Mental Health and Psychosocial Wellbeing Among Palestinian Refugees in Lebanon

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List of Abbreviations

AUB
American University in Beirut
CBO
Community Based Organization
ECHO
European Commission's Humanitarian Aid and Civil Protection Department
FGD
Focus Group Discussion
GIZ
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
HI
Handicap International
IASC
Inter-Agency Standing Committee
INEE
International Network for Education in Emergencies
IO
International Organization
LNGO
Local Non-Governmental Organization
MAP
Medical Aid for Palestinians
MHPSS
Mental Health and Psychosocial Support
MOPH
Ministry of Public Health
MSF
Médecins Sans Frontières
NBC
Nahr el-Bared Camp
PRL
Palestinian Refugees in Lebanon
PRS
Palestinian Refugees who fled Syria into Lebanon
RI
Response International
SME
Small and Medium sized Enterprises
UNDP
United Nations Development Programme
UNHABITAT
United Nations Human Settlements Programme
UNICEF
United Nations Children's Fund
UNRWA
United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP
World Food Program
WHO
World Health Organization

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I. INTRODUCTION

The recent refugee MHPSS literature eventually reflects the dominance of the symptom-focused trauma-centered approach. As a matter of fact, it reports increased rates of emotional and behavioral dysfunctions among children and youth, as well as symptoms of anxiety, stress, depression or Post-Traumatic Stress Disorder (PTSD) that often mirror those of adults, even though most of the population does not explicitly meet the diagnostic criteria of those psychiatric disorders (Lustig et al., 2004; Al Amine et al., 2007). Moreover, some longitudinal studies show a decrease in symptomatology after longer periods of time in the host country, though some symptoms may persist over time (Becker et al., 1999). In addition, several authors went on to question the medicalization approach of refugees' psychosocial well-being namely for social and cultural factors, which may often lead to the shortfall of decontextualizing the refugee's experience and narrowing it to a series of psychiatric definitions (Losi, 2000).

Based on this, psychosocial suffering would be a characteristic of most individual and collective experiences of displacement (especially war related, which are usually accompanied by several main stress factors) (Losi, 2001). These include economic constraints, security issues, breakdown of social and primary economic structures and consequent devaluation or modification of social roles, violence, persecution and discrimination and loss of loved ones.

Likewise, instable and precarious life conditions, the difficult access to services and the losing of systems of social meanings create a very uncertain future. Often these elements bring about a series of feelings, including grief, loss, and guilt towards the people who did not flee or other members of the family, a sense of inferiority compared with the resident population, isolation, anger, angst and insecurity-instability.

The crisis in Syria continues to take a devastating toll on the country's civilian population, and on neighboring countries. Lebanon hosts over 1 million registered Syrian refugees, more than any other country, making it the largest per capita recipient of refugees in the world. This is in addition to hundreds of thousands of Syrians living in Lebanon without eligibility for registration and approximately 45,000 Palestinian refugees who have fled into Lebanon from Syria (PRS).

The large influx of Palestinian refugees from Syria and Syrian refugees into Palestinian communities in Lebanon has sparked heavy competition in the Palestinian camps and gatherings in Lebanon, with longtime residents losing jobs, as well as in access to basic medical and educational services. Very little research has looked into the psychosocial impact of the Syria crisis on the Palestinian community in Syria and neighboring countries over the past few years. As media remains the public's main source of information about the ongoing plight of the Palestinian community, most existing studies focus on protection aspects (UNICEF, 2010; Amnesty International, 2013), and livelihoods (ANERA, 2012; UNDP and UN-HABITAT, 2014).

1. Aim

The major aim of this assessment is to provide a broad overview of the mental health and psychosocial concerns related to the Palestinian communities in Lebanon in the context of the Syrian crisis induced displacement situation.

2. Objectives

The objectives of this assessment are to determine if there are any unmet mental health/psychosocial needs by:

1. Identifying the trends and patterns of common mental health and psychosocial conditions, including the recognition of gaps in appropriate services.

2. Identifying the current MHPSS service provision in the Palestinian communities in Lebanon according to population need.

3. Understanding how existing referral network models work with particular population/cultural barriers to accessing mental health and psychosocial care in order to improve access to services and decrease stigma and discrimination.

3. Working Definitions

Palestinian Refugee (UNRWA) [1]

Palestinian refugees are defined as "persons whose normal place of residence was Palestine during the period 1 June 1946 to 15 May 1948, and who lost both home and means of livelihood as a result of the 1948 conflict." The descendants of Palestinian refugee males, including adopted children, are also eligible for registration.

Mental Health and Psychosocial Wellbeing [2] [3]

WHO defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. [4]" Closely linked, but with a slightly different emphasis, INEE defines psychosocial wellbeing as follows: "The term psychosocial underscores the close connection between psychological aspects of our experience (e.g., our thoughts, emotions, and behavior) and our wider social experience (e.g., our relationships, traditions and culture). Mental disorders, which often benefit from clinical treatment, tend to involve severe psychosocial difficulties in managing thoughts and feelings, maintaining relationships, and functioning in expected social roles.

However, many psychosocial problems do not require clinical treatment but are rooted in stigmatization, lost hope, chronic poverty, uprooting, inability to meet basic needs, and inability to fill normal social roles such as that of student/learner. Wellbeing is a condition of holistic health in all its dimensions: physical, cognitive, emotional, social, and spiritual. Also a process, well-being consists of the full range of what is good for a person: participating in a meaningful social role; feeling happy and hopeful; living according to good values, as locally defined; having positive social relations and a supportive environment; coping with challenges through the use of appropriate life skills; and having security, protection, and access to quality services."[5] Mental Health and Psychosocial Wellbeing are thus terms that complement and enhance each other.

1 The present definition is a working one that defines eligibility criteria to UNRWA services (http://www.unrwa.org/palestine-refugees).

2 The following definition was developed and agreed upon in an UNRWA workshop that took place in Amman on September 14-15, 2014, titled "Forum to Support the Development of an Agency-Wide Psychosocial Conceptual Framework".

3 The IASC guidelines define the composite term mental health and psychosocial support (MHPSS) as "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder of individuals, families and communities." Thus on one hand a linkage between Mental Health (MH) and Psychosocial Support (PSS) is assumed, connecting different types of intervention. On the other hand a logical confusion is constructed, because PSS necessarily describes one or several activities, while MH is a generic term that refers first of all to a state of mind and only on a second level to an activity. From a conceptual point of view it makes thus more sense to speak of Mental Health and Psychosocial Wellbeing (MHPSW).

4 www.who.int/features/factfiles/mental_health/en

5 INEE, Thematic Issue Brief: Psychosocial Wellbeing.

II. LITERATURE REVIEW

Data driven from peer-reviewed literature was coded and systematized. After the full literature review, themes similar to those found in the interviews and the field survey were identified. Differences between the themes found in the interviews and the existing literature were identified and analyzed. The full range of data ultimately helped to put the data obtained in interviews into the context of the greater field and confirmed that these data were not merely outliers.

Lebanon hosts over 1 million registered Syrian refugees in addition to hundreds of thousands of Syrians living in Lebanon without eligibility for registration and approximately 45,000 PRS who have fled into Lebanon [6], making it the largest per capita recipient of refugees in the world. With this influx, the camps have become overburdened, with approximately 27,000 new residents living in the twelve official camps.

6 Until May 2014, following entry into Lebanon through an official border post, PRS were given a transit visa, which was then converted into a residency visa valid for 3 months; renewable up to 4 times at a General Security Office, for a total stay of 1 year. Thereafter PRS could pay a fee of approximately US$200 and remain in Lebanon, although not all refugees appear to have been able to do this. In May 2014, the Lebanese authorities put in place new requirements for PRS trying to enter Lebanon. Prior to entry, they are required to demonstrate that they meet certain conditions for temporary residence in Lebanon or that they are transiting through Lebanon. Under the new system, PRS willing to enter Lebanon must possess 1 of 3 Lebanese documents: an entry visa approved by the General Directorate of General Security; a Lebanese residency visa of 1 to 3 years; or an exit and return visa. Obtaining any of these documents before leaving Syria is extremely difficult. Even prior to the May 2014 changes in policy, PRS faced different conditions for entry into Lebanon, including a requirement that they first obtain permission to exit Syria from the Syrian authorities, for which they had to pay. Additional conditions of entry for PRS were imposed in August 2013, limiting entry to those who could demonstrate that they had certain family connections or a medical or embassy appointment. In addition, it appears that some PRS already residing in Lebanon are not being allowed to renew their temporary residency visas, leaving them without a clear legal status in the country and at risk of arrest and deportation. According to an Amnesty International Report (2014), some would have entered Lebanon irregularly because they were unable to meet the requirements for official entry; others couldn't afford to pay the fees to renew visas that have expired. Challenges faced by those who do not have legal status in Lebanon also include the facts that they cannot register births and marriages or obtain health care at government facilities; students cannot take official exams.

The large influx of PRS has sparked heavy competition in the Palestinian camps and gatherings in Lebanon, with longtime residents losing jobs as well as access to basic medical and educational services. According to the joint UNDP and UN-Habitat report released in August 2014, original dwellers are losing jobs because new refugees who are demanding lower wages are replacing them. The report highlights the fact that a Palestinian worker earns on average a monthly income of LL 537,000 (USD 358), mostly due to harsh work restrictions that narrow down employment opportunities to manual labor or informal jobs. The spotted increase in unemployment results from an increase in competition on available jobs, with an ever growing amount of refugees competing over a limited supply of work opportunities. The report also revealed that the 42 gatherings for PRL were originally inhabited by about 110 thousand residents before the outbreak of the Syrian crisis. Since the onset of the crisis, the official refugee camps and gatherings, notoriously overcrowded, have been squeezing the ever-increasing population of Syrian refugees and PRS into finite areas. Most of the structures, built as temporary shelters, have deteriorated over the decades from lack of funding for proper maintenance. Poor housing conditions, leaky pipes, deteriorated water and sewage treatment systems, contaminated water, jerry-rigged electrical connections and open drainage ditches all contribute to sub-standard living conditions. Expansion of the camps to accommodate the increased population is prohibited by local laws. There are also restrictions on rehabilitation work, however minor, and on the entry of materials into the camps needed for repairs and renovation.

With regards to health facilities, hospitals and medical facilities in Palestinian gatherings, these have been overwhelmed with a larger consumer base, utilizing the same facilities and creating greater competition with the original dwellers (UNDP and UN-HABITAT, 2014). According to the report, the lack of access to hygiene has introduced a new wave of health problems among the incoming refugees, such as lice and tuberculosis.

The negative sentiment harbored towards PRS has spilled over into UNRWA schools, where discrimination and bullying of students from Syria was reported to be widely prevalent. The arrival of refugees from Syria has exerted pressure on the educational facilities that are struggling to absorb the number of new enrollments. While crisis related exposure events constitute an important contextual factor in our analysis, the present assessment will naturally assess other exposure events connected to personalized individual experiences connected to daily life outside of conflict (Abouchedid, 2008). This would be justified for the following reasons: 1) the validity of examining the effects of exposure events in one single episode of violence on the symptomatology of victims would be questionable due to possible previous exposure that predated the conflict (Papadopoulos, 2001; Lustig et al., 2004), and 2) most people are exposed to at least one violent/life-threatening event in their lifetime, which renders them vulnerable to subsequent mental health implications (Ozer, 2003).

Very little research has looked into the psychosocial impact of the Syria crisis on the Palestinian community in Syria and neighboring countries over the past three years.

Most existing studies focus on protection aspects (UNICEF, 2010; Amnesty International, 2013), and livelihoods (ANERA, 2012; UNDP and UN-HABITAT, 2014), while studies documenting mental

health and psychosocial needs among Palestinians received insufficient attention and the existing ones are mostly case studies and project documentation, focusing on interpretation rather than quantification, and are oriented towards process rather than outcome. Besides, the essential feature of comparing the emergent trends in the Palestinian population is undermined because tying the existing literature to trends is limited by the low internal validity, generalizability, and theory building from case study research methodologies.

In March 2014, UNRWA and WFP jointly published an assessment consisting of a nation-wide household survey and focus group discussions carried out in October 2013, mainly aiming at providing an overview of the socio-economic conditions and needs of the Palestinian Refugees displaced to Lebanon from Syria. While the report comprises informative results on socio-economic indicators (Demographics, Shelter, Education, Health, Nutrition, Food Security, Livelihoods and Employment), reference to psychosocial issues remained evasively mentioned.

A mission report assessment of GIZ and the Office for Psychosocial Issues (Becker and Mohammed, 2013) showed that the current situation of Palestinian Refugees in Lebanon combines three juxtaposed problems: 1) the chronic suffering of PRL in the last sixty years, 2) the acute suffering of PRS through the war in Syria and their experience of flight and 3) the complex situation for each group and between PRL and PRS. The report narrative provides a rationale to demonstrate the need to develop psychosocial support and counseling within UNRWA's different programs in Lebanon in order to respond to the individualized and joint needs of PRL and PRS.

In 2011, the DRC conducted a study to explore distinguishing features of Palestinians not registered with UNRWA in terms of their general living conditions, with a focus on access to basic services, and their aspirations. The main limitation of this statistical survey is the representativity of the sample given the absence of a comprehensive database on Non Registered Palestinians [7].

In April 2010, UNICEF Lebanon carried out a household survey on violence in the Palestinian camps in Lebanon. Data sources were derived from a representative sample of 4,000 households by means of person to person interviews, and covered UNRWA's 12 mandated camps and 5 major gatherings in North Lebanon, Saida, Tyre and Beirut. Major findings from the study showed that: over-crowdedness reaches 1.8 person/room, 56% of household face conflict with family members and/or neighbors, 75% of 10-24 years old children and youth indulge in conflicts as a result of economic problems, over-crowdedness and maltreatment by parents, 25% of children and youth were exposed to physical abuse during the year prior to undertaking the study (either by parents, or at school), 21.4% of abused children and youth suffered physiological and psychological problems, 2% of women were sexually abused (with others reporting other forms of violence acts or threats), 20% of whom suffer either physical (26%) or psychological (47.5%) problems.

7 An older DRC assessment undertaken in 2005 covered 39 Palestinian gatherings in Lebanon. It was found that some gatherings had more extensive needs than others, most visually regarding rehabilitation of houses or improvement of infrastructure such as water supply facilities, sewerage network, and garbage collection. There were however also distinct differences among gatherings in the fields of health, education, social services and recreational opportunities for mainly children and youth. According to the study, almost all gatherings have vulnerable groups with special needs. These included elderly, people with disabilities and non-ID refugees.

In December of the same year, Shaaban et al. conducted a socio-economic survey of Palestinian Refugees in Lebanon. The report published by the AUB and UNRWA, took a multi-dimensional approach to delineate the social exclusion of Palestinian refugees in Lebanon and explore poverty along five dimensions namely economic status, housing conditions, health, food security and education.

Other aspects of protection were also retrieved in older literature covering needs, living conditions and risk factors among the poorest children and mothers within the Palestinian community in Lebanon (Save the Children, 1995; UNICEF, 2004; UNICEF and PCBSNR, 1999; FAFO, 2000; Najdeh, 2004; Khawaja & Blome, 2003).

In 2010, an assessment carried out by Welfare Association among a sample of 1,200 Palestinian women from Nahr el-Bared Camp in North Lebanon showed that 61% of the respondents noted that they are facing restrictions in movement, 92% of respondents noted that they are still able to keep their cultural beliefs, customs and lifestyles in their current living space. The main barriers for those who could not maintain their cultural and social habits (8%) were related to bad economic conditions, significant changes in livelihoods and in their psychosocial well-being. Most respondents noted that changes in their social and recreational spheres resulted in psychological distress, sadness and instability. Uneasiness and distress was widely common (99.5%), although there are differences between locations. The reasons behind distress were common, as 70% of respondents in all areas mentioned "instability" to be a main factor in their uneasiness and distress.

In 2009, the joint "Nahr el-Bared Camp Statistical Report" published by Lebanon Support, in association with UNRWA, UNDP, ECHO and HI, defined the main trends and findings on the conditions and situation of Nahr el-Bared Camp displaced and returnee population through a series of socio-economic indicators (Demographics, Shelter, Health, State of Services, Education, Work and Employment and SMEs in NBC) without specific reference to psychosocial implications of displacement or return.

From 2008 to 2014, MSF has implemented a mental health program for vulnerable Palestinian refugees living in and around Burj el-Barajneh camp in southern Beirut. Over the past years, several quality policy papers, project reports and case studies have been published (MSF, 2008, 2011, 2012). Although some of the papers report estimates of psychiatric disorders prevalence rates, generalizability remains questionable given that numbers were based on their own indicators reflecting MSF community approach that brings together psychiatric and psychological care with social and community support.

In 2005, RI conducted a normative mental health needs assessment in Palestinian refugee camps and concluded to the necessity of: 1) promoting mental health and prevention of mental illness as a cross sector responsibility (ie. health, social services, and education), 2) including access to basic mental health care with adequate quality as part of primary care provision, 3) taking into consideration and allowing for techniques which help patients to cope by themselves with their mental health impairments, disabilities and handicaps, 4) providing care while involving communities, families and consumers, 5) carrying out mental health assessments in accordance with internationally accepted principles, 6) establishing policies, procedures, programmes and legislation, 7) building needed human resources, 8) increasing the availability of supervised prescribed psychotropic medicines and 9) increasing efforts on monitoring and evaluation and research.

Until 2006, MHPSS provision was often viewed as a composite issue in Lebanon. This perception resulted from the fact that this international intervention trend was only introduced and promoted in Lebanon following the magnitude and sequalae of July 2006 War in Lebanon, based on the Inter-Agency Standing Committee (IASC) guiding principles. Prior to that, mental health services rather fell under general health and education practice, which used to induce the detection and referral of pronounced cases to specialized mental health services.

In December, 2013, a UNHCR report on mental health and psychosocial service assessment for Syrian refugees in Lebanon highlighted the need for a coordination mechanism (El Chammay, 2014). As a result, a Mental Health and Psycho-Social Support (MHPSS) task force chaired by the MOPH, co-chaired by UNICEF and WHO, and including all actors involved in MHPSS services was established/launched in May 2014, with clear objectives to mainstream an MHPSS approach in all sectors (education, protection, water sanitation and hygiene, shelter, etc) and harmonize services at the different levels of the Inter-Agency Standing Committee in a culturally sensitive manner, using and adapting international methods and guidelines. Building on the support provided by International Medical Corps (IMC), WHO, and UNICEF, the MOPH has also created a national mental health programme to reform the mental health system in the country (service organization, legislation [8], and financing). A national consensus on a mental health strategy will be discussed in November 2014 (El Chammay, 2014). Palestinian refugees and UNRWA will be included in this strategy. However, the Palestinian refugee population remains out of the task force's terms of reference.

8 The mental health system benefits from different acts and legislations in different areas of mental health, namely: the Lebanese Act no 72-9/9/1983 Welfare Act and Protection and Treatment of Mentally ill Patients, the Lebanese Act no 673-16/3/1998 Narcotic Drugs and Psychotropic Substances and Precursors, the Lebanese Act no 220-29/5/2000 Rights of Mentally Handicapped in Lebanon and the Lebanese Act no 574-11/2/2004 Patients' Rights and Informed Consent. Between 2008 and 2009, a proposed Mental Health Law was prepared by the Institute for Development, Research, Advocacy and Applied Care (IDRAAC), through a grant from the European Union and with the coordination of the Office of the Minister of State for Administrative Reform and Development. The proposed law, however, remained widely unknown to psychiatrists and to the public.

III. METHODOLOGY

In order to identify the range of psychosocial problems that are common among PRL and PRS in Lebanon and to develop propositions for potential methods for improving psychosocial conditions, this paper utilizes information obtained through: field survey, focus groups and personal interviews with stakeholders and beneficiaries, supplemented by a review of the existing peer-reviewed literature and work published by prominent international organizations in the field.


ACTION

1. Preparation of Field Work

A Steering Committee was formed comprising: GIZ Project Advisor in Lebanon, GIZ recruited Consultant/Research Lead, UNRWA Senior Mental Health Advisor, UNRWA Programme Support Officer, and SGBV/Protection/Disability Officers. The Committee convened for a series of weekly meetings to follow-up on developments.

The research team consisted of twelve volunteers, a research leader and a research assistant. They were screened and trained by the research leader on surveying techniques and Mental Health and Psychosocial Support (MHPSS) basics.

2. Secondary Data Analysis

To describe the socio-economic profile of the target area population, authoritative secondary data sources were used, including the UNRWA statistics and registration figures, NGOs head count, IOs recent reports and others. Some of the data were compiled by the volunteers for this needs assessment; others were accessed directly.

3. Sample Selection

The household survey covered 1,500 households in the 42 gatherings and 12 camps in the five administrative areas: the North, Beirut and Mount Lebanon, Saida, Tyre and the Bekaa. The sample was distributed using a probability model proportional to a displacement size sampling that would be considered representative of the diversity of PRL and PRS locations in Lebanon. The sample size is considered large enough to adequately estimate the main characteristics of the targeted population.

The response rate was 96.4%. In order to achieve the maximum rate, surveyors were provided with an additional number of targets in each of the catchment areas. The main respondent was the head of the household. Households from Saida area and its surrounding comprised the biggest group, accounting for 24% of the sample.

Concerning the main source of income, 18% affirmed living on humanitarian assistance. 69% stated that they had at least one source of income (though unstable) distributed as follows: up to two third scored their job under artisans/handicrafts and freelancer (including among others: agriculture, small commerce, drivers, construction workers…), while the rest scored as employees and teachers.

With regards to parents' level of education, the father was illiterate in 9.5% of the surveyed households, while the percentage reached 25.9% among mothers. 13% of fathers were university graduates. It is also noteworthy to mention that 83.7% of mothers were housewives.

The number of children per household varied between 1 and 17 with an average of 6.3 children per household.

List of Gatherings
(UNDP and UN-Habitat)

Beirut
Daouk
Gaza Bldgs
Said Ghawash
Naameh Sahel

Beqaa
Bar Elias
Goro
Taalabaya/Saadnayel
Marej

North
Bab el Ramel
Bab el Tabaneh
Mina
Zahrieh
Mankoubin
Muhajjarin Beddawi
NBC AA
Muhajjarin NBC

Saida
Bustan Abu Jamil
Baraksat
Bustan el Qods
Fadlowakim
Hamchari
Hay el Souhoun
Mieh Mieh Surrounding
Sirob
Wadi el Zeineh
Chehim
Old Saida
Sekke
Jabal el Halib
Tawari

Tyre
Adloun
Baysarieh
Chabriha
Ebb
Itanieh
Jal el Bahr
Jim Jim
Kfarbada
Qasmieh
Wasta
Bureghlieh
Maachouk

4. Household Survey

Using a combination of tools selected from "WHO-UNHCR Toolkit for Assessing MHPSS Needs & Resources in Humanitarian Settings", and the "Exposure to War Inventory" (EWI, LAES 2006, partially adapted from Merhej, 2005 and further developed by the research team of the present assessment to fit in well with the Palestinian context in terms of types of exposure and stressors [9]), field work was carried out in the second half of August 2014. The central team conducted a process of control over the fieldwork, through daily follow-up, facilitation of the team's work, and direct/indirect checking affirming the accuracy of the work. Collected questionnaires were scrutinized and numbered, and the data entered using the Statistical Package for Social Sciences (SPSS).

5. Focus Group Methodology

During the second half of August 2014, the research leader and research assistant conducted eight focus group discussions in person with fifty two organizations from various sectors (education, health care, faith-based organizations, local NGOs, community leaders, activists and others), in the five administrative areas: North, Central Area, Saida, Tyre and Bekaa. FGDs were conducted in Arabic (spoken dialect) based on a facilitator's guide prepared in advance (see Annex 2). Throughout the course of the interviews, questions were spontaneously altered as seen fit based on comments made by interviewees. Sessions were recorded upon consent and transcribed, so that the testimonies could be used in the analytical text of the assessment report.

Participants discussed the most common psychosocial problems that they have been encountering when working with PRL and PRS, especially over the past 3-4 years (onset of the Syria crisis and its impact on the Palestinian community in Lebanon). Interviewees also described: 1) the methods and mitigations that they use to overcome social/cultural barriers and prevent over-pathologization of psychosocial ailments and 2) the differences between psychosocial ailments that they have found to be common among PRL and the way they differ from the ones encountered by PRS. Stakeholders finally spoke about their current practice norms with special emphasis on non-controllable issues such as coordination gaps and their alternative mitigations, funding constraints, human resources/capacity building challenges. Focus group discussions content allowed us to build a comprehensive 4W (Who is Where, When doing What?) matrix that captures MHPSS/Protection intervention for PRL and PRS, including specific protection concerns.

9 The exposure events were mapped out through the adapted tool along two levels of classification, in order to determine whether the impact of individual or cumulative events would help in explaining the demonstrated symptomatology: 1) violent and non-violent events that predated Syria crisis and 2) events that occurred throughout the Syria crisis and related displacement situation (2011 - onwards)

IV. RESULTS

1. Focus Group Discussions with Stakeholders

Participants discussed the need to identify the strengths, the resilience, the skills and coping mechanisms that so many Palestinian individuals, families and communities have and identify how best to assist and enhance these positive characteristics at the same time as supporting those in crisis appropriately. Taking into consideration on one hand the limitations of the Focus Group Discussions methodology, and on the other the ambiguity of the Palestinian refugees case in Lebanon, the paragraph below presents the key issues reported by interviewed stakeholders during the FGDs held in August 2014 (for list of interviewees, see Annex 3).

The section below represents the content of FGDs, followed by a highlight on cross-cutting issues reported in the course of the FGDs.

1.1 Main Findings of FGDs per Sector Meeting

1.1.1 Mental Health/Psychosocial Wellbeing and Primary Health Care

• Almost one-third of primary health care visits involve behavioral, emotional or developmental concerns.

• Half of mental health visits are to a primary care physician rather than to a specialist.

• People who are experiencing emotional and behavioral problems, or higher levels of psychosocial distress, are more frequent visitors to their primary care provider, and incur higher health care costs (higher somatization complaints).

• Inappropriately triaged cases are hampering the provision of ongoing care (with increasing demand).

• General Practitioners (GPs) tend to under identify cases with mental health problems, with detection being particularly focused on urgent appointments. Only a minority of cases are identified as having a mental health problem by their GP and are referred to a mental health service provider.

• Many families will not address their mental health needs if their health insurance does not offer adequate coverage. Additional obstacles comprise lack of transportation means, financial constraints, and stigmas related to mental health problems.

• Practices need sound triage policies and protocols in place for clinical and non-clinical staff to deal with emergency situations.

• Need to adopt and promulgate written guidelines for staff to ensure that patients are appropriately clinically prioritized.

• Need to provide appropriate training and support tools for all front-line staff.

• Need to improve ongoing collection and analysis of data on case referral and case management.

1.1.2. Mental Health/Psychosocial Wellbeing and Education

• 12-22% of enrolled Palestinian youngsters under age 18 are in need of services due to mental, emotional or behavioral problems broken down as follow:

  • One in five children and adolescents seen as experiencing signs and symptoms of an emotional or/and behavioral disorder during the course of a year.
  • Up to 12% seen as experiencing significant functional impairment [10],
  • Up to 5 % experiencing extreme functional impairment.

• Reported cases of risk behaviors: suicidal attempts, heavy drinking (alcohol and energy drinks), frequent cigarette and shisha use and hallucination pills among enrolled youngsters.

• Referral is not an automated/structured process.

• School counseling work is not an integral part of the education system in every UNRWA school.

• Not every school is provided with a school counselor.

• School counseling services are provided in a limited way by either counseling specialists, or classroom teachers who have such duties added to their typical teaching load.

1.1.3. Mental Health/Psychosocial Wellbeing and LNGOs, IOs, CBOs

Through camp visits, one-to-one meetings and the series of focus group discussions one hundred MHPSS referral and resource networking actors/potential actors were identified (for full list see Annex 4).

The regular 4W exercise allowed us to draw the concentration per activity type through descriptive analysis of the 4W reported programmes. Main findings are summarized in the tables on pages 26 and 27 in order to demonstrate how the activities relate to the IASC Pyramid.

The role and approach of those elements (LNGOs, IOs and CBOs) has radically changed over the last fifteen to twenty years. They are now accepted as significant contributors to the development process of underprivileged areas by government, but also local communities.

Based on the exercise's findings, some interventions managed to leave an impact (e.g. MAP Community Mothers intervention in Ain el Helwe), especially in terms of life changes induced by psychosocial interventions and awareness raised on mental health issues that were stigmatized shadowed in the past. Impacts of such interventions were sometimes related to the specific objectives of the projects (inputs of a single project towards output-outcome), but also according to implementing parties, changes were sometimes unanticipated, most probably caused by interaction or links with other projects and the catalytic effect of the constantly changing environment (complementarity of inputs towards same output-outcomes). The main findings of LNGOs, IOs and CBOs FGDs are summarized below:

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• Attitudinal change within their own service and marked improvement in outreach capacities.

• Self-sufficient referral networks based on informal area network mapping.

• People may not know how to ask for MHPSS related services, may not value network services, or on the contrary may have high expectations.

• Eligibility criteria for individuals to take part in MHPSS programs of partner organizations may not align with profile of clients referred.

• While health facilities and some CBO's accept to provide service to people who just show up, many community-based service providers have different approaches, such as outreach visits.

• While the Ministry of Public Health has a coordinating mechanism to foster a multi-sector response, the Palestinian Refugees population is not included in its Terms of Reference.

• Lack of referral documentation is making it difficult to ensure everyone is fully involved in the referral process, which can result in lost referrals when there are transfers from one facility to another. In addition, traveling to multiple sites or units for services can result in low uptake.

10 The DSM term "functional impairment" is not specifically defined. It is used to mean limitations in the social and occupational spheres of life.

• Need for systemic/automated coordination, information sharing and documentation of referrals in a given geographical area.

• Need to aggregate operating organizations in a platform that provides comprehensive services to meet the needs of indivuduals, their families and their caregivers, within a defined geographical area. The platform will eventually have the following roles: coordination, regular information sharing and documentation of referrals, and establishment of standardized referral processes.

• Need for unification of training curricula in order to avoid waste of resources.

• Need for a holistic MHPSS approach, especially taking into consideration age, gender and vulnerability criteria.

• Need to involve more the Palestinian community in the decision making process and the delivery of services.

• Need to consider sustainability and ownership of any intervention/initiative, as it could undermine the planned outcomes.

It took me months to knock doors introduce myself as Community Mother and build confidence bridges with household wives whose experiences are so similar to mine... My son was victim of a bad gang who spiked his tea... he was about to die... Can you imagine he was arrested when he left ICU... I decided afterwards that I should commit as a mother to prevent such incidents from happening in the future...

- M.A. 52 years

1.1.4. Mental Health/Psychosocial Wellbeing and Community (Community Leaders, Religious Leaders and Factions)

• Even though the evidence is limited, some reports claim that law enforcement officials treat youths arrested for drug or substance abuse with discrimination.

• Inclusive community approach in most of the areas. Demonstrated increase in awareness and active involvement in the provision of multi-faceted support to 'victims' as called of domestic or sexual abuse, arrested minors, drug users etc.

• Psychiatric cases referral facilitated to private/public psychiatric facilities outside the camps (remains however highly costly).

• Some religious leaders are using their platforms to raise awareness and advocate on certain psychosocial, human rights and reproductive health issues (documented practices of several stakeholders).

• Increased demand on psychosocial assistance coupled with sensitivity on some cultural issues.

> **We have records of each and every young drug user in Ain el Helwe camp and they are consciously ready to get help and reintegrate in the community... but it's really expensive and not available in the vicinity... we as leaders, are more than willing to do our best to support any initiative to take those youngsters out of the streets where they are at risk of exploitation and recruitment...**
>
> - M.M.,
> Political Faction,
> Ain el Helwe camp

100 Actors' Reported Programmes Related to the IASC Pyramid

Activity	Reported (%)
Basic services and security / Community and family supports	
1. Information dissemination to the community at large	
1.1. Information on current situation	16
1.2. Psycho-education/ awareness raising	24
1.3. Other information provision	11
2. Supporting the inclusion of social/ psychological considerations in protection, health services, nutrition, food aid, shelter, site planning, or water and sanitation	
2.1. Orientation/ advocacy with aid workers	26
3. Facilitation of conditions for community mobilization, community organization, community ownership or community control over relief activities in general	
3.1. Supporting community-initiated humanitarian activities	27
3.2. Supporting community action through facilitating meetings/ spaces	17
3.3. Other community mobilization	21
4. Strengthening community and family support	
4.1. Supporting community-initiated social support	42
4.2. Strengthening parenting/ family support	14
4.3. Facilitation of community support to vulnerable individuals	43
4.4. Structured social activities	41
4.5. Structured recreational/ creative activities	42
4.6. Early childhood development activities	32
4.7. Facilitation of conditions for indigenous traditional, spiritual or religious supports	7
4.8. Other community/ family support	4
5. Safe spaces	
5.1. Child-friendly spaces	34
5.2. Other safe spaces	31

Focused, non-specialised supports / Specialised services

6. Psychosocial support in education	
6.1. Psychosocial support to teachers at schools	36
6.2. Psychosocial support to pupils at schools	57
6.3. Other psychosocial support in education	21
7. (Case-focused) psychosocial work	
7.1. Psychological First Aid	19
7.2. Linking vulnerable individuals to general humanitarian resources	21
7.3. Other case-focused psychosocial work	21
8. Psychological intervention	
8.1. Basic counseling for individuals	39
8.2. Basic counseling for groups/ families	32
8.3. Interventions for alcohol/ substance use	17
8.4. Psychotherapy	34
8.5. Individual or group psychological debriefing	41
8.6. Other psychological interventions	16
9. Clinical management of mental disorders by non-specialized health care providers	
9.1. Non-pharmacological management	4
9.2. Pharmacological management	5
9.3. Identification, referral, and follow-up by community workers	28
10. Clinical management of mental disorders by specialized health care providers (e.g. psychiatrists, psychiatric nurses, and psychologists working at primary health care/ general/ mental health facilities)	
10.1. Non-pharmacological management	5
10.2. Pharmacological management	21
10.3. Inpatient mental health care	7
10.4. Other specialist clinical management	7

General activities to support MHPSS	
11.1. Situation analysis/ assessment	5
11.2. Training/ orientation	59
11.3. Technical or clinical supervision	16
11.4. Psychosocial support for staff/ volunteers	7
11.5. Research, monitoring and evaluation	25
11.6. Other general activities	8

1.2 Cross-Cutting Issues Reported in the Course of FGDs

1.2.1. Nature of Perceived Trauma

While protracted exile/displacement situations are a growing challenge for the international community, the refugee literature outlines three durable solutions for refugees: voluntary repatriation, local integration, or resettlement in a third location. Designed originally with refugees in mind, these solutions have been extended to IDPs (Guiding Principles on Internal Displacement), but not to the case of Palestinian refugees [11], which can explain the exacerbation of psychosocial uneasiness of Palestinian refugees, especially coupled with the harsh living conditions and restrictions on employment in Lebanon as indicated in the narratives (distrust of the world, chronic sorrow, an ever-present fear of danger, lack of stability and predictability, lack of rootedness and sense of belonging, lack of entitlement, unclear boundaries, overprotectiveness within a narcissist family system).

The narratives of PRS showed a different facet of the traumatic experience. Having fled war atrocities in Syria through harsh displacement conditions, they reported their traumatic experience more acutely. Notwithstanding the complexities and uncertainties of their current living conditions with few options and prospects for the future, they remember their way of life in Syria before it became a hotbed of violent conflict and they forced to flee, as they used to enjoy almost the same rights of Syrian citizens (especially with regards to basic services such as health and education). Despite the current harsh living circumstances, they try to find a reason for having survived while others did not, for which they are thankful.

1.2.2. Transgenerational Effect of Trauma, Coping Mechanisms and Protective Factors

As this part of the study was purely qualitative, its findings cannot be generalized to the entire Palestinian population in Lebanon. However, the exploration of narratives, meanings and subjective perceptions in the context of the Syria crisis and the last episode of war in Gaza (Summer 2014) enabled us to better understand the transgenerational transmission of trauma and resilience in the offspring of Palestinian refugees in Lebanon. Content analysis revealed multiple effects of transgenerational transmission of trauma, which showed to be neither linear nor one-dimensional occurrence. The main conceptual themes are reported below:

• Having grown up in distressing life conditions and demanding societal conditions that are considered significant threats or severe adversities (66 years of alienation in Lebanon).

• The Palestinian community is achieving somehow a positive adaptation despite experiences of significant adversity. The records show that people tend to denounce stressors, disruptive events and/or threats to their psychosocial wellbeing while distancing themselves from their severe impact, using narratives of war and displacement that Palestinian people have been living since 1948 as sort of symbolic cushion.

The theme of a nation united against foreign threats is carried through into certain discourses, presenting war and violence (referring to Syria and Gaza), as sites of victory, heroism and triumph.

• Most of the interviewed families reported a range of affective and emotional symptoms transmitted over generations: distrust of the world, chronic sorrow, an ever-present fear of danger, lack of stability and predictability, lack of rootedness and sense of belonging, attempts to understand and justify survival (PRS), separation anxiety, lack of entitlement, unclear boundaries, experiences of guilt, victimization and submission, and overprotectiveness within a narcissist family system.

• The presence of protective factors, including internal assets and external resources that may be associated with counteracting the effects of risk factors (reliance on political, family, and religious support and political or civic engagement, role of nuclear family and organizational factors such as availability of 'quality services').

• The revival of the Palestinian heritage through art is being used as a possible mean of symbolically working over transgenerational traumatic experiences.

11 Palestinian Refugees in the five UNRWA fields of operation (Gaza, West Bank, Jordan, Syria and Lebanon) are not covered by the mandate of UNHCR.

"Syria crisis and the last episode of war in Gaza reopened our wounds... We were children. I was the oldest. We spent the nights frightened... One day, my father said that the only solution was for us to go to Lebanon... Our parents were convinced it was temporary, a question of two or three weeks, the time it would take for Arab arms to liberate Palestine."

- Abu Ahmed, 72 years

1.2.3. Differentiated Threats to Psychosocial Wellbeing

Data driven from peer-reviewed literature was coded and systematized. After the full literature review, similarities and differences were identified and analyzed. The full range of data ultimately helped to put the data obtained in the focus group discussions in the context of the greater field and confirmed that these data were not merely outliers. Findings are reported in the adjacent Table 2.

> **Those who don't remember the past will always repeat it.**
>
> - Abu Ali, 67 years

Psychosocial wellbeing of PRL and PRS based on information provided by peer-reviewed literature review and stakeholders in FGDs

Group	Threat to psychosocial wellbeing include:
Peer-reviewed literature review	Loss of independence and self-sufficiency
	Loss of security and stability/Hopelessness about the future
	Family separation/re-unification
	Loss of freedom of movement
	Overcrowded places and lack of privacy
	Loss of material possessions
	Loss of connection to family and friends
	Isolation, social exclusion and school bullying
	Abuse
PRL	Heavy competition and fear of losing jobs
	Overwhelmed education and health facilities
	Overcrowded places and lack of privacy
	Loss of independence and self-sufficiency
	Hopelessness about the future
	Loss of value of education and professional experience
	Lack of trust in the system
	Abuse
PRS	Displacement related issues that are still very recent
	Loss of status and rights they enjoyed in Syria before the crisis
	Overcrowded places and lack of privacy
	Discrimination prejudice and indications from nationals that they are unwanted in their new home or workplace.
	Constant worry and uncertainty about legal and immigration procedures and policies, loss of easy access to safe haven
	Family separation/re-unification
	Forced dependence on the system and lack of autonomy
	Loss of self-sufficiency
	Loss of privacy and stability (the wish for one's own residence)
	Conflicts arising between ethnic/national groups living in close proximity
	Loss of freedom of movement
	Acculturation difficulties
	Hopelessness and uncertainty about the future
	Loss of material possessions
	Loss of value of education and professional experience
	Loss of connection to family and friends
	Lack of trust in the system
	Isolation, social exclusion, bullying and abuse

2. Field Survey

2.1 Type of Exposure Events

Exposure events were mapped out through the adapted tool along two levels of classification, in order to determine whether the impact of individual or cumulative events would help in explaining the demonstrated symptomatology: 1) violent and non-violent events that predated Syria crisis and 2) events that occurred throughout the Syria crisis and related displacement situation (2011 – onwards).

The adapted scale comprised in addition to socio-demographic data: One Likert Scale (exposure to Gaza war related news), 12 binary (true/false) questions related to exposure to stressors since the onset of Syria crisis and 7 binary questions related to exposure to personal experience stressors before the onset of Syria crisis. The average number of exposure items per household was 11.

63% of respondents followed Gaza news 6-8 hours/day (Summer 2014).

Items with the highest percentages among PRS before Syria crisis were non-conflict physical assault (38.7%) and deprivation (34%), whereas witnessing war-related incidents and related losses, loss of freedom of movement and social exclusion/bullying scored the highest percentage since the onset of the Syria crisis (respectively 67%, 65% and 62%). As for PRL, items with the highest percentages before Syria crisis were deprivation/restriction on employment opportunities (88.7%) and deprivation (74%), whereas socio-economic deprivation scored the highest percentage since the onset of the Syria crisis (86%).

Other often-reported traumatic events included material losses reported by 69.3%; witnessed injury with a weapon, reported by 47.7%; experiencing crossfire or sniper attacks, reported by 30.3%, personal experience of non-conflict violence incidents 42%.

The percentages overlap as most respondents experienced multiple traumatic events. As for exposure levels, they can be categorized as follows:

Exposure levels before the Syria crisis

PRL 21% scored low
46% scored mild
33% scored high

PRS 41% scored low
37% scored mild
22 % scored high

Exposure levels since the onset of the Syria crisis

PRL 14% scored low
31% scored mild
55% scored high

PRS 12% scored low
56% scored mild
32% scored high

2.2 Psychosocial Wellbeing

Mental health symptoms reported by respondents as varying between 'always' and 'a little bit' in the two weeks preceding the assessment exercise [12]:

• 68.4% felt so angry that nothing could calm them down.

• 38.8% felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset.

• 26.3% felt uninterested in things that they used to like.

• 24.2% felt so hopeless that they did not want to carry on living.

• 22.7% felt severely upset that they tried to avoid places, people, conversations or activities that reminded them of such events.

• 15.1% felt so afraid that nothing could calm them down.

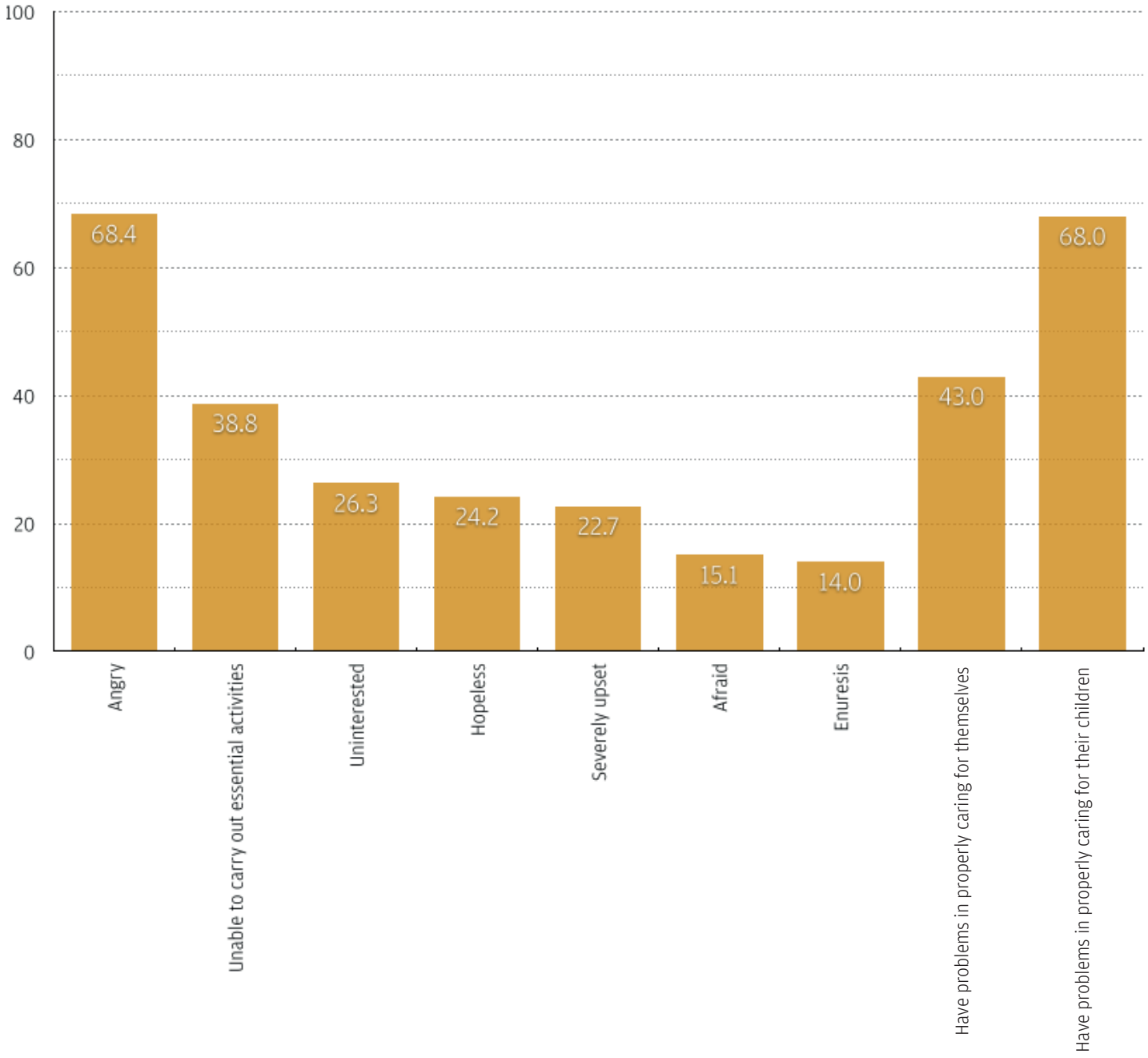
• 14% of households with children aged 5-12 reported nocturnal enuresis (bedwetting) at least twice in the 2 weeks preceding the study. Most of these children (74%) presented this problem one year ago.

• 43% of family members reported problems in properly caring for themselves due to feeling distressed, disturbed, or upset.

• 68% of family members (21% of the total population) reported problems in properly caring for their children due to feeling distressed, disturbed or upset.

• Problematic emotional, behavioral and psychosomatic complaints: panic (21%), sadness (74%), tension (76%), anxiety (68%), tiredness (86%), sleep disorders (56%), weight disorders (66%), appetite changes (71%), aggressive behavior (53%), social withdrawal (46%), nightmares (46%), somatic complaints (76%), impulsive cry (46%), hyperactivity (62%), death ideas (12%), learning problems (69%), loss of control (34%), finger sucking (61%), enuresis (14%) and bruxism (11%).

12 T-test showed no statistically significant differences among PRL and PRS groups.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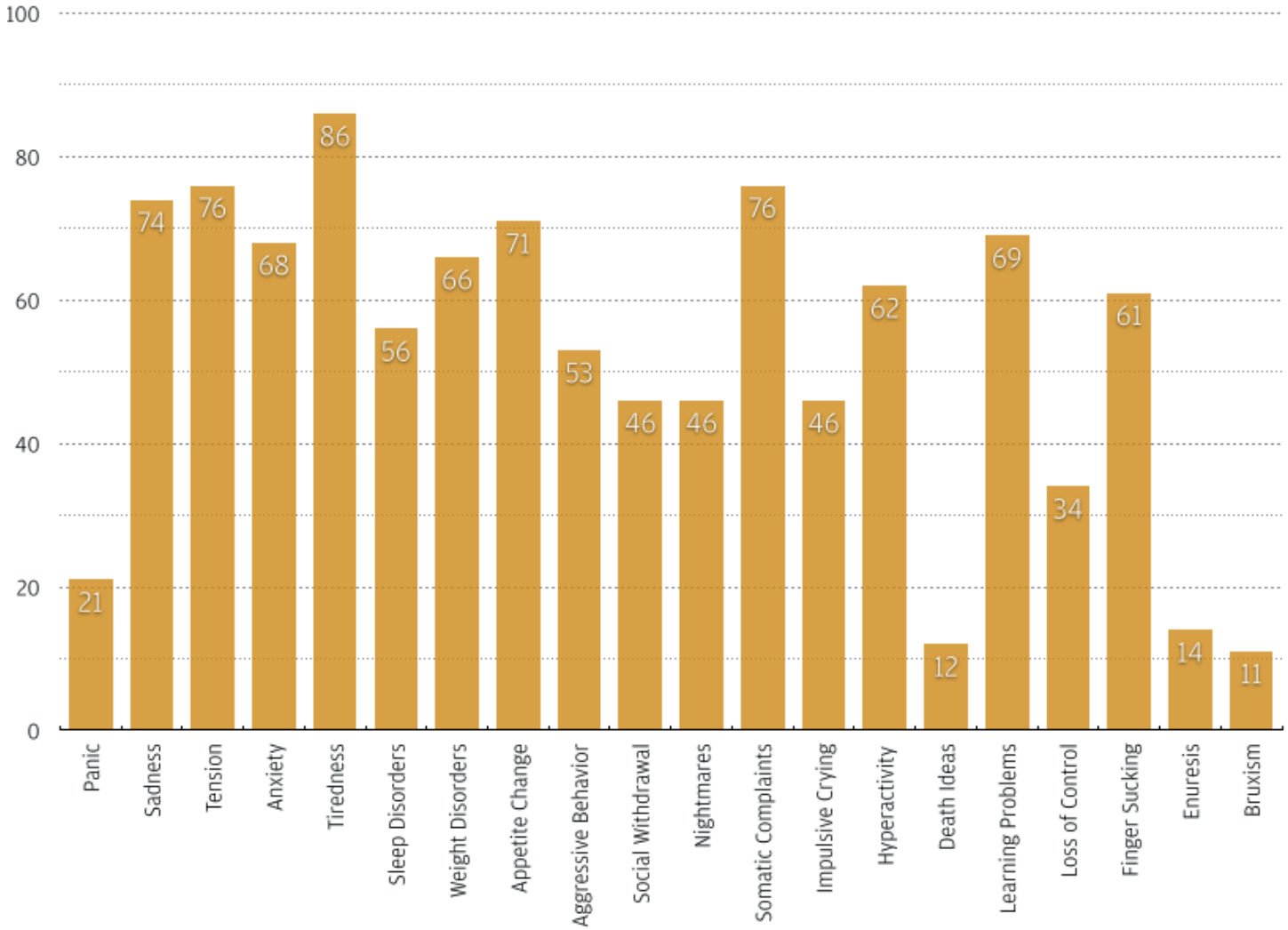
Have problems in properly caring for their children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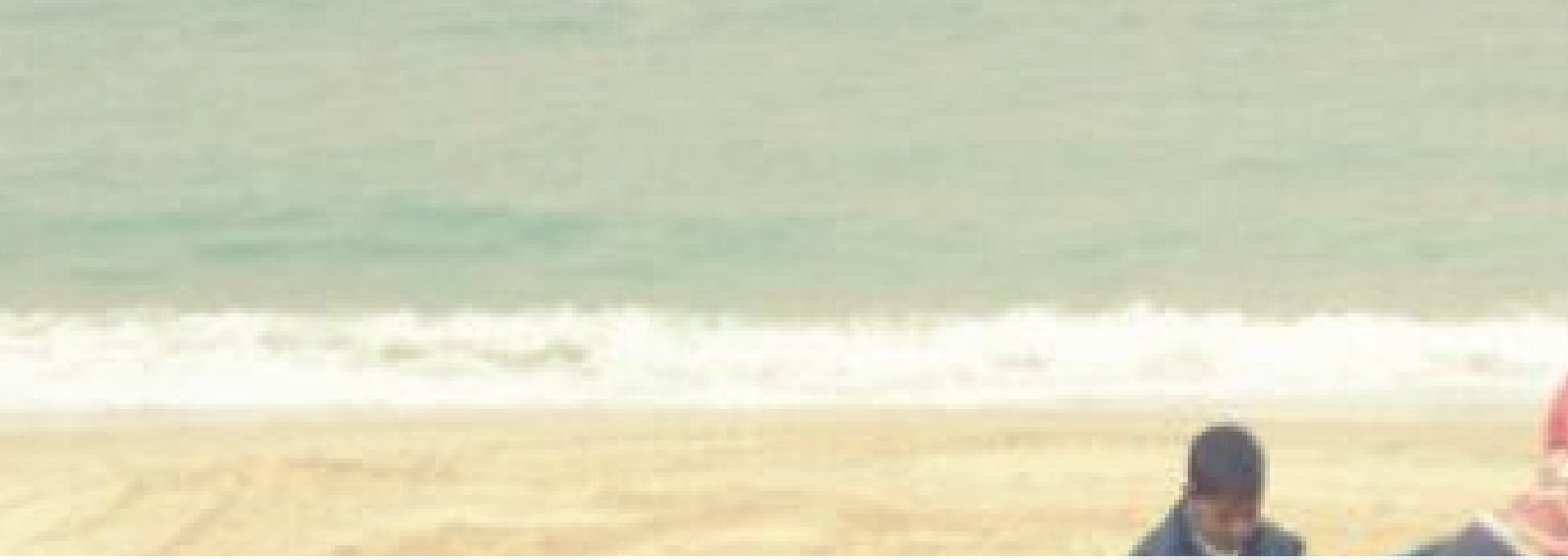
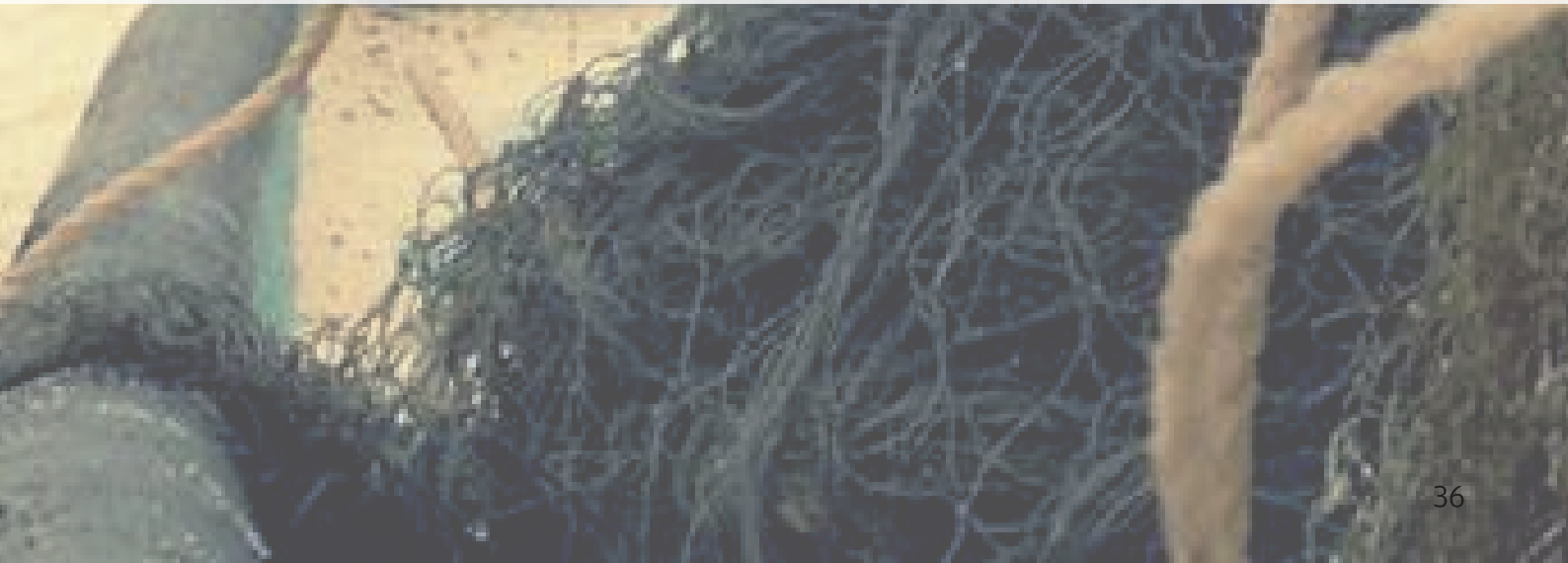
Impulsive Crying
Hyperactivity
Death Ideas
Learning Problems
Loss of Control
Finger Sucking
Enuresis
Bruxism

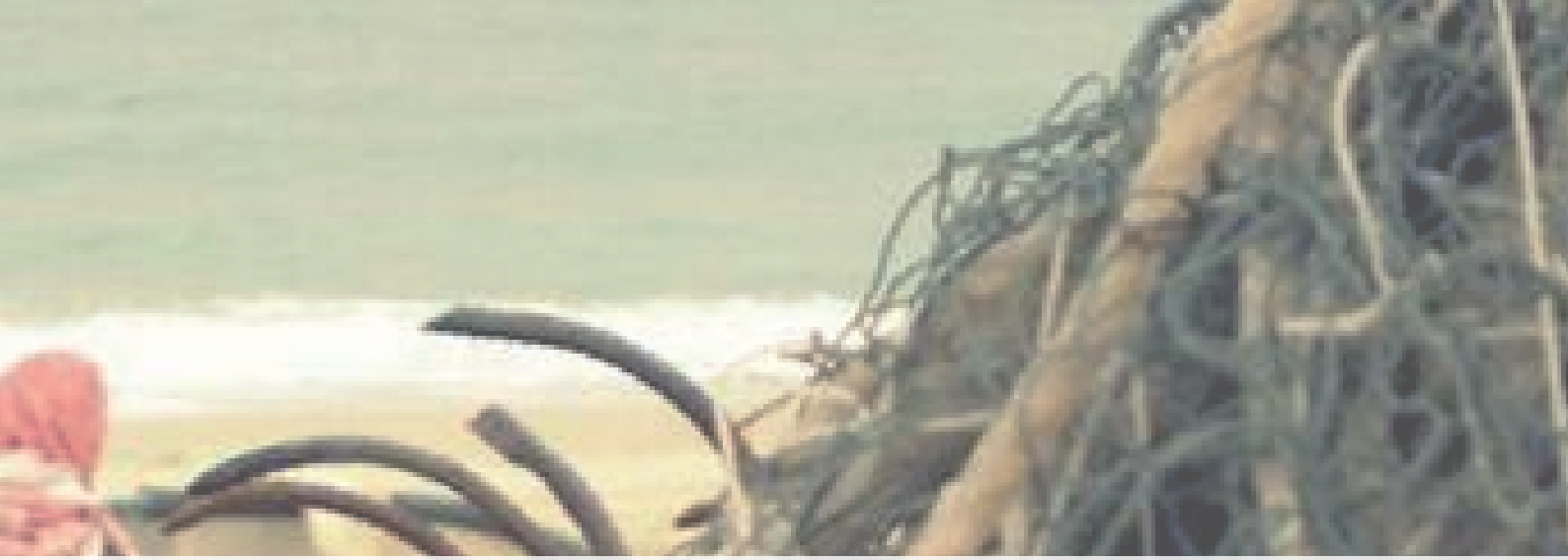


V. DISCUSSION & RECOMMENDATIONS

The current assessment is a twofold exercise designed to monitor the mental health and psychosocial wellbeing of Palestinian refugees in Lebanon. The results of both the qualitative and the quantitative part showed that most people have expressed either psychological, emotional, or behavioral symptoms, as delineated in the recent literature of refugees and war.

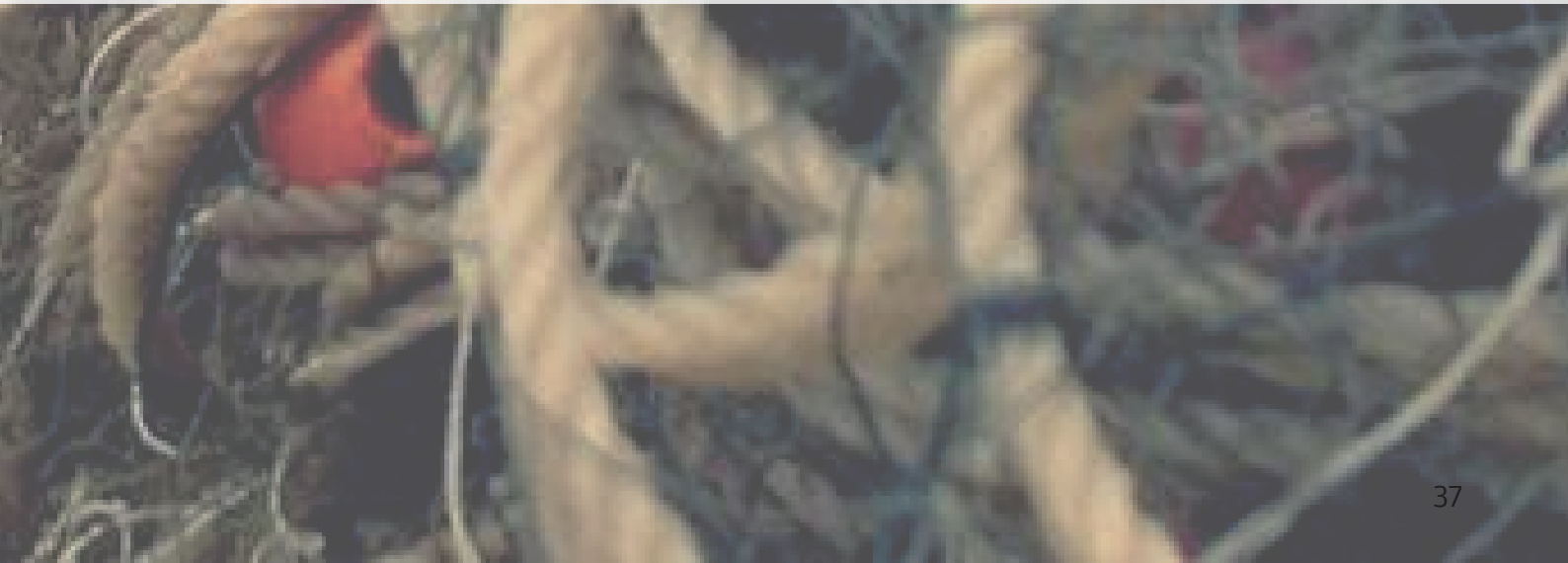
Away from a trauma-centered or symptom-focused exercise, the present assessment adopted a community perspective, where the social, cultural and political specificities of the Palestinian population in Lebanon were taken into account. A transactional and intergenerational dimension was adopted, as well, since family is considered in such an environment as an influential and dynamic context of cultural and social values and practices, which is particularly essential to bridge the psychological and the socio-cultural dimensions, but also to enhance understanding on resilience and identify risk and protective factors.





One of the most striking results was the absence of significant statistical differences in reported symptoms among PRL and PRS groups. The considerable psychosocial uneasiness was compounded in both groups by legitimate concerns about their protection rights, basic rights, safety concerns and significant financial consequences.

On the other hand, the transgenerational effect of trauma traced in the collected narratives provided a temporal framework for examining the life course of this population exposed to decades of alienation, with emphasis at particular exposure points in time. However, the differentiated aspect was the nature of the traumatic experience. As demonstrated in the FGDs, PRS reported their traumatic experiences more acutely in their narratives. Notwithstanding the complexities and uncertainties of their current living conditions with few options and prospects for the future, they remember their way of life in Syria before it became a hotbed of violent conflict and they forced to flee, as they used to enjoy almost the same rights of Syrian citizens (especially with regards to basic services such as health and education).



Despite the current harsh living circumstances, they try to find a reason for having survived while others did not, for which they are thankful. On the other hand, PRL accounts reflected the shadow of 66 years of alienation and deprivation, which was only exacerbated by the Syria crisis and its impact on the Palestinian communities in Lebanon. This is consistent with the refugee literature which describes the chronological phases of the forced migration process, in which the accumulation of a myriad of phase specific risk factors challenges the mental health of refugees (Fazel and Stein, 2002; Lustig et al., 2004; Papadopoulos, 2001).

Several researchers have argued the limitations of the mono-causal perspective on trauma, given the dynamic interplay between pre- and post- displacement stressors that operate in a complex mode (Silove and Ekblad, 2002).

It is commonly believed that the Palestinian refugees living in Lebanon face more hardship and are less integrated into the host country communities than those refugees living in any other country in the Middle East. With regards to the governance of Palestinian refugee camps, a careful review of country facts may be revealing. In Syria and Jordan, the state closely controls camps. In contrast to this classical state control over slum areas (including camps), the situation in Lebanon is radically different: There is a network of complex power structures composed of popular committees, a security committee, UNRWA camp service officers, notables, political factions, the Palestinian Liberation Organization (PLO)'s popular unions and organizations (workers, women, engineers, etc), Community-Based Organizations (CBOs), NGOs and the Palestinian Scholars' League (imam coalition close to Islamic Resistant Movement-Hamas).

These forces vary in importance from camp to camp and from area to area. In each camp, leaders impose measures, and these in turn have a habit of changing; a consequence of a constantly shifting balance of power between these different groups. The Popular Committee, however, stands out as the most important local governing body in Palestinian Camps in Lebanon.

With the exponentially increasing pressure on the Palestinian communities in Lebanon, the focus of mental health and psychosocial support providers should go beyond the 'protection' and 'assistance' scopes to seize the issue of bringing 'sustainable' and 'community owned' stability in such a fragile context.

Based on the positive coping mechanisms identified in the present exercise (pro-social bonding, revival of Palestinian heritage…) and the protective factors including internal assets and external resources that may be associated with counteracting the effects of risk factors (reliance on political, family, and religious support and political or civic engagement, role of nuclear family and organizational factors such as availability of 'quality services'), programs such as psychological rehabilitation and reintegration of ex-mobilized youth; addressing gender and age inequalities through women and youth empowerment and capacity building and rehabilitation and reintegration of marginalized youth, may lead to less violence, greater trust in the system and the future, and greater community satisfaction.

Based on the present assessment, networking would be essential for understanding and addressing the needs of local areas. This will involve establishing and maintaining relations of trust with relevant members in an area of catchment, including service providers, community and spiritual leaders and representatives of vulnerable groups. This effort is a

cornerstone for short-, mid- and long-term perspectives, for it to be beneficial to all parties. It is particularly useful to:
1) mobilize and support local self-help mechanisms; 2) increase the referral capacity of a given project by connecting it to existing local care systems (i.e. women's groups, income-generating projects) and 3) support "ownership" and "sustainability" in local communities through their participatory involvement in the decision making and implementation process, given that local informants can be deemed helpful in developing culturally and even politically accepted approaches for delivery of support. Participatory interventions regarding area potential shall be built upon the existing networking options (past successful experiences, relying on local activists/ volunteers capacities).

The below suggested psychosocial interventions focusing on community stabilization were informed by the assessment results and the examination of literature.

1. On the Community Level

• Facilitate community identification of priority actions using participatory methods.

• Creation of self-help groups.

• Support community-based recreational and ritual activities.

• Support oral history, life stories and revival of Palestinian heritage to constructively improve the sense of belonging, and discourage negative ways of coping (specifically discouraging coping through use of alcohol and other substances).

• Provide psycho-education to reduce people's anxieties, through the provision of information about what is happening, services, missing persons, security. This will strengthen existing coping mechanisms, to reassurance and normalization by systematically providing information on common stress reactions to general populations. Those reactions might be experienced without any knowledge or understanding of their origin.

• Support occupational activities such as for instance camp cleaning, jointly cooking, teaching children, laboring the land, repairing or maintaining buildings and machinery and caring for vulnerable people that are useful for increasing feelings of ownership and improving self-control.

• Provide basic psychological support and social support to children to stimulate positive coping mechanisms. This can be facilitated in schools and health centers.

• Allocate resources for marginalized groups in order to prevent relapse of violence. People at-risk (ex-combatants, drug users, delinquents, prostitutes…) should be identified, registered for tracing and follow-up, and provided with psychosocial rehabilitation (individual and group counseling, conflict resolution and mediation, life skills and anger management skills, psychiatric follow-up), social re-integration and economic empowerment through connection to income-generating models (based on community sensitization and participation as well). Schools, clubs and vocational training centers identified in the camps are potential niches.

• Rely on identified/existing communities' social fabric to support the regeneration and revitalization of people's protective mechanisms. Existing grassroot initiatives need assistance and stimulation (through systemization of their work) – even on small scale – since they are currently providing vital practical support in their communities.

• Support to existing innovative local cultural groups such as theatre groups or folk/ singing companies can do a great deal to improve spirits and community cohesion.

2. On the System Level

• Stretch from crisis/relief intervention to development mode to sustain 'stabilization effects' of interventions.

• Systemize integration of mental health services and psychosocial support in the (primary) health care system and the education system.

• Reduce administrative and financial barriers to access and coordination.

• Ensure that policies are in place to support effective, community-based practice. Ensure there are policies at regional and national level to support holistic mental health and psychosocial programs, organize all layers of the intervention pyramid, and limit harmful programmes such as counseling by poorly trained, unsupervised counsellors.

• Support integration of early assessments and referral mechanisms in education, health and social services domains.

• Support collaborative efforts across community-serving systems (PHC, schools, juvenile justice, case management and more).

• Champion the cause of prevention (i.e. nurse-family partnering or community mothers initiatives).

• Support decision making for clinical and non–clinical staff through establishment of standardized triage protocols and screening tools.

• Explore school resources and elaboration of a comprehensive multifaceted and cohesive continuum of school-community interventions to address barriers to psychosocial wellbeing, learning and health development (co-located if possible).

• Provide capacity building, training and increase sustainability for existing CBOs, in addition to increase of grants available for CBOs.

VI. CONCLUSION

After more than six decades of forced displacement, Palestinian refugees in Lebanon find themselves bearing the burden of years of deprivation and alienation. As shown in the recent literature, their situation has been exponentially exacerbated since the onset of the Syria crisis and its subsequent impact on Lebanon and ethnic/national communities living there.

With the additional load of up to 50,000 PRS and thousands of Syrian refugees (lack of documentation on exact number) fleeing Syria to settle in Palestinian camps and gatherings, agencies found themselves countering new emergency liabilities, with more budget cuts and more evident coordination gaps, making it impossible to meet the long list of needs: It starts from the most evident needs such as basic services, protection rights, right to work, expansion of social services and more.

When it comes to the mental health and psychosocial wellbeing of local Palestinian communities, whether in camps or gatherings, international organizations, donors, community based-organizations, local capacities should start by joining together to help bridge the gap, decrease costs and increase 'sustainable' and 'community owned' benefits, while putting reduction of multiple aspects of violence on their planning agenda, and consequently the post-2015 development agenda especially for fragile or conflict-affected countries.

ANNEXES

ANNEX 1
References

ANNEX 2
Focus Group Discussion Facilitator's Guide

ANNEX 3
List of Interviewed Stakeholders

ANNEX 4
List of Identified MHPSS Referral
and Resource Networking

ANNEX 5
Survey Tools

ANNEX 1

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ANNEX 2

Focus Group Discussion Facilitator's Guide

Good morning and welcome. Thanks for taking the time to join our discussion about Mental Health and Psychosocial Services Benefiting Palestinian Refugees in Lebanon. My name is Cosette Maiky and I will serve as the moderator for today's focus group discussion. The purpose of today's discussion is to get information from you about the challenges encountered by individuals, communities and service providers especially during the past 3-4 years (Syria crisis and its implication/impact on the Palestinian communities in Lebanon), for us all to draw better practices in the future. You were invited because you were identified as active stakeholder in the domain. There are no right or wrong answers to the questions I am about to ask. Please feel free to share your point of view even if it differs from what others have said. We're interested in hearing from each of you. We are tape recording the session because we don't want to miss any of your comments, but no names will be included in any reports.

Opening questions
I'd like you to talk about the perceived mental health and psychosocial needs of Palestinian communities in Lebanon particularly since 2011. Tell me more about how you've been involved in this domain and what are the current needs trends and major response gaps?

Key questions
(perception of relevance, efficiency, effectiveness, coordination and sustainability of current action)
• Are actions relevant to people's needs?
• Do actions line with agencies' regular programs (before Syria crisis), or adapting to the emergency mode?
• Are actions integrated with any different/complementary type of support/assistance?
• How are existing referral networks working? Any available mapping or coordination?
• Did you manage to adapt your approach to your current/changing context/circumstances?
• What are the major constraints/challenges either in outreach or accessibility?
• How well your staff was/is prepared and responsive to the occurring situation and the workload in their catchment area?
• Are there any special protection considerations for vulnerable groups (women headed households, elderly, disabled, children, delinquent minors, drug users….)

Impact questions
In what way current conflict and non-conflict stressors are impacting people's lives? And what were the repercussions on your workload as stakeholders (direct and indirect)?

Ending questions
Is there anything we should have talked about, but didn't?

ANNEX 3

List of Interviewed Stakeholders

1 Al Baraem Association
2 Al-Karama Association
3 Al-Khoutwa Association
4 Al-Shahid Organization
5 Al-Shorouq Association
6 Al-Tadamun Social and Cultural Association
7 Arab Women's Association of Palestine
8 Association for the Development of Palestinian Camps (INAACH)
9 Child Protection Network
10 Danish Red Cross (DRC)
11 DARI Recreation and Counseling Centre for Families
12 Disability Union Association
13 Early Intervention Unit (EIU-TYRE)
14 Ghassan Kanafani Cultural Foundation (GKCF)
15 Hamza Medical Centre, Buss
16 Hana Association
17 Handicap International- Development action team (HI-DAD)
18 Human Development Centre
19 International Medical Corps (IMC)
20 International Rescue committee (IRC)
21 KAFA (enough) violence and exploitation
22 Medecins sans Frontières (MSF)
23 Medical Aid for Palestinians (MAG)
24 Mercy Corps
25 Nabaa Association
26 Nachet Association
27 Najdeh Association
28 National Association for Medical Social Care (NAMSC)
29 National Institution for Social Care & Vocational Training (NISCVT) - BEIT ATFAL ASSUMOUD –
30 National Platform for Palestine Martyrs
31 NGOs Platform of Saida
32 Norwegian People's Aid (NPA)
33 Norwegian Refugee Council (NRC)
34 Oxfam Quebec
35 Palestinian Arab Women League (PAWL)
36 Palestinian Factions in the five administrative areas
37 Palestinian Red Crescent
38 Palestinian Return Centre
39 Palestinian Scouts and Guides Association
40 Palestinian Youth Movement
41 Popular Aid for Relief and Development (PARD)
42 PRS Committee in Lebanon
43 PURSUE, Ltd.
44 Sanabel Association for Relief and Development
45 Save the Children
46 Sawaed Association for Relief and Development (SARD)
47 Social Communication Centre (Ajyal)
48 Terre des Hommes (TDH)
49 United Nations Agency for Relief and Work of Palestine Refugees in the Near East
50 Vocational Training Centre (VTC)
51 Welfare Association
52 Women Program Centre
53 Women's Humanitarian Organization
54 Zaytouna Association

ANNEX 4

List of Identified MHPSS Referral and Resource Networking [13]

1 Active Ageing House/Society Support Organization
2 Al-Amal Society for Development & Social Care
3 Al-Baraem Association
4 Al-Ghad Social and Cultural Association
5 Al-Hanan Centre for Palestinian Disabled
6 Al-Jaleel Organization for Development
7 Al-Karama Centre for Palestinian Disabled
8 Al-Khoutwa Association
9 Al-Sabeel Charitable Foundation
10 Al-Shahid Organization
11 Al-Shorouq Association
12 Al-Tadamun Association
13 AMEL Association International
14 Arab Resource Center for Popular Arts (ARCPA)
15 Arab Resource Center for Popular Arts
16 Arab Women's Association of Palestine
17 Association for Protection of Juveniles in Lebanon (UPEL)
18 Association for the Development of Palestinian Camps (INAACH)
19 Association Najdeh
20 Blue Mission Foundation
21 Caritas Lebanon Migrants Center
22 Child Protection Network
23 Children and Youth Centre (CYC)
24 Children of Al-Jaleel Centre
25 Community Based Rehabilitation
26 Community Development Centre (CDC)
27 Danish Red Cross (DRC) and Italian Red Cross (ITRC)
28 Dar Al Amal Aged Home
29 DARI Recreation and Counseling Centre for Families
30 Disability Union Association
31 Early Intervention Unit (EIU-TYRE)
32 El Eslah Charitable Association
33 Fraternity Association for Educational and Social Work
34 General Union of Palestinian Women (GUPW)
35 GhassanKanafani Cultural Foundation (GKCF)
36 Hamza Medical Centre, Buss
37 Hana Association
38 Handicap International- Development action team (HI-DAD)
39 Human Appeal International
40 Imam Sadr Foundation (ISF)
41 International Federation of Red Cross and Red Crescent Societies
42 International Medical Corps (IMC)
43 International Organization for Migration (IOM)
44 International Rescue committee (IRC)
45 Irshad&Islah Beneficiary Association
46 Islamic Care Committee
47 Joint Christian Committee (JCC)
48 KAFA (enough) violence and exploitation
49 Lebanon Health Care Society
50 Medecins du Monde France-(MdM France)
51 Medecins sans Frontières (MSF)
52 Medecins Sans Frontieres Operational Center Brussels (MSFOCB)
53 Medical Aid for Palestinians (MAG)
54 Mercy Corps
55 Mosan Centre
56 Mouvement Social
57 Nabaa Association
58 Nachit Association
59 National Association for Vocational Training and Social services (NAVTSS)
60 National Association of Medical Social Care (NAMSC)
61 National Institution for Social Care & Vocational Training (NISCVT) - BEIT ATFAL ASSUMOUD -
62 National Platform for Palestine Martyrs
63 NGOs Platform of Saida
64 Norwegian People's Aid (NPA)
65 Norwegian Refugee Council (NRC)
66 Nowat (Al-Tadamon Social Centre)
67 Orphans House Saida
68 Oum el Nour Organization
69 Oxfam Quebec
70 Palestine's Children Relief Fund
71 Palestinian Arab Women League (PAWL)
72 Palestinian Children Relief Foundation
73 Palestinian Children Youth Institution (PCYI)

74 Palestinian Red Crescent Society
75 Palestinian Return Centre
76 Palestinian Scouts and Guides Association
77 Palestinian Youth Movement
78 Popular Aid for Relief and Development (PARD)
79 PURSUE, Ltd.
80 RESTART Center for rehabilitation of victims of torture and violence.
81 Right to Play
82 Sanabel Association for Relief and Development
83 Save the Children
84 Sawaed Association for Relief and Development (SARD)
85 Social Communication Centre (Ajyal)
86 Social Welfare Association
87 Soukoun, Lebanese Addiction Centre
88 Tadamun and Tanmieh
89 Takaful for Child Welfare
90 Terre des Hommes (TDH)
91 Unite Lebanon Youth Project
92 United Nations Agency for Relief and Work of Palestine Refugees in the Near East (UNRWA)
93 United Nations Children's Fund (UNICEF)
94 Welfare Association
95 Women Program Centre
96 Women's Humanitarian Organization
97 World Vision International (WVI)
98 Young Men's Christian Association
99 Young Women's Christian Association
100 Zaytouna Association

13 Psychosocial services available for PRL and PRS based on information provided by peer-reviewed literature review and stakeholders in FGDs

ANNEX 5

Survey Tools

ASSESSING MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND RESOURCES

Toolkit for humanitarian settings

World Health Organization

UNHCR The UN Refugee Agency

يهدف هذا الاستقصاء إلى التعرف على الأحوال النفسية والاجتماعية للفلسطينيين المقيمين في لبنان، لن يطلع أحد على الأجوبة وسوف تستعمل لأغراض إحصائية وعلمية فقط. يرجى الإجابة على **جميع الأسئلة**، إما بكتابة ما يلزم أو بوضع دائرة حول الجواب المناسب. و شكرًا

خلال العدوان على غزة ٢٠١٤، كم ساعة تقريباً كنت تقضي في متابعة الأخبار التي كانت تغطي الحرب (التلفزيون، الراديو، الإنترنت والصحف). رجاءً ضع دائرة حول خيار واحد فقط:

١. ولا ساعة في اليوم ٢. تقريباً ١-٢ ساعة في اليوم ٣. تقريباً ٣-٥ ساعات في اليوم ٤. تقريباً ٦-٨ ساعات في اليوم
٥. أكثر من ٨ ساعات في اليوم

هذه لائحة ببعض الأمور التي قد تكون واجهتك في لبنان منذ اندلاع الأزمة في سوريا (رجاءً ضع دائرة حول الجواب المناسب).					
تابعت الأخبار بشكل دقيق عبر الاستماع إلى أحاديث الأهل والأصدقاء؟	نعم	كلا	تعرّضت أملاكك للأضرار (البيت، السيارة، الخ.)؟	نعم	كلا
شاهدت صوراً حيّة عن الحرب عبر وسائل الإعلام (التلفزيون، الجريدة، الإنترنت)؟	نعم	كلا	عانيت من نقص في الماء والطعام؟	نعم	كلا
سمعت أصوات قصف جوي؟	نعم	كلا	عانيت من نقص في الوقود والكهرباء؟	نعم	كلا
عانيت اضطراباً في النوم بسبب تحليق الطائرات والغارات الجويّة؟	نعم	كلا	عانيت من نقص في الأدوية الضرورية؟	نعم	كلا
افترقت عن أسرتك؟	نعم	كلا	أصبح منزلك غير صالح للسكن؟	نعم	كلا
رأيت جريحاً؟	نعم	كلا	خسرت أسرتك مدخولها؟	نعم	كلا
رأيت قتلى؟	نعم	كلا	انقطع اتصالك بعائلتك؟	نعم	كلا
فقدت أحد أفراد أسرتك؟	نعم	كلا	اضطررت لمغادرة منزلك؟	نعم	كلا
اضطررت إلى النزوح إلى منطقة أخرى؟ مخيم آخر أو بلد آخر؟ متى وأين	نعم	كلا	أصبت بجراح؟	نعم	كلا
أقمت في مدرسة مع النازحين؟ أو في الشارع أو الحديقة مع النازحين؟	نعم	كلا	أصيبَ أحد أقاربك؟	نعم	كلا
عانيت من عوائق تحد من إمكانية تحركك بسهولة (من وإلى البلد أو ضمن البلد نفسه)؟	نعم	كلا	أحداث إضافية حصلت لك خلال الأزمة في سوريا بت. حدّد: _____		
عانيت من أي شكل من أشكال التمييز العنصري من المجتمع المضيف؟	نعم	كلا			

هل تعرضت شخصياً، في الماضي قبل الأزمة في سوريا، إلى الحوادث التالية:					
السرقة؟	نعم	كلا	إصابة جسدية؟	نعم	كلا
اعتداء جسدي؟	نعم	كلا	مرض شديد؟	نعم	كلا
اعتداءات عسكرية أو حربية؟	نعم	كلا	تعرض أحد أفراد أسرتك للأسر؟	نعم	كلا
حادث سيارة مروع أدى إلى إصابة أحد الأشخاص أو وفاته؟	نعم	كلا	تشهد أحد أفراد أسرتك؟	نعم	كلا
أصيبَ أحد أفراد أسرتك إصابة قاتلة؟	نعم	كلا	وفاة مفاجئة لأحد أفراد أسرتك؟	نعم	كلا
وفاة مفاجئة لأحد أصدقائك؟	نعم	كلا	عانيت من أي شكل من أشكال التمييز العنصري من المجتمع المضيف؟	نعم	كلا
عانيت من عوائق تحد من إمكانية تحركك بسهولة (من وإلى البلد أو ضمن البلد نفسه)؟	نعم	كلا	حوادث أخرى قبل الأزمة، حدّد: _____		

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