in this study reported that they had suspended beneficiaries' co-payments because many service users could not afford to pay.

There is at present no clear picture of Gaza's annual health budget – a situation that is exacerbated by diverse sources of funding and by political divisions associated with having two ministries of health in the Gaza Strip. The MoH's financial and procurement system is heavily centralised and cumbersome (MOH, 2014b), which makes it difficult to systematically explore the links between inputs and outputs. The overly bureaucratic management system and the lack of personnel with the skills needed for cost-effective analysis makes it difficult to ensure the optimal use of available resources.

5 Accessing psychosocial and mental health services

Although every individual service user or beneficiary of psychosocial support involved in this study has had a unique experience and journey, there are some common factors in how people access services and their experiences of care. Box 4 provides a general picture, which touches on the attitudes and behaviours of service providers (which vary widely), and service users' perceptions of the quality of care they receive.

Box 4: Experiences with psychosocial services

This account was given by a 35-year-old mother from Gaza who referred her son and daughters to mental health services. The family has eight members, and survive on a low income (the father earns a living by selling tea and coffee to passers-by).

'I ended up with three of my children with mental problems... During the first war [2008/2009], my daughter [now aged 12] had convulsions and we took her by ambulance to the general hospital. The doctor there told me she can improve with follow-up only with no medicines... But I did not follow on that till the second war [2012] when she [again had]... episodes of convulsions. Also, her nine-year-old sister started to have similar episodes. I took her at once to the UNRWA clinic and they told me she is normal and asked me to stop thinking and worrying about her health. Later, I took them both to the hospital [outpatient paediatric clinics in a general hospital]. The doctor there told me not to bring the older girl because it is no longer acceptable for her to be a mental health patient... He said this affects her future. He did not tell me why!

For the younger girl... the hospital said she has excess electricity pulses in her brain and she also had skin issues, which have been treated easily with medication. I did not follow a lot with her case because when I go to the hospital; they do not tell me details and leave me without understanding the problem. My neighbours advised me to take her to a healer known to use Quran only in his treatment. I went there, and the outcome was good; she didn't suffer from anything for two months since we started but I stopped going there because of the last war [2014]. She [again] started to have strong episodes of convulsion during the last war. Especially after a huge bombing in our neighbourhood.

In the last war, my son [13 years] started to have nightmares and cover his face with the blanket. Also he had bed-wetting issue... He did not tell me about it but I discovered it while washing the clothes. At first, he denied having a problem and said it is the little brother who has bed-wetting. But then I said I must do something before he turns like his sisters and develops convulsions. So I convinced him that we go to a place where many toys are there [an NGO-run programme] and he agreed because he loves toys and we have none. He goes there and is improving greatly. He likes the counsellor... When he misbehaves, I threaten to tell the counsellor and he then apologises and behaves nicely.

Recently, I took my nine-year-old daughter with me when we went to that NGO and the counsellor told me that the girl has a problem and needs follow-up. He said, "bring her with her brother to play together". I feel my morale is getting better after I took my kids there because the counsellor who follows my son's case is professional and engages us in the process of treatment.

I did not know that what my daughters have is epilepsy until the NGO field team visited our home. They told me that, but the hospital team did not. I feel sad for my daughters. I am nervous, as the doctor who used to follow my older daughter's case asked me not to take her to a doctor but to focus on treating the younger girl. In the hospital, she [the older daughter] does not have a file and her doctor refused to give me a report about her case. He said "I do not open files for similar cases and this is better for her future". He also refused to give her any medicine because of the side effects. Recently, I asked another doctor what I have to do with her. He advised me to start giving her medicine to prevent her case getting worse. I am confused about what I should do to help her! I don't know if it is better to take medicine or not...'

5.1 Accessibility

Access to services concerns availability, adequacy, affordability and, most importantly, utilisation (uptake). The extent to which households and individuals have adequate access also depends on whether there are physical, financial, organisational and/or socio-cultural barriers that prevent them utilising services. In conservative communities in contexts such as the Gaza Strip, socio-cultural barriers hinder people's ability to access mental health services. During data collection, it was interesting that most interviewees referred to physical barriers only.

The study findings reveal that people have inadequate access to psychosocial and mental health services in Gaza. Even under 'normal' conditions, there is a scarcity of psychosocial and mental health programmes, which are too few to meet the needs of families that have been exposed to huge psychological stressors for extended periods. During the acute stage of a conflict in Gaza, almost no psychosocial or mental health services are provided due to security reasons and the absence of a well-coordinated emergency preparedness plan. Post-conflict, there tend to be many reactive, uncoordinated, donor-driven psychosocial programmes provided as part of international agencies' emergency response.

Review of documents revealed that psychosocial services generally only reach those who seek them out, rather than those who need them. There are gaps in terms of 'horizontal targeting efficiency' (the ratio of people who need the services and receive them to those who need them) and 'vertical targeting efficiency' (the extent to which services go to those who need them rather than those who do not).

Psychosocial services are not proactive in screening, identifying or supporting needy populations. Those that are available are more accessible to children, women and adolescents (with more adolescent girls than boys accessing services). Women living close to where services are physically situated and those with family members (or connections with other families) working for such programmes have greater access. Adolescents in school have access to school counselling programmes (although the quality varies considerably due to a shortage of trained and experienced counsellors, and lack of technical guidelines). There has been an increase in the number of schools providing counselling (more than 80% of MoE schools now).

Access to specialist mental health care is even more difficult than psychosocial care, whether in 'normal' circumstances in Gaza or post-conflict. There are only two service providers (MoH and the GCMHP), but low utilisation tends to reflect the poor quality of services. Generally speaking, adolescent girls have less access to mental health services because of socio-cultural barriers and stigma. Many families are reluctant to seek services for adolescent girls at mental health institutions, fearing that doing so might harm their chances of marrying; some health providers are reluctant to treat girls for the same reasons. The older the girl, the less likely it is that she will receive mental health services (despite needing them) as this may affect her reputation and chances of marrying. Statistics on access reveal some interesting differences in the gender of patients receiving treatment: at MoH mental health facilities, 22.9% of patients were girls, while at the GCMHP, this was nearly 50%. This perhaps reflects the greater privacy and confidentiality afforded to service users/beneficiaries of NGO programmes compared with MoH services.

5.1.1 Barriers to physical access

Physical access to services in the Gaza Strip is reasonable, given its small geographical size; the main constraints are the Israeli occupation and quality of services. Nearly half of service users attending MoH primary health care (PHC) centres (which also house mental health services) walked to the facility, and half used transport (Anan and Hamad, 2013; Hamad, 2013). A 2012 study of MoH community mental health centres (CMHCs) found that patients rated 'easy access to services' high (3.9 out of 5) (Mudallal, 2012). In the same study, items which elicited the lowest score were home visits when the service user is unable to seek services at the clinic (1.46 out of 5). Service users' perceptions of waiting times at PHC clinics were positive; nearly half reported waiting less than 30 minutes and around 16% reported waiting more than 50 minutes (Anan and Hamad, 2013).

The literature reveals that nearly a quarter of people attending mental health facilities were served by more than one site (Colliard and Hamad, 2010; Mudallal, 2012). Half of those attending the GCMHP visited the clinic almost every month; self-referrals accounted for 79% of registered cases, while referrals from other programmes constituted 21% (Colliard and Hamad, 2010).

Key facilities (the mental health hospital and the GCMHP) are located in the centre of Gaza, which can take 40 minutes to get to from areas near the borders. For some households, transport costs are not easily affordable, so constitute a barrier to access. Finally, physical access to mental health facilities is problematic for people with disabilities; services are generally not located on the ground floor, and the buildings have no elevators.

The mental health hospital organises transport for patients attending for rehabilitation. As one key informant explained: *'The majority of clients who receive rehabilitation services will not come if the transport cost is not covered through donors, which sometimes happens.'* Admission is free, even for those not enrolled in a health insurance scheme. It is worth noting that adolescent girls cannot seek services at the hospital unless they are accompanied by a family member; girls usually need male approval (the father or oldest brother) before seeking such services.

There is one Ministry of Health CMHC in each district, except for Gaza district, which has two, reflecting the district's greater population density. Physical accessibility is good; as one key informant said: *'People can reach the clinic by car or on feet easily within 10 to 30 minutes.'* Mudallal's (2012) study of all six CMHCs found that service users suffered from a variety of mental health conditions, including mood disorders (34%), psychotic disorders (29.5%) and anxiety disorders (13.7%). Among those attending CMHCs, 5% were people with disabilities, even though most centres were not adapted to meet disabled people's needs (only one-third had been fully adapted).

Access to information

There are serious gaps in access to information. Local communities generally have little knowledge of the range of psychosocial and mental health services available (MoH, 2014b), which constitutes a barrier to accessibility. Some facilities have put up posters with information on mental health services and with messages to combat stigma attached to seeking support, but these are generally only seen by visitors in the waiting area, and are not appealing or informative. Efforts to increase people's awareness were more common among psychosocial programmes than mental health services.

Mental health facilities generally have insufficient signage, usually posted at the entrance. But the specific services provided at the facility and the target groups were rarely displayed. Key informants talked about recruiting service users/beneficiaries through different mediums, including radio broadcasts, TV slots, operating phone hotlines, distributing pamphlets, organising community awareness sessions, conducting outreach programmes, and face-to-face contact with regular beneficiaries. But there is no clear strategy for proactive targeting of beneficiaries/service users. Brochures about mental health were not seen frequently at the assessed facilities. None of the channels currently used to reach potential service users addressed adolescents as a group with specific needs for psychosocial support or mental health services.

For their part, most service users/beneficiaries reported getting information about available services from relatives, friends and neighbours. But this information was not always reliable, and could even be dangerous. As one caregiver said: *'My neighbours advised me to treat my daughter by reading Quran (Ruqia). I took her to a religious man who read Quran (Ruqia). She got better after and was not exposed to any epileptic seizures for around two months. But she had a strong epileptic seizure every day during the last war.'*

5.1.2 Financial barriers

People are generally not required to pay for counselling or to attend mental health facilities, so financial accessibility does not constitute a barrier to service uptake. However, service users with mental health problems are required to pay for regular health services. At a private facility, the fee for a mental health consultation is similar to the fee for regular health services (around \$15). At MoH facilities (the mental health hospital and specialist CMHCs), service users are required to pay fees for some diagnostic

investigations (usually electroencephalogram or EEG) if they do not have medical insurance or are not already registered at the facility (the fee being 20-50 NIS, or \$5-\$13).

Although most facilities and organisations offer free consultations, some facilities require co-payment for medicines, although the MoH recently decided to exempt all mental health service users from co-payment arrangements. Within the GCMHP, service users/beneficiaries are supposed to pay a contribution towards medicines, but none have been collected since 2000. Availability of drugs is a key factor in affordability of services in Gaza. Reports indicate that at least 80% of essential psychotropic medicines are provided free of charge. However, when there are shortages, many people cannot afford to buy medicines; the cost of private antipsychotic and antidepressant medication is 5% and 7% respectively of the minimum daily wage (Saymah et al., 2015).

A small proportion of respondents mentioned having difficulty affording transport to get to a facility; one caregiver (mother) said *'we walk to the centre to save transportation cost'* and one service user (a 10-year-old boy) said *'we cancel the session because cannot afford the transport cost'*.

5.2 Gender differences in access

Responses from key informants and beneficiaries indicate that school-aged girls find it easier to access psychosocial and mental health services than boys, although older adolescent girls find it more difficult because of socio-cultural norms and restrictions on their freedom of movement outside the home. As one key informant remarked: *'90% of female teenagers can access mental health and psychosocial services as they go to schools where they can find the services.'* At girls' schools, utilisation of services is greater, but there is not always sufficient time for counselling and the service is not prioritised. Another view maintained that both sexes face barriers to accessing services, but girls face more obstacles: *'Access of females to mental health and psychosocial services is more restricted, because of the stigma. Adolescent girls at that age don't have a culturally acceptable reason to go to health facilities (excuses) like being a child or a pregnant. Boys participate more in social activities and NGOs' work and can have better access.'* This key informant added, *'Accessibility is a problem for both boys and girls, there is inadequate access to services at schools and at the larger community due to lack of specialist services and the social barriers.'*

The other main barrier to girls' accessing services is that girls need permission to do so from a male family member, as one key informant confirmed: *'When women/females come to the hospital seeking treatment, we cannot make admission for them unless an adult male from the family brings them.'* This issue underlines a major ethical and/or moral dilemma in the provision of mental health services for the population of Gaza. On the one hand, socio-cultural norms influence the behaviour of health providers, but on the other hand, services should prioritise protecting and supporting vulnerable people who need those services most.

The problems facing women and girls in Gaza have an immense impact on their psychological wellbeing. As one key informant said: *'In collective centres, families were exposed to huge suffering, from lack of safety to lack of services. Some women were praying that they would rather die before being displaced and living in schools.'*

Although it seems to be easier for girls to access psychosocial support from counsellors in schools, respondents reported that there is still stigma attached to seeking help in school. Some adolescent girls reported that despite the availability of counselling services, they did not use them because they did not trust them and feared expressing their problems. In a focus group discussion with girls aged 12-16, one girl said: *'I can't trust people, I can never tell them what I feel or share my problems with them'*; another added *'But when girls don't share their problems, their psychological status will be harmed.'*

The research highlighted numerous insights about how socio-cultural norms influence mental health service utilisation in Gaza, as follows.

- Men and boys find it relatively easier to access mental health services, and tend to seek services earlier, than women and girls (particularly older adolescent girls) who face high levels of social stigma. The families of adolescent girls (aged 11-12) often seek help due to their daughters' bed-wetting.

- Until they become grandmothers, women have little say in decisions related to their daughters' access to mental health services, although they have more say over access to psychosocial services. This is particularly true among the most conservative communities in Gaza.
- Widows find it particularly difficult to decide to approach mental health services for their offspring, particularly daughters, given they have to make the decision in the absence of a partner.
- If a family has to prioritise which of their children to seek help for, they generally choose boys over girls. This is partly because of prevailing socio-cultural norms, and partly because boys tend to express mental ill-being through violent behaviours, which can be more destructive and become more pressing.
- School counselling fulfils an important role but there are concerns around quality. Counsellors' attitudes, stigma, and poor quality of services contribute to low levels of access among boys.
- Psychosocial support programmes implemented after intense periods of heightened conflict have increased the utilisation of mental health services as a result of outreach activities, identification of cases, and referral initiatives.
- Seeking mental health services is seldom reported by beneficiaries or service users as their main coping strategy.
- Adolescents (boys and girls) prefer to seek services from NGOs or PHC centres than specialist MoH clinics, mainly because there is less stigma attached to them, and they can interact with their peers at those services.
- Most service users/beneficiaries are not clear about the differences between psychosocial support and mental health services.

5.3 Role of the family in accessing/utilising services

In the absence of proactive targeting on the part of service providers, families (particularly mothers) are playing a central role not only in determining adolescent girls' access to and uptake of psychosocial and mental health services but also their treatment outcomes. As well as seeking out sources of psychosocial support, mothers also play an important role in convincing the adolescent child and other family members to take up the services. As stated earlier, around 80% of cases presenting to mental health institutions were self- or family referrals. One girl in a focus group discussion of 12-17-year-old girls said: *'I went to the school counsellor. In fact, my mother did, and then, the school counsellor sent us here to clinic.'* Another aged 17 said: *'When we came here, I was afraid that people may say I have a psychological problem. But my mother convinced me and she kept this as a secret from all the family.'*

Most mothers accompanied their son or daughter to the clinics, whereas few fathers reported doing so. One girl (aged 10-14) living in a collective centre said that she participated in psychosocial activities because *'my father advised me to join any recreational activity in order to feel better'*.

At the other end of the spectrum, many families reported that one of their coping strategies was to seek the services of a traditional healer, which may present higher risks to the vulnerable person. Again, families find it more difficult to send daughters to mental health facilities than sons.

A recent study of the MoH's PHC centres in Gaza (including clinics providing mental health services) showed that service users were not satisfied with their involvement in planning and implementation of services (Anan and Hamad, 2013). It also highlighted poor communication between PHC staff and service users and their families.

NGOs were reported to pay more attention to involving beneficiaries in their programmes. Moreover, complaint boxes/system is not available mostly in half of the checked facilities and few use the system and take feedback into considerations. One key informant claimed that the system is not widely used because people don't prefer writing and they talk face to face with providers when they have complaints.

The family role in treating their son or daughter usually involves ensuring that they take their prescribed medicine and attend follow-up appointments. Some facilities have tried to set up meetings with local communities to engage them and hear their perspectives and concerns. These meetings usually involve community leaders; key informants said that adolescents did not participate but their voices were heard

during programme implementation. Another key informant from a PHC centre said *'The clinic has a friendship committee composed of 12-13 persons. They meet with the clinic management every month but neither females nor adolescents participate. All are adult men.'*

5.4 Staff attitudes towards adolescents with psychosocial or mental health needs

Positive attitudes on the part of service providers are a critical element of effective service delivery and good treatment outcomes, as they help to build trusting relationships. Regardless of their role or professional specialism, most providers involved in this study were found to be enthusiastic, caring and keen to improve. There were some exceptions, but the general impression was of positive provider attitudes. However, at service delivery level, there is a lack of age- and gender-sensitivity, with some unacceptable practices.

Staff morale may account for some of this; the literature indicates that little attention is paid to motivating staff to maintain good morale (Colliard and Hamad, 2010). There is a high level of burnout (10%) (using the Maslach Burnout Inventory), and little recognition of the emotional exhaustion that can accompany working in the mental health sector.

A review of UNRWA's community mental health programme in Gaza revealed that counsellors generally felt quite isolated and undervalued, as evidenced by requests for psychological support and encouragement to staff in-service, as well as calls for better communication and cooperation between different UNRWA departments, more interaction with local organisations, and a public relations strategy for informing local people about the programme, through written material and promotional activities (Terahata, 2009).

Other studies have found evidence of serious problems in the attitudes and practices of mental health service providers at facility level, with 73% admitting that cultural norms influence how they deal with patients presenting with mental health illnesses. Maghari (2010) studied UNRWA's PHC services, pointing out that 34.9% of health care providers reported seeing patients with mental health illnesses at their clinics and most of them advised those individuals to seek a psychologist's help; yet, strangely, 81% advised those patients to seek help from a traditional healer. Almost all the health care providers surveyed were supportive of integrating mental health services into regular PHC centres; but 63.6% reported that their practices change when they realise the patient in front of them has a mental illness.

There were contradictory responses from participants in this study regarding attitudes of counsellors at schools and clinics. Although some respondents did say positive things, most adolescents (especially girls) mistrust school counsellors because of a lack of confidentiality (with some counsellors seemingly telling the child's parents and/or school administration about certain matters. As one senior key informant said: *'People don't trust their providers due to lack of confidentiality...'* And one adolescent boy (aged 13-16) said: *'School counsellor can tell others about your problem.'*

The performance of counsellors varies; in only one facility (out of five) were working to a child protection policy and protocol. There were also wide variations in practice in relation to confidentiality and privacy. Some adolescents felt that school counsellors were only interested in helping with academic attainment rather than helping to solve personal problems. Counsellors based at health centres were more positively perceived (with one girl commenting that they allow more time to play). Some beneficiaries and key informants claimed that counsellors at government facilities were more likely to be stressed (perhaps because of low salaries or even non-payment). Another important issue is the availability of sufficient female counsellors to run sessions for adolescent girls.

Some problems appear to stem from the fact that psychosocial services have been integrated into PHC centres without proper management of the process, which would involve sensitising and providing training for managers and staff to ensure that they are supportive of their colleagues in mental health. At one clinic, a manager stated: *'I don't like the idea of having the psychosocial services as a programme, I don't believe in the work of counsellors, I am against any further expansion.. We should focus on other, more important issues such as immunisation or antenatal care.'* The same manager added, *'I accommodate them in this clinic just to be in line with the organization's vision.'*

In the absence of written policies and protocols guiding the working practices of counsellors, people's own culture, experiences and beliefs can influence how they treat service users and beneficiaries, often in negative rather than positive ways. The research found cause for concern in this regard, particularly in the attitudes of some health workers towards the challenges facing adolescents. One counsellor based at a clinic, showing a clear lack of empathy, said: *'I don't show any empathy to females who fall in love and behave against the cultural mainstreamed behaviours. How can I support a girl who falls in love during the war in a collective centre...'* The same counsellor said, *'All stories we hear are related to love, stories on mobile and things that may God protects us from them.'*

Some (male) health providers reported feeling reluctant to treat adolescent girls unless they were accompanied by a family member. Others rely heavily on their faith and spiritual beliefs as a method of treatment. One said: *'The best method to treat mental illnesses is to be closer to God and to keep faith'*; he claimed that this approach had worked with almost all the people he sees.

Some counsellors at clinics reported that they themselves do not feel safe, and are exposed to violence by patients who themselves are behaving more violently, particularly after intense periods of conflict. One manager at a PHC centre suggested that patients who 'misbehave' should not be eligible for services again for a few months.

Another issue relates to a lack of awareness among policy-makers of the different strategies involved in helping people with psychosocial or mental health support, letting their own judgements interfere with the kind of approach used. One senior expert explained a situation he had encountered: *'A policy-maker described mental health and psychosocial services teams from an NGO as bad, impolite, rude, and strange because one counsellor/social worker organised dancing sessions for girls at collective centres for IDPs. That policy-maker prevented the NGOs from supporting the IDPs at collective centres because he believed that these NGOs are doing terrible unethical things and spoiling the girls.'* The interviewee added, *'This is a problem in the mentality of people regardless of their education and position.'*

5.5 Perceptions of quality of services

Assessing quality should address two main components: factual information and service users/beneficiaries' perceptions (Hamad, 2005). Factual information that can be verified includes approved standards and protocols, competent/skilled providers, adequately equipped and supplied facilities, the availability of appropriate service user information and materials, effective supervision systems, and service utilisation. Service users' perceptions focus on people's level of satisfaction with mental health services available in Gaza, as well as the outcomes of those services on users' quality of life and wellbeing.

In the field of mental health, recovery does not necessarily mean a complete or lifelong cure; rather it means that patients regain their ability to function on a day-to-day basis and improve their quality of life. Most care models within mental health view recovery as a personal journey that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning (Colliard and Hamad, 2010). Essentially, care should involve a baseline assessment followed by monitoring of individual service users in terms of improvements in their ability to function, using a recognised assessment measure.

5.5.1 Individualised care management plans and impact assessment tools

There was little evidence of such a system of care at most of the facilities and programmes assessed as part of this study. Implementers claimed they have individualised care plans with clear goals and timeframes; but they did not disclose any of these plans. Many key informants from international organisations and consultants pointed to the absence of individualised case management plans as a serious gap in mental health service provision in Gaza. One key informant said, *'We don't assess the impact of our interventions; we don't ascertain the effectiveness of our interventions or our therapeutic models.'* He added: *'We don't work according to clear individualised management plan.'* The findings of this study are congruent with the local literature, which shows that there is no evidence-based practice in the mental health sector in Gaza (Colliard and Hamad, 2010). Also, the same source indicates that it is difficult to measure impact of activities due to the absence of baseline data.

When asked to reflect on the tools they use to assess the impact of their activities on service users, staff at most organisations said there were no assessment tools, for adolescents or other groups. Even where tools were available, they were not used systematically. One key informant from an international organisation said: *‘We use [Colombia tool] to monitor the impact of our interventions through pre and post-tests. The question is, does that tool fit the Gaza Strip context? Does it credibly measure impact? There are tools to monitor psychosocial interventions but these are not standardised and do not necessarily reflect the progress in the case... It is not individually used as part of a case management approach.’* A colleague of hers stated: *‘Which impact do you expect from a short-term project? I have never been asked by the organisation to assess impacts.’*

Some international organisations such as Mercy Corp are working with universities to develop more contextually relevant impact assessment tools for use in Gaza, as many existing tools are not necessarily culturally appropriate. Some NGOs reported using (or planning to use) the International Classification of Functioning, Disability and Health (ICF), which measures the impact of the treatment process for adult patients in relation to their ability to function and take part patient in everyday life, as well as the Strengths and Difficulties Questionnaire (SDQ), which is used with children and adolescents. Again, though, when asked about the evidence produced from using these tools, it was clear that their use is problematic.

5.5.2 Service users’ perceptions of quality

There have been some recent studies focusing on service users’ perceptions of quality of mental health services provided in Gaza. A 2010 study found that the services provided by the GCMHP had favourable effects on users’ health status (Colliard and Hamad, 2010). Most felt that their health condition had improved after starting treatment (77%). Patients surveyed reported that their energy level had increased (79%) and their perspectives on life had improved (68%). To a lesser extent, they reported some improvement in their ability to adapt and cope (59%).

Mental health service managers from a range of organisations have paid little systematic attention to monitoring and measuring service users’ satisfaction and gaining their feedback. Some rely on informal feedback such as suggestion boxes inside facilities. The research team was not able to find one mental health service provider with a clear complaints system for users. Providers tended to assume that people would prefer not to write about a complaint but to present at the facility to make a verbal complaint instead.

In another study, Mudallal (2012) assessed service users’ satisfaction about the quality of services provided by the MoH’s CMHCs and found that less than 12% considered them ‘very good’ or ‘excellent’; nearly 40% judged them ‘good’ and 48% judged them ‘fair’ or ‘poor’. The satisfaction scores ranged from 58.19% to 77.81%. The highest level of satisfaction was found in relation to the physical environment at the centres; the lowest rates were for accessibility, communication, interaction and information. These figures suggest that mental health services have the lowest satisfaction scores of all health services in the Gaza Strip (MoH, 2014c). At the MoH’s PHC centres, around one-third of service users reported being sent home without receiving what they came for. The most frequently cited reason was lack of medications (80%) (Anan and Hamad, 2013). The same source suggested that the most important factors determining good quality of mental health care services from the service user’s perspective were availability of drugs (67.3%), respect (46.5%), and being cured 34% (Anan and Hamad, 2013).

Another small-scale study assessed satisfaction among people using the three GCMHP centres. One-third of those interviewed reported that their sessions had been cancelled at least once, usually by the service team (Colliard and Hamad, 2010). The same study showed that only 3% of those surveyed had been involved in their care management plan. Still, 93% wanted to continue receiving services from the programme. Overall satisfaction with the services received was 88% – much higher than the figure reported at the CMHCs (Colliard and Hamad, 2010). Service users were most satisfied with the physical environment and staff, and least satisfied with waiting times and limited health improvements. However, almost half of the participants (47.2%) reported going home without receiving what they had come for (in the year that preceded data collection). Reasons included unavailability of a doctor, lack of drugs, staff vacation, staff meetings or closure of the centre on that day. All these reasons could be avoided by better coordination and service management.

Many key informants mentioned that people tend to distrust mental health services and are more likely to trust informal services such as traditional healers. As one key informant said: *'People don't trust mental health services, local systems, politicians and leadership – they trust traditional healers... Most cases come to seek services very late, after trying traditional healers; they come with serious complications'*. Another one also said *'Usually cases with mental health problems present late to health facilities, after being seen by traditional healers and after developing serious complications.'* Some key informants claimed that negative perceptions regarding mental health and psychosocial services were based on prior experience of bad practice, and the lack of regulation. As one key informant said: *'Now, anyone in Gaza can establish a psychosocial organisation; licensing is easy, just few people can form a board and rent a flat... Psychosocial interventions are not easy, it is not like giving paracetamol to a client. Some organisations did more harm than benefit...'* Also, cultural norms in different geographical areas can influence service users' perceptions. During a focus group discussion, one provider said: *'Areas do affect how people behave. Two sisters with similar education and income had their kids suffer after the war. The one living in Shajaia sent her kid to a traditional healer while the one who lives in Remal sent her kid to a psychologist.'*

Several beneficiaries interviewed reported positive impressions about the services they received. One caregiver was pleased because her son had stopped bed-wetting, his psychological wellbeing was improving, and he was doing very well at school. Her son (aged 10), who was also interviewed, said he feels he has improved significantly and wants to keep going to the centre. *'The counsellor in GCMHP saves no effort to make me laugh. He doesn't stop trying until I feel happy'*. Another 13-year-old boy said: *'I get better after taking the medicine. It helps me to release the painful headache.'* And a 16-year-old said: *'After joining the programme, I can control myself much more than before.'* By contrast, one adolescent girl dropped out of the GCMHP because the appointments were inconvenient; another service user describes the service as insufficient and ineffective; while another still felt some relief but their problems had not been solved. Many adolescents perceived school counsellors as not being helpful, as one 10-year-old boy who was being physically abused by his teacher explained: *'The school counsellor is not bad but is not helpful. We seldom go to him but I tried that once when the teacher beaten me but he did nothing.'*

One caregiver expressed her perspectives about the inadequacy of services, saying, *'Services are not adequate, we are afraid to send her to places where her problem increases, we have experienced this before.'* Moreover, in focus group discussions, beneficiaries reported that the services are too limited and too short in duration, which limits their effectiveness, as one girl in a focus group with 12-16 year-olds said: *'Mental health and psychosocial services stereotype in Gaza is limited to fun and recreational activities. Two counsellors came to see adolescents in the organisation only for two weeks.'* She added, *'What I understand in mental health and psychosocial services is there should be a counsellor who you can share your problems and feelings with and you trust that this information will remain as a secret with him/her.'* A 16-year-old boy complained that psychosocial activities were not always age-appropriate: *'They do some mental health and psychosocial services here and gather the small children to play or speak about war. I don't join these activities simply because they don't suit me, we are no longer kids!'*

A key informant agreed with this: *'Care is not standardised. Everyone assumes he is an expert'*, adding, *'Usually interventions are fragmented, not integrated... Education, health, social services – you can't effectively address needs unless we integrate these components.'* In addition, service providers themselves reported that there is a need to apply protocols which could improve their performance and protect beneficiaries as well. One provider stated: *'When providers don't know where to stop in our interventions, we may open wounds that never heal.'* Absence of protocols and guidelines, combined with inadequate follow-up, result in confusion and uncertainty for service users/beneficiaries. One caregiver (a mother) said: *'I am so confused because none of the doctors told what I have to do for my older daughter. Some of them scared me from the side effects of medicine on my daughter if she takes it. In contrary, others blamed me when I tried to stop the medicine.'*

5.6 Gender/age differences in treatment outcomes

Service users and caregivers – male and female – reported feeling better as a result of receiving care, although some male caregivers did not see any progress and perceived care as insufficient to be effective. Adolescent boys' tend to find it easier to access mental health services and therefore benefit more from

those services than adolescent girls. On the contrary, girls benefit more from school-based counselling and from psychosocial programmes. When adolescent girls do access mental health services from the variety of service providers, they have more positive outcomes than their male counterparts. Also, discussions with key informants indicated that girls have many more success stories, make significant progress and achieve better treatment outcomes. They claimed that girls are more reliable, more compliant with the continuum of care and more committed to treatment. One key informant said: *'Females are more emotionally resilient, cleverer in coping. They are more stigmatised due to social norms than males.'* However, some study participants highlighted that there is no evidence on which to base conclusions about any gender difference in treatment outcomes.

In addition, coping strategies employed by adolescent girls tend to be more constructive than those employed by boys (such as focusing on education), which contributes to a feeling of returning to 'normal' life and hence better outcomes. By contrast, adolescent boys tend to deny their problems and adopt negative coping approaches (such as using painkillers like Tramadol), which further complicates their mental status and delays their recovery. As one key informant from an international organisation said: *'Women find it easier to talk about their illnesses than men; men find it too much for their ego.'*

5.7 Stigma towards mental health and psychosocial services

Although stigma associated with mental illnesses has been widely investigated in other countries, little is known about community perceptions toward people with mental health problems in Gaza and the underlying causes of any negative reactions. Despite being not the focus of this study, attitudes and reactions of stakeholders about mental ill health have been explored in some depth.

Participants reported that stigma still exists, but is decreasing, particularly so for psychosocial problems as opposed to mental ill health. Key informants and policy-makers believe that the increasing need for psychosocial and mental health services in Gaza because of frequent episodes of conflict has decreased the stigma associated with seeking such services. In most cases, communities perceive psychosocial services as a post-conflict intervention that focuses on children, to decrease their fear and anxiety. This perception that such interventions target children increases their acceptance. Also, because psychosocial support services are often provided by non-specialist organisations, there is no obvious link between those organisations and mental health service providers, which again reduces stigma.

For mental health services though, stigma remains strong; there has been a reported decline, partly due to better education and the integration of mental health services with mainstream health care in recent years. As already noted though, stigma means that families may take years to seek support for one or more of their children from a mental health service provider, often having sought services from traditional healers during that time to avoid being stigmatised by seeking formal mental health care. Also, according to one key informant, stigma is sufficiently strong that those who can afford to do so choose to travel outside the Gaza Strip to access mental health care.

Again, as already noted, stigma seems to affect adolescent girls in particular, not just at the time of seeking treatment but potentially a longer-lasting problem. One caregiver cited the negative attitudes of a health provider when they sought care for their daughters: *'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. He told the caregiver, 'It is enough, don't take her to any doctor. This will affect her if people know about her case.'*

Perhaps reflecting the community's negative perceptions, a study of medical students at universities in Gaza (El-Kahlout, 2014) concluded that the most popular choice of career was general surgery, while psychiatry was least popular (1.8%).

Interestingly, one counsellor described how she went to the mosque in her area and volunteered to present a lecture on psychosocial issues services. She described the reaction of women to be very positive; they asked her to schedule weekly lectures. During the discussion with the counsellor, women said, this is what

we need to hear, we of course are interested to learn about religious topics but we want more opportunities where we can share our problems and learn about solutions.

The study findings suggest that boys are more affected by stigma attached to psychosocial services provided at schools. Adolescent boys in school, especially those over 12, seldom approach school counsellors, and stigma is one of the main reasons. Students felt others would mock them for being unable to handle any issues, and that there was a weakness attached to seeking help (equating to 'behaving like kids/girls').

Key informants gave their own thoughts about how Palestinian culture affects people's perceptions of mental ill health and how it affects their coping mechanisms. One expert described that mental ill health is associated with losing one's mind; a terrifying thought, but particularly for men in the context of Gaza. When they have problems, they feel like they are losing control, so they deny it for the longest period possible. When the issue concerns a family member, especially his daughter or wife, the situation gets worse because it affects the whole family and could be seen to 'infect' any other family his daughter marries into. These cultural perceptions affect how people deal with seeking help for mental health needs. One expert explained: *'It is a million times easier for families to take girls to traditional healers than mental health providers. This removes any blame from the family, which is perceived by the community as a victim of external evils who envy their daughter because she is pretty and wonderful. This perception is highly rewarding to the family, while on the contrary, when the girl receives specialist mental health care, then she has a problem. Her family may also have problems, so people tend to avoid them and will not consider them for engagement and marriage options.'*

While men can be more sensitive to stigma (according to some experts), women seem to be more stigmatised when they have mental health as opposed to psychosocial problems. As one key informant said (reflecting perceptions of mental ill health as madness): *'By itself, being a woman is an issue. What about being a woman and being crazy too?'* It was frequently reported that there is less stigma attached to men seeking support for conflict-related psychosocial issues. *'The community regard psychological problems with less sensitivity than they used to, especially when problems are related to the war, as it is not a personal issue. It affects many people and is out of their control. But when the problem is not war related, that is when people feel stigma.'* Another key informant (provider) commented: *'When it is pure mental health [referring to the person's problems], stigma is still there. The neighbours ask the mother "why do you take your daughter to a psychologist or a doctor, is she crazy?"'* Moreover, people with disabilities suffering from mental illnesses are even more stigmatised. One key informant from an NGO noted: *'Stigma is there, it's a big barrier that hinders the opportunity of people with disabilities to seek mental health and psychosocial services. In general, people with disabilities are less confident than others...'* He went on to say *'A girl, a teenager and disabled – three major issues.'*

Experts cited the media as playing a large part in reinforcing negative stereotypes of people with mental health problems as either dangerous or 'funny crazy' people. Our study also found evidence that some mental health care providers themselves contribute to these kinds of attitudes, according mental health care a lower status than physical health care. As one senior key informant commented, *'I manage this department [referring to mental health] because no one is interested in it. When we meet at senior management level, the directors of departments used to make fun of the person in charge – he is a director also – they make fun of him because he works on this field.'*

To conclude, it is difficult to assess the real prevalence of psychosocial problems and mental ill health among the general community in Gaza and among specific groups in particular because stigma drives families to hide the fact that one or more of their members may need help. Overcoming these difficulties should be a priority not just for mental health service providers but for the communities themselves, to meet the pressing needs of vulnerable young people, particularly adolescent girls, whose needs do not appear to be met at present.

6 Addressing service gaps and challenges through evidence-based strategies

Overall, the study has identified important gaps and challenges affecting the psychosocial wellbeing of people in the Gaza Strip, particularly adolescents, which have significant implications for policy-makers, programme designers and implementers, as well as international development agencies and the larger international community.

A wide array of social, political, structural and cultural challenges affect the psychosocial wellbeing of the population in Gaza, but particularly adolescent girls. The prevailing combination of chronic economic, political, cultural and social vulnerabilities, and the limited capacity of social services, has exacerbated the already dire mental health status of many people, but adolescent girls are a particularly vulnerable group. Delivering improvements in girls' psychosocial status and mental wellbeing is closely linked to other contextual issues such as economic growth, community empowerment, social justice, gender equity, and political resolution of the Palestinian case. Determinants of mental health such as peace, equity, social justice, gender equity, employment, education and women's empowerment need to be constantly strived for, with adequate attention to the needs of adolescent girls. The ongoing political conflict and repeated outbreaks of intense fighting have increased, and will continue to increase, the need for psychosocial and mental health services.

Although international support during and after these repeated conflicts has been crucial to fill some gaps in state-run psychosocial and mental health services, much more is needed. The research found that many short-term, largely uncoordinated, donor-driven psychosocial activities were implemented in the immediate post-conflict period, mostly focusing on young children. While these are valuable, they do not help meet the needs of other vulnerable age groups. It also means that longer-term interventions and specialist mental health services receive less attention and support. Because the personal consequences of trauma usually take some months or years to come to the fore, stakeholders (including donors) need to consider supporting longer-term interventions with a more strategic orientation. Despite the existence of many psychosocial programmes in Gaza, people's psychosocial and mental health needs are far from being met, especially during an emergency and immediately after. Serious gaps in planning and emergency preparedness need to be addressed to improve the quality and targeting of service provision when such services are needed most.

Rarely do service providers, parents or health care systems reflect an adequate understanding of the psychosocial and mental health issues faced by adolescents, especially girls. Moreover, there are major inadequacies in regulations, legislations and policies to ensure provision of adolescent-sensitive services, and poor coordination within and between state or NGO providers is an added challenge.

6.1 The main stressors facing adolescents

The study findings show that the severity and impact of pre-existing vulnerabilities among adolescents in Gaza are significantly increased during and after periods of conflict. Adolescent girls cited their main sources of stress as losing their homes or family livelihoods, the death of a loved one (especially the breadwinner), exposure to physical injury, feelings of physical insecurity, loss of privacy, lack of access to health services, witnessing or seeing terrifying images of people who have been injured or killed, the risk

of gender-based violence, and the challenges of living in collective centres. The experience of living in temporary shelters was associated with a major loss of privacy and dignity, with lack of access to sufficient hygiene and sanitation facilities, and even greater restrictions on their daily lives.

Adolescent boys cited their main stressors as security and exposure to physical injuries. Prior to a period of intense conflict, the main stressors facing adolescent girls include economic hardships, cultural norms and their associated restrictions, fear of exposure to sexual harassment, early marriage, lack of voice in decision-making, and limited access to education. Adolescent boys and girls alike found it stressful not to have places to go for recreation; however, spending time outside the house on their own is easier for boys than girls. Parents' understanding of the challenges facing their adolescent children is limited; however, they are more lenient towards their adolescent sons, particularly regarding any perceived culturally inappropriate behaviours.

6.2 Coping strategies

Coping strategies included performing religious practices, mindfulness, accepting the grief in the name of a broader 'Nobel' national cause (especially girls). Adolescent boys tend to have more freedom to seek recreational activities outside the home (such as hanging out on streets or doing sports when the security situation allows). Post-conflict, adolescents and their families resumed their traditional coping mechanisms, especially seeking support from their social network, going to traditional healers or seeking psychosocial services (especially women and younger girls). Also, girls reported using mind-based coping strategies (such as day-dreaming, imagination/fantasy feeling, drawing, writing, and using social media) whereas boys tended to do these less. Some adolescent boys turned violent or chose to become isolated, or resorted to painkillers or other addictive substances to cope. Others dropped out of school to find work, especially orphaned children.

6.3 Quality and coverage of services

Although coverage of psychosocial programmes is good, there are still many people whose needs are not met. The main problems include quality of services and their duration (few take a long-term approach). Many of the post-conflict psychosocial programmes are available only for a very short period of time. Although these programmes reach large numbers of people, they tend to target young children and mothers, and do not attempt to identify other vulnerable groups or individuals. Many adolescents need such services but have not benefited from them.

Within mental health, as noted, there are serious gaps in both coverage and quality, with only two organisations providing specialist services. If adolescents are targeted it is usually as part of the community or household rather than being directly targeted as a vulnerable group. None of the service providers had organised specific programmes for adolescents, boys or girls.

The school counselling programme implemented at UNRWA and MoE facilities is not adequately utilised. Although it has proved helpful (especially to girls, given that boys face certain barriers to using such services), counsellors often focus on academic performance and conduct disorders rather than providing psychosocial support. In many cases, adolescents do not trust school counsellors to keep any information confidential; in some instances, counsellors have behaved inappropriately and even used violence against students. Because schools are where adolescents can be easily reached without bringing stigma on them, the weaknesses in this programme represent a missed opportunity to promote adolescent wellbeing, as well as early identification of potentially more serious cases and early referral to specialist services.

Despite the major issues around quality and coverage, many service users (especially females) reported an improvement in their condition after taking part in psychosocial programmes. Of those who accessed mental health services, adolescent girls generally had better treatment outcomes than boys.

It should be noted, however, that the needs of people with disabilities, who may be more prone to psychosocial vulnerabilities, are totally overlooked. Mental health institutions assume that people with disabilities are being or should be served by specialist disability organisations, whereas those organisations claim that people with disabilities need services from specialist mental health services.

6.4 Lack of protocols and adherence to standards

As with many mainstream health services, psychosocial and mental health practice is not standardised or implemented according to national protocols. Subsequently, different providers use different treatment modalities without any kind of complementarity or coordination. Also, there is no clearly defined therapeutic model endorsed by mental health programmes. Generally, psychosocial interventions are generic and not tailored to the individual, with a clear care management plan. Moreover, health care providers do not systematically assess the outcomes of their interventions; there are many reasons for this, but they include a lack of assessment tools (for adolescents or other groups).

6.5 Workforce gaps and planning

Findings indicate that there are serious gaps in human resources (HR) – in terms of quantity of qualified personal and quality – for psychosocial and mental health services. There are too few psychiatrists, clinical psychologists and doctors qualified in mental health subspecialties, and there are few female clinicians.

The study revealed other gaps in terms of morale and attitudes among staff working for service providers. Some reported feeling isolated, insecure, undervalued, and undermined by colleagues and peers within and across different organisations. More importantly, staff performance is shaped by their own personal and family experiences, which have often been negatively influenced by local culture; this means that stereotypes and attitudes can affect their ability to provide quality care. Some providers rely on spiritualism as their main method of treatment, which reflects a lack of professionalism.

6.6 Changing attitudes and improving systems

Providers' attitudes about age and gender in the provision of mental health services need to be urgently addressed. Organisations delivering psychosocial support and those delivering mental health services need support to manage their human and financial resources more effectively in order to deliver better quality services. There is a need to develop managerial structures, guidelines and policies, supervision, strategic thinking, advocacy and networking. This study has disclosed serious gaps in information systems and decision-making at facility level.

Available information on service users' perspectives indicate that they are reasonably satisfied with mental health and psychosocial services in Gaza, but there are missed opportunities for adequate counselling and providing information. The study has also highlighted acute shortages of essential drugs and other resources that could jeopardise service users' treatment plans. The infrastructure in some facilities requires improvement, especially the mental health hospital. Other MoH facilities require repairs, renovations and maintenance, as well as improvements to the physical conditions and improved safety measures.

Our study has also highlighted a number of areas where changes could bring some real improvements in the psychosocial status of the Gazan population, particularly adolescent girls. These include introducing protective policies (e.g. enforcing a minimum age of marriage, reducing school-based violence), better regulation of services, promoting positive coping strategies, and increasing coverage, quality and utilisation of services. Alongside these changes, there is an urgent need to build capacity and empower staff at facility level, as well as strengthening management and coordination systems.

Table 6 presents a range of evidence-informed policy and programming recommendations based on the findings of this study, which are addressed to the Ministry of Health, UNRWA, NGOs and development partners implementing psychosocial support programmes or mental health services. The recommendations cover five key areas:

- Policies, strategies, regulation and coordination
- Psychosocial vulnerabilities and coping strategies
- Service coverage, quality, accessibility and approaches
- Human resources and capacity building
- Management systems

We believe that implementing these recommendations would do much not only to reduce psychosocial vulnerabilities among adolescents in Gaza and maximise the impact of existing programmes and services, but also to promote the psychosocial wellbeing of adolescent girls in particular. We have organised our recommendations into five key areas, divided further into quick wins, short-term and longer-term actions, to provide some guidance on possible sequencing of interventions.

Table 6: Evidence-informed policy and programing recommendations for psychosocial and mental health service stakeholders

Area of intervention	Quick wins	Short-term actions	Longer-term actions
<i>Policies, strategies, regulations and coordination</i>			
Reducing psychosocial vulnerabilities prior to, during and post-conflict periods	<p>Recruit extra resources to meet people’s post-conflict psychosocial needs</p> <p>Launch adolescent-sensitive psychosocial programmes that respond to their specific needs</p> <p>Provide urgent technical and financial support to organisations providing mental health services</p>	<p>Balance strategies that aim to reduce urgent humanitarian needs arising from the conflict with longer-term development needs</p> <p>Increase community awareness about adolescents’ needs and perspectives (particularly adolescent girls)</p>	<p>Tackle broader psychosocial vulnerabilities by promoting the key determinants of mental wellbeing among adolescents, including advocating for peace, equity, social justice, gender equity, livelihoods, employment, education, and women’s empowerment,</p> <p>Design cross-sectoral interventions that consider the multifaceted nature of psychosocial wellbeing</p> <p>Introduce national protective policies for adolescent girls</p>
Reinforcing emergency preparedness planning		<p>Review performance of the social sector and psychosocial services in mitigating the psychosocial challenges people face during and post-conflict</p> <p>Include section on psychosocial needs as part of the emergency preparedness plan currently under development</p>	<p>Update the psychosocial section of the emergency preparedness plan with adequate involvement of stakeholders in its development and training on its use</p>
Strengthening coordination, regulation and integration of psychosocial services	<p>Reinforce coordination among actors and programmes at the community and cluster levels through better utilisation of the existing structures (UN-led psychosocial cluster)</p> <p>Reactivate the MoH-led National Steering Committee for Mental Health, which involves all key stakeholders in regulating the provision of mental health services</p> <p>Promote exchange of information among different service providers and actors</p> <p>Make better use of available referral forms, including through on the job training and mentoring</p>	<p>Strengthen MoH role as legitimate regulator of psychosocial services</p> <p>Agree roles, responsibilities, targets and catchment areas of different psychosocial service providers</p> <p>Create coordination forums among providers at district level</p> <p>Reinforce referrals process among providers with prompt feedback</p>	<p>Tighten up the current licensing and accreditation procedures (as a quality control measure) for the various psychosocial and mental health service providers</p> <p>Develop a conceptual framework for psychosocial and mental health services with clear standards to act as a reference for licensing, assessments and improvement initiatives</p> <p>Initiate a mapping process for psychosocial and mental health services and resources, including HR, in order to better inform the planning process</p> <p>Enhance integration of services to ensure continuity of care</p>
Ascertaining the magnitude and risk factors of mental and psychosocial health conditions	<p>Monitor trends and services statistics and respond accordingly</p>		<p>Conduct a national baseline study at the household level in order to accurately estimate the prevalence of psychosocial/mental health conditions and to identify which groups of people are more exposed or at greater risk</p>

Area of intervention	Quick wins	Short-term actions	Longer-term actions
<i>Psychosocial vulnerabilities and coping approaches</i>			
Enhancing proactive identification of vulnerable groups (including adolescent girls) and addressing their needs	Proactively identify at-risk groups due to their greater vulnerability as a result of social, political, economic and health factors; tailor activities to meet their needs	Work with caregivers to increase their understanding of adolescents' needs (particularly adolescent girls)	Work with communities to increase their understanding of adolescents' characteristics, needs and perspectives by organising awareness and mobilisation initiatives with the participation of media, schools and colleges, community groups/leaders and adolescents themselves
Promoting access to basic livelihood resources during and after conflict	As a matter of urgency, improve conditions for IDPs at collective centres/shelters, including provision of adequate health services, hygiene, sanitation facilities, food and water Ensure that the shelters provide adequate privacy for IDPs, especially adolescent girls		Ensure that families have a safety net to fall back on during emergency situations through multi-sectoral collaboration to sustain livelihoods
	Ensure that those who have lost their homes are accommodated in safe houses; provide basic household goods for those who have lost all their assets		
Addressing psychosocial needs of particular vulnerable groups	Design psychosocial programmes for conflict-affected families, including those who have lost family members or have sustained serious injuries, IDPs, those who have lost their homes and assets, and orphans Design psychosocial programmes for people who have experienced gender-based violence	Strengthen the ability of mental health providers to manage cases that require referral from psychosocial programmes	
Promoting appropriate coping strategies	Train adolescents and their caregivers on basic coping strategies such as debriefing, mind-body techniques, seeking family/friends' support, etc Encourage the use of social networks including family members, friends and caring members of the family	Proactively monitor and target vulnerable groups at risk of developing negative coping strategies (such as boys using Tramadol and other addictive substances) Support initiatives to promote self-confidence, self-esteem and resilience; these might make reference to value systems and spiritual beliefs	Build basic life skills of children and adolescents to promote positive self-image and self-esteem Support programmes to help strengthen ties and nurture relationships between adolescents and their families, especially at an early age Invest in education as a means of strengthening self-esteem and resilience
Reinforcing the provision of school-based psychosocial services	Intensify the provision of psychosocial support in schools	Develop protocols for school counseling services Enhance the implementation of the developed school counseling protocols through training, provision of needed	Reform the school counselling programme to focus more on prevention and early detection of psychosocial and mental health issues

Area of intervention	Quick wins	Short-term actions	Longer-term actions
		resources coincide with monitoring and follow up	
Coverage, utilisation, access and approach			
Ensuring that safe (do no harm) psychosocial services are provided to service users	Take regulatory/control measures to ensure that psychosocial services/programmes are safe and appropriate. Services need to be provided by trained counsellors	Provide internship programmes to new graduate and involve them in clinical practice as a pre-entry requirements to the professional practice	
Intensifying efforts to combat stigma around mental health, especially around the mental health issues facing adolescent girls	Fulfil adolescent girls' psychosocial needs through provision of services integrated with mainstream health and education services At MoH, expand the model of integrating mental health services within PHC centres (NCD departments) to other health services	Address stereotypes and prejudices in provider attitudes about mental health challenges, especially among adolescent girls Integrate mental health services in other MoH facilities and facilities of other providers such as UNRWA and NGOs Draw up written guidelines for case confidentiality and privacy; provide training and follow-up supervision for staff tasked with implementing them	Investigate the underlying causes of stigma attached to mental health issues, especially in relation to adolescent girls, and implement initiatives to combat negative perceptions among the public Make better use of media and community resources to deter people from using traditional healers and seek formal psychosocial and mental health services instead
Discourage people from seeking unprofessional practices by traditional healers	Promote availability of and access to psychosocial and mental health services, particularly at schools and integrated within regular health services	Intensify efforts to provide information to service users through awareness-raising and promoting active involvement of families in their care	Introduce policies to protect adolescents (particularly girls) from harmful practices
Proactive targeting of groups at risk and addressing their needs	Proactively target vulnerable groups such as adolescents through specific programmes to address their unique needs		Increase awareness of policy-makers to implement adolescent-sensitive programmes and work with caregivers to increase uptake of these programmes
	Screen, identify and provide psychosocial services for conflict- affected populations, including adolescents		
Promoting the performance and the role of school counsellors in improving adolescents' psychosocial wellbeing	Extend school counselling services to all schools Intensify training programmes for counsellors to enhance their role in prevention, early detection and referral of students with psychosocial problems	Recruit more qualified counsellors to ensure an adequate ratio of counsellors to children Promote a more professional approach to counselling, focusing on developing standards and codes of conduct to ensure quality performance	Develop protocols for school counselling with clear referral systems, linkages with other complementary services and clear indicators and standards Integrate mental health within the current school health programme, which only focuses on physical aspects of adolescent health
Strengthening the capacity of	Urgently secure resources to strengthen the capacity of		

Area of intervention	Quick wins	Short-term actions	Longer-term actions
organisations to provide mental health services	mental health care providers to respond to increased demand for specialist care		
Promoting the quality of psychosocial and mental health services	Encourage appropriate mental health-seeking behaviours, targeting adolescent girls Fill gaps in coverage of psychosocial services, especially for vulnerable groups including adolescent girls and those from areas with particularly strict/conservative social norms	Introduce individualised care plans as part of service provision, through case management and individualised counselling Develop the capacity of specialist mental health providers to deliver advanced mental health services, focusing on both hardware and software components of managing complex cases	Streamline girls' access to mental health services by removing the psychological and cultural barriers that hinder service uptake at the community and service delivery levels; this will require awareness-raising and community mobilisation
Enhancing the provision of standardised psychosocial services according to approved protocols	Disseminate PHC protocols developed by the MoH/WHO to other PHC providers (NGOs and WHO) and providing training on use of the protocol	.	Develop new national protocols for mental health services. Protocols should be congruent with child and adolescent protection policy and be gender-sensitive Ensure that protocols are available and accessible; provide training and follow-up alongside managerial support and policies to safeguard implementation
Meeting the psychosocial needs of people with disabilities	Proactively target people with disabilities through psychosocial programmes implemented by different actors, taking into account people's specific vulnerabilities	Draw up policies to regulate the provision of psychosocial and mental health services for people with disabilities	Ensure that the psychosocial problems facing people with disabilities are adequately addressed within the national strategic plan for mental health services
Promoting communities' capacity to demand and support psychosocial wellbeing	Raise community awareness about mental health issues focusing on stigma, stress management techniques, positive coping strategies, early signs of mental illnesses, gender differences, adolescents' needs and perspectives, risks associated with approaching traditional healers, etc.	Develop a communication and marketing strategy for mental health services	Formulate a community mobilisation strategy for mental health in order to promote appropriate practices within communities
Human resources and capacity building			
Introducing a cadre of mental health care providers capable of providing quality mental health services	Fill major gaps in HR by deploying specialist professionals, particularly in psychiatry, child/adolescent psychiatry and clinical psychology		Formulate a national human resource strategy for the mental health sector, including developing standards for practice, with clear indicators
Fostering investments in relevant training and capacity building activities	Provide training on emergency preparedness and emergency psychosocial support, gender mainstreaming, dealing with gender-based violence, and	Organise intensive training courses in mental health treatment modalities; priority areas include case management, assessment/impact	

Area of intervention	Quick wins	Short-term actions	Longer-term actions
	early identification of mental health illness	measurement, psychotherapy, cognitive behavioral therapy, family therapy, team case management, occupational and rehabilitation skills, substance abuse, forensic psychiatry, crisis intervention, and community-based interventions	
Reinforcing on-the-job training	Provide on-the-job training and link it with formal training to ensure that learning is applied at facility level Benchmark the MoH approach applied at PHC centres (the integrated programme) where on-the-job training is assigned to supervisors	Develop tools for on-the-job training such as supervisory checklists Develop a conceptual approach and strategy for on-the-job training	
Promoting morale and professionalism among mental health care providers	Address negative perceptions/ attitudes and low morale among mental health providers by recognising good performance and organising debriefing sessions to help them deal with difficult situations	Provide training on professional conduct and work ethics in mental health Improve interactions among mental health care providers and between them and staff from other disciplines Monitor job satisfaction and morale among mental health providers and respond accordingly by adopting policies to motivate good performance	
Management systems			
Strengthening managerial functions and capacity of mental health care providers	Provide short training courses on basic management approaches such as motivation, improving morale and supervision	Provide training courses in planning, equal opportunities, managing diversity, leadership, and using impact assessment indicators	
Improving health information systems	Upgrade service users' files at psychosocial and mental health programmes to facilitate a more effective case management approach Strengthen documentation and reporting practices	Launch systems for tracking prevalence of psychosocial conditions and mental ill health Develop a performance monitoring plan with clear performance indicators, which need to consider utilisation and outcome levels, disaggregated by gender and age, as well as exchange of information among stakeholders	Create a culture of using information and evidence to guide decision-making and practice in mental health; administration systems should be computerised
Providing user-centred mental health services	Promote interactions and therapeutic communications between mental health providers and service users Improve counselling services by providing intensive training to counsellors Conduct regular meetings with beneficiaries and communities	Install suggestion boxes, develop an appeals system and ensure effective feedback mechanisms for service users/beneficiaries Monitor service users' satisfaction regularly	Develop a strategy for regular involvement of communities, families and service users (including adolescents) in the design, implementation and evaluation of psychosocial programmes

Area of intervention	Quick wins	Short-term actions	Longer-term actions
Maintaining adequate supply of drugs	Secure adequate stock of drugs sufficient for at least six months	Monitor drug storage status and keep adequate stock of essential drugs at all times	
Filling gaps in equipment and resources needed for the provision of mental health services	Enhance service provision at facility level by providing computers, filing equipment and stationery, emergency equipment, and first aid items (such as emergency trolleys) and other vital equipment		
Improving infrastructure of mental health organisations	Improve physical conditions of counselling areas (eg, by installing curtains to maintain privacy, repainting walls and making rooms adolescent-friendly) Adapt health facilities so that they are accessible to people with disabilities	Deploy adequate spaces for provision of mental health services at PHC facilities Improve hygiene and sanitary conditions at the mental health hospital, particularly the seclusion areas	Renovate MoH mental health centres and the hospital
Promoting safety equipment within mental health care providers	Provide essential emergency first aid tools and materials Secure back-up ambulance services Make repairs and install exit signs, fire extinguishers, repair broken stairs, etc.	Organise training sessions on safety and security for staff of mental health service providers	Remove/replace the outdated and harmful incinerator at the mental health hospital

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Appendix

Table A1: Service mapping of mental health/psychosocial services in Shajaja Area/Gaza City

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Structured sessions with caregivers Jan – Dec 2014 and Sep 2014 – Feb 2015	Enhance the children resilience	Local NGO: Palestinian Center for Democracy and Conflict Resolution/ SC	Al Shajaja	N/A Target is 90 parents	Strengthening community and family support	Stand-alone interventions. However, the organization interfere with other issues such as legal support and conflict resolution activities	Parents	Child focused activity but the target is parents
Raising awareness sessions with the community members Jan – Dec 2014 and Sep 2014 – Feb 2015	Raising awareness on PSS services and UXO training	Local NGO: Palestinian Center for Democracy and Conflict Resolution/ United Nations Children's Fund, SC	Al Shajaja	N/A	Disseminating information to the community at large	Stand-alone interventions. However, the organization interfere with other issues such as legal support and conflict resolution activities	Community members are targeted. Adolescents may attend but not purposefully targeted	Community members are targeted. Adolescents may attend but not purposefully targeted

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
One community based session activity for children In Sep 2014 In Oct 2014	Capacity building & support sessions for carers who live with violence and harmful practice	INGO: Qattan Center For The Child	Al Shajaja	1,845 children	Strengthening community and family support	The center offer education and recreation services to children	Children	Not clear if target is adolescents or children in general
Respond to Psychosocial Distress and Mental Disorders From Jan 2014 to June 2015	Implementing reational activities as psychosocial support and debriefing for children in UNRWA schools	National NGO: Palestine Trauma Center/ PTC – UK	Al Shajaja	5,777 children	Psychosocial support in education	Stand-alone service of specialized NGO	Children both genders	Not clear if target is adolescents or children in general
Respond to Psychosocial Distress and Mental Disorders From Sep 2014 to Dec 2014	Open days for children	National NGO: Palestinian Center for Democracy and Conflict Resolution/ SC	Al Shajaja	109	Strengthening community and family Support (social activities)	Stand-alone interventions. However, the organization interfere with other issues such as legal support and conflict resolution activities	Children	Attend but no confirmation on % or purposive intended targeting
Respond to Psychosocial Distress and Mental Disorders 16 Oct 2014	Open days for children and mothers jointly	National NGO: Palestinian Working Women Society for Development	Al Shajaja	30	Strengthening community and family Support (social activities)	Stand-alone interventions.	Children and mothers	Not purposive intended targeting for adolescents

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Respond to Psychosocial Distress and Mental Disorders 23 Aug – 30 Sept	Providing Psychosocial intervention for women and children. We have to reach 1500 women and 2500 children in the community and schools.	National NGO: Palestinian Working Women Society for Development/ CFD	Al Shajaja	300	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children and mothers	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders 1 Aug – 31 Dec 2014	providing Psychosocial intervention for groups of adults and children	National NGO: Palestinian Red Crescent Society/ UNDP	Al Shajaja	551	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children and adults	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Jan 14 – Feb 15	providing Psychosocial intervention children through home visits	Local NGO: Palestinian Center for Democracy and Conflict Resolution/ United Nations Children's Fund, SC	Al Shajaja	1507	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children	Not purposive intended targeting for adolescents
Respond to Psychosocial	Psychosocial First Aid	INGO: IMC/DFID	Al Shajaja	NA	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children	Not purposive intended targeting for adolescents

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Distress and Mental Disorders Aug – Oct 2014								
Respond to Psychosocial Distress and Mental Disorders	Classroom Based Intervention Training for child care workers	INGO: IMC/DFID	Al Shajaja	8	General activities to support MHPSS	Stand-alone interventions.	Teachers	Child focused but don't target adolescents in specific as indirect beneficiaries
Aug – Oct 2014								
Respond to Psychosocial Distress and Mental Disorders	Psychosocial First Aid	National NGO: Al Saada/ WV	Al Shajaja	711	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Aug 2014 – Jan 2015								
Respond to Psychosocial Distress and Mental Disorders	Psychosocial First Aid	National NGO: Al Saada/ WV	Al Shajaja	711	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions.	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Aug 2014 – Jan 2015								
Respond to Psychosocial	Psychological first aid and detection of cases, operating a referral system	National NGO: Gaza Community Mental Health Program/ SDC, Dignity, True care	Al Shajaja	118	(Person-focused) psychosocial work Psychological first aid	Stand-alone interventions from a specialized center	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Distress and Mental Disorders ³⁴ Aug – Dec 2014								
Respond to Psychosocial Distress and Mental Disorders Aug – Dec 2014	Awareness raising.	National NGO: Gaza Community Mental Health Program/ SDC, Dignity, True care	Al Shajaia	118 (same)	Disseminating information to the community at large	Stand-alone interventions from a specialized center	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Aug 2014	Group activities, sport and recreational activities	National NGO: Maan Development center/ UNICEF	Al Shajaia	440	Strengthening community and family Support (Structured social activities (e.g. group activities) And (Structured recreational or creative activities	Stand-alone interventions	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Aug - Sep	Group activities, sport and recreational activities	INGO: War Child Holland/ UK Aid and Community Training Center and Crisis Management	Al Shajaia	30	Strengthening community and family Support (Structured social activities (e.g. group activities)	Stand-alone interventions	Children and adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents

³ Linkages: yes

⁴ Results: Yes but no systematic methodology based on standardized and national indicators

Programme/ service & Period of implementation	Objectives	Implementing agency / Management	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Respond to Psychosocial Distress and Mental Disorders Aug - Sep	Group activities, psychosocial Support cycle	INGO: War Child Holland/ UK Aid and Community Training Center and Crisis Management	Al Shajaja	30	Strengthening community and family Support (Structured social activities (e.g. group activities)	Stand-alone interventions	30 Children and 40 adults. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Sep 2014 – June 2015	providing Psychosocial support through sessions for children on children resilience	Local NGO: Palestinian Center for Democracy and Conflict Resolution/ SC	Al Shajaja	97	Strengthening community and family Support (Structured social activities (e.g. group activities)	Stand-alone interventions.	Target is 532 Children	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Sep 2014	Group counselling	Local NGO: Palestinian Working women society for development/ CFD	Al Shajaja	11	Psychological intervention	Stand-alone interventions.	Target is Children	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Sep 2014	Group counselling	Local NGO: Palestinian Working women society for development/ CFD	Al Shajaja	62 women	Psychological intervention (Basic counselling)	Stand-alone interventions.	Target is women and part of activities evolve around child care	Adults
Respond to Psychosocial Distress and Mental Disorders Sep 2014	Through mobilizing previously trained community	INGO: IMC/DFID	Al Shajaja	190	Strengthening community and family	Stand-alone interventions.	Children	Not purposive intended targeting for adolescents

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Distress and Mental Disorders Aug – Oct 2014	volunteers and child care workers, including peer leaders linked to IMC's early childhood development program and existing CBO staff, children will be engaged				Support (Early childhood development (ECD) activities)			
Respond to Psychosocial Distress and Mental Disorders Aug – Oct 2014	Group counselling to caregivers	INGO: IMC/DFID	Al Shajaia	106 parents	Psychological intervention (Basic counselling)	Stand-alone interventions.	Target is women and part of activities evolve around child care	Adult caregivers
Respond to Psychosocial Distress and Mental Disorders ⁵ Aug – Oct 2014	Group and individual counselling to children	INGO: IMC/DFID	Al Shajaia	NA	Psychological intervention (Basic counselling)	Stand-alone interventions.	children	Not purposive intended targeting for adolescents

⁵ Linkages: Yes, referral system is there

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Respond to Psychosocial Distress and Mental Disorders Sep – Oct 2014	Group activity on MB medicine	National NGO: Center of Mind and Body Medicine/ CMBM in US	Al Shajaja	10 children and 12 adults	Strengthening community and family Support (structured group activity)	Stand-alone interventions from a specialized center	Children and adults	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Aug 2014 – Jan 2015	Structured group sessions for children	INGO: WV and national NGO: Al Sada	Al Shajaja	100	Strengthening community and family Support (structured group activity)	Stand-alone interventions.	Children. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Respond to Psychosocial Distress and Mental Disorders Nov 2014 – Mar 2015	Structured group sessions for children and caregivers	National NGO: Women's Graduate Society/ Pontifical Mission	Al Shajaja	855	Strengthening community and family Support (structured group activity)	Stand-alone interventions.	855 Children and 66 parents. No confirmation on intended targeting of adolescents	Not purposive intended targeting for adolescents
Specializes MH care ^{6,7} 2005 - current	Wide range of M services including case management (with and without medication) and counselling	Government: Sorani PHC center	Al Shajaja	All clients are 1300 average monthly beneficiarie s (follow	Clinical management of mental disorders by specialized mental health care providers	Integrated with PHC	No data about no of children in adolescence age	Not purposive intended targeting for adolescents

⁶ Linkages: Referral from and to the center exist but not organised

⁷ No measurement of outcomes except the observation and cases with clinical files

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
Specializes MH care ^{8,9} 2005 - current	Wide range of M services including case management (with and without medication) and counselling	Government: Sorani PHC center	Al Shajaja	up and new cases) In Dec, 1516 All clients are 1300 average monthly beneficiarie s for substance use problems is 2 or 3 new cases) In Dec, 2 cases	Psychological intervention (substance use problems)	Integrated with PHC	No data about no of children in adolescence age	Not purposive intended targeting for adolescents
PSS services NECC ^{10,11} 2009 – current	Provision of PSS services through group activities and individual	INGO: Near East Church Council/ different donors	Al Shajaja	Sep- Dec 2014 800 children age 6-18	Strengthening community and family Support (group activities)	Integrated services in PHC center	General population with focus on children and adolescents	Most of group activities and recreational services are made for adolescents

⁸ Linkages: Referral from and to the center exist but not organised

⁹ No measurement of outcomes except the observation and cases with clinical files

¹⁰ Linkages: Referral services exist but not organised and documented

¹¹ Results: No standardised measurement of outcomes. However, reported cases of progress are there

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
	counselling to adults and children			years joined recreational and group activities				
PSS services NECC ^{12,13} Sep – Dec 2014	Provision of PSS services through group activities to adults and children	INGO: Near East Church Council/ CRS	Al Shajaja	122 adolescents	Strengthening community and family Support (group activities)	Integrated services in PHC center	Target is children 4 – 15 years and caregivers	No adolescent intended targeting or tailored activities
MHPSS service at UNRWA clinics ^{14,15} 2005 – current	Provision of MHPSS services through group activities and individual counselling to adults and children	UNRWA	Al Shajaja	NA	Clinical management of mental disorders by no specialized health care providers (Basic counselling to individual and groups, psychological debriefing)	Integrated services in PHC center	General population 222 persons/ 3 months	No adolescent intended targeting or tailored activities
MHPSS service at UNRWA clinics 2005 – current	Raising awareness about MHPSS service and psycho-education	UNRWA	Al Shajaja	NA	Disseminating information to the community at large (Raising awareness on	Integrated services in PHC center	General population 30 activities/ 3 months	No adolescent intended targeting or tailored activities

¹² Linkages: Internal referral to PHC counsellor

¹³ Results: Pre/post-test application

¹⁴ Linkages: Internal referral to PHC counsellor and to other service providers

¹⁵ Results: Some application of post-test and pre-test but not for all cases

Programme/ service & Period of implementation	Objectives	Implementing agency /	Geographic coverage	Scale of service uptake	Approach(es)	Implementation strategy and activities	Target group	Adolescent-tailored service
MH hospital ^{16,17} 1982 - current	Provide advanced MH care	MOH	GS	All persons received in 2013 are 2163 but no info on number of adolescents	mental health and psychosocial support) Clinical management of mental disorders by specialized mental health care providers	Stand-alone service	General population	No tailored services to adolescents

¹⁶ Linkages: Referral exist from the centers to the hospital. A few cases may referred outside GS

¹⁷ No impact measurement based on national indicators

Table A2: List of organizations providing psychosocial services after the most recent conflict as extracted from UNICEF database in Shajia neighbourhood, Gaza municipality, Gaza governorate

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Maan Development Centre	National NGO	Maan Development Centre	UNICEF	Psychosocial Distress and Mental Disorders	Structured group activities	1- Conducting different sport activities to fresh up the participants.2- Conducting different stress release and relaxation sessions.3- Opening self-expression cycles that contain (painting, drawings, writings, storytelling, stand-up comedy, acting, singing ...etc).	Shajia	Community	Completed	28-Aug-14 28-Aug-14	Child: 440 Adult: 10
Maan Development Centre	National NGO	Maan Development Centre	UNICEF	Psychosocial Distress and Mental Disorders	Open Days	conducting about 2 hours of recreational activities in each school, with a team consisted of 12 animators each 4 are responsible of a corner, MAAN's three corners are (self-expression corner, sport activities and Art corner)	Shajia	Government Shelter	Completed	14-Sep-14 19-Sep-14	Child: 9,837 Adult: 0
Mercy Corps	International NGO	Community Training Centre and Crisis Management	USAID	Psychosocial Distress and Mental Disorders	Open Days	Community Open Days organized in large Events' halls through rental arrangements by respective partner CBOs. Each activity	Shajia	Community	Completed	11-Aug-14 18-Aug-14	Child: 599 Adult: 298

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
War Child Holland	International NGO	Community Training Centre and Crisis Management	UK Aid	Psychosocial Distress and Mental Disorders	Structured group activities	involves a variety of psychosocial support and recreational activities including clown team shows, competitions, folk dance (Dabkeh), songs, etc., in addition to a brief psycho-educational (awareness) component. Conduct 1 psychosocial Support cycle for 30 children (include 6 sessions , 2 hrs. each session),and conduct 1 psychosocial Support cycle for 30 women (each cycle include 4 sessions , 2 hrs. each session)	Shajaia	Community	Completed	30-Aug-14 4-Sep-14	Child: 30 Adult: 40
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Distribution of 250 family-level recreational kits	Shajaia	Community	Completed	1-Sep-14 30-Sep-14	Child: 0 Adult: 250
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Distribution of 300 family-level recreational kits	Shajaia	Community	Completed	1-Sep-14 30-Sep-14	Child: 0 Adult: 300
Palestinian Centre for	National NGO	Palestinian Centre for	Save the Children	Psychosocial Distress and	Awareness raising	1 group will be formed, each consists of 15 parents	Shajaia	Community	Completed	1-Sep-14	Child: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Democracy and Conflict Resolution		Democracy and Conflict Resolution		Mental Disorders		and to benefit from CR 4 sessions				30-Sep-14	Adult: 15
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Structured group activities	1 group will be formed, each consists of 13 children and to benefit from 15 CR sessions	Shajaja	Community	Completed	1-Sep-14 30-Sep-14	Child: 13 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Open Days	open days were organized to the children in governmental schools	Shajaja	Government Shelter	Completed	1-Sep-14 30-Dec-14	Child: 200 Adult: 0
Theatre day Productions	National NGO	Theatre day Productions	PAN, UNRWA, Diakonia	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Psychosocial support through theatre presentations connected to life times of pain during war and crisis with creativity, humour and soul searching.	Shajaja	Community	Completed	14-Sep-14 27-Sep-14	Child: 2,283 Adult: 85
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Providing group counselling sessions for 11 children, The staff use CBI manual during 8 intervention sessions.	Shajaja	Community	Fund is released/ secured	9-Jan-14 9-Oct-14	Child: 11 Adult: 0
Palestinian Working Women	National NGO	Palestinian Working Women	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Providing group psychosocial intervention for women.	Shajaja	Community	Fund is released/ secured	9-Jul-14 9-Oct-14	Child: 0 Adult: 15

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Society for Development Palestinian Working Women Society for Development	National NGO	Society for Development Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Providing group sessions for women	Shajaia	Community	Fund is released/ secured	14-Sep-14 30-Sep-14	Child: 0 Adult: 17
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	PWWSD Campaign	Psychosocial Distress and Mental Disorders	Open Days	Holding an open day for 30 women and girls finished structured groups as a closing day.	Shajaia	Community	Fund is released/ secured	16-Oct-14 16-Oct-14	Child: 10 Adult: 20
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Scheduled 8 sessions for 17 women about behavioural problems among children, psychological stress disorder, alternative punishment.	Shajaia	Community	Fund is released/ secured	14-Oct-14 30-Oct-14	Child: 0 Adult: 17
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Doing group sessions for 25 women using debriefing, psychological support, dealing with adolescence.	Shajaia	Community	Fund is released/ secured	30-Sep-14 16-Oct-14	Child: 0 Adult: 25
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Doing group sessions for 20 women using debriefing, psychological support	Shajaia	Community	Fund is released/ secured	18-Sep-14 22-Oct-14	Child: 0 Adult: 20
International Medical Corps	International NGO	IMC	DFID	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Psychosocial First Aid+ Classroom Based Intervention Training for child care workers	Shajaia	Community	Ongoing	3-Aug-14 27-Oct-14	Child: 0 Adult: 8

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
International Medical Corps	International NGO	IMC	DFID	Psychosocial Distress and Mental Disorders	Structured group activities	Through mobilizing previously trained community volunteers and child care workers, including peer leaders linked to IMC's early childhood development program and existing CBO staff, children will be engaged in age-appropriate recreational activities in designated child friendly spaces within the community spaces	Shajaia	Community	Ongoing	3-Aug-14 27-Oct-14	Child: 190 Adult: 0
International Medical Corps	International NGO	IMC	DFID	Psychosocial Distress and Mental Disorders	Structured group activities	Based on previous work in Gaza, IMC will work with mothers and caregivers, focusing on training them on common reactions to stressful events and how to offer comfort and support to their children affected by the crisis	Shajaia	Community	Ongoing	3-Aug-14 27-Oct-14	Child: 0 Adult: 106
International Medical Corps	International NGO	IMC	DFID	Psychosocial Distress and Mental Disorders	Structured group activities	Trained psychosocial workers will provide additional support sessions for identified children and their families that are severely distressed. Psychosocial workers will assess the behaviour during these sessions and record	Shajaia	Community	Ongoing	3-Aug-14 27-Oct-14	Child: 0 Adult: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Centre of Mind and Body Medicine	International NGO	CMBM	CMBM-main branch- Washington DC	Psychosocial Distress and Mental Disorders	Structured group activities	any improvements. If needed they will refer them to organisations/agencies that offer additional specialized services	Shajaia	Community	Ongoing	21-Sep-14 25-Sep-14	Child: 10 Adult: 12
Qattan Centre For The Child	International NGO	Qattan Centre For The Child	Qattan Centre For The Child	Physical Violence and other Harmful Practices	Capacity building & support sessions for carers	Shajaia School for boys, Asqoula circle, Gaza	Shajaia	Community	Ongoing	16-Sep-14 16-Sep-14	Child: 850 Adult: 0
Qattan Centre For The Child	International NGO	Qattan Centre For The Child	Qattan Centre For The Child	Physical Violence and other Harmful Practices	Capacity building & support sessions for carers	Somaia Bint Khayyat (A) Morning Shift	Shajaia	Government Shelter	Ongoing	15-Oct-14 15-Oct-14	Child: 508 Adult: 0
Qattan Centre For The Child	International NGO	Qattan Centre For The Child	Qattan Centre For The Child	Physical Violence and other Harmful Practices	Capacity building & support sessions for carers	Somaia Bint Khayyat (A) Morning Shift	Shajaia	Government Shelter	Ongoing	15-Oct-14 15-Oct-14	Child: 487 Adult: 0
World Vision	International NGO	Assada society for family support & supervision	World Vision	Psychosocial Distress and Mental Disorders	Structured group activities	Psychosocial Support	Shajaia	Community	Ongoing	8-Jan-14 31-Jan-15	Child: 100 Adult: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
World Vision	International NGO	Assada society for family support & supervision	World Vision	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Psychosocial Support	Shajaia	Community	Ongoing	8-Jan-14 31-Jan-15	Child: 711 Adult: 488
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis interventions including psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 78 Adult: 35
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis interventions including psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 3 Adult: 4
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis interventions including psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 6 Adult: 30

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 7 Adult: 6
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 0 Adult: 3
Gaza Community Mental Health Program	National NGO	Gaza Community Mental Health Program	SDC, Dignity, True care, French Consulate	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Through the emergency response plan of GCMHP, we are currently implementing crisis psychological first aid and detection of cases, operating a referral system and awareness raising.	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 24 Adult: 27

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Open Days	1 open day will be organized targeting a total of 50 children	Shajaia	Community	Ongoing	1-Sep-14 1-Dec-14	Child: 109 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	727 emergency visits will be conducted for affected children by the war	Shajaia	Community	Ongoing	5-Jan-14 31-Dec-14	Child: 867 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Awareness raising	5 groups will be formed, each consists of 15 parents and to benefit from 4 Child Resilience (CR) sessions	Shajaia	Community	Ongoing	9-Jan-14 31-Dec-15	Child: 0 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Structured group activities	5 groups will be formed, each consists of 13 children and will benefit from 15 CR sessions	Shajaia	Community	Ongoing	9-Jan-14 31-Dec-15	Child: 13 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Awareness raising	Organize and implement 2 awareness raising sessions on community-based child protection mechanisms and referral system	Shajaia	Community	Ongoing	9-Jan-14 31-Dec-15	Child: 0 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Danger and Injuries (ERW)	Awareness raising	Conduct 5 UXO and mine risk education sessions. Each session will target 25 children	Shajaia	Community	Ongoing	9-Jan-14 31-Dec-15	Child: 0 Adult: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	Save the Children	Psychosocial Distress and Mental Disorders	Structured group activities	37 groups will be formed, each consists of 12 children and to benefit from 6 basic psychosocial support sessions	Shajaia	Community	Ongoing	1-Sep-14 30-Jun-15	Child: 60 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	United Nations Children's Fund	Psychosocial Distress and Mental Disorders	Psychosocial First Aid		Shajaia	Community	Ongoing	15-Sep-14 14-Feb-15	Child: 640 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	United Nations Children's Fund	Psychosocial Distress and Mental Disorders	Structured group activities		Shajaia	Community	Ongoing	15-Sep-14 14-Feb-15	Child: 24 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	United Nations Children's Fund	Psychosocial Distress and Mental Disorders	Awareness raising		Shajaia	Community	Ongoing	15-Sep-14 14-Feb-15	Child: 0 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	United Nations Children's Fund	Psychosocial Distress and Mental Disorders	Awareness raising		Shajaia	Community	Ongoing	15-Sep-14 14-Feb-15	Child: 0 Adult: 0
Palestinian Centre for Democracy and Conflict Resolution	National NGO	Palestinian Centre for Democracy and Conflict Resolution	United Nations Children's Fund	Psychosocial Distress and Mental Disorders	Awareness raising		Shajaia	Community	Ongoing	15-Sep-14 14-Feb-15	Child: 0 Adult: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Democracy and Conflict Resolution		Democracy and Conflict Resolution	Children's Fund	Mental Disorders						14-Feb-15	Adult: 50
Palestine Trauma Centre	National NGO	Palestine Trauma Centre	PTC- UK	Psychosocial Distress and Mental Disorders	Individual counselling/case management	Implementing recreational activities as psychosocial support and debriefing for children in UNRWA schools	Shajaia	Community	Ongoing	7-Jan-14 30-Jun-15	Child: 5,770 Adult: 190
Women's Graduate Society	National NGO	Women's Graduate Society	Pontifical Mission	Psychosocial Distress and Mental Disorders	Structured group activities	Conducting the psychological support sessions for children and parents	Shajaia	Community	Ongoing	15-Nov-14 31-Mar-15	Child: 855 Adult: 86
Palestinian Red Crescent Society	Red Cross & Crescent Movement	Palestinian Red Crescent Society		Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Group	Shajaia	Community	Ongoing	1-Aug-14 31-Dec-14	Child: 551 Adult: 474
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Psychosocial First Aid	Providing Psychosocial intervention for women and children. We have to reach 1500 women and 2500 children in the community and schools.	Shajaia	UNRWA shelter	Ongoing	23-Aug-14 14-Sep-14	Child: 300 Adult: 93
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Providing group Psychosocial intervention for 8 women groups each 20 women.	Shajaia	UNRWA shelter	Ongoing	26-Jul-14 31-Dec-14	Child: 0 Adult: 40
Palestinian Working Women	National NGO	Palestinian Working Women	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Providing group counselling for 6 children groups, 15 children in each.	Shajaia	UNRWA shelter	Ongoing	23-Aug-14 14-Sep-14	Child: 15 Adult: 0

Organisation	Type	Implementing Partner	Financing / Technical Partner	Needs	Activity	Description	Neighbourhood	Type of location	Status	Activity start/end Date	Child & adult beneficiaries
Society for Development		Society for Development		Mental Disorders		The staff use CBI manual which contains 8 sessions for each group.					
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Individual counselling/case management	Providing individual counselling for 200 women.	Shajaia	UNRWA shelter	Ongoing	1-Jan-14 31-Dec-14	Child: 0 Adult: 30
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	PWWSD Campaign	Several	Case management	Distribution for 104 hygiene kits for women benefited from pwwsd's psychosocial services.	Shajaia	Community	Ongoing	17-Sep-14 20-Sep-14	Child: 30 Adult: 47
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Individual counselling/case management	6 cases reached pwwsd for individual intervention	Shajaia	Community	Ongoing	1-Nov-14 31-Dec-14	Child: 0 Adult: 6
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Structured group activities	Counselling session for 20 women using mind and body technic	Shajaia	Community	Ongoing	18-Nov-14 18-Dec-14	Child: 0 Adult: 20
Palestinian Working Women Society for Development	National NGO	Palestinian Working Women Society for Development	CFD	Psychosocial Distress and Mental Disorders	Individual counselling/case management	Individual counselling session was held for 2 women have psychological problems	Shajaia	Community	Ongoing	5-Nov-14 8-Dec-14	Child: 0 Adult: 2

Figure A1: Key informants interviewed

Name	Organisation
Ala'a Al Wahadi	UNRWA-Primary Health Care Centres
Aya Al Haj	UNRWA
Badoour Al Helo	Near East Council of Churches
Dr Ahmad Abu Tawahena	Consultant
Dr Ahmad Sharqawi	Ministry of Health-Community Mental Health Hospital
Dr Bassam Zaggout	Palestinian Medical Relief Society
Dr Dia'a Saima	World Health Organization
Dr Fuad Al Essawi	Ministry of Education-Primary Health Care Directorate
Dr Mustafa Al Masri	Consultant
Dr Safa Naser	UNICEF
Dr Yasser Abu Jamma'a	Gaza Community Mental Health Programme
Hanadi Lolo	Ministry of Education
Hassan Zaida	Gaza Community Mental Health Programme
Ibrahim Younis	UNRWA's Mental Health Programme
Leila Bayoumi	Ma'an Development Centre
Lubna Sabah	Near East Council of Churches
Mahnoor Yarkhan	UNICEF
Mohammad Abu Shawish	Ministry of Health-Community Mental Health Hospital
Naem Kabaja	Atfaluna Society
Ramadan El Helo	Independent Consultant
Wala Hassan	Ministry of Education



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Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ

Tel +44 (0)20 7922 0300
Fax +44 (0)20 7922 0399

Cover image: A girl from Shajaia area sitting on the rubble of her demolished house during the conflict in 2014, © Mohammad Hammada, 2015