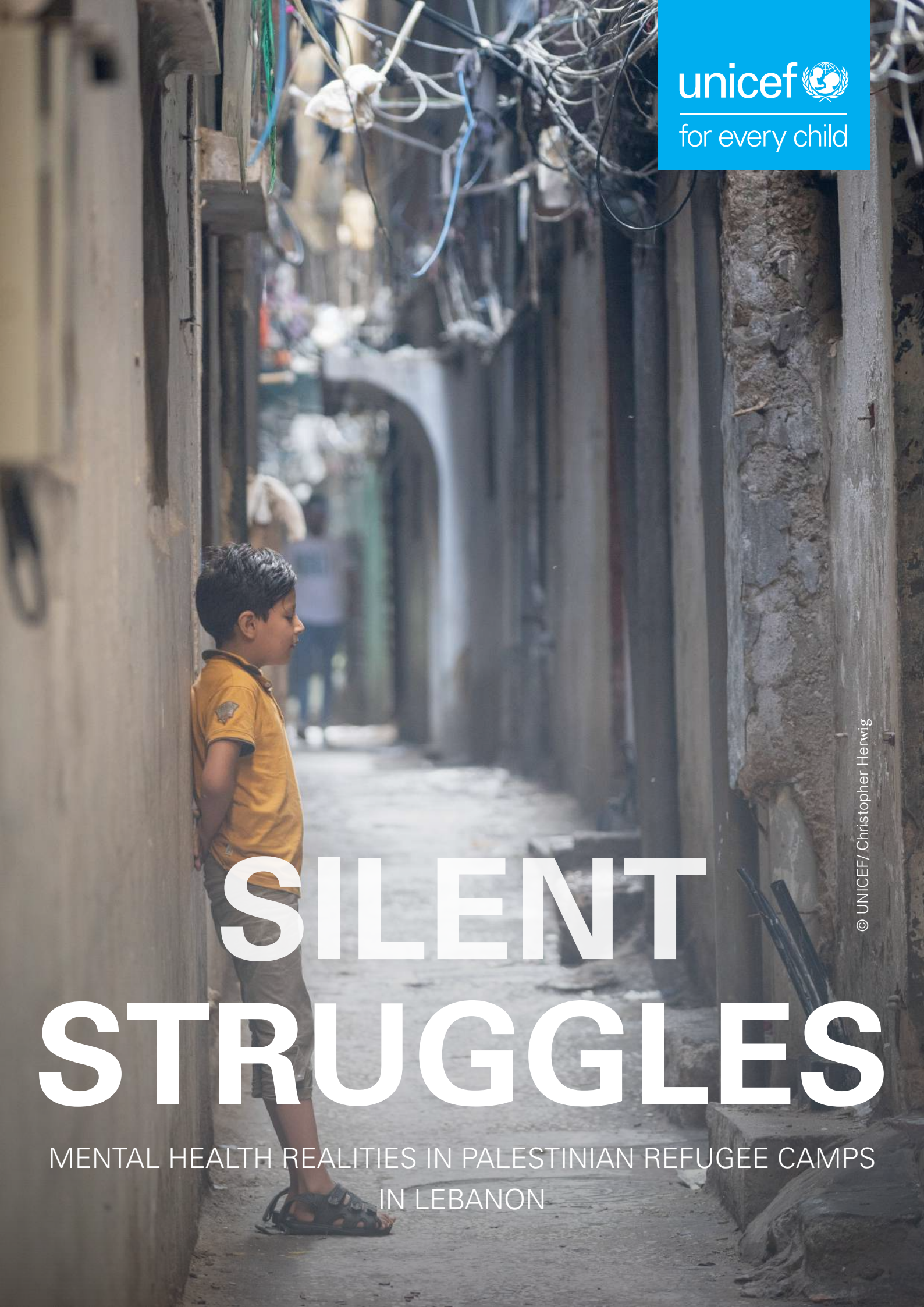

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SILENT STRUGGLES

MENTAL HEALTH REALITIES IN PALESTINIAN REFUGEE CAMPS IN LEBANON

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28.03.2024

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LIST OF ACRONYMS

ADAP	Adolescent Development and Participation
ARCPA	Arab Resource Centre for Popular Art
CBT	Cognitive Behaviour Therapy
CP	Child Protection
DAM	Data Analysis Matrix
ERB	Ethics Review Board
FGD	Focus Group Discussion
GBV	Gender Based Violence
GDP	Gross Domestic Product
IDIs	In-Depth Interviews
IFRC	International Federation of Red Cross and Red Crescent Societies
IRB	Institutional Review Board
LCO	Lebanon Country Office
MAP	Medical Aid for Palestinians
MAXQDA	Software for Qualitative Data Analysis
MHPSS	Mental Health and Psychosocial Support
MN	Methodological Note
PLO	Palestinian Liberation Organisation
PPL	Palestinian Programme in Lebanon
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
PwD	Persons with Disability
SGBV	Sexual and Gender Based Violence
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency

KEY DEFINITIONS

Term	Definition
Collective Trauma	Collective trauma impacts entire groups of people, communities, or societies. Unlike individual trauma, which affects specific individuals, collective trauma refers to the impact of a traumatic experience that involves entire groups. It can alter relationships, policies, societal functioning, and social norms.
Desensitisation	Desensitisation to adverse events occurs when someone becomes habituated to witnessing or experiencing distressing situations. Initially distressing events become routine or less emotionally impactful due to repeated exposure
Emotional Numbness	Emotional numbness is the mental and emotional process of shutting out feelings. It may manifest as deficits in emotional responsiveness or reactivity. People experiencing emotional numbness may feel distant, detached, and unable to fully participate in life. They might also lose interest in activities they once enjoyed and prefer isolation over social interactions.
Intergenerational Trauma	The transmission of trauma or its legacy, resulting in psychological consequences for subsequent generations.
Secondary Trauma	Secondary trauma is a stress response triggered by hearing about or witnessing the firsthand traumatic experience of another person. It can manifest as emotional exhaustion, hypervigilance, and other symptoms similar to post-traumatic stress disorder (PTSD).
Self-reliance	Self-reliance is the ability to independently choose and execute a course of action that results in achieving something you desire. It involves relying on your own efforts, acting with confidence, and achieving success without excessive dependence on others.

BACKGROUND

In recent years, Lebanon has grappled with an escalating social and economic crisis that precipitated in 2019. The depths of this crisis remain largely uncharted, as an increasing number of individuals plunge into poverty with no clear recovery strategy in sight. Within this bleak backdrop, vulnerable groups find themselves sinking further into poverty and uncertainty. Among these vulnerable groups are Palestinian refugees in Lebanon, who have endured refugee status for over seven decades. The majority of them have been born and raised in Lebanon as refugees. From the outset, Palestinians in Lebanon have faced significant challenges. Palestinian refugees in Lebanon, numbering around 250,000, confront dire socio-economic realities characterised by extreme poverty, limited accessibility, and scarce employment prospects. These refugees are primarily concentrated in overcrowded camps, where living conditions are challenging and access to basic services is severely constrained. Legal and systemic barriers prevent Palestinian refugees from owning property or securing formal employment, exacerbating their economic marginalisation. Notably, 44% of Palestinians in Lebanon are children and youth, highlighting the youthfulness of the population. However, these young individuals encounter additional difficulties in terms of accessing employment and education, among other issues. Legal restrictions further limit their rights, including the prohibition to work in 39 professions and own property, as well as restricted access to state-provided services such as healthcare and education. Initially, under the 1964 decree no. 1756, all non-Lebanese residents, including Palestinians, were required to secure work permits, with certain jobs exclusively reserved for Lebanese nationals. In 2005, this policy was partially relaxed through a ministerial decision, which granted Palestinians born and registered in Lebanon the right to work in 70 previously restricted professions. The legislative environment improved further in 2010 when an amendment to the Labour Law exempted Palestinians from the reciprocity condition, which required equal treatment for Lebanese in the refugees' country of origin, and also abolished the fees for their work permits. However, these reforms still excluded Palestinians from liberal professions, which remain under strict regulatory controls specific to professional syndicates. In 2021, a decree was issued by the Ministry of Labour that allowed Palestinian access to more jobs in the market.

The situation is further exacerbated by Lebanon's broader economic crisis, exemplified by a staggering nominal Gross Domestic Product (GDP) decline of 67% compared to pre-crisis levels. Triple-digit inflation rates, reaching 177% as of January 2024, have significantly eroded purchasing power and exacerbated poverty among Palestinian refugees. With the cost of the survival minimum food expenditure basket soaring by 164% in local currency and 28% in USD compared to the previous year, Palestinian refugees are increasingly reliant on humanitarian assistance for sustenance.

Another protection concern is the exposure to violence. Palestinian refugees in Lebanon, particularly children, are significantly exposed to various forms of violence, both within and outside their communities. In the overcrowded and under-resourced refugee camps, children are vulnerable to physical and psychological violence, with reports indicating that a considerable percentage of them experience aggressive discipline and other violent interactions as a normative aspect of daily life. Additionally, this insecurity, marked by sporadic clashes, leaves many refugees, especially women and children, in a constant state of vulnerability and fear. The most recent armed clashes occurring in September 2023, in the largest Palestinian camp, Ein el Hilwe, are indicative of this. According to the International Federation of Red Cross and Red Crescent Societies (IFRC), these recent clashes had severe consequences, resulting in over 12 deaths and more than 60 injuries, with half of the camp's residents fleeing their homes. Additionally, the United Nations (UN) Secretary General Guterres expressed deep concern about the ongoing militarisation of Palestinian camps in Lebanon emphasising that armed groups should never use educational institutions or other UN facilities for military purposes, which has been done during the clashes in Ein el Hilwe.

These violent incidents have exacerbated the existing socio-economic vulnerabilities of the camp's inhabitants, leading to significant displacement and damage to the camp's infrastructure. Additionally, the situation has intensified mental health challenges among the affected population. With preexisting intergenerational trauma compounded by frequent exposure to armed conflicts, Palestinian children and youth face an **increased risk of experiencing trauma-related symptoms and other mental health concerns.** The transition from attending schools outside the camps to the challenges of unsafe buildings within the camp and adapting to new environments **further exacerbates stressors for children, teachers, and caregivers.** Simultaneously, ongoing aggression in Gaza, Palestine, and the South of Lebanon **intensifies feelings of tension, uncertainty, and anxiety,** significantly impacting the mental health and psychosocial well-being of Palestinian youth and children in Lebanon. This exposure also contributes to secondary trauma, with caregivers inadvertently exposing children to stressors and potential traumatic triggers through their constant engagement with media reports.

Following the war in Gaza, Palestinians in Lebanon suffered further distress. This conflict started in October 2023, after Hamas, a Palestinian group, launched a large-scale assault on Israel, infiltrating communities near the Gaza Strip and killing around 1,200 Israelis while capturing over 250 hostages. In response, Israel launched extensive air and artillery strikes, leading to over 33,000 Palestinian casualties, according to Gaza's health ministry. Consequently, the conflict in southern Lebanon involved intense cross-border exchanges between the Israeli military and Hezbollah, with Israel launching air and artillery strikes on Hezbollah targets. The conflict has led to the displacement of over 91,000 people, with around 24,000 in the city of Tyre alone, where many are staying with friends, renting homes, or sheltering in temporary accommodations. In these shelters, approximately 790 individuals are struggling with cramped conditions and limited resources, exacerbating mental health issues. The ongoing conflict has prevented about 10,000 children from attending school, contributing to widespread psychological distress among them. Signs of trauma, such as bed-wetting and phobias related to the conflict, are common, indicating a severe impact on mental health due to the prolonged crisis. Additionally, health experts indicate that exposure to the violence has resulted in a range of psychological issues for children, including attachment disorders, nightmares, flashbacks, and persistent anxiety. The severe impact on their mental health is further exacerbated by their direct experiences of war, loss, and displacement, leading to symptoms such as uncontrollable shaking, panic attacks, and emotional shutdown. The trauma experienced is a form of toxic stress that affects both physical and psychological well-being, manifesting in physical symptoms like headaches and stomach aches. Another factor impacting the mental health of children and youth is the exposure to social media. Recent research indicates that young people are experiencing a notable decline in happiness compared to older generations, attributing this decline largely to inadequate social media regulation, which is described as an "untested drug". This year's Ramadan has been especially challenging for Palestinian refugees, marked by reflections on the disparities between their lives and those suffering in Gaza. Additionally, Palestinian refugees feel a persistent sense of displacement, frustration and lack of belonging in Lebanon, with no end in sight to their statelessness or the broader conflict.

Based on the recent news articles, current trends on the ground indicate concerning behaviours in children, including substance use, an increase in school dropouts, discrimination between children of different nationalities in shelters, harmful media exposure, and grief. Moreover, frontline workers themselves are also affected by these challenges. In light of these circumstances, UNICEF Lebanon Country Office (LCO) aims to tailor and **strengthen its existing cross-sectoral Mental Health and Psychosocial Support (MHPSS) programs** to address the emerging emotional, psychosocial, and mental health needs of Palestinian children and youth in Lebanon; considering their direct or indirect exposure to traumatic events.

IMPACT OF VIOLENCE ON MENTAL HEALTH

The impact of violence on mental health is profound, with victims experiencing various mental health consequences. The significant medical and mental health outcomes of interpersonal violence, particularly among women, include developing mental health issues such as Trauma and Stressor-Related Disorders, depression, and anxiety disorders. The various forms of violence, including child abuse, intimate partner violence, elder abuse, and community violence are all interconnected. All these types are linked to an increased risk of mental health issues such as depression, anxiety, post-traumatic stress disorder, and various physical health concerns, including cardiovascular diseases and impaired immune function.

In Palestinian refugee camps in Lebanon, gender-based violence (GBV) is reported at high rates, with physical assault, sexual violence, and domestic abuse prevalent due to overcrowded living conditions and limited privacy. Children are notably vulnerable, with exposure to violence affecting their psychological well-being. Reports indicate that 38% of GBV cases involve physical assault, and a significant portion of sexual violence incidents—23%—impact minors. The absence of adequate legal oversight and protective services in these settings exacerbates these issues, making it challenging to provide effective support and intervention for those affected.

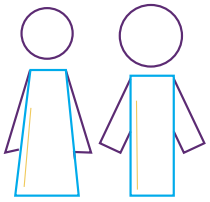
Ultimately, it is important to explore the impact of communal violence and conflict settings on mental health. Conflict-affected populations experience a significantly higher burden of mental disorders, with an estimated 22% of individuals in such environments affected by mental health conditions such as depression, anxiety, Post-Traumatic Stress Disorder (PTSD), bipolar disorder, and schizophrenia at any given time. In fact, the increase in the prevalence of severe mental disorders in conflict-affected populations, estimated at 5%, which is a considerable increase from previous estimates. Moreover, focusing on the mental health of individuals who are forcibly displaced due to war or persecution, reveals that the everyday difficulties, including in interpersonal relationships and challenges in securing basic needs in their new environments, exacerbates mental health problems among these groups. These day-to-day challenges hinder their ability to adapt and assimilate into new communities.

The impact of conflict settings and violence on mental health, particularly in regions like the Middle East, is a significant and growing concern. The Middle East presents a significant example of how violence can affect the mental well-being of populations. Studies from countries like Syria, Iraq, and Yemen show that the mental health impact of conflict extends far beyond those directly involved in the violence, affecting generations, and leading to long-term psychological distress. The disruption of normal life, the constant fear of violence, and the experience of displacement create conditions ripe for mental health crises.

Another aspect rooted in the violence is the intergenerational trauma which has significantly impacted the psychological well-being of Palestinian refugees. This form of trauma, often referred to as intergenerational trauma, gets passed down from the original survivors of traumatic events to their children and grandchildren. The transmission can occur through various channels, including parenting practices influenced by past traumas, prolonged exposure to stress, and potential epigenetic modifications. The history of Palestine, shaped by major events like the 1948 displacement and the 1967 Six-Day War, has created a cycle of trauma that impacts both individuals and the broader community's collective memory and mental health. Ultimately, studies have shown that this transgenerational transmission of trauma has led to prevalent mental health conditions across various age groups in Palestinian society, including widespread cases of depression, anxiety, and PTSD. These conditions are further complicated by ongoing instability and insecurity, which perpetuate a sense of loss, grief, and anger among the population. The impact of such widespread trauma extends beyond personal suffering, affecting social relationships, community dynamics, and even the political landscape of the region.

War trauma experienced by parents is transmitted to their children through psychological maltreatment. Fathers' exposure to war trauma significantly correlates with negative psychological outcomes in their children, where such trauma is mediated through increased psychological maltreatment. This maltreatment then contributes to greater attachment insecurity and elevated levels of depression, aggression, and post-traumatic stress symptoms among the children. Conversely, the effects of mothers' war trauma on children manifest differently, often leading to a decrease in psychological maltreatment, possibly due to a protective response where traumatised mothers become more nurturing and emotionally available. Additionally, there

are significant gender differences in parental impacts on children, with fathers' trauma often resulting in harsher parenting styles, while mothers might adopt more protective behaviours. This underscores the complex interplay of individual, familial, and sociocultural factors in trauma transmission and highlight the importance of targeted interventions to address both parental psychological health and parenting practices in conflict-affected regions, aiming to break the cycle of trauma and promote healthier generations.



GENDER DIFFERENCES

In Palestinian refugee camps in Lebanon, there are notable differences between men and women in terms of mental health resulting from distinct cultural, societal, and psychological factors. Men often face intense cultural pressure to be the primary breadwinners and may view seeking help for mental issues as a sign of weakness, leading to a significant underreporting and reluctance to engage with mental health services. Women, though also stigmatised, are more likely to seek help due to somewhat greater societal acceptance of their involvement in health-related issues, yet they may face accessibility barriers linked to mobility restrictions or caregiving responsibilities. The prevalence of mental health conditions also varies, with women more likely to report mood disorders like depression and anxiety, while men show higher incidences of substance abuse and antisocial behaviour as coping mechanisms for stress or trauma. These realities that underpin a difference in expression of emotional distress is not limited to Palestinian refugees in Lebanon but is also reflective of the general literature on the matter.

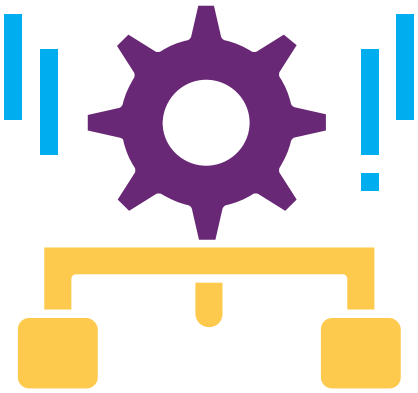
In fact, a study reveals that children, from as early as 13 months to 83 months old, exhibit distinct patterns of emotional expression and the ability to self-regulate, differentiated by gender. The findings reveal that girls were observed to have more neutral, calm, or peaceful-related emotional expressions, while boys tended to express emotions related to surprise, curiosity, anger, or frustration. Moreover, traditional gender roles significantly affect how men and women handle emotional expression, with men often experiencing and showing less emotion than women. This tendency is partly due to societal expectations and the pressure on men to adhere to stereotypically masculine behaviours, including emotional restraint. It is also suggested that this restraint is not a reflection of actual emotional experience but rather a response to societal norms that discourage men from expressing certain emotions considered non-masculine, such as sadness or vulnerability. Women, on the other hand, are generally more expressive of their emotions and face fewer societal stigma for doing so. On the other hand, men are socialised from a young age to prioritise self-sufficiency, avoid showing weakness, and suppress vulnerable emotions.

UNICEF'S MHPSS PROGRAMME

UNICEF Lebanon's MHPSS programme is grounded in the application of the **social ecological model in programme design and implementation**. This approach involves a profound understanding of the dynamic relationships between children/adolescents and every element of their environment, and how these dynamics impact their mental health and psychosocial requirements. UNICEF recognises the importance of multiple entry points for MHPSS interventions to effectively cater to the needs of all children and caregivers. To ensure comprehensive care, a multisectoral approach to mental health and psychosocial well-being is adopted, with a strong emphasis on establishing continuity of services, coordination, and communication mechanisms across sectors to bridge any potential gaps and address the continuum of care.

Within the LCO, the MHPSS response is built upon a multi-sectoral approach, ensuring the effective integration, and mainstreaming of MHPSS interventions within Child Protection, Health, Youth and Adolescents Programme including, Adolescent Development and Participation (ADAP), Palestinian Programme and Education programmes. Across the years, the MHPSS services provided to the Palestinian Population in Lebanon includes Psychosocial Support (PSS), Parenting, and MHPSS awareness sessions, as well as access to specialised mental health services.

The motivation for this research stemmed from the conflicts in Ein el Hilwe and was influenced by the events in Gaza. **Its objective is to guarantee that MHPSS interventions not only address the needs of Palestinian children, youth, and caregivers in the camps but are also specifically adapted and timely in response to the distinct challenges they face.**



RESEARCH METHODOLOGY

PURPOSE AND OBJECTIVES

The scope of this research assignment included all Palestinian camps where children, youth, or their caregivers are already participating in MHPSS interventions rolled out by UNICEF partners. The research aimed to reach a series of objectives, intending to provide comprehensive insights into the MHPSS needs of Palestinian children and youth in Lebanon. These are listed below.

- **Understanding mental health and psychosocial needs** of children, youth, and caregivers, and staff in relation to the current context and war in Gaza.
- Understanding what **MHPSS services** from UNICEF, UNRWA and other partners they are currently receiving and **where are the gaps**.
- **Recommendations on what more can be done** by UNICEF and partners to support their mental health and wellbeing needs.

This research will be used by UNICEF Lebanon to identify gaps, needs, and ensure appropriate programming of MHPSS interventions across different sections which include but are not limited to Child Protection, Youth and Adolescents, Education, Health, and Palestinian Programme in Lebanon (PPL).

RESEARCH METHODS

This research employed **qualitative research methods (FGDs and IDIs)** to address its goals, facilitating a broader and more profound comprehension of the perspectives of Palestinian children, adolescents, youth, caregivers and MHPSS staff. The research protocol, including the informed consent and data collection tools, were approved by the Health Media Lab (HML) Institutional Review Board (IRB) (REF: HML IRB Review #846PALE24) on the 29th of February 2024 (see Annex D).

The research process consisted of three clear stages: inception, data collection, analysis, and reporting (see Figure 1), with each phase comprising several steps and specific deliverables. The inception phase culminated in the submission of the data collection tools and a methodological note (See Annexes A and B). The data collection phase culminated in the collection of raw data from 6th to 19th March 2024. This report along with a presentation of findings serve as the final deliverables and results from the analysis and reporting phase of the research assignment.

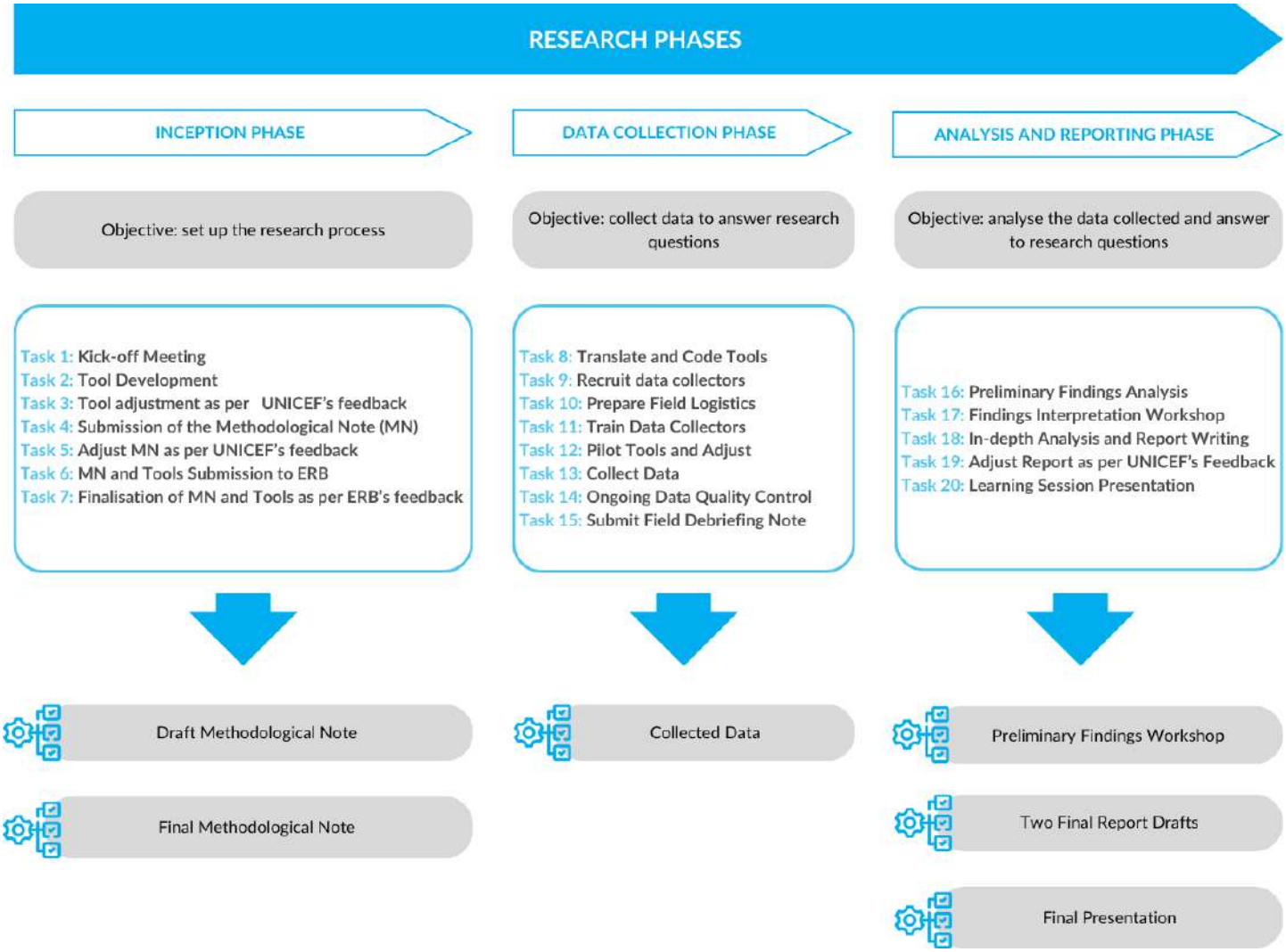


Figure 1. Research Methodology

DATA COLLECTION TOOLS

Six Focus Group Discussion (FGD) guides were developed in total (see Annex A): three using play-based techniques for data collection with children and adolescents, and three using standard techniques for data collection with adults and subject matter specialists. Each FGD guide included assent and consent statements tailored to the age of the participants, followed by ice-breaker games to set a relaxed atmosphere. The tools for child participants involved game and colouring activities, encouraging physical movement and engagement in drawing, and writing tasks. For adolescents, the tools were also play-based and interactive, incorporating movement, writing, and responses to questions based on vignette stories. Vignette stories were used to adapt to the age appropriateness of respondents across youth and caregivers' groups, allowing participants to express opinions about mental health through hypothetical scenarios. Feedback from the field team indicated generally interactive sessions across all age groups, with suggestions for more engaging icebreakers for younger children and adjustments to question formulation for certain age groups. Caregivers' FGDs highlighted gender-based differences in engagement levels, prompting recommendations for improved question formulation. MHPSS Staff FGD guides required no specific adjustments. Further details can be found in the Field Debrief report (Annex C).

The research tools underwent a comprehensive translation process known as the "Back Translation Approach", consisting of two phases. Initially, they were translated from English, the original language, into Arabic, with a focus on linguistic precision. Subsequently, a back-translation into English identified and addressed any discrepancies, ensuring that the tools accurately conveyed their intended meaning and cultural nuances across languages. This approach preserved the integrity and effectiveness of the tools post-translation and involved two dedicated research team members; each assigned a phase of the process.

SAMPLE AND RECRUITMENT

The study participants were recruited from seven Palestinian camps where children, youth, and their caregivers are already participating in MHPSS interventions rolled out by UNICEF partners. Similarly, the MHPSS staff participating in the study were also those who work across the selected Palestinian camps and are staff of partner organisations to UNICEF. UNICEF partners provided Qualisus with a list of beneficiaries from each of the camps, from which a random sample was drawn as potential study participants. For participants under the age of 18 years, consent was sought from their caregivers ahead of the participation (sample consent form used can be found in Annex F). Assent was also gathered from all child participants on the day of the data collection. For participants over the age of 18 consent to participate was gathered verbally on the day of data collection.

Data collection occurred in Ein el Hilwe, Burj el Brajneh, Beddawi, and El Buss camps. In El Buss camp, participants from Burj Chemali and Rashdiyeh camps were also included. Likewise, FGDs in Beddawi camp involved participants from both Beddawi and Nahr el Bared camps.

Focus Box

Initially, random sampling was employed. However, as some participants in the younger age groups were unavailable, and in order to achieve the optimal number of participants required for an FGD, individuals meeting the same criteria—Palestinians residing in designated camps and beneficiaries of one of UNICEF's MHPSS partner programmes—were substituted for those unavailable. Further elaboration on this issue is provided in the subsequent "Limitations" section.

Figure 2. Focus Box - Alterations to the Sampling Frame

Data was gathered from six different groups, encompassing children (aged 6-10), younger adolescents (aged 11-14), older adolescents (aged 15-18), and youth (aged 19-24), as well as caregivers and Mental Health and Psychosocial Support (MHPSS) staff. The individuals under the age of 18 and youth included in the study were actively participating in MHPSS programs facilitated by UNICEF partners within specified camps. Caregivers referred to individuals responsible for the well-being of children and youth involved in these MHPSS activities, while the MHPSS Staff group comprised of social workers, facilitators, and PSS coordinators actively involved in delivering Mental Health and Psychosocial Support interventions.

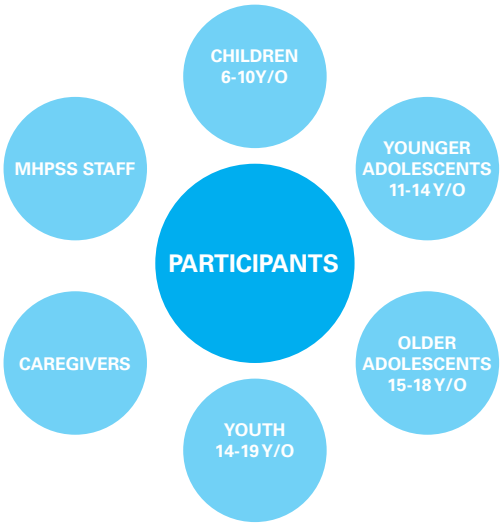


Figure 3. Participant Groups

DATA COLLECTION

The recruitment of data collectors for the MHPSS research involved rigorous selection criteria to ensure technical proficiency, ethical sensitivity, cultural competence, and familiarity with local contexts, especially regarding Palestinian refugees in Lebanon. Data collectors were chosen based on relevant experience in psychology or social work, interpersonal skills to build trust, familiarity with the local context, child safeguarding knowledge, amongst other things. For more detailed information on the selection of data collectors, please refer to Annex E.

All data collectors underwent a comprehensive training day. UNICEF delivered the first half of the training on child protection core concepts, child safeguarding, and the referral procedure and pathway to be used in case cases in need of additional support came up during the assessment. This was followed by a session delivered by the Qualisus MHPSS expert on MHPSS core concepts. The last part of the training was delivered by the Qualisus team and focused on data collection itself, roleplays, and a refresher on the ethical guidelines and considerations that the team should follow during the research. In preparing for data collection, teams were meticulously formed to ensure gender balance, serving multiple purposes. Firstly, this promoted inclusivity and comfort for respondents of all genders, potentially yielding more candid responses, especially in sensitive cultural contexts. Secondly, a balanced team facilitated communication with a broader respondent pool, fostering trust and improving data quality for a more comprehensive dataset.

Finally, the performance of data collection tools was monitored closely during day one of data collection, seeking feedback on their performance from both data collectors and the Qualisus team on the ground. The tools demonstrated overall effectiveness, requiring no adjustments. This step was crucial to help identify any issues with the questions, formulation, before implementing them on a larger scale. In terms of access, Qualisus coordinated closely with UNICEF and partner organisations to ensure alignment with local procedures and protocols regarding accessibility to research locations.

The data collection occurred in two distinct phases, spanning from **the 6th to the 19th of March.** Phase one encompassed El Buss, Burj el Brajneh, and Ein el Hilwe camps, taking place between the 6th and 8th of March. However, due to low attendance impeding the achievement of focus group discussion (FGD) targets, a second phase was undertaken on the 18th and 19th of March in Beddawi and Ein El Hilwe camps. In cases where insufficient participants attended to form an FGD, individual in-depth interviews (IDIs) were conducted with those who did attend the FGD sessions. A total of **29 FGDs and 7 IDIs** were conducted. Further details are available in the Field Debrief Report (Annex C) and a summary of target vs achieved can be seen in table below.

Table 1. Target vs. Achieved

Target Audience	Target	Reach	Area				IDIs
			El Buss camp	Burj El Brajneh	Ein El Hilwe camp	Beddawi camp	
Children	3	3	1	1	1	0	0
Boys aged 11-14	3	3	1	1	1	0	0
Girls aged 11-14	3	3	1	1	1	0	0
Boys aged 15-18	3	3	1	0	1	1	0
Girls aged 15-18	3	3	1	0	1	1	2
Male youth 19-24	3	3	1	0	1	1	1
Female youth 19-24	3	3	1	0	1	1	2
Male Caregivers	3	2	0	1	1	1	2
Female Caregivers	3	3	1	1	1	0	0
MHPSS Staff	3	3	1	1	1	0	0

CHALLENGES DURING DATA COLLECTION

In various locations, challenges were encountered during FGDs, including high participant numbers leading to difficulties in data quality and participation, low attendance on certain days impacting data capturing, school schedule conflicts introducing selection bias, space constraints affecting confidentiality and comfort, participant expectations of compensation, and security disruptions halting sessions. Mitigation measures included additional facilitator support, clarifying attendance limits, conducting compensatory IDIs, negotiating with schools for leave, adjusting settings, emphasising voluntary participation and confidentiality, adhering to ethical guidelines for consent, and ensuring safety during disruptions. Additional details can be found in the Field Debrief Report (Annex C).

ANALYSIS AND REPORTING

The qualitative data analysis was conducted using a rigorous and structured approach that included a systematic process of coding responses based on the thematic focus of the assignment and according to the research objectives. The analysis was conducted using MAXQDA software and was overseen by two qualitative analysts to ensure accuracy and consistency.

The qualitative analysis process involved multiple distinct steps. The first step consisted of an in-depth reading of the transcripts while paying close attention to emerging themes and trends. The findings were documented in the MAXQDA logbook and memos to ensure all relevant information was captured. The second step involved developing a codebook based on the inductively identified themes and trends, as well as the research questions. The codebook was developed through multiple rounds of discussion and under the supervision of a master coder to ensure comprehensiveness and accuracy. Next, the segments were coded according to the agreed-upon codebook by two coders who worked under the supervision of the master coder to ensure accuracy and consistency. Once the segments were coded, they were analysed under each theme, taking into account the research questions, sub-themes, and emerging trends. This allowed for a deeper understanding of the data and the drawing of meaningful conclusions.

A data analysis matrix (DAM) was developed to aggregate the findings of the thematic analysis across the research questions. The qualitative findings were integrated into the DAM, ensuring evidence triangulation.

The DAM ensured that the data was presented in a clear and concise manner, with the main takeaways of the research highlighted. Following that, Qualisus prepared a preliminary findings presentation and conducted a validation workshop with UNICEF on the 26th of March 2024. This helped both in validating and interpreting the findings, as well as in generating recommendations.

ETHICAL CONSIDERATIONS AND GUIDELINES

Qualisus adhered to UNICEF's Procedure for Ethical Standards in Research, Evaluation, Data Collection, and Analysis, ensuring comprehensive compliance with rigorous quality assurance and ethical standards. Key ethical principles included respect for human dignity through comprehensive introductory statements, informed consent processes, private data collection settings, confidentiality and anonymity measures, beneficence, non-maleficence, respect for autonomy and voluntariness, child safeguarding, avoidance of stereotypes, and a commitment to data handling and dissemination ethics (see Annex G).

LIMITATIONS

There are three overall limitations identified when it comes to this research study.

- **Generalisability of the Research Findings**: The methodology exclusive reliance on qualitative methodology has its limitations. Firstly, its context-specific nature may restrict its generalisability to broader populations or settings. Moreover, qualitative data collection relies on human interpretation, introducing subjectivity and potential bias. While qualitative methods offer a deep understanding of the subject matter, they may lack the breadth required to comprehensively capture large-scale patterns.

- **Validity of Research Findings**: The findings could be influenced by bias since the individuals interviewed were beneficiaries of MHPSS services provided by organisations partnered with UNICEF, potentially leading to a higher level of awareness and knowledge regarding MHPSS. This could, in turn, limit the representativeness and generalisability of their responses across the broader community and its knowledge levels. While acknowledging this bias, the research findings still offer valuable insights into the mental health needs of Palestinian children and youth, considering that the interviewed population originates from Palestinian camps and communities in Lebanon. Additionally, it can be inferred that children not benefiting from MHPSS programmes may face even greater challenges related to mental health or require additional support.

- **Lack of disability lens**: the scope of the current research was limited in the population sampled (looking at beneficiaries of MHPSS services provided by organizations partnered with UNICEF, as mentioned above), and did not actively seek to capture the potential experiences or opinions of children and persons with disability. Future research could benefit greatly from including persons with disability, and examining whether people with disabilities have differential experiences from those without disabilities.

FINDINGS

The overall structure of the findings section is split into **three main sections** in line with the research questions set out at the start of the assignment:

1. Mental Health and Psychosocial Needs of Children, Youth and Caregivers
2. Current MHPSS Service Landscape and Gaps
3. Recommendations

Throughout the presentation of the findings, the population groups will be defined as illustrated in the figure below.

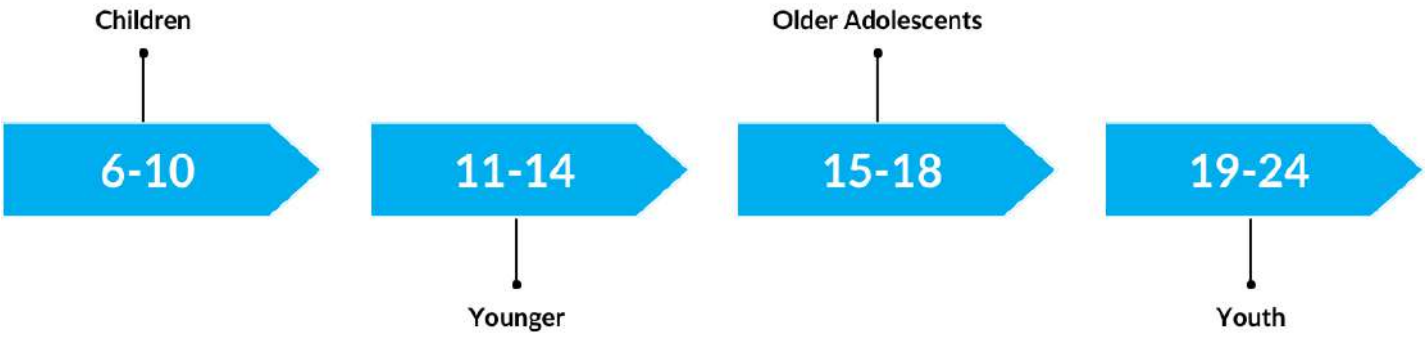


Figure 4. Age Groups

When discussing geographical areas, camp names will be utilised. It's important to clarify that when findings pertain to the El Buss camp, this encompasses participants from all camps in the Southern Area, including El Buss, Burj Chemali, Rashidiyeh. Similarly, when findings pertain to Beddawi Camp, this includes participants from El Beddawi and Nahr el Bared camps. To streamline presentation, the research team will refer to the participants from these areas as stemming collectively from the El Buss and El Beddawi camps.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS OF CHILDREN, YOUTH, AND CAREGIVERS

To obtain a comprehensive understanding of the mental health and psychosocial needs of children, youth, and caregivers across the Palestinian camps in Lebanon, the research team investigated various aspects. These included identifying **sources of emotional distress**, assessing its **impact on different population groups** and geographical areas, and exploring **coping mechanisms employed by different groups**. As a result, this section of the findings has been divided into **three sub-sections** based on the outlined themes. Each sub-section will commence with a summary of the findings, followed by a comprehensive overview and comparative analysis.

SUB-SECTION 1: EVENTS CAUSING EMOTIONAL DISTRESS

Various factors contribute to emotional distress among different population groups and geographic areas. These factors can generally be divided into **six main themes** based on their cited frequency during FGDs across the majority of population groups and regions. These themes include **conflict and safety concerns within camps**, **concerns related to conflict in the South**, the **impact of the Gaza War**, **education-related concerns**, **experiences of harassment**, **bullying**, and **violence**, and **challenges stemming from poor socio-economic conditions**. The specific events cited by each population group are outlined in the figure below. Additionally, some **geographic variations** were observed in terms of reporting adverse events. Participants from **Ein el Hilwe and El Buss camps primarily highlighted a greater impact from conflict in the South**, while those from **Beddawi camp expressed more concern about the effects of poor socio-economic conditions** and conflicts within the camps themselves.

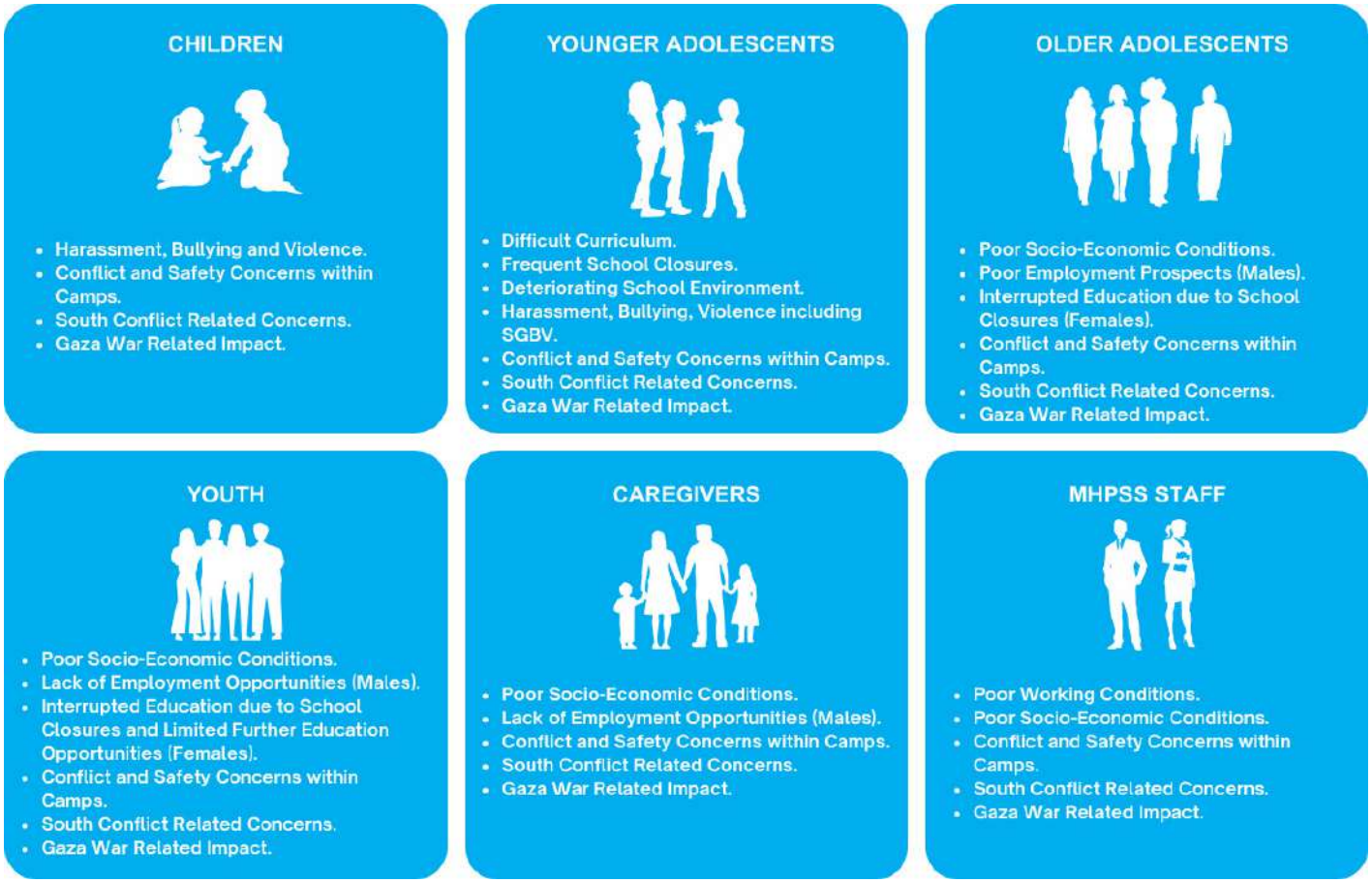


Figure 5. Adverse Events by Population Group

CONFLICT AND SAFETY CONCERNS WITHIN THE CAMPS

The primary source of emotional distress across all geographic locations and age groups was conflict within the camps. Children, adolescents, youth, and young people consistently mentioned **enduring persistent fear and anxiety due to ongoing conflicts and violence between various factions and individuals**. They recounted witnessing and experiencing **physical violence**, **shouting**, **fighting**, **celebratory gunfire** and loud **noises** associated with the conflict (e.g. gun shots, explosions etc).

> ***"I'm scared of the war and weapons. I hear them inside the camp, they are fighting and shooting each other here" - (Child, 6-10, Burj el Brajneh).***

Caregivers and older adolescents from all camps expressed **concern for the safety of their children and older male siblings** respectively when they venture outside their homes within the camps. There was notable apprehension directed towards males from older adolescents and youth age categories, given their increased susceptibility to being targeted by warring factions, attacked, or inadvertently harmed by stray bullets.

> ***"Once a missile was heard, my daughter held her younger brother to run with him. I started yelling and as another missile was heard, I put on whatever clothes I had, and my brother-in-law came and took my children downstairs." - (Female caregiver, Ein el Hilwe)***

Younger adolescents across all camps added that **celebratory gun fire and firecrackers are a source of distress** as they mimic violence or war sounds.

> ***"My cousin almost got accidentally shot because of these celebrations' shootings" - (Female, Younger adolescent, Burj el Brajneh).***

Moreover, heightened conflict within the camps is causing certain children to **recall past losses** of family members, including grandparents, aunts, and siblings, suffered during previous conflicts, leading to distress and affecting their mental wellbeing.

> ***"The death of my aunt… they [child's parents] saw it on television" (Child, El Buss).***

Likewise, youth from different areas recounted **previous encounters with armed conflict and the loss of homes**, which have been brought to the forefront by the current escalation of fighting in the camps and the surge in violence, leading to emotional distress.

> ***"My friend, his home was destroyed, his mental health wasn't good" (Male, Youth, Ein el Hilwe).***

Younger adolescents, especially from El Buss camp, voiced **concerns about playing outside due to stray animals**, which had reportedly attacked and fatally injured a child in Rashidiyeh camp. Although mentioned in only one FGD among younger adolescents, this incident hints at additional threats within camp environments that affect children's safety perceptions.

> ***"People were shooting in the sky while mourning the loss of a child due to a dog attack" (Female, Younger adolescent, El Buss).***

MHPSS staff members acknowledge that they are **equally impacted by security and safety concerns**, as they originate from the communities where they operate.

SOUTH CONFLICT RELATED CONCERNS

Participants from Ein el Hilwe and El Buss camps, across all demographic groups, frequently described experiencing **emotional distress due to the ongoing cross-border fighting in the South**. They recounted hearing and witnessing bombs falling close to their neighbourhoods or villages. MHPSS staff members also mentioned rumours circulating daily within the Southern camp settings about potential targets for future bombings nearby, leading to a pervasive sense of panic and fear within the community. **Recent bombing incidents** were particularly emphasised during FGDs, especially among children. For instance, in Ein el Hilwe camp, children recalled the shelling of a school in the Marej area. Furthermore, **individuals from other camps also reported episodes of panic and anxious feelings caused** by the frequent sonic booms produced by passing military aircraft. Some described instances of planes flying at alarmingly low altitudes, causing buildings to tremble and raising concerns about potential collapse.

"You'd be sitting somewhere and suddenly the warplanes are almost above your head, we are now afraid of Lebanese helicopters, we think at first that those are the sounds of Israeli planes" (Female, Older adolescent, Beddawi).

GAZA WAR RELATED IMPACT

Participants across all age groups and all geographic areas shared experiences of **emotional distress and psychological impact related to the ongoing situation in Gaza**. Children were affected by witnessing deaths through media platforms, while older adolescents expressed guilt over their access to food compared to starvation in Gaza.

"I feel the guilt, especially in Ramadan, where one would have lots of food in comparison what an average Gazan has/can find" (Female, Older adolescent, Beddawi).

Older adolescents also reported being influenced by events in Gaza, leading to emotional distress and disruptions in daily life. Youth participants are **experiencing stress, fear, sadness, triggered by distressing images and news from Gaza** and constant **worrying about relatives and loved ones**. They are also experiencing a sense of hopelessness for not being able to help and fear of being the next target.

"She gets easily influenced by whatever is going on and because of social media, Instagram and videos on Gazan news, she was deeply affected and stopped going to school. She was told, to deactivate her social media accounts and just pray for them because after all, it's a matter of 'fate and destiny'. She hasn't been able to fully get over that, as she was suffering since the seventh of October." - (Female, Older adolescents, Beddawi)

POOR SOCIO-ECONOMIC CONDITIONS

Older adolescents **experience economic and personal problems** leading to symptoms like depression, isolation, and even resorting to negative coping mechanisms such as stealing due to desperate economic situations. Youth also struggle with economic challenges, including decreased work opportunities and financial instability, leading to stress and difficulties in meeting basic needs.

Additionally, caregivers, both male and female, express challenges related to financial support, such as being **unable to provide basic necessities** like new shoes for children, **contributing to emotional distress within families**. MHPSS staff members mention that displacement due to conflict and economic hardships are further exacerbating the challenges faced by all the camp residents.

"No matter how difficult the situation was before, it's now worse with what happened after the conflicts and clashes, people who used to live here and barely ensure their needs have now left the camp and are unable to provide for themselves" (MHPSS staff, Ein el Hilwe).

MHPSS staff members also highlighted **poor working conditions** as a cause of significant emotional distress to them, including not having a space to conduct work, working in unsafe centre conditions.

"I want a laptop. I also want an office and space that is mine where I can put my stuff and files. A cabinet that is mine where I can put my stuff. I don't only want a shelf or be sitting somewhere, and someone would ask me to leave or give the chair because they need to work. Also, something about centers. Rooms are very small and they put 40 to 60 students. And also, water is dropping from the ceiling" (MHPSS Staff, Burj el Brajneh).

HARASSMENT, BULLYING AND VIOLENCE

Children report **experiences of bullying**, including being targeted for their physical appearance or name, which contributes to feelings of sadness and distress. Additionally, personal **experiences of violence**, such as being hit by a friend, further compound their feelings of upset and worry.

"I get bullied because of my name and eyebrows" (Child,6-10, Burj el Brajneh).

Younger adolescents also **encounter bullying, harassment, and physical violence** from peers or older children, along with incidents like **theft of personal items or food** at school. Some girls express fear of **sexual and gender-based violence (SGBV) attacks** from men in the camp. Moreover, younger adolescents, particularly boys, mention experiences of **physical violence from parents**, such as being hit by their fathers.

"I feel scared the moment I heard of an assault case by a man in a close neighbourhood" - (Female, Young adolescent, El Buss camp).

EDUCATION RELATED CHALLENGES

Younger adolescents' express **challenges with a difficult curriculum** and **frequent school closures**, with girls often mentioning surprise exams. Older female adolescents and youth female participants also note a **decline in ambition and motivation**, especially due to interrupted education and **lack of further education opportunities**, as a result of prevailing difficulties, violence, and school closures. Furthermore, the MHPSS staff highlight **threats to education funding** and the **deterioration of school environments**, contributing to distress among caregivers and students, including concerns about the quality of education that is being provided by the main education service provider in the camps.

"Gaza aside, I am a grade 12 student on the verge of attending college. As we see our relatives and older siblings, who were university students with high GPAs, are unemployed and at home doing nothing, our mental health gets disrupted and we know by then that the certificate we would be working on is useless as we're Palestinians" (Female, Older adolescent, Beddawi).

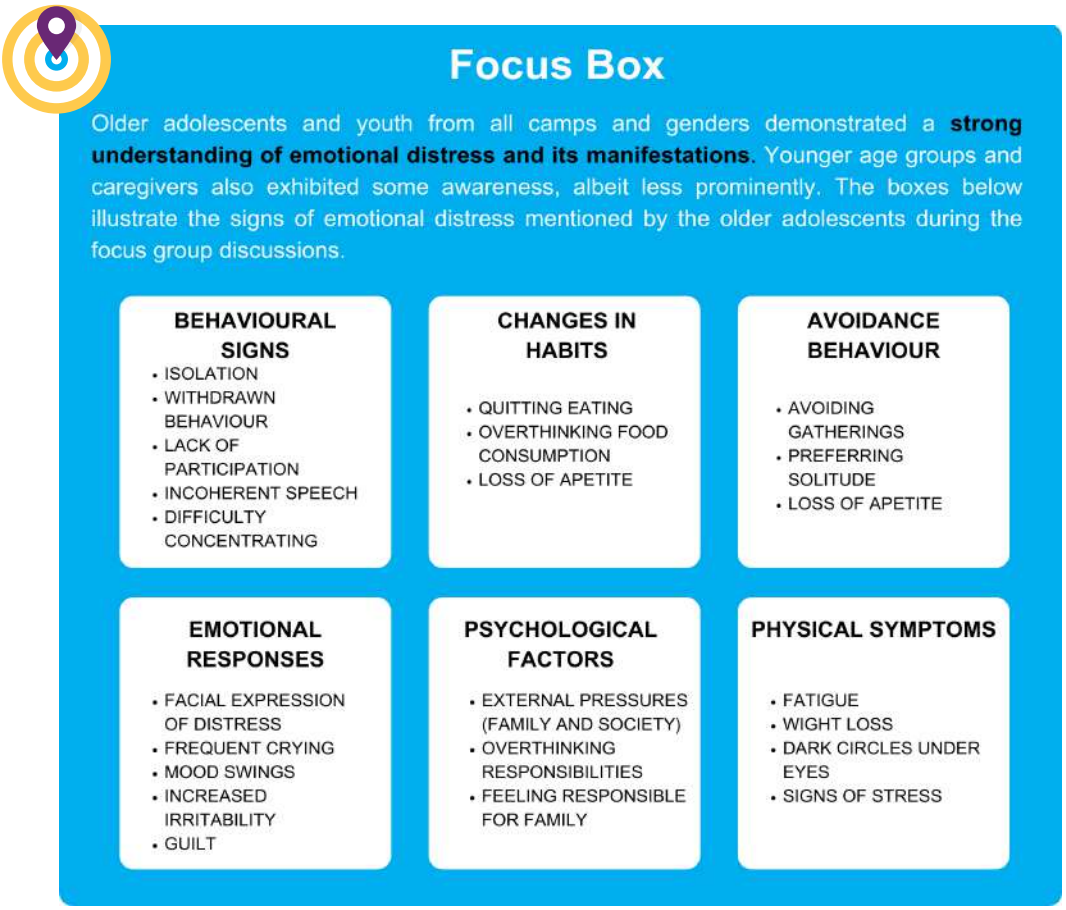


Figure 6. Focus Box - Recognising Emotional Distress

ANALYSIS OF THE ADVERSE EVENTS

The purpose of this section is to examine the findings from the research into the events that trigger emotional distress among the primary respondents. More precisely, it aims to address the question of "***what does this mean***" regarding the exposure of this population and various age groups to different adverse events and how this affects their mental health. The analysis in this section aims to connect the findings with the existing body of knowledge regarding adverse events and their impact on the mental health and well-being of children, youth, and adults.

The consequences of prolonged exposure to multiple adverse events within a community are profound and far-reaching, impacting various aspects of individuals' lives and the collective social fabric. The findings presented in this sub-section illustrate that the Palestinian community, encompassing children, youth, and adults, currently confronts exposure to a minimum of **four broad** categories of adverse events characterised by their violent and unpredictable nature (see Figure 5 for details). **Children** specifically reported encountering at least **four broad categories** of adverse events, including harassment, bullying, and violence, as well as conflict and safety concerns within camps, southern conflict-related concerns, and the impact of the Gaza war. Meanwhile, **younger adolescents** contend with as many as **seven such categories** simultaneously, including poor socio-economic conditions, lack of employment opportunities, interrupted education, conflict and safety concerns within camps, southern conflict-related concerns, and the impact of the Gaza War. It's important to note that the research did not delve into long-term adverse event exposure; instead, it focused solely on recent months. Therefore, the total exposure to adverse events per population group outlined in this section is not exhaustive. Given the context of multiple crises in Lebanon detailed in the Background section of this report, it's **highly probable that many participants had pre-existing exposure to traumatic events**, which might not have been disclosed.

Research consistently shows that **exposure to adverse events** during childhood, including exposure to violence, is **negatively associated with various physical, social, emotional, and behavioural problems in adulthood**. Furthermore, the severity and frequency of these events contribute to the overall burden on a child's mental health with more adverse events experienced being linked with heightened risk for mental health difficulties . As such, the exposure to this complexity and multitude of adverse events place the Palestinian children and youth at a heightened risk category for **developing psychological distress**, **short term and long-term negative mental health outcomes** and **disrupted development**. Moreover, the Palestinian community as a whole faces an **elevated risk of developing collective trauma**, as adverse events affect not only individuals but also their families, schools, neighbourhoods, and wider social systems. The interconnected nature of trauma experiences contributes to collective trauma. The prevalence of high adverse events weakens the collective resilience of a community, as resilience depends on supportive networks that can be strained by adverse events. Furthermore, adverse events experienced by caregivers can impact their parenting behaviours, emotional regulation, and overall well-being. This in turn affects the upbringing of their children and can lead to **inter-generational trauma transmission**. Therefore, due to frequent and prolonged exposure to adverse events, the **Palestinian community in Lebanon faces an elevated risk of experiencing trauma at both individual and collective levels, potentially leading to the transmission of trauma to future generations**.

However, the **increased awareness and strong understanding of signs of emotional distress** observed during the research study, particularly among the older adolescent and youth groups, is encouraging and can be regarded as **a protective factor**. This heightened awareness enables early recognition and intervention, potentially reducing the impact of adverse events on mental health. By recognising signs of emotional distress, young people can support each other and seek professional help, when necessary, thereby fostering resilience and community well-being. Moreover, it remains crucial to continue raising awareness about mental health overall, including the impact of adverse events and available sources of support among caregivers. With increased awareness, caregivers will be better equipped to provide a supportive environment for their children, which is another critical protective factor against adverse events.

SUB-SECTION 2: IMPACT OF ADVERSE EVENTS

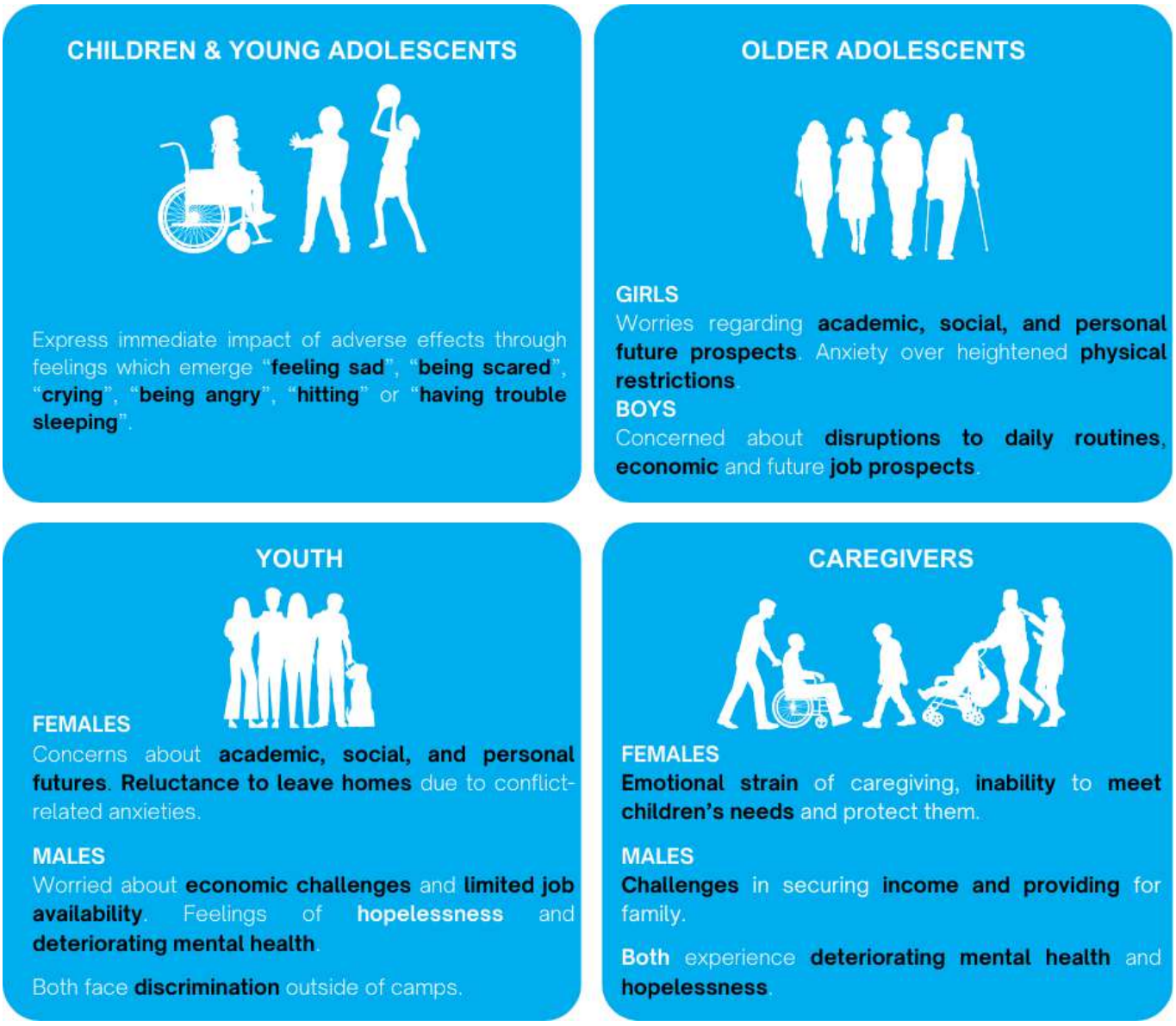


Figure 7. Impact by Population Group

Findings reveal the diverse impacts of ongoing conflicts and crises on different demographic groups across the geographic areas, with the **presence of hopelessness** evident across multiple groups. **Younger age groups express immediate emotional responses, while older adolescents voice concerns about disruptions to their daily routines and poor education prospects**. Economic concerns, fear, and anxiety are prevalent among youth, with males focusing on economic opportunity disruptions and females on personal and academic worries. Furthermore, older adolescent boys, male youth, and male caregivers all report **becoming accustomed to violence, conflict and adverse events, which could be indicative of desensitisation and emotional numbing**. Caregivers highlight financial strain and emotional burden amid ongoing crises, impacting their well-being and ability to protecting their children. MHPSS staff observations underscore the profound strain faced by communities, exacerbated by economic instability, leading to both mental and physical health issues. The figure below presents the impacts of adverse events by population group.

Younger age groups, including **children and younger adolescents**, primarily express immediate impact of adverse effects through feelings which emerge "*feeling sad*", "*being scared*", "*crying*", "*being angry*", "*hitting*" or "*having trouble sleeping*".

Older adolescent boys expressed concerns about the **practical disruptions to their daily routines** caused by road closures and conflicts, as well as the **economic consequences stemming from recent events** and heightened violence, such as reduced work opportunities and disruptions to family businesses.

> ***"People are always anxious everywhere. People are horrified. You live in an Islamic section; you cannot go to section of Fateh or something. You will be a prisoner in your section" (Male, Older adolescents, Ein el Hilwe).***

Older adolescent girls voiced concerns regarding their **academic, social, and personal future prospects** due to the impact of ongoing conflicts within camps and the Gaza War on the **education system and employment opportunities**. Additionally, they mentioned being more frequently **physically confined** by their parents from leaving their homes out of fear for their safety. Consequently, they feel increasingly **confined and hopeless** within their immediate surroundings, their camp, and their broader predicament as Palestinian nationals.

> ***"Why would we study and get exhausted in our lives if our future is unclear?" (Female Older adolescents, Beddawi).***

Male Youth are similarly troubled by economic strains and a scarcity of job prospects in their immediate vicinity. They express apprehension about their future and are reluctant to start families amidst the prevailing environment of economic hardship. They acknowledge the detrimental impact of adverse events on their mental well-being, with a **palpable sense of hopelessness evident in their demeanour.** Additionally, they express concern about the normalisation of violence in their surroundings. Moreover, some **young males admit to resorting to substance abuse and being compelled to adopt violent methods to address problems out of fear for their safety.**

> ***"When confronted with an insult, one is faced with a dilemma. I would ask myself a thousand times what to do be because before reacting because I only have 2 choices die or kill" (Male, Youth, Beddawi).***

Female Youth, similar to their adolescent counterparts, voiced **concerns regarding their academic, social, and personal future prospects due to the impact of ongoing conflicts** within camps and the Gaza War on the education system and employment opportunities. Furthermore, they also being more frequently physically confined to their homes due to fear from the conflict that is frequently taking place in their camps.

> ***"Even if my job wasn't affected [the participant lost her job], I wouldn't have the guts to go because of what is happening" (Female, Youth, Ein el Hilwe).***

Moreover, both male and female youth participants noted **experiencing verbal and physical assaults** from individuals when they venture outside their camps, particularly in the southern camp region. The Palestinian youth feel unfairly blamed and held accountable by local communities for the recent Israeli attacks in the South. They sense that the locals believe if Palestinian refugees hadn't settled in those areas, they wouldn't have faced such hostility. This leads to a **prevailing sense of isolation and mistrust among the youth demographic** when engaging with outsiders.

> ***"You become an offensive person when you go outside of the camp and meet people. If I say to them that I am from the camp, people will look at me differently because of what is happening inside even if I am not part of any conflict" (Male, Youth, El Buss).***

According to **caregivers**, the crises have resulted in financial hardship, impacting families' capacity to support children and sustain their livelihoods. They share common worries about job security, escalating living expenses, and interruptions in aid distribution. **Both men and women expressed feelings of hopelessness, fear, stress, and anxiety, significantly impacting their daily routines and sense of security**.

> ***"I suffer from psychological depression, leading to numbness in my head... I also face shortness of breath... my head becomes numb" (Male Caregiver, Burj el Brajneh).***

Focus Box

Older adolescent boys, young males, and male caregivers all expressed **becoming accustomed** to the violence, conflict, and adverse events. For them, witnessing violence and gun-related incidents in the camps is viewed as something **commonplace and routine** rather than distressing. These are risk factors for developing **EMOTIONAL NUMBING** and **DESENSITISATION**.

> ***"The act of killing has become normalised in our community. If someone engages in a fight, they are likely to resort to shooting because they always carry a gun" (Male, Youth, Beddawi).***

Additionally, an older adolescent boy suggested that emotional distress experienced by adolescents is a sign of "**maturing**," implying that such signs and symptoms are considered commonplace for both adolescents and adults on a daily basis.

> ***"According to the problems that is happening to Loay, he is now in the phase of maturity from a child to a more aware being. So, he is in need for his personality to be relaxed at ease, but he is facing problems in the camp like the conflicts and struggles, it is probable that while he is walking the street any time it could escalate into a war zone and something bad happens to him" (Male, Older adolescent, Ein el Hilwe) .***

Figure 8. Focus Box - Male Perceptions of Emotional Distress

Female caregivers frequently mentioned the emotional strain of caregiving, **feeling overwhelmed when they are unable to fulfil their children's needs and attempting to protect them from negative news and imagery**. Additionally, female caregivers voiced significant concerns about the well-being and emotional impact on children, noting how children often mirror the distress experienced by their caregivers.

> ***"Whatever is inflicted on the mother is being mirrored to her children, as the most challenging responsibility lies in a mother's hand; as whatever state she's in, one would see her effect on her family and the community as well" (Female Caregiver, El Buss).***

Male caregivers directed their attention towards **practical repercussions such as challenges in securing employment**, **worries about safety and security**, and the effects these aspects are having on family dynamics and stability.

> ***"The economic crisis is affecting the father…These things, when you feel you're not sufficient, this will change your attitude towards the family" (Male caregiver, Beddawi).***

As depicted in **Figure 8 – Focus Box**, a notable trend emerges among older adolescent males, youth males, and male caregiver, where adverse events are perceived as "***commonplace and routine***". There are instances where signs of emotional distress among younger adolescents are even interpreted as indicators of maturation, suggesting a prevalence of such symptoms among older adolescent males in Palestinian camps. Of particular concern is the potential for habitual exposure to witnessing and experiencing acts of war and violence to lead to **desensitisation**. Moreover, continually suppressing feelings and explaining emotional distress as a sign of maturity can result in **emotional numbing** or a lack of emotional responsiveness. The male Palestinian population across camps seems to be at a higher risk of experiencing both desensitisation and emotional numbing, based on the findings of this research and the explanations provided by these male population groups regarding the impact of adverse events on them. The mental health implications of desensitisation and emotional numbing are further explored in the subsequent analysis section.

Observations by **MHPSS staff** underscore the immense strain faced by communities, where mental health crises are worsened by economic instability and restricted access to essential resources. They observed that emotional distress not only impacts individuals' mental well-being but also their physical health, manifesting in psychosomatic symptoms like tachycardia, gastrointestinal issues, and disrupted sleep patterns.

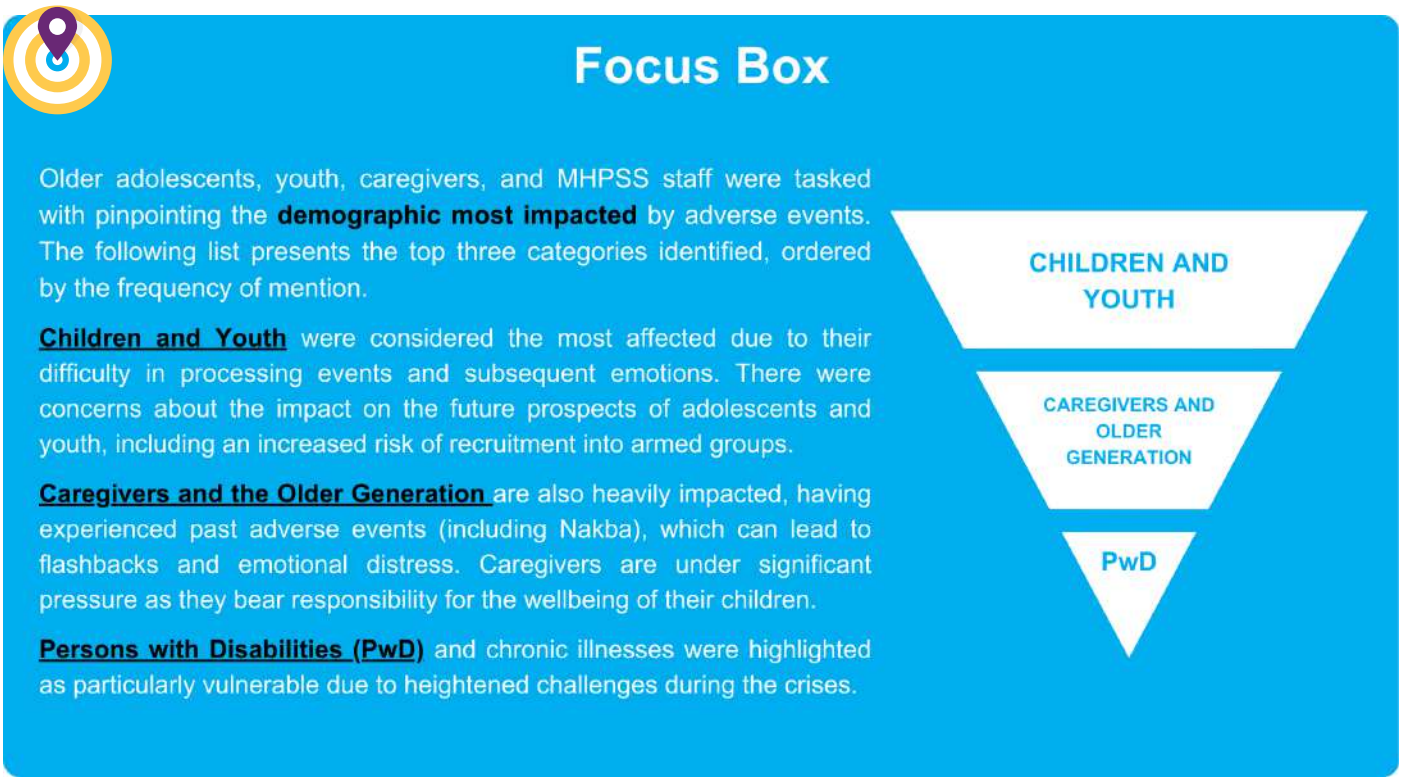


Figure 9. Focus Box - Most Affected Community Groups

ANALYSIS OF THE IMPACT OF ADVERSE EVENTS

This section serves to delve into the research findings on the effects of adverse events that induce emotional distress among the primary respondents. Specifically, it seeks to answer the question of "***what does this mean***" concerning how different age groups within the Palestinian population are affected by these events. The analysis in this section endeavours to link the findings with the existing body of knowledge regarding the impact of adverse events on the mental health and well-being of children, youth, and adults.

The research findings reveal the pervasive and far-reaching impact of multiple and complex adverse events on the community, affecting all members in varying forms and to different extents. Younger age groups express immediate emotional responses such as "**crying**" and "**having trouble sleeping**", while older adolescents voice concerns about **disruptions to their daily routines** and **poor education prospects**. Economic concerns, fear, and anxiety are prevalent among youth, with males focusing on economic opportunity disruptions and females on personal and academic worries. Of particular concern is the **prevalence of**

hopelessness across multiple population groups and the fact that older adolescent boys, male youth, and male caregivers all report becoming accustomed to violence, conflict, and adverse events, which could be indicative of **desensitisation** and **emotional numbing**.

> Feelings of **hopelessness** denote a distressing cognitive state closely linked with depression and suicide . This encompasses a spectrum of negative thoughts and emotions, including **sadness**, **absence of positive feelings**, **diminished self-esteem**, **demoralisation**, and **contemplation of suicide**. It's estimated that approximately 9–12% of the global population experiences clinically relevant levels of hopelessness, with similar prevalence rates among both men and women. Significantly, hopelessness serves as a substantial predictor of future outcomes, such as **depressive symptoms**, **thoughts of suicide**, **poor health**, and **increased mortality**. Hopelessness **strains social connections**, prompting individuals to withdraw or become isolated from their support networks. **Isolation**, in turn, encourages individuals to detach from vital support networks, which serve as crucial sources of assistance during periods of stress and adversity. This consequently **hampers their capacity to rebuild resilience** and employ healthy coping mechanisms to navigate challenges effectively. Feelings of hopelessness may drive individuals towards **engaging in risky behaviours**, as they perceive little to lose in their circumstances, this includes lifestyle and dietary choices. For this reason, **hopelessness is associated with negative health outcomes**, increased substance abuse as well as overall increased mortality rate. Ultimately, hopelessness correlates inversely with the **propensity to seek help**, potentially stemming from the pessimistic outlook on life and the future commonly experienced by those grappling with hopelessness.

Desensitisation to adverse events occurs when someone becomes **habituated to** witnessing or experiencing distressing situations. Initially distressing events become **routine or less emotionally impactful due to repeated exposure**. Whereas emotional numbness is the **mental and emotional process of shutting out feelings**. It may manifest as deficits in emotional responsiveness or reactivity. People experiencing emotional numbness may feel distant, detached, and unable to fully participate in life. They might also lose interest in activities they once enjoyed and prefer isolation over social interactions. People regularly exposed to adverse events might engage in **desensitisation and emotional numbing as key coping mechanisms**. Emotional desensitisation and emotional numbing may **diminish the perception of distress** even in challenging circumstances. Consequently, individuals **might underestimate the seriousness of their emotional challenges and postpone seeking help**.

Overall, experiencing violence is known to trigger the body's stress response system thus increasing levels of cortisol (a stress hormone) and higher blood pressure. While most research suggests that violence-exposed adolescents have higher cortisol and blood pressure, some studies found the opposite, especially among those from highly disadvantaged areas . This indicates a nuanced connection between exposure to violence and how our bodies react, **highlighting the need for further research**, particularly within population groups regularly subjected to ongoing violence, such as the Palestinian community in Lebanon.

In summary, addressing hopelessness and desensitisation is imperative for promoting mental health, bolstering resilience, and fostering community cohesion. **Efforts to mitigate these negative impacts should prioritise interventions aimed at restoring hope, and challenging the normalisation of violence within the community.**

SUB-SECTION 3: COPING STRATEGIES

In the FGDs, participants highlighted a **variety of coping strategies and sources of support**, which could be broadly classified into five main categories: **lack of support**, **self-reliance**, **support from family and peers**, **assistance from school and community and mental health support**. These categories were identified based on how frequently they were mentioned across all geographic areas and by the majority of population groups. There were **no notable geographic differences** in the coping strategies reported by the population group. The specific coping mechanisms cited by each population group are outlined in the figure below.

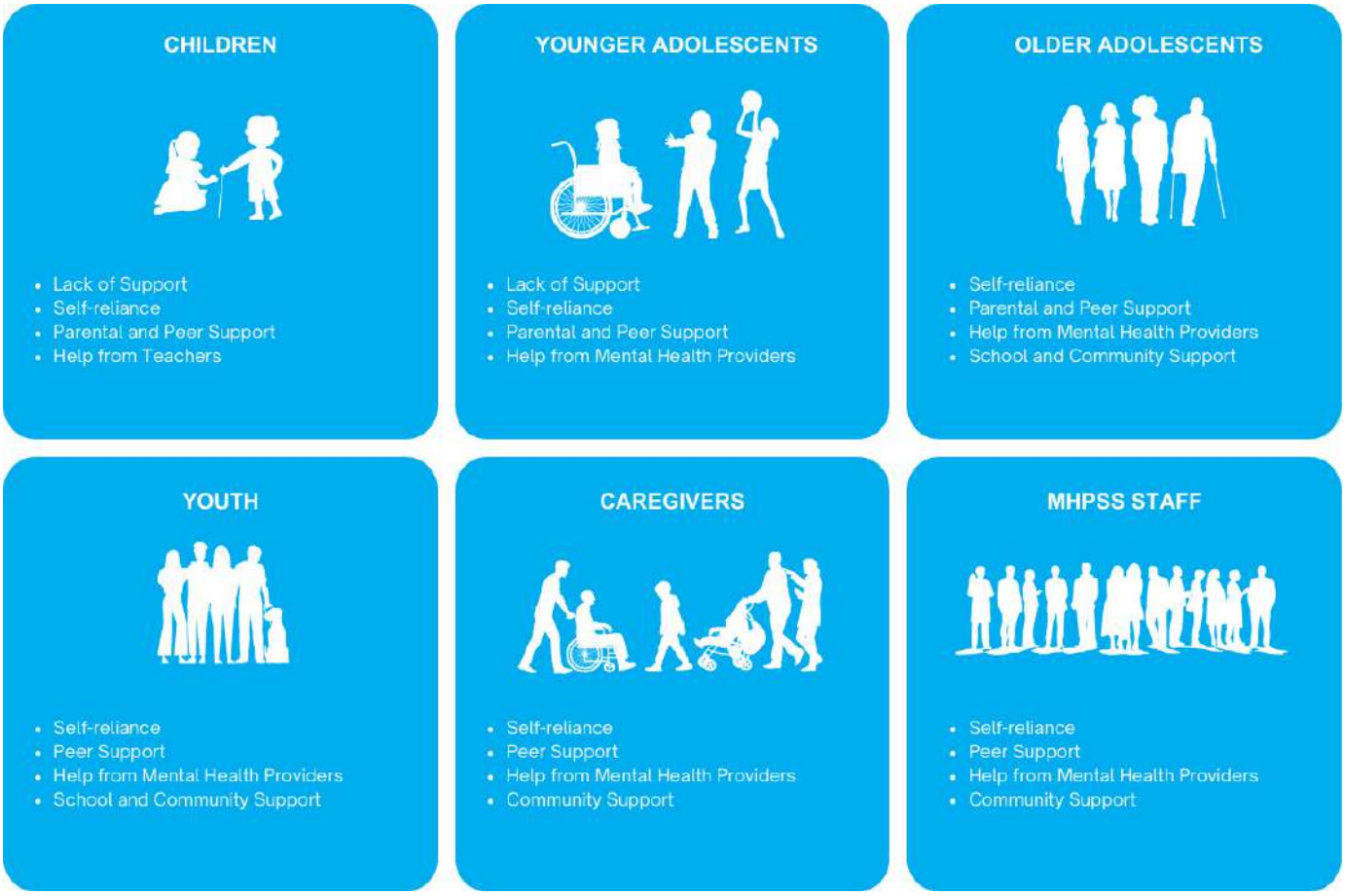


Figure 10. Coping Strategies by Population Group

OVERARCHING OBSERVATION- LACK OF SUPPORT

Children and younger adolescent boys, frequently report a **lack of support and often resort to self-reliance.** This self-reliance manifests in several coping strategies, including finding solutions independently, confronting bullies, retaliating when attacked, and using physical violence as a last resort.

> ***"I have nobody to talk to - not many people help us in the camp" (Male, Younger adolescent, Burj el Brajneh).***

> ***"Whoever hits me, I hit him back, I always resolve my problems alone, if someone bully me, I bully him back… if someone did something bad to me, I do the same. I protect myself" (Child,6-10, El Buss).***

SELF-RELIANCE

All population groups across all geographic locations mentioned at least some form of self-reliance coping mechanisms, which varied according to the age category of the respondent. They can largely be categorised into emotional, physical and intellectual activities (see Figure below).

- **Children** often reported engaging in activities such as drawing, swimming, reading, taking naps, and having a cry.
- **Young adolescents** engaged in activities such as playing, talking, walking, doing sports, doing yoga and deep breathing exercises.
- **Older adolescents and Youth** often mentioned finding quieter spots and places in nature where they can go to think and express their emotions. Older adolescent boys mentioned engaging in sports, finding space away from others and sometimes using drugs to alleviate distress. Reading books, browsing the web and watching YouTube were also frequently cited activities.
- **Caregiver and MHPSS** staff cited finding personal safe spaces where they can allow themselves to experience emotions, going for walks, in the nature (such as going to the beach front, leaving the camp and going to the mountain etc), going shopping (females) and engaging in sports activities (males).

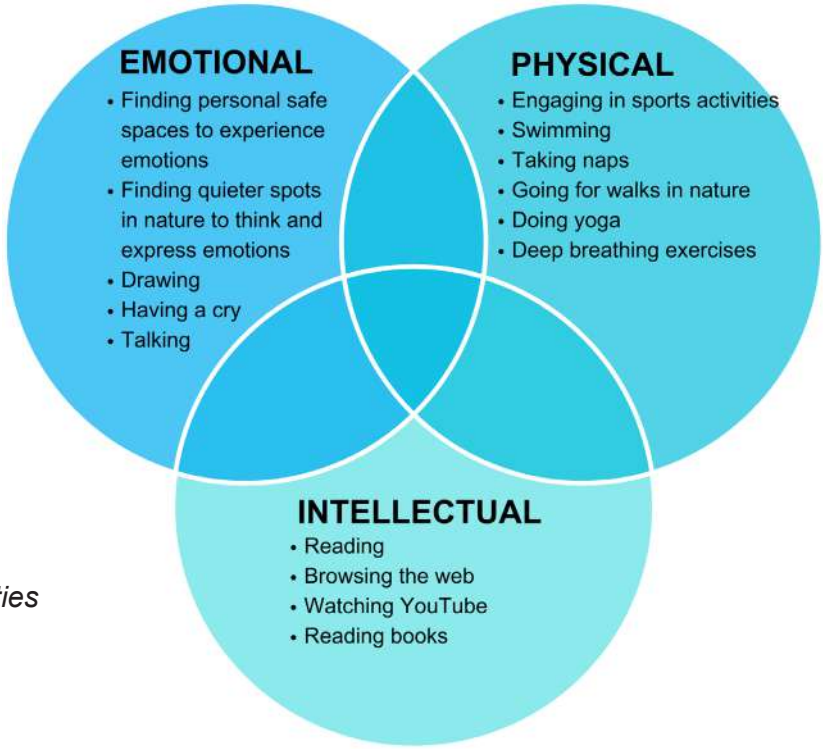


Figure 11. Types of Self-reliance Activities

FAMILY AND PEER SUPPORT

In all geographic areas, individuals across all age groups mentioned seeking support and advice from their family, friends, and neighbours. Children and adolescents of both genders predominantly sought help from their parents (especially mothers), siblings, and cousins, while older adolescents, youth, and caregivers relied on their friends and neighbours for support. **Female respondents were more likely to reach out to others to discuss their emotions, while males tended to prefer solitary, self-reliant coping mechanisms.** Further details on the differences between female and male coping strategies can be found in the figure below.

> ***"If a woman couldn't find support from her parents, she could take some fresh air by taking a walk on the beach, going shopping, seeking a therapist, talking with her own friends, or talking with one's spouse" (Female, Caregiver, El Buss).***

Interestingly, the role of influencers on social media, particularly those from Gaza, is noted as a **source of inspiration and hope, especially for younger and older adolescent group.**

> ***"There were influencers who used to make us laugh. Now, we are scared for their safety, as they reside in Gaza and are constantly sharing whatever's happening there. They are what makes us strong" (Female, Older adolescent, Beddawi).***

Mental Health Support

There is an observed trend towards **increased acceptance of seeking mental health support,** with both younger and older adolescents mentioning seeking help from counsellors, mental health specialists, or therapists. Caregivers also report seeking **support from therapists for themselves or their children**. Moreover, MHPSS staff have observed **a shift towards greater acceptance of psychotherapy**, particularly among mothers, suggesting a broader societal recognition and acceptance on the importance of mental health care.

> ***"If my daughter has a psychological problem, and if I didn't know how to help her then I have to seek help of course so she won't stay in that distress state. Like for example this centre has services of psychological help and awareness " (Male, Caregiver, Ein el Hilwe).***

Nevertheless, as noted by MHPSS staff, **challenges persist**, encompassing perceptions regarding the role of aid organisations. Numerous community members perceive aid organisations primarily in terms of providing material assistance, such as cash or in-kind items. **Some individuals may attend solely on the condition of receiving aid, which is indicative of basic needs being a priority over mental health awareness**. Nevertheless, MHPSS awareness sessions are perceived to be important by the various age groups and MHPSS staff, pointing to a need for a holistic aid delivery approach encompassing basic needs and MHPSS awareness sessions. Additional hurdles include limited access to psychiatric services, and the stigma surrounding mental health within specific demographic groups.

> ***"They think that their job [organisations] is to support people financially or distributing aid. That's it… and unfortunately, not everyone is receiving this support" (MHPSS staff, Burj El Brajneh).***

SCHOOL AND COMMUNITY SUPPORT

Children and younger adolescent cited **sometimes turning to their teachers for support**. Older adolescents, especially females, expressed channelling their frustration, anger and sense of hopelessness into focus on education in order to have a better future, with some highlighting the **desire to help people in Gaza**.

> ***"Life goes on for us to be able to be stronger and more educated to help them (people in Gaza) liberate themselves." - (Female older adolescent, Beddawi camp)***

The findings highlight a **notable reliance on external organisations for community support** among all age groups, with limited initiatives at the grassroots level. Family members, particularly the older generation, are the primary source of support, followed by neighbours, religious institutions, and camp-based organisations. Caregivers note a **shift towards decreased community connections** and increased individualism in addressing emotional distress. The **younger generation** is believed to be coping with challenges in a **more individualistic manner**, prioritising their own needs or their immediate nuclear families over the well-being of the community as a whole. However, MHPSS staff observe a **strong sense of community solidarity**, particularly in times of crisis, although there has been a decline in communal activities due to **heightened individual burdens**, especially evident in Ein el Hilwe camp.

Furthermore, **religious and spiritual practices such as praying**, **reading the Quran**, and **seeking solace in faith-related activities** are mentioned as coping mechanisms across male older adolescents, young males, and both genders from caregivers' groups.

> ***"…people can help us through many things, but God alone is the one capable of changing everything" - (Female older adolescent, Beddawi Camp).***

Finally, the MHPSS staff find **that their own well-being improves when they can make a positive impact on someone else's life**.

> ***"When I'm sad or tired, if I make someone feel better, I feel better… this is something in my job that I like" - (Female staff, El Buss Camp)***

COMMUNITY PERCEPTIONS ON MENTAL HEALTH

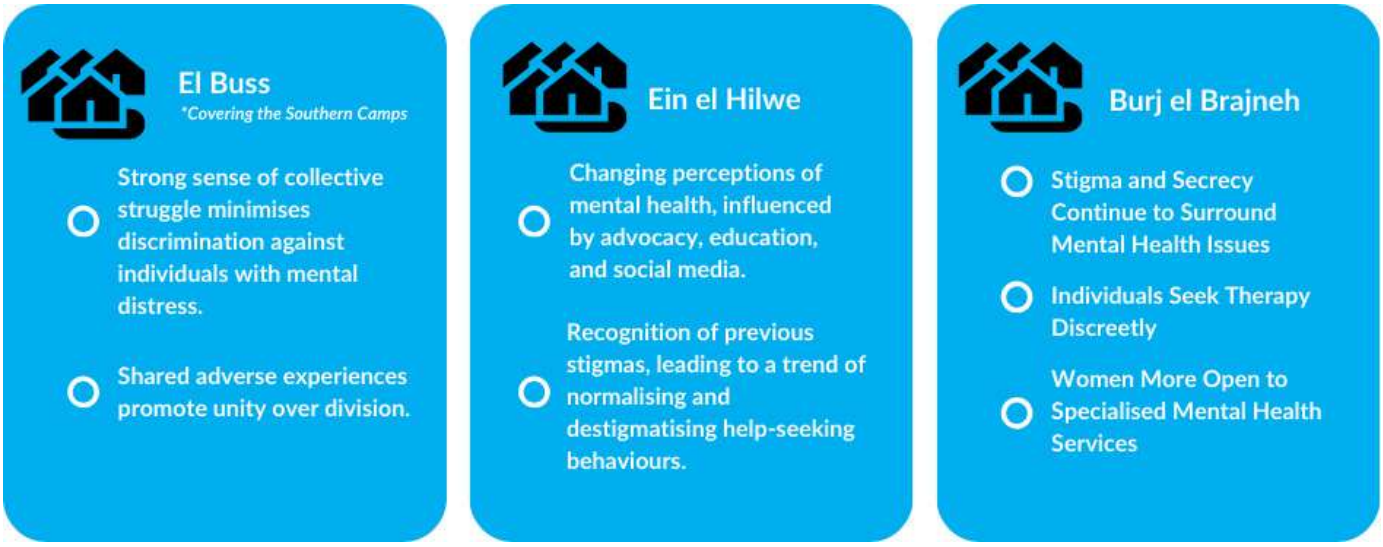


Figure 12. Perception of Mental Health by Camp

According to the MHPSS staff, **attitudes toward mental health and the readiness to seek support differ noticeably among camps**. Nevertheless, there is an **overall positive trend** indicating increased acceptance of both specialised and non-specialised mental health services, accompanied by a reduction in stigma. Further specifics for each camp are provided in the figure below.
Figure 12. Perception of Mental Health by Camp

Participants were asked whether men and women experience and react to adverse events and emotional distress differently. Overall, consensus suggests that such **differences exist**, largely influenced by societal norms and expectations.

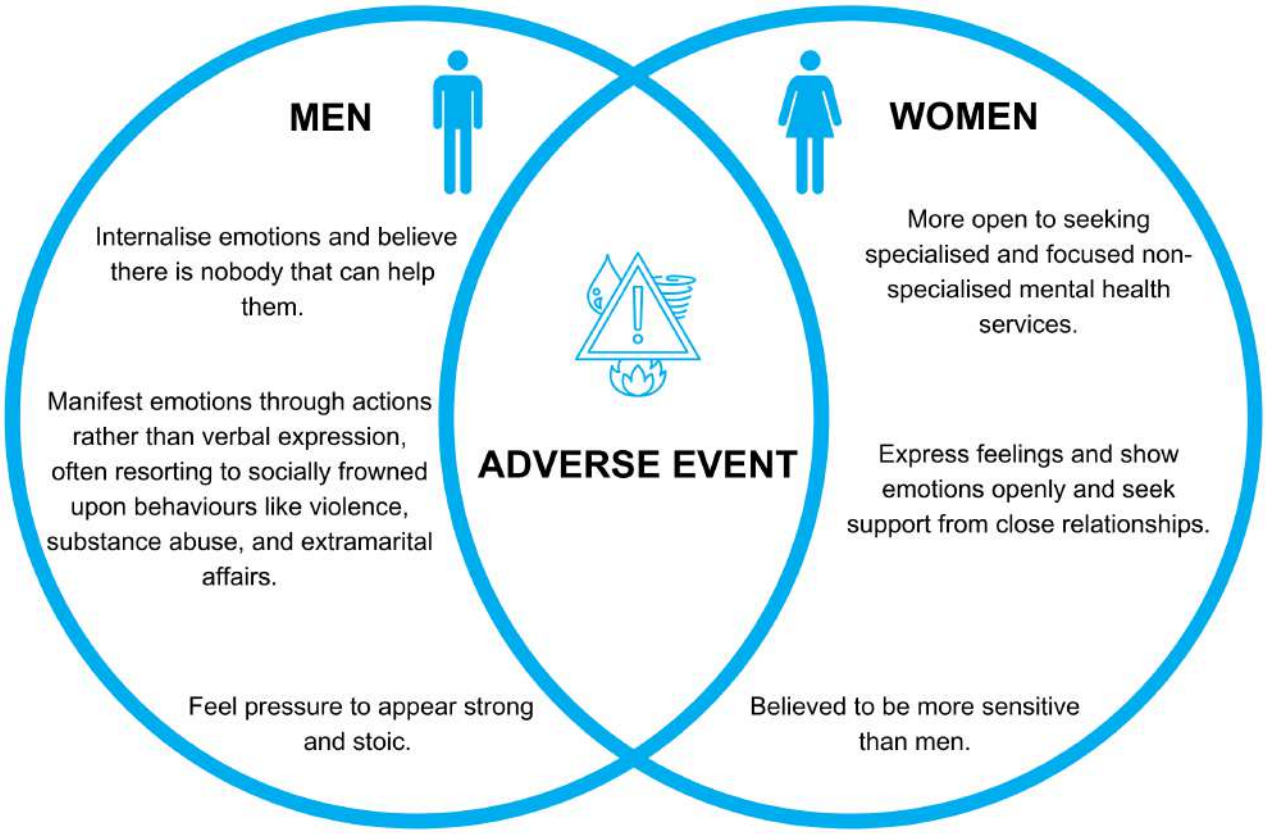


Figure 13. Differences in Coping Strategies, Men Vs. Women

ANALYSIS OF COPING STRATEGIES

This section serves to delve into the research findings on the coping strategies used by the primary respondents. Specifically, it seeks to answer the question of "*what does this mean*" concerning how the Palestinian community in Lebanon copes with the emotionally distressing events. The analysis in this section endeavours to link the findings with the existing body of knowledge regarding the coping strategies employed.

The findings presented in this section illustrate a variety of coping mechanisms utilised by the Palestinian community in Lebanon, delineated into five primary categories: lack of support, self-reliance, support from family and peers, assistance from school and community, and mental health support. Of notable concern are **reports of perceived lack of support, predominantly among children and young adolescents—mainly boys—as well as instances of isolation and internalisation of emotional distress observed among male caregivers.** Additionally, the prevalence of unhealthy coping strategies, such as violence and substance abuse (especially among male adolescents and youth), warrants particular attention.

The perception of lacking support, especially among children and young adolescents, particularly boys, **poses significant risks with long-lasting implications**. Without adequate emotional safety nets, **individuals may grapple with feelings of anxiety, depression, and abandonment, which can detrimentally impact their mental and emotional well-being**, potentially extending into adulthood.

The phenomenon of **male caregivers internalising their emotions** signifies an immense emotional burden. These findings are not new, given that traditional gender roles significantly affect how men and women handle emotional expression, with men often experiencing and showing less emotion than women. This tendency is partly due to societal expectations and the pressure on men to adhere to stereotypically masculine behaviours, including emotional restraint. It is also suggested that this **restraint is not a reflection of actual emotional experience but rather a response to societal norms** that discourage men from expressing certain emotions considered non-masculine, such as sadness or vulnerability. This internalisation,

compounded by feelings of isolation, presents a **formidable barrier to seeking help or sharing struggles**. Consequently, these individuals may suffer in silence, exacerbating their emotional distress and hindering their ability to effectively cope with challenges.

The reliance on unhealthy coping mechanisms, such as resorting to violence as a last resort or turning to substance abuse to escape distress, perpetuates harm and exacerbates mental and physical health issues. These maladaptive strategies not only fail to address underlying issues but also compound existing challenges, creating a cycle of distress and dysfunction within individuals and communities.

The cumulative effect of these challenges extends beyond individual experiences to impact the entire community's resilience. The strain placed on caregivers and young individuals reverberates through families and neighbourhoods, compromising collective well-being and exacerbating existing vulnerabilities. **Without intervention, the ripple effects of these challenges can further erode community cohesion and resilience, perpetuating cycles of adversity**.

Nevertheless, there is **reason for optimism** in the observed **transformations occurring across various geographical areas regarding the changing attitudes**, destigmatisation efforts, and the integration of mental health support into everyday discourse. This includes an **increased willingness among older adolescent females, youth females, and female caregivers to seek both specialised and non-specialised mental health services**. MHPSS personnel are encouraged by the significant progress witnessed in the community's embracing and utilisation of mental health services, which serves to foster resilience and inclusivity of persons with mental health issues within the community.

CURRENT MHPSS SERVICE LANDSCAPE AND GAPS

In order to gain a thorough understanding of the MHPSS landscape and identified gaps within the Palestinian camps in Lebanon, the research team investigated a range of aspects. This **involved examining the available services** based on input from children, adolescents, youth, caregivers, and MHPSS staff, as well **as identifying any missing or needed services** according to these same target groups across all geographic areas. A discussion on the service gaps will be had alongside the findings on the current service landscape. This section will commence with a summary of the overall findings in burgundy, followed by a comprehensive overview and comparative analysis.

CURRENTLY AVAILABLE SERVICES AND GAPS

Across all geographic areas, there is a clear indication that while **mental health and psychosocial support** are critical, they are **part of a broader spectrum of needs** that also include healthcare, economic empowerment, education, and support for creativity and personal development. **The findings highlight a community in need of comprehensive holistic support systems that address both basic needs like safety, health, and economic survival and more specialised MHPSS needs such as access to PSS activities, awareness sessions and specialised mental health services.** These insights underscore the importance of a holistic approach to MHPSS, one that recognises the multifaceted nature of human well-being.

Participants from various geographic regions were invited to discuss the range of services aiding them in managing emotional distress. Across different FGDs, numerous civil organisations were mentioned as providers of various forms of MHPSS and non-MHPSS services, as reported by FGD participants. These organisations have been grouped by area and are illustrated in Figure 4. It's important to note that the classification provided below reflects the perceptions of the FGD participants and **may not represent a comprehensive or entirely accurate list of all services available within each camp.** Additionally, the classification **doesn't solely focus on the MHPSS services offered by UNICEF and its partners**. Rather, it aims to showcase participants' awareness and perceptions of the organisations operating within their camps.

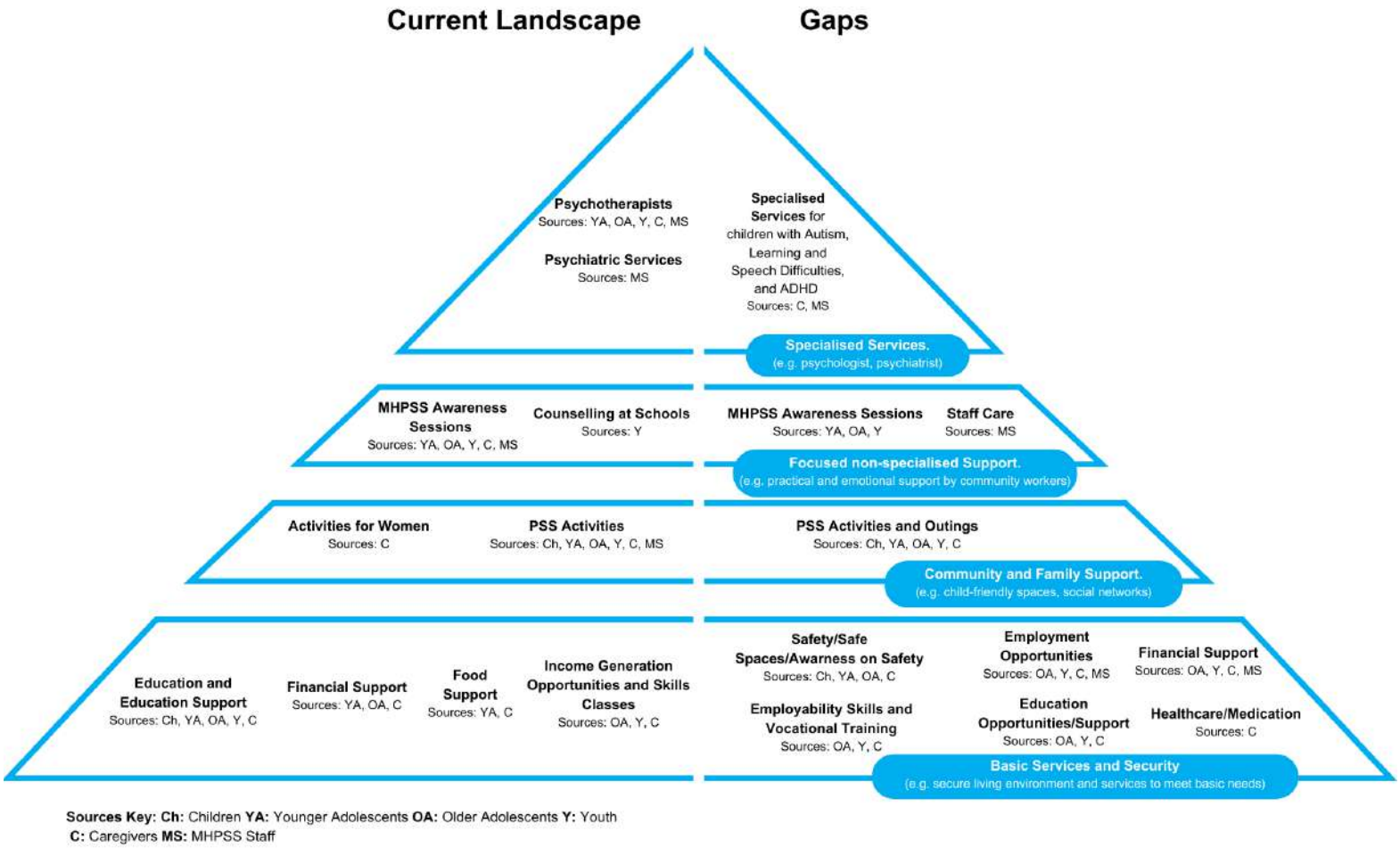
Figure 14. Organisations Classified per Camp

In order to map out the different available MHPSS services and the service gaps, the research team used the **MHPSS Intervention Pyramid approach**. The MHPSS Intervention Pyramid, established by the Inter-Agency Standing Committee (IASC) in 2007, outlines a comprehensive framework for MHPSS. It encompasses four tiers:

Layer 1. Universal Preventative Interventions and Social Considerations in Basic Services and Security
Layer 2. Family and Community Support (Selective Prevention)
Layer 3. Focused Care (Indicative Prevention)
Layer 4. Specialised Services (Management)

All tiers are crucial and should be accessible simultaneously to effectively address the needs of individuals, families, and communities, particularly in times of emergencies. The following figure (below) displays the service landscape and gaps in the pyramid setup. Once more, it's important to note that the service categorisation below reflects the perceptions of the FGD participants and **may not represent a comprehensive or entirely accurate depiction of all services provided across the camps.** Additionally, the classification **doesn't solely focus on the MHPSS services offered by UNICEF and its partners**. Rather, it aims to showcase participants' awareness and perceptions of the available services at the different layers of the pyramid within their communities. The findings will further be unpacked according to the different tiers within the pyramid.

Figure 15. MHPSS Pyramid - Current Landscape Vs. Gaps



Sources Key: Ch: Children **YA:** Younger Adolescents **OA:** Older Adolescents **Y:** Youth **C:** Caregivers **MS:** MHPSS Staff

SPECIALISED SERVICES

At level 4- "Specialised Services", there appears to be a **generally high level of awareness** of the existence of such services across all geographic areas, as noted by both younger and older adolescents, particularly female adolescents, youth, caregivers, and MHPSS staff. When discussing "Specialised Services," most respondents from all categories mention the **availability of therapists** and the awareness of support for children with special needs. The presence of psychiatric services was only acknowledged by MHPSS staff and not by any other respondent group, since these are provided through UNRWA clinics for a limited number of referred cases. This could be attributed to a potential misunderstanding or assumption that psychologists and psychiatrists offer similar services, though this aspect cannot be conclusively confirmed by this research study.

> ***"Organisations in this camp have a therapist in duty; Najde, Fraternity and Naba'e are offering such. Tadamon and UNRWA are offering such as well, in addition to other activities" (Female, Older adolescent, El Buss).***

When it comes to service gaps at the level of "Specialised Services", both caregivers and the MHPSS staff highlighted **gaps in addressing specialised needs such as learning and speech difficulties, ADHD, and autism**. This finding was especially prominent in the Ein el Hilwe camp, although similar sentiments were also echoed from caregivers in Burj el Brajneh camp.

> ***"There are no autism centres in the camp, and it costs USD 35 for centres outside the camp and USD15 for transportation. That's USD 50! " (Male, Caregiver, Ein el Hilwe).***

FOCUSED CARE

At the "Focused Care" level (level 3) of the pyramid, the sole service mentioned and only by the youth participants was the **availability of counselling services** within schools. No other focused care was mentioned by the respondents that would correspond to this level within the MHPSS pyramid.

When it comes to gaps, MHPSS staff **emphasised the necessity for the implementation of staff care measures throughout all geographic regions and organisations.** The term "staff care" was used by MHPSS staff to encompass mental health support, improved working conditions—such as personal office space and enhanced physical workspace conditions—flexibility in annual leave, improved transportation allowances, and revised sick leave policies. Specific mental health support was also requested by for those who have experienced stress and adverse events due to their frontline work.

> ***"If we get sick, they have a new policy that we have to get checked by a doctor and give a report. If I want to go to a specialised doctor, I will have to pay USD 30-40 which is half my salary. For example, when I get my period, I have to go to a doctor every month because I have my period. Why would I need to go to a doctor, I know why I'm sick. In this time, I have to rest. There used to be a menstrual leave, but they removed it." (MHPSS Staff, Burj el Brajneh).***

FAMILY AND COMMUNITY SUPPORT

The **MHPSS support activity** most cited by all research participants across all geographic regions was Community based PSS activities for children, young adolescents and older adolescents categorised under level 2 – the "Family and Community Support" tier in the intervention pyramid. These activities take place in designated safe areas and encompass a variety of recreational options, **including games, challenges, Lego play, colouring, yoga, and sports activities**. Occasionally, organisations organise and facilitate trips and excursions outside of the camps to nature places and active sports activities, such as swimming pools.

> ***"We know that local organisations such as Nabe3 and Soumoud offer psychosocial support for kids" (Male, Youth, El Buss).***

Female caregiver further highlighted **receiving special attention, activities, and free services on special occasion**, such as the Mother's Day and Women's Day.

> ***"There are also activities for mothers on Mothers' Day and decorated the centre for Ramadan month in Naba'e and Najde association. The women are excited for Women's International Day on March 8 where they are promised with self-care services such as hairdressing." (Female Caregiver, Ein el Hilwe).***

Children, young and older adolescents, youth, and caregivers all would like to benefit from **more activities** of this nature, especially from excursions or as they refer to them **"outings"** allowing them to leave their environment and clear their minds.

> ***"They should get us out of this atmosphere as we are facing the same routine on a daily basis" (Female, Caregiver, Ein el Hilwe).***

Besides excursions and trips outside of the camps, children and young adolescents request **more games and activities that promote social interactions and enjoyment.** Older adolescent boys are also keen to have **spaces for sports** and recreational activities such as **playgrounds, entertainment parks and water parks**. Whereas adolescent girls seek **safe spaces for girls exclusively** to meet and interact, especially given that they feel that their freedoms are especially restricted as a result of the intensified clashes and Gaza situation, as explained earlier**. Female caregivers are requesting PSS activities** for them, as well as having opportunities to participate in recreational activities alongside their children.

> ***"Providing lecture like these [referring to the FGD] where woman let it all out and hear stuff from others that one has never paid attention to before at home" (Female, Caregiver, Burj el Brajneh).***

UNIVERSAL PREVENTATIVE INTERVENTIONS AND SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY

One of the most frequently cited service at the Level 1 of the MHPSS pyramid were **MHPSS awareness sessions**. MHPSS awareness sessions were one of the most frequently recognised MHPSS services reported by all participants across all geographic locations except children. Particularly, **female caregivers highly praised these sessions** in all areas, regarding them as invaluable sources of information. They saw these sessions as empowering, enabling them to pass on crucial knowledge to future generations.

> ***"I wouldn't have been this strong and happy in my marital life, that started at the age of 16, had it not been for the mental health sessions and activities being provided. I learned from these, got empowered and educated through the sessions and I am passing my notes down to my daughter, who is to-be-engaged soon. I refuse the idea of wedding children at ages like 16" (Female, Caregiver, El Buss).***

It's important to note that the **extensive availability of MHPSS awareness sessions** across all geographic regions likely played a significant role in **increasing knowledge** and awareness of the signs of emotional distress among older adolescents, youth, and caregivers, as discussed in the previous section. **Younger and older adolescents and youth would like to see more mental health awareness sessions being conducted as they found them highly beneficial.**

At the same time, **MHPSS staff pointed out the redundancy in the focus of multiple organisations on general MHPSS themes** likes parenting skills and awareness sessions, and recommended revisiting the awareness session curriculum in a coordinated manner across all implementing agencies.

Beyond MHPSS sessions, the other key service themes most frequently mentioned regarding current availability across different geographic areas and age groups include **access to education opportunities, financial support, and food aid**. Additionally, income generation opportunities such as **life skills and vocational training were commonly cited**. While all these basic services are highly appreciated and reported to be much needed, male, and female caregivers across all geographic areas raised the **issue of quantity and equity of access to these services**. These concerns were **especially** raised from participants **in the Ein el Hilwe camp**.

> ***"They are helping whom they can, they are supporting 20% or 30 %." (Male, Caregiver, Ein el Hilwe).***

Quantity of basic service availability and **access** is reported to be an issue across all geographic locations. **The term "basic services" includes education, employability and vocational skills, healthcare, employment opportunities and financial support**. All interviewed groups, including children, younger and older adolescents, youth, caregivers and MHPSS Staff are in need of a great majority of the services listed and are requesting such support in order to be able to meet their basic survival needs and rights. However, beyond the availability of the services, the bigger and more prominent prevalent issue is reported to be the equitable access to basic services. **Aid distribution and selection of beneficiaries is perceived to be biased and unfair**. A **few caregivers** mention that they know **people who have benefitted from several rounds** of awareness sessions, while there are **others who have not been enlisted to benefit from any** at all.

> ***"There's problems regarding who's getting help. There isn't help in a fair way." (Male, Caregivers, Beddawi).***

Most caregivers, especially in Ein el Hilwe camp, hold a belief that **the way basic services are distributed within the camps is not equitable or fair**. Questions are raised on the **selection criteria** that are being used to select those who will benefit.

> ***"I give u an example of X and Y. They both are in need. They both have children. But one of them owns a house and the other pays rent. The aid goes to the one who owns a house. It is not fair. I have been married for 7 years I never got one single food aid box. The service given is not fair" (Male, Caregiver, Ein el Hilwe).***

Some caregivers believe that **there is favouritism and nepotism** within the aid delivery structures at the level of the camps. A few female caregivers mentioned that they had **applied** or requested services from organisations **but never received any response, callback, or support**. This lack of follow-up has led to the assumption that having a connection or some affiliation with individuals in charge was necessary to access services or aid.

> ***"Those in the "committee" hand out to their brother, cousins and those who are acquainted with them. As for the rest 'we have nothing to do with them'" (Female Caregiver, Ein el Hilwe).***

Additionally, **a few caregivers shared** instances where they were asked to **pay a fee** to enrol for services *"We send our names, but they're either not enlisted or there are mediations or you have to pay half the price" (Female, Caregiver, Ein el Hilwe).* Or to **pay fees for services that were supposed to be free**, such as being pressured to "informally" pay doctors after consultations even though the medical services were supposed to be provided without charge.

> ***"Even where you do not have to pay for the doctor, my brother is paying as the doctor is asking for compensation to his work." (Female, Caregiver, Ein el Hilwe).***

At a minimum, in terms of the seriousness of complaints concerning equity in aid distribution, caregivers **report encountering difficulties when trying to register** for inclusion in lists for basic services.

> ***"We definitely face obstacles, they don't easily agree to enlist our names," (Female, Caregiver, El Buss).***

Given the reported scarcity and equity issues surrounding the provision of basic services, caregivers have expressed the **need for a revised approach that ensures the provision of a wide range of essential services**.

Furthermore, almost all participant group across all geographic areas and especially children, young and older adolescents are **asking for improved safety and sense of security**. With the increased tensions across the camps, children, young and older adolescents are **experiencing increase instances of harassment, bullying, physical violence, and express the need to be shielded from these**. Children are seeking safe spaces, while female adolescents seek safe spaces for girls specifically and male adolescents wish for awareness sessions on self-defence and how to tackle bullying. Below are some quotes extracted from children's drawings and writing during the play-based focus group discussions.

> ***"Going to schools to protect me from danger." (Female, Child, Ein el Hilwe).***

> ***"I want safety from bullying and awareness on this." (Male, Younger adolescent, El Buss).***

ANALYSIS ON THE SERVICES LANDSCAPE AND GAPS

This section serves to delve into the research findings on the services landscape and gaps. Specifically, it seeks to answer the question of "***what does this mean***" concerning the Palestinian community's access to essential services.

Although the research findings indicate that the Palestinian community in Lebanon has access to various services across different tiers of the MHPSS Intervention Pyramid, the prevailing view is that these services are inadequate and distributed inequitably. Additionally, there is a **noticeable demand for a broader array of services at the "Universal Preventative Interventions and Social Considerations in Basic Services and Security" and "Specialised Support" tiers.** As underscored in the IASC's MHPSS Intervention Pyramid, the simultaneous accessibility of all tiers is deemed crucial for effectively addressing the needs of individuals, families, and communities, particularly in volatile environments. **Thus, both basic and specialised services assume a pivotal role in the delivery of MHPSS interventions**. This perspective finds endorsement among MHPSS staff members, who acknowledge that while MHPSS services are indispensable, they constitute only a portion of the broader spectrum of needs encompassing healthcare, economic empowerment, education, and support for creativity and personal development.

The findings shed light on a community that requires comprehensive support systems addressing fundamental necessities such as safety, health, and economic sustainability, alongside more specialised MHPSS requirements like access to psychosocial support (PSS) activities, awareness sessions, and specialised mental health services. These insights underscore the significance of adopting a holistic approach to MHPSS, one that acknowledges the multifaceted nature of human well-being.

CONCLUSION

The findings from the research assignment paint a complex and sobering picture of the mental health and psychosocial needs among Palestinian children, youth, and adults in Lebanon. The consequences of prolonged exposure to various adverse events within the Palestinian community are profound, affecting individuals' lives and the collective social fabric. The research reveals exposure to a minimum of four broad categories of adverse events, with children facing at least four categories and younger adolescents up to seven simultaneously. This complexity places the community at an elevated risk for collective and continuous trauma, psychological distress, disrupted development, and other challenges. However, there is hope in the heightened awareness among older adolescents and youth, facilitating early intervention to mitigate adverse impacts.

Moreover, the findings underscore the pervasive impact of adverse events, particularly alarming is the prevalence of hopelessness and desensitisation to violence among various population groups. This coexistence leads to detrimental effects spanning mental health resilience, social relationships, and community well-being. The coping mechanisms employed by the Palestinian community highlight concerns such as perceived lack of support, isolation, and unhealthy strategies like violence and substance abuse. These issues pose enduring risks and perpetuate cycles of distress within individuals and communities, necessitating urgent intervention to bolster resilience. However, there is also hope in the noted changes across different geographic locations concerning shifting perceptions, destigmatisation, and the normalisation of mental health needs, as well as seeking both specialised and non-specialised mental health services, particularly among older adolescent females, youth females, and female caregivers. MHPSS staff highlight significant positive strides in the community's acceptance and utilisation of MHPSS services, contributing to the development of a more resilient and tolerant community.

Additionally, while the Palestinian community in Lebanon has access to various services across different tiers of the MHPSS Intervention Pyramid, concerns persist about their adequacy and equitable distribution. There is a notable demand for broader services, especially at the " Universal Preventative Interventions and Social Considerations in Basic Services and Security" and "Specialised Support" tiers. The simultaneous accessibility of all tiers is crucial, as highlighted in the IASC's MHPSS Intervention Pyramid. This underscores the importance of adopting a holistic approach to MHPSS.

Before presenting recommendations, it's crucial to acknowledge the legal limitations faced by Palestinian people in Lebanon. These restrictions greatly impact their access to income, education, and basic services, limiting mobility, job opportunities, and social safety nets. While the recommendations always strive to adhere to international standards and best practices, it is imperative to recognise that implementing them will be challenging due to legal constraints. Advocacy for policy changes, humanitarian support, and international cooperation becomes essential to address these systemic challenges and create an environment conducive to mental health and well-being

RECOMMENDATIONS

The research team has developed several key recommendations in response to the research findings. The recommendations are categorised into three levels of priority using a three-point scale.

- Short-Term Actions (Level 1): Urgent priorities requiring immediate attention.
- Mid-Term Actions (Level 2): Moderately prioritised actions to be addressed expediently. Implement based on available resources and timelines.
- Long-Term Actions (Level 3): Actions of lower priority managed over a longer timeframe. Consider for implementation in subsequent programme phases or as resources permit.

Priority	Recommendation	Rationale	UNICEF Respective Section
Level 1	Continue Raising Awareness on MHPSS	Continue conducting mental health awareness sessions to promote the importance of MHPSS and to further normalise the seeking of mental health services. While awareness levels are higher among older adolescents and youth, efforts should be directed towards less-aware groups such as children, younger adolescents, and caregivers. Building upon MHPSS staff recommendations and study findings, consider expanding the MHPSS curriculum to address issues like coping with hopelessness, desensitisation, emotional internalisation, and social isolation. Priority should be given to interventions aimed at restoring hope, fostering empathy, and challenging the acceptance of violence within the community. Additionally, raise awareness about the potential negative effects of exposure to distressing news and images from the Gaza war, as this can lead to secondary trauma, particularly among children, adolescents, and youth. Given the influence of Palestinian social media influencers on younger demographics, explore opportunities to engage with influencers to advocate for increased awareness of mental health needs and destigmatise help-seeking behaviours, with a specific focus on males of all ages. **Specific actions and way forward:** • Increase mental health awareness raising with caregivers to better understand the importance of mental health, and how to take care of their own wellbeing. The Child Protection section in partnership with Embrace are currently providing workshops for caregivers on this topic. Action: Roll out of the MH Workshops by Embrace with PPL Partners in Q2/Q3. • Advocacy for UNRWA to raise awareness on MH in schools, health centers and vocational training centers • Develop IeC material for different groups, based on the suggested topics with CP, YAD SBC Teams; to be disseminated through existing community platforms.	Child Protection Section, SBC team, PPL Team, YAD

Level 1	Conduct Regular MHPSS Service Mapping	To address the perceived service gap and improve equitable access, it is recommended to conduct regular quarterly mapping of all available MHPSS services across different geographic areas, adhering to the tiered approach outlined in the MHPSS Pyramid. The compiled list of services should then be disseminated to the Palestinian community through various channels simultaneously, including social media platforms utilising local Palestinian influencers, educational institutions, religious centres, medical facilities, and women's groups. Additionally, the development of a mobile application with details of available services and contact information could serve as an effective tool for facilitating the spread of this information. **Specific actions and way forward:** • Train and refer PPL Partners on the NMHP 4Ws platform for mapping and updating of available MHPSS services, in addition to the red flag identification. • Train PPL partners on the CP Sector 4W's and update pathways available on services available. • Mapping of Psychologists available at PPL Partners centers	PPL Team
Level 1	Implement Gender-Sensitive Interventions	In light of the observed gender variations concerning the effects of adverse events and coping strategies, it is advisable to review the existing MHPSS service delivery programme content. This entails identifying areas where awareness and service delivery can be more effectively tailored to address the identified differences in coping mechanisms and the impact of emotional distress. This is particularly relevant for boys and men, who frequently report experiencing elevated levels of hopelessness and desensitisation. Additionally, they tend to isolate and internalise emotions, factors that contribute to reduced help-seeking behaviour and an increased reliance on negative coping mechanisms. **Specific actions and way forward:** • Introduce Gender-Transformative Parenting Intervention for caregivers.	PPL Team

Level 1	Ensure Integrated Service Delivery	To address the demand for services at tiers 1 and 4 of the MHPSS pyramid, it is advisable to incorporate mental health components into existing services, including education, healthcare, and social support. A holistic and multi-sectoral approach is recommended, tailoring aid packages to each community's needs by leveraging available services and addressing existing service gaps in accordance with the MHPSS pyramid approach. This entails ensuring the availability of basic services and security alongside community, non-specialised, and specialised mental health services. Moreover, it is advisable to establish unified standard operating procedures for organisations serving the Palestinian community, particularly within each camp, to address disparities in equitable service delivery. Finally, it is recommended to ensure and encourage more transparency with project beneficiaries including clarity on selection criteria, objectives of activities, impact, sharing results. **Specific actions and way forward:** • Refer caregivers and staff to the Step-by-Step digital mental health intervention for depression and anxiety by NMHP and WHO. Factsheet on the application and how to use will be shared by Riwa to Bochra, in order to share with PPL Partners. Please follow up with PPL partners to make sure the proper guidance is given and this is done. • Capacitate PPL Partners on Self Help for caregivers. • Adaptation of PSS Activities materials, based on the needs that came out of this assessment, incorporating material that is relevant at the moment. (For example: anxieties, fears from stray animals…)	PPL Team, UNICEF, UNRWA, NMHP

Level 1	Improve MHPSS Staff Care	In order to address the various gaps identified in the care of MHPSS staff and to guarantee the sustained delivery of high-quality local MHPSS interventions by local specialists, it is advised to assess and enhance the existing staff care provisions for MHPSS personnel. This encompasses improving physical working conditions, addressing mental health care requirements, revising financial compensation, and refining policies related to leaves and sick leave. **Specific actions and way forward:** • Roll out of the UNICEF Frontliners Wellbeing Preventative Care Package with frontliners from PPL partners (CP Program) • Advocate for the inclusion of a budget line specific to the Wellbeing of frontline workers in PPL PD's with partners, to hold partners accountable in taking care of the mental health and wellbeing of their respective frontline workers. • Circulate material on Self Care and Circulate NMHP Self Care videos across PPL Partners for staff to benefit.	

Level 1	Invest in Developing Further Safe Spaces for Children, Adolescents and Youth	In light of the requests from children, adolescents, youth, and caregivers for access to secure environments and PSS activities, including outings, it is advisable to reassess the current extent and reach of PSS services provided by organisations across different areas and identify potential gaps. There is a suggestion to invest in the development or enhancement of existing community centres and recreational spaces to enhance the availability of secure areas for sports and leisure activities. Additionally, contemplate the incorporation of martial arts and boxing as viable sporting options especially for male children and youth, to offer a safe avenue for channelling anger through sports, thereby mitigating involvement in street violence. Needs and interest-based sports and recreational programmes should also be made available to female children and youth. Furthermore, consider expanding PSS support to encompass safe spaces for female caregivers, female adolescents, and youth to convene and interact. **Specific actions and way forward:** • Encourage NGO's to incorporate sports activities into their CBPSS interventions, as a means for children and youth to express their feelings in a proactive and positive way. • Advocate for the use of UNRWA playgrounds for recreational play, Sports for Development programs, and as safe spaces. • Adapt CBPSS interventions content based on the needs of the assessment, to address anxieties, fears and distresses. • Advocate for sports for wellbeing activities for youth. • Create additional safe spaces in communities for youth.	UNICEF, advocacy with UNRWA and partners

Level 1	Invest in Raising Awareness on Personal Safety and Security Measures	In light of the heightened exposure to conflict, violence, and incidents such as gunshots, bombings, and increased harassment including SGBV and bullying, it is advisable to provide age-appropriate personal safety and security awareness sessions. Security training could cover essential protocols for various scenarios such as encountering gunfire while walking on the street, responding to grenade attacks, identifying safe shelters during bombings, and understanding survival essentials for 72 hours. Additionally, offering first aid training across all age groups is recommended. Awareness sessions should also focus on bullying, harassment, and SGBV, particularly tailored for children, young adolescents, and older adolescents, covering aspects such as recognising these behaviours and responding effectively to protect oneself. **Specific actions and way forward:** • This intervention should be tailored and implemented mainly inside UNRWA schools and at local NGOs centres. These are different interventions that implies the engagement of different specialised services.	To discuss with ICRC, UNRWA, Partners, CPNs, committees in the camps and CP stakeholders
Level 2	Scalable Psychological Interventions	In light of the findings revealing a lack of specialised and limited non-specialised MHPSS services, coupled with the need to enhance affordability and combat ongoing stigmatisation of mental health, it is advisable to introduce modified, evidence-based psychological treatments tailored for resource-constrained communities like the Palestinian camps. These may include condensed versions of cognitive-behavioural therapy (CBT) or interpersonal therapy, alongside self-help resources such as books, audiovisual materials, and online platforms, as well as guided self-help programmes like mobile applications grounded in CBT techniques. **Specific actions and way forward:** • Promote the availability of Psychologists at PPL partners centres- Share the mapping with all PPL partners. • Mapping of MHPSS services in Palestinian camps. • Training for the 4W's platform. • Raise awareness on the councillors available in schools.	

Level 2	Community-Based Interventions	To address the perceived lack of community cohesion and community-led initiatives during adverse events, the focus should shift towards developing community-driven interventions. These initiatives would involve actively engaging community members in the planning and execution of MHPSS programs. It is recommended to provide training in basic MHPSS principles to community leaders, teachers, and local influencers. Additionally, local providers should be trained to deliver specialised services tailored to community needs. Establishing and training peer support groups within the community can further enhance ongoing emotional support mechanisms. **Specific actions and way forward:** • Integration of MHPSS key messages into the QUDWA package, for community members and local advocates to sensitize communities on the importance of mental health, how to take care of their wellbeing, and who they can reach out to for MH support.	x
Level 2	Social Cohesion Programmes	Given the recorded instances of verbal and physical assaults faced by youth when they venture outside the camps due to negative perceptions and blame from local community members, it is prudent to explore the feasibility of implementing area-based social cohesion initiatives and programmes. This involves ensuring comprehensive service delivery is accessible not only to the Palestinian population but also to local Lebanese communities. **Specific actions and way forward:** • Promote social cohesion programs inside and outside Palestinian camps through Youth and volunteer programs. • Re-activate summer schools and workshops for children inside and outside Palestinian camps. • Encourage volunteer programs and volunteering activities within the Palestinian camps. • Set up visits to parliamentarians by youth advocate for social cohesion.	UNICEF, UNRWA, PPL, YAD, LPDC

Level 3	Invest in Advocacy Efforts	Considering the numerous legal restrictions hindering Palestinian community members from accessing employment opportunities and various social services, advocating for legal reforms is essential. These reforms should aim to grant Palestinian refugees additional rights, such as the right to work. Additionally, it is recommended to advocate for the integration of MHPSS education into school curricula. This integration would help normalise discussions around mental health and encourage help-seeking behaviours across all age groups of children and adolescents. Furthermore, it is crucial to advocate for long-term funding for MHPSS programs to ensure the sustained provision of comprehensive support. **Specific actions and way forward:** • Integration of MHPSS in school curricula and system: integrating awareness-raising on mental health conditions. This approach aims to normalize and destigmatize mental health issues and seeking help when needed. • Increase fundraising efforts for long-term MHPSS programs. • Train educators on Mental Health and Wellbeing • Development and roll out of the Mental Health policy in schools. • Supporting policy-level advocacy to solve the issues of non-ID's and dependents isolated in camps, as they are being forced to be engage in risky behaviours. • Mobilize Lebanese Palestinian dialogue committee to attract attention to youth inside and outside the camps, to restore hope.	LPDC

Annexes

Annex A – Completed Tools

Annex B – Methodological Note

Annex C – Field Debriefing Note

Annex D – ERB Approval

Annex E – Recruitment of Data Collectors

Annex F – Written Consent Form – Caregivers

Annex G – Ethical Considerations and Guidelines

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