



# Assessing the Need for Mental Health Services in UNRWA Clinics in Lebanon for Palestinian Refugees From Syria

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## **Title Page**

**Scholarly Report submitted in partial fulfillment of the MD Degree at Harvard Medical School**

**Date:** 10 April 2017

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**Scholarly Report Title:** Assessing the Need for Mental Health Services in UNRWA Clinics in Lebanon for Palestinian Refugees from Syria (HKS PAE Title: Bringing Mental Health Services to Palestinian Refugees From Syria)

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## **Abstract**

**TITLE:** Assessing the Need for Mental Health Services in UNRWA Clinics in Lebanon for Palestinian Refugees from Syria

Samia Osman, BS, BA

**Purpose:** Since the Syrian Civil War broke out in 2011, Palestinian refugees from Syria (PRS) have been forced to relocate to United Nations Relief and Work Agency (UNWRA) refugee camps in neighboring countries. As there is no mental health diagnosis made, it is unknown as to the extent of untreated patients in this vulnerable population. The purpose of the project is to assess the needs for mental health services particularly to stress-related disorders.

**Methods:** The Primary Health Questionnaire 9 (PHQ-9) and the Clinician-administrated PTSD scale (CAPS) were used to assess depression/anxiety disorder and Post Traumatic Stress Disorder (PTSD). 224 PRS were screened. Of those, 40 completed a more in-depth interview. 42 UNRWA primary healthcare providers were surveyed to assess barriers to providing mental healthcare services.

**Results:** The results show that 92% of PRS demonstrated mild to severe depression symptoms and 85% demonstrated mild to severe PTSD symptoms. UNRWA healthcare providers tend to underestimate the frequency of significant psychological distress among their patients and expressed willingness to receive more training on mental illness identification and treatment. There is currently no structured mental health service available for PRS nor any physical or mental service for victims of sexual assault provided in the UNRWA clinics. While healthcare providers believe women and children are most vulnerable to psychological distress, the prevalence of psychological distress among adult male and children remains unknown. Lastly, systematic factors, such as crowdedness in the camp and discrimination, are cited as most common exacerbating agents to psychological distress.

**Conclusions:** This research project concludes that there is a dire need for mental health services in the PRS population, and UNRWA can start laying the groundwork for providing mental

healthcare by establishing a task force and by forging partnerships with other NGOs and cross-sector agencies.



# BRINGING MENTAL HEALTH SERVICES TO PALESTINIAN REFUGEES FROM SYRIA

A Plea for Getting All Patients Treated

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Professors Julie Boatright Wilson (HKS, PAC Seminar Leader), Dr. Emma Morton-Eggleston (HMS 2012-2014), Dr. Myron Belfer (HMS, 2016)

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Finally, I would like to express my deepest admiration for the healthcare providers at UNRWA taking care of the most vulnerable patients in the region. It was my sincere pleasure to meet and speak with some of them in the course of completing this work.

## Executive Summary

Since the Syrian Civil War broke out in 2011, the international community has been tackling the Syrian refugee crisis. Yet, one minority refugee group is struggling to receive the attention and assistance that it also requires – Palestinian refugees relocated to or born in Syria, or the Twice Refugees. Palestinian refugees from Syria (PRS) are those who were forced to flee their homeland Palestine in the mid-20<sup>th</sup> century and sought refuge in Syria, and their descendants who were born in Syria. Before the Syrian conflict broke out, PRS were given legal status to live and work in Syria. They were, and still are, under the care of the United Nations Relief and Works Agency (UNRWA), which was established decades ago to provide vital services for the well-being, human development and protection of Palestine refugees.

Yet, since 2011, PRS, without a Syrian passport, found themselves to be an invisible minority in the complicated refugee situation. When resources are mainly going towards bigger refugee organizations, UNRWA are scrambling for resources to provide services for PRS relocating to UNRWA refugee camps in neighboring countries. It is not difficult to imagine that PRS has undergone immense trauma – physical, psychological, or both. Yet as resources are limited and an unforgiving social stigma on mental illnesses, psychological and psychiatric healthcare has not given the priority it deserves. Without proper healthcare that encompasses mental health services, PRS cannot fully function or be integrated into the new society.

As the largest, and often time, only, humanitarian agency that provides healthcare to Palestinian refugees in the Middle East region, UNRWA seeks to mitigate the lack of proper mental health services that the PRS need. Therefore, this paper is prepared for UNRWA to address the following question:

**How can the United Nations Relief and Work Agency effectively provide services that meet the mental health needs of the Palestinian Refugees from Syria?**

### Approach

To answer the main question posted above, this Policy Analysis Exercise first explored the following objectives during the research stage.

- *Identify the urgency for mental health services by screening for unattended psychological symptoms among PRS*
- *Identify mental health services, if any, that are available Palestinian refugees from Syria (PRS)*
- *Assess attitude towards mental health needs in the refugee population, the drivers of those needs, and populations at particular risk*
- *Identify the barriers in providing mental health services*



First, this paper provided evidence for the need to implement mental healthcare. I specifically focused on stress related disorders given its prevalence to the conflict context. This was done by administering standard mental health screening questionnaires for depression and anxiety disorders to PFS in Lebanon who came to UNRWA clinic for primary care purposes unrelated to mental health concerns.

The latter three objectives were explored by interviewing 40 PFSs who could be clinically suffering from a depression or an anxiety disorder based on the screenings mentioned above, and 42 primary healthcare providers at UNRWA clinics in Lebanon.

Based the screening results and interviews, I provided recommendations for UNRWA to move forward with providing effective mental healthcare services to PRS.

### **Key Findings**

The research methodology yielded the following key findings:

- There is a dire need for mental health services. Overwhelming majority of the PRS screened demonstrated mild to severe symptoms of depression and anxiety disorder/PTSD.
- There is no structured or unstructured mental health services available for PRS in the UNRWA camps, nor any physical or mental service for victims of sexual assault.
- Most healthcare providers received no or minimal training on diagnosing and treating stress related mental health conditions.
- Providers tend to underestimate the frequency of psychological distress cases among their patients, with several physicians claiming there is no mental illness in this population.
- Over-population in the camps, immobility on social ladder, and prevalence of crime and a lack of formal law enforcement and justice system within the camps were identified by both providers and patients as structural exacerbating agents to psychological distress.

### **Recommendations:**

Based on the research findings, this paper offers the following recommendations for providing effective mental healthcare.

- Mandate mental health screening for PRS at their initial clinic visit and/or primary care visits
- Engage stakeholders to help train healthcare providers in order to better identify and treat patients with psychological distress

- Partner with other NGOs and entities to overcome capacity limitations and provide mental healthcare to PRS and comprehensive healthcare to victims of sexual assault
- Collaborate with cross-sector agencies to address exacerbating agents to psychological distress
- Promote outreach, support groups, and peer social gatherings to alleviate tensions between Palestinian refugees residing in Lebanon and PRS.

## Introduction

### Background

The Syrian Civil War has destroyed hundreds of thousands of houses, and has forced 4.8 million refugees to flee the country as this figure continues to rise every day<sup>1</sup>. Amid this unconscionable bloodshed and destruction, Palestine refugees in Syria (PRS) remain particularly vulnerable and have been disproportionately affected by the conflict, due to their camps' proximity to conflict areas inside Syria, high rates of poverty, and their tenuous legal status.

PRS are those who were forced to flee their homeland Palestine since the mid-20<sup>th</sup> century and sought refuge in Syria, and their descendants who were born in Syria. They have been under the care of the United Nations Relief and Work Agency (UNRWA) since 1948, along with the rest of the Palestinian refugee population that have been relocated to four other areas - Lebanon, Jordan, the West Bank, and Gaza. UNRWA, thus, is the primary, and often the only, body that delivers relief and medical services to PRS. The violence in Syria has turned this already-vulnerable population into Twice Refugees.

While 560,000 Palestinian refugees were registered in Syria before the Syrian Civil War started in 2011, 280,000 have been displaced internally, and 120,000 externally<sup>2</sup>. UNRWA camps in Lebanon have received the largest relocations, with around 42,000 PRS moving into shelters originally housing Palestinian refugees in Lebanon (PRL).

Discriminated by the Syrian government, PRS were unable to move around safely and faced severe restrictions owing to escalating threats from shelling and armed clashes, exacerbating vulnerabilities that existed prior to the Syrian conflict. Even when they are relocated, many PRS in Lebanon have been pushed into a precarious and marginalized existence due to their uncertain legal status, and face limited social protection, making them heavily reliant on UNRWA for their basic needs.

While this population suffered from warfare and structural violence, no mental health services, including psychological counseling, was officially provided by UNRWA before 2013 to those that

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<sup>1</sup>United Nations High Commissioner for Refugees (2016). *Syria Regional Refugee Response*. Retrieved May 26, 2016, from <https://data.unhcr.org/syrianrefugees/regional.php>

<sup>2</sup>United Nations Relief and Works Agency (2016). *Syria Crisis*. Retrieved March 25<sup>th</sup>, 2016, from <http://www.unrwa.org/syria-crisis#Syria-Crisis-and-Palestine-refugees>

were forced again into exile. As there is no official record of mental health diagnoses made, the extent of untreated patients in this Twice Refugee population remained unknown.

### Importance

Fear has always been used as a psychological warfare tactic. It is certain that most of these refugees have endured some sort of traumatic experience. In most other conflict-infused areas, such as the West Bank, the most basic form of mental health service - group counseling sessions - were implemented<sup>3</sup>. However, since the Syrian war started in 2011, no formal mental health services have been provided by UNRWA, the only source of health services provided to PRS.

It is clear that one's mental state strongly affects one's wellbeing and capability to function in a society. The validity of the relationship between mental health and wellbeing is so prominent that that the General Assembly of the United Nations has proclaimed that "[a]ll persons have the right to the best available mental health care, which shall be part of the health and social care system"<sup>4</sup>. Healthcare providers, service providers, and policymaker must recognize the importance of mental health and incorporate mental health services into the myriad of services they provide to refugees.

This paper aims to identify the major barriers to providing mental health services to the Palestinian refugees who recently fled Syria from its warfare. It also aims to offer potential solutions that mitigates these barriers. An emphasis is placed on stress-related disorders given the emergency context of warfare and forced migration, and the need for agencies to collaborate given the resource-limited setting. The goal is to lay the ground work for UNRWA to effectively provide mental health services that meet the needs of the Palestinian Refugees from Syria during this volatile time.

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<sup>3</sup> United Nations Relief and Works Agency (2011). *UNRWA West Bank Community Mental Health Programme*. Retrieved May 26, 2016, from <https://www.unrwa.org/userfiles/2011051512435.pdf>.

<sup>4</sup> United Nations General Assembly (1991). *Resolution 46/119 The Protection of Persons with Mental Illness and the Improvement of Mental Health care*. Passed at the 75<sup>th</sup> Plenary Meeting, December 17, 1991.

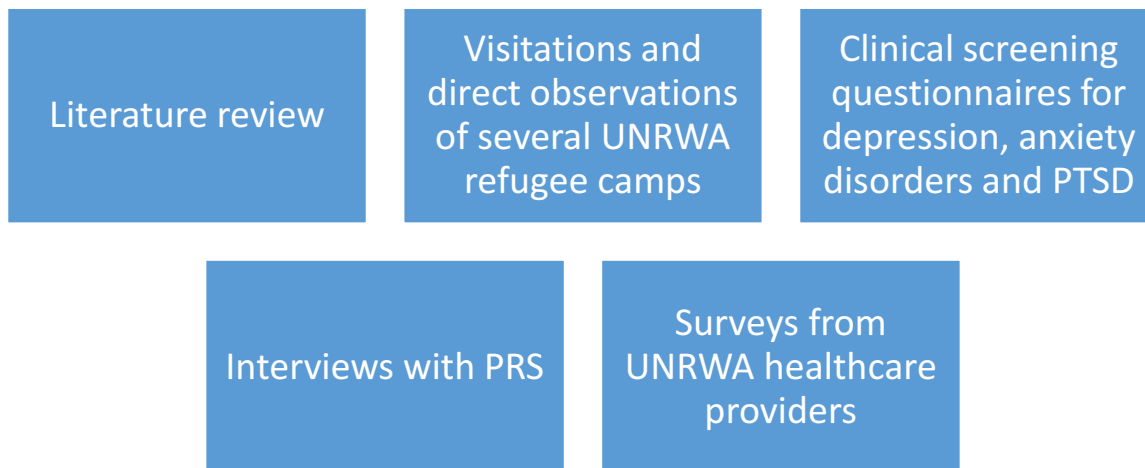
## Methodology

In order for the project to be researchable and evidence-based, I rephrased and divided the main question of the project – how can UNRWA provide effective mental health services to PRS – into four measurable objectives. The following four objectives shaped the research design:

- Identify the urgency for mental health services by screening for unattended mental symptoms in this population
- Identify physical health services and mental health services, if any, that are available to Palestinian Refugees from Syria (PRS)
- Assess PRS and UNRWA healthcare providers' perceptions on mental health needs in the refugee population, the drivers of those needs, and populations at particular risk.
- Assess UNRWA healthcare providers' perspectives on barriers in creating mental health services and solutions to those barriers

## Research Design

To answer the objectives noted above, I used several research methods, including:



### A. Literature Review

Peer-reviewed research articles on mental health in the Middle East refugee population, especially peri-conflict period, was close to non-existence at the time when the literature review was conducted. Since the main objective and the four sub-objectives are fairly niche, and that mental health is a taboo topic in the region, such dearth of literature was expected.

Consequently, the bulk of my literature review was finding valid screening tools for stress-related disorders and proper ways to administer them. This was how the Primary Health Questionnaire 9 (PHQ-9) and Clinician-administrated PTSD scale (CAPS) came to be the screening surveys used to detect unattended depression, anxiety, and PTSD mental symptoms for this study. See Appendix A for the bibliography.

### *B. Direct Observation*

I visited numerous UNRWA camps in Lebanon (Beirut and Sidon areas) and Jordan (Amman and numerous rural areas) in the months of June to August 2013. These visits also guided how I phrased the questions on the interviews.

### *C. Clinical screening questionnaires for depression/anxiety disorders and PTSD*

The Primary Health Questionnaire 9 (PHQ-9) and the Clinician-administrated PTSD scale (CAPS) were used to assess depression/anxiety disorder and Post Traumatic Stress Disorder (PTSD), respectively. Both of these screening tools have been routinely used in American and global settings to screen for stress-related disorders.

While PHQ-9 was originally designed in English, it was translated into Arabic with the help of the UNRWA staff<sup>5</sup>. The questionnaire can be taken as a survey; yet, to make it simpler on patients and eliminate any concerns with literacy or misinterpretation of the questions, a health professional administered the PHQ-9 and recorded patients' answers.

As its name indicated, the Clinician-administered PTSD scale (CAPS)<sup>6</sup> required a healthcare provider to administer the screening. Five healthcare providers from the UNRWA headquarter were trained using training materials provided by the U.S. Department of Veterans Affairs. These five CAPS administrators had never provided any direct healthcare to the PRS participants, as a way to eliminate any discomfort in answering sensitive questions.

*Site Selection:* Each UNRWA camp is equipped with one UNRWA clinic that provided primary healthcare and prenatal healthcare for expecting mothers. Given that most PRS were relocated to Lebanon, Lebanon was chosen as the country. Considering safety concerns, we then selected two camps in the Beirut area with the largest PRS population – Shatila and Burj Barajneh.

*PRS Participant Selection:* PRS who participated in the PHQ-9 and CAPS screening were PRS patients who arrived at the UNRWA clinics for primary care or prenatal purposes. Primary care

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<sup>5</sup> Appendix B and C

<sup>6</sup> Appendix D

visits included, but not limited to, wellbeing check-ups, management of chronic illnesses (i.e. diabetes, hypertension), and urgent care. Given ethical concerns, for pediatric visits, the parents/guardians were asked to participate, not the child. Informed consent was obtained from the participants. No participants under the age of 18 will be included in this study due to ethical concerns.

Using sample size proportion test, it is determined that 180 participants would be needed based on a population size of 2124, anticipated % frequency of 85, confidence limits of 5%, design effect of 1.0, and confidence level at 95%. We have obtained results for PHQ-9 and CAPS from 224 participants.

#### *D. Interviews with PRS*

PRS who participated in the screening above and scored mild and above on either of the screenings were also asked to participate in an in-depth interview with one of the CAPS administrators. The questions were crafted based on my literature review, visitations to the camps, and input from the UNRWA staff. I partook in some of the interviews. Some were voice recorded with the consent of the participants for detailed answers. For confidentiality, participants were asked not to identify themselves or others during the interviews. If participants accidentally do so, the recording was stopped and any identifier was deleted. For this portion, 40 PRS in-depth interviews were completed.

#### *E. Surveys from UNRWA healthcare providers*

To assess UNRWA healthcare providers' perception towards mental health, a survey was given to all healthcare providers in the Shatila and Burj Barajenh camps, and an email was sent out to healthcare providers in Lebanon UNRWA clinics that took care of relocated PRS. To ensure confidentiality, participants were not asked to provide their identities. Only gender, age, job title, and years of experience were asked and were used in an aggregate manner as sample size diversity indicators.

Survey was chosen as the method rather than interviews for several reasons. First, healthcare providers raised the issue of not having time to be interviewed. The clinics were indeed busy, and the average time for each patient consultation was only 3 minutes, due to limited resources and large patient volume. Also, given that the interviewers would have been their colleagues or superiors from the headquarter, it would create a conflict of interest. A survey would have ensured honest, detailed answers. For this portion, 42 UNRWA clinic healthcare providers completed the survey.

### Ethical Consideration/IRB

The two screening questionnaires, PHQ-9 and CAPS, were be scored objectively using the standard scoring guide provided in the literature review, immediately after each screening. Due to ethical concerns, participants who scored above the normal threshold were made known of their results, and were provided with the contact information of a mental health counselor from the Médecins Sans Frontières (Doctors without Borders). It was done this way to ensure participants' confidentiality and autonomy, while providing them a resource to seek help for demonstrated unattended psychological symptoms.

I obtained the approval from the UNRWA Ethics committee and the Harvard Medical School Institutional Review Board (IRB) before beginning the research. All data was to be reported in an aggregate manner. Interview questions were refined with the input of UNRWA staff to ensure culturally appropriate wording of survey questions.

### Risk and Benefits

Discomfort from participants was foreseeable, as mental health was still a taboo in the region. Confidentiality was ensured to not protect participants' legal status, employability, and reputation. The benefits of this study was to provide evidence for the dire need of mental health services. It was a step closer to ensuring those who suffered from mental distress would receive the services they needed.



## Key Findings

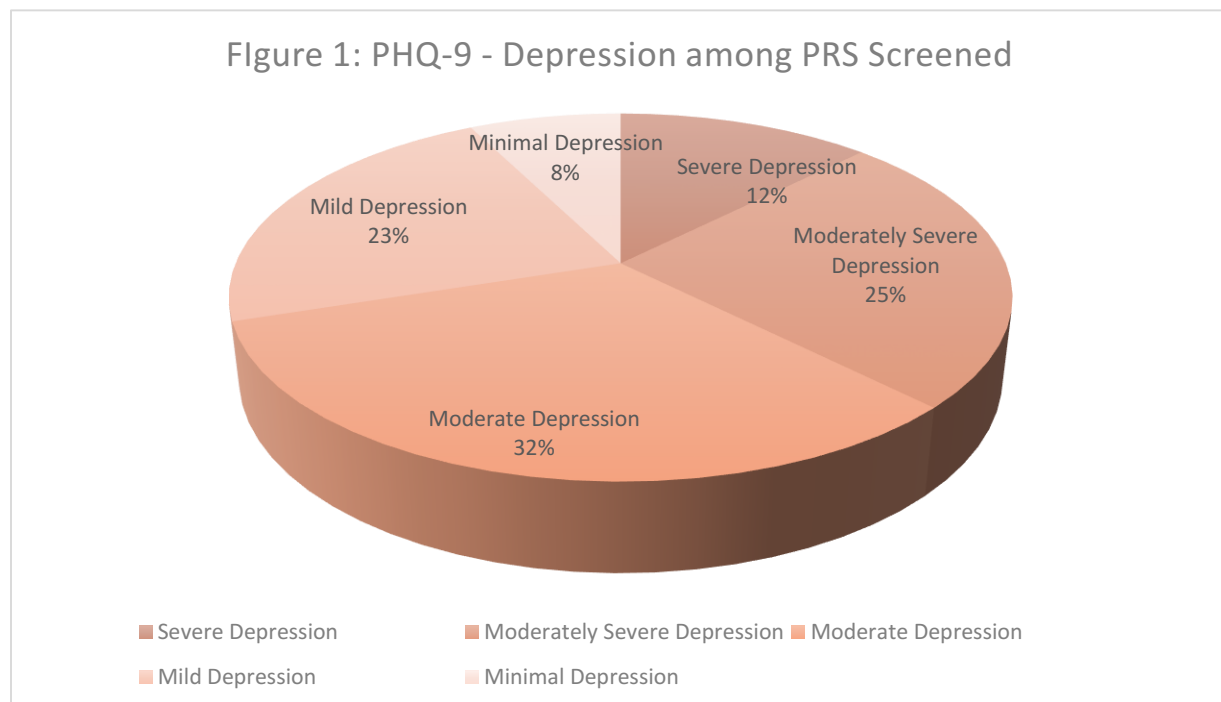
The research methodology yielded significant amounts of information and insights on the urgency for mental health services, the current state of mental health services, the attitude towards mental health, and the barriers to providing effective mental health services to Palestinian refugees from Syria (PRS) in the Lebanon United Nations Relief and Work Agency (UNRWA) camps.

This section highlights the key findings which guided the development of the final recommendations and the next steps.

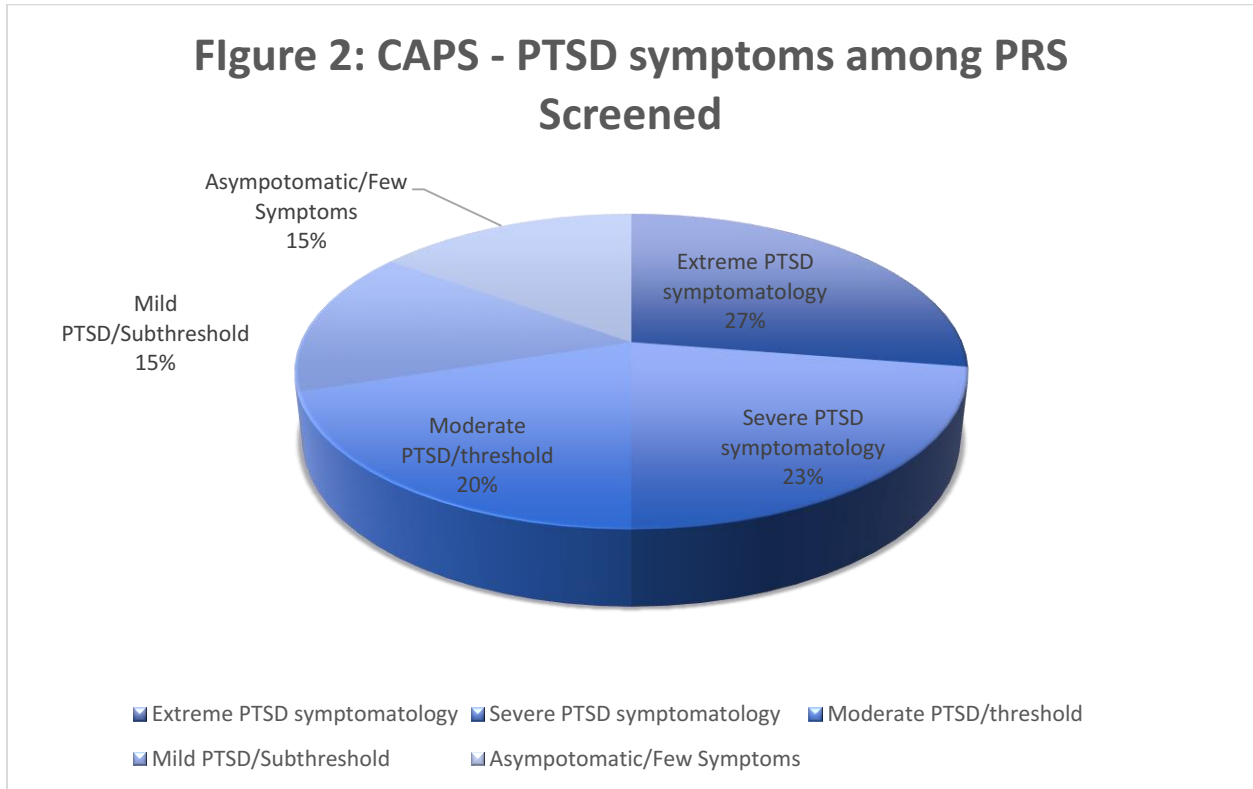
**Key Finding 1:** There is a dire need for mental health services among Palestinian Refugees from Syria. Overwhelming majority of the PRS screened demonstrated mild to severe symptoms of psychological distress.

To provide evidence on the urgency for mental health services, the Primary Health Questionnaire 9 (PHQ-9) and the Clinician-administrated PTSD scale (CAPS) were used to screen for unattended psychological symptoms among PRS. Of the 224 PRS completed the screening, 92% demonstrated mild to severe depression symptoms and 85% demonstrated mild to severe post-traumatic stress disorder symptoms.

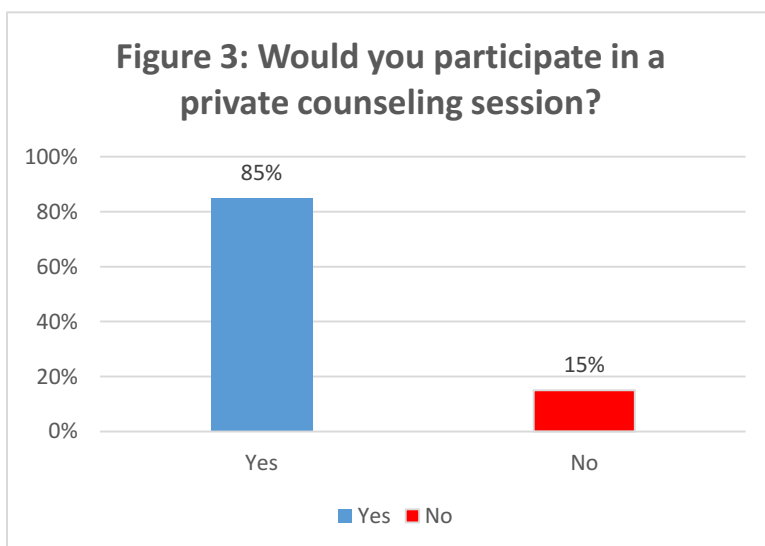
Depression: Chart 1 presents how PRS scored on PHQ-9 related to the severity of depression symptoms. Only 8% of PRS demonstrated minimal depression, with almost 70% demonstrating moderate to severe depression that required definite mental healthcare provider's further evaluation.



Post-Traumatic Stress Disorder (PTSD): Figure 2 presents how PRS scored on CAPS related to the severity of PTSD symptoms. Only 15% of PRS demonstrated minimal depression, while 70% demonstrating moderate to severe depression that required definite mental healthcare provider’s further evaluation.



These results indicate that the majority of the PRS who came into an UNRWA clinic seeking for physical healthcare services have psychological distress symptoms that are unidentified and thus untreated.



One could argue that a patient might not seek treatment even if symptoms were identified. To counter this claim, I asked PRS interviewees whether they would participate in a private counseling session if that were provided. 85% responded that they would like to participate in a private counseling session if available (Figure 3). Of those who responded no, 50% indicated their responsibility to

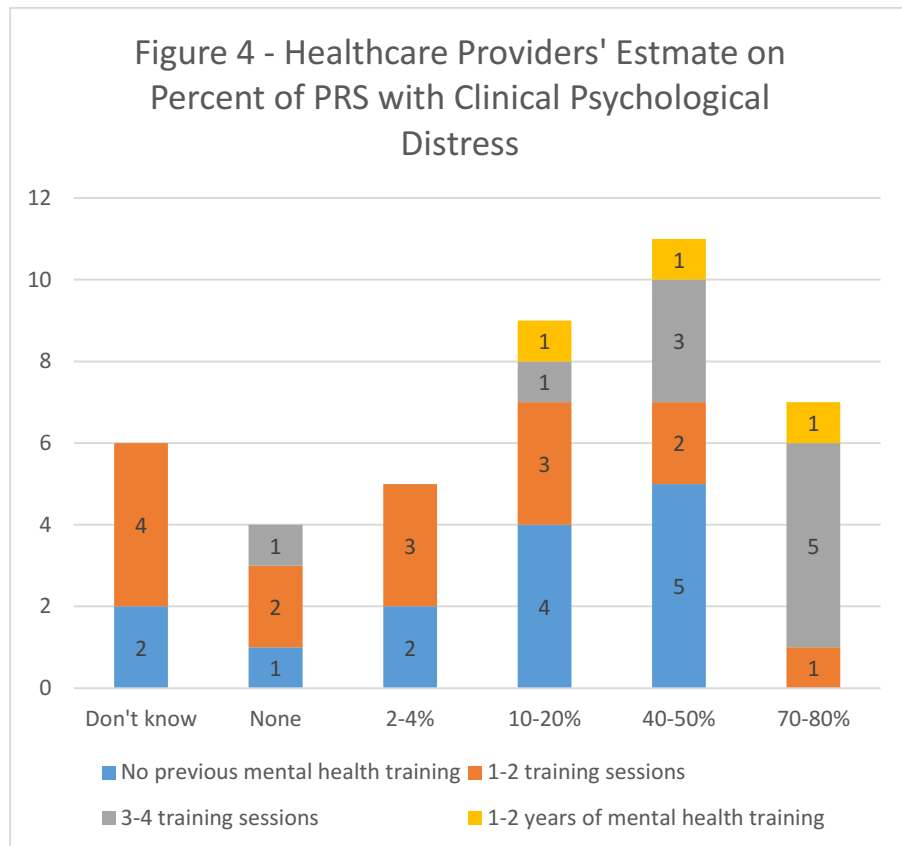
their children would be a barrier for them to attend a private session. To summarize, these results demonstrate a dire need and a demand for mental health services among PRS.

**Key Finding 2:** Providers tend to underestimate the frequency of significant psychological distress among their patients, and would like more training on diagnosing and treating mental illness.

Interestingly, psychological distress in PRS patient population was noted by the healthcare providers. According to the healthcare providers’ survey results, all healthcare providers but one cited at least one depression or anxiety symptoms (such as sleep troubles, sadness, lack of energy, lack of interest) as a common chief complaint of a PRS visit. About 86% UNRWA healthcare providers specifically used the word “depression” and/or “anxiety” in their answers to the same question.

Yet, when asked “what percent of PRS do you estimate is experiencing significant psychological distress that requires clinical attention,” only 17% of healthcare providers gave an estimated prevalent rate that is close to the actual prevalence rate established above in Finding 1 – 70% on either depression or PTSD. The overwhelming majority of healthcare providers tend to underestimate the frequency of significant psychological symptoms in PRS. Figure 4 provides an

illustration of the healthcare providers’ responses, based on the self-reported amount of training they received in identifying and diagnosing stress related mental health conditions. Those with more self-reporting mental health training tends to guess a closer to the actual prevalence established earlier in the study.



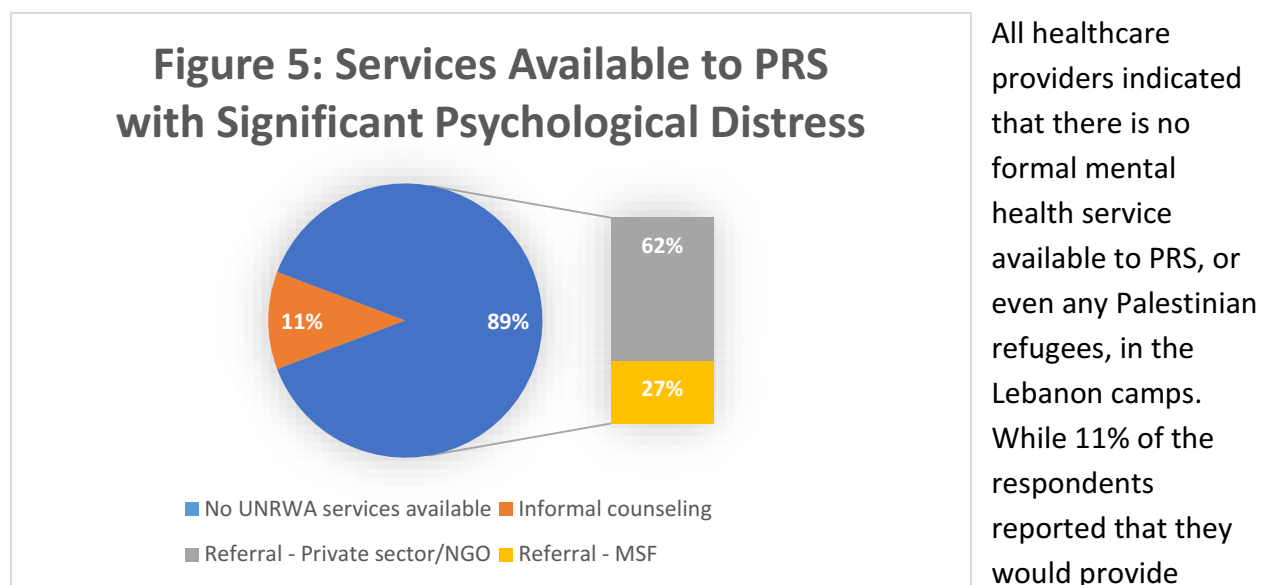
Notably, there were four healthcare providers who claimed there was no mental illnesses in the Middle East. All four were physicians and two of them had been practicing for at least 20 years.

Nonetheless when asked if more mental health training would be helpful for them in providing care for the PRS patients, all but four responded yes. Of the four who responded that training would not help, three were the ones who denied the existence of mental illnesses.

To summarize, while the most healthcare providers significantly underestimated the prevalence of clinical psychological distress, they believe more training in identifying and diagnosing stress related mental health conditions would be beneficial.

**Key Finding 3:** There is no structured mental health services available for PRS nor any physical or mental service for victims of sexual assault provided in the UNRWA clinics.

While there is a large demand for mental health services, the inconvenient truth is that there was no formal mental health service available to PRS in the UNRWA camps.



informal counseling at the visit where they encountered a PRS with significant psychological distress, almost 90% of healthcare providers would refer them to an outside entity for services. Médecins Sans Frontières (MSF) was cited specifically by 29% of the respondents.

Of note, while some healthcare providers considered referral to private sector as an option, such referral would not be covered by the UNRWA and patients would be responsible for securing transportation to outside clinics and any financial costs one incurs from such referral.

With MSF referrals, patients also must secure their own transportation. In addition, after an informal interview with the Director of Mental Health of MSF in Beirut, I found out that other NGOs also referred patients to the MSF. Given limited resources, they had yet to see PRS who

were referred by the UNRWA. Nonetheless, an MSF staff member had visited several UNRWA camps to deliver mental health training sessions to UNRWA healthcare providers.

In regards to medical services provided to victims of sexual assaults, all healthcare providers unequivocally answered there is no provided in the UNRWA camps. Table 1 summarizes findings regarding sexual assault.

**Table 1 Summary of Healthcare Providers' Responses to Questions Regarding Sexual Assault**

Services for victims of sexual assault provided in UNRWA clinics	<b>None</b>	While there was no official sexual case reported, almost 20% of healthcare providers responded they had encountered suspected cases of sexual assault in the clinic. Of note, two healthcare providers claimed encountering suspected sexual assaults involving a girl under the age of 18.
# of official registered cases by healthcare providers	0	
# of healthcare providers who have had encountered patients who might be a victim based on history, symptoms, and/or physical findings but patient did not come to the clinic for sexual assault as the chief complaint	8	
# of healthcare providers who encountered suspected cases and referred patient to the hospital	6	
# of healthcare providers who encountered suspected cases that involved patient that was a female under the age of 18	2	
# of healthcare providers cited "shameful" or "stigma" as the cause of victims of sexual assault not seeking medical care	28	When discussing stigma and shame on sexual assault during informal interviews, several healthcare providers noted that there is no formal legal system within the walls of these two camps in Lebanon. When a crime occurred, de-facto camp leaders from the two political sects, Fatah and Hamas, would strike an agreement on how to proceed. Compared to more "serious crimes," such as stabbing or any attack involving a

male party member, sexual assault or crimes involving women were not seen as serious offenses. Party leaders would not be willing to spend their political capital on pursuing justice on behalf of a powerless population. In addition, as PRS are seen as outsiders whom they are forced to share space and resources with, the party leaders in the Lebanon UNRWA camps had no incentive to help PRS victims. Even if a PRS victim were to report a sexual assault, the victim would most likely be blamed for the crime and her marital prospect or status would be jeopardized. Stigma, shame, and the lack of justice, therefore, can be seen as the main reasons why victims of sexual assaults are unwilling to report or seek help.

To summarize, the lack of officially reported sexual assault cases does not mean no sexual assault had taken place in the camps. Rather there is evidence of barriers to reporting and

seeking services after a sexual assault. In addition, what is certain is that if a victim of sexual assault were to seek medical and psychological services from UNRWA camps, none would be provided.

**Key Finding 4:** Healthcare providers believe women and children are most vulnerable to psychological distress. Yet, the prevalence of psychological distress among adult male and children remains unknown.

Around 62% of surveyed UNRWA healthcare providers believe women to be particularly vulnerable to psychological distress. While this research did not include children under the age of 18 in the screening process<sup>7</sup>, around 62% of healthcare providers also believed this age group is at particular risk for psychological distress. Table 2 illustrates a list of subgroups whom healthcare providers believe to be vulnerable to psychological distress and the frequency they appeared in the surveys.

**Table 2 Subgroups Vulnerable to Psychological Distress According to Healthcare Providers**

<b>Subgroup of PRS Most Vulnerable to Psychological Distress According to Healthcare Providers</b>	<b># of Times Subgroup Was Mentioned</b>	When discussing why women and children were believed to be more prone to mental distress, most healthcare providers cited that these two subgroups often cried, displayed emotions and/or verbalized sadness during clinic visits. Some also cited that women and minors cannot provide living needs for themselves. A few providers responded that the inability to divulge domestic abuse or sexual assault as an element that makes these subgroups vulnerable.
Women	27	Yet, it must be recognized that healthcare providers often encounter women more than men, as the former tend to be the primary caregivers for children and other family members such as elderly parents who have illnesses. Also, given the nature of prenatal visits, by default healthcare providers see more female patients.
Children	26	
Elderly	13	
Those who lost loved ones	13	
Economically disadvantaged	10	
Victims of Sexual Assault	5	
Patients with Disability	4	
18-24 y/o	4	
Patients with chronic disease	3	

<sup>7</sup> As previously mentioned in the Methodology section, IRB would only approve the participation of PRS above 18 years of age as they could easily give informed consent.

On the other hand, adult men tend not to visit the clinics as they are usually in good physical health. And as the default breadwinner of the household, they are expected to be outside working or finding jobs, making them less likely to accompany their children, wife, or parents to the clinic. In addition, due to gender role that is similar to “machismo,” adult men are not expected to show sadness or signs of weakness, making them less likely to seek medical attention or divulge emotions.

The gender bias was also evident during the recruitment process of PRS participants for screening and interviews. Out of the 224 PRS participated in the screening, 76.34% were women. The median age of female respondents was 28, while the median age of male respondents was 48. Of the 13 who refused to participate in the screening, 11 were men. This merely demonstrates sample bias, as seen by the healthcare providers during their encounters. We cannot conclude that men are less prone to psychological distress based on this finding.

In summary, while women and children are cited as the most vulnerable subgroups, UNRWA lacks a clear demographic picture of who are prone to stress-related disorders.

**Key Finding 5:** Systematic factors that are out of one’s control are cited as most common exacerbating agents to psychological distress.

When asked what they hoped for in the very near future, 90% of the PRS surveyed yearn to go back to Syria. Around 5% stated they are hopeless, and only one person wished to stay in Lebanon<sup>8</sup>. This result then yielded led us to explore what factors are exacerbating the psychological distress during their stay in Lebanon. The most frequently discussed factors include:

**Crowdedness:** This is by far the most common attributed factor with a 78% cited rate. The UNRWA camps in Lebanon were at full capacity before the PRS arrived. Unlike the United Nations High Commissioner, temporary camps are not allowed to be built outside of the designated UNRWA camp walls as no government has granted such requests. To accommodate the influx of PRS, UNRWA has mandated that families must share existing apartments in the camps originally inhabited by Palestinian refugees in Lebanon (PRL). The sight of 15-26 people in an apartment is not uncommon during my visits to the camps. While PRS have the option of living outside the camps, rent and the higher cost of living in Lebanon discourage families from doing so.

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<sup>8</sup> One elderly gentleman (Age 70) expressed to go back to his home in Palestine. It was rather interesting to see the younger generations of PRS have considered Syria camps as their home.

**Discrimination:** Many PRS expressed that discrimination, mainly from PRL, as an exacerbating agent to their psychological distress. Despite the fact that everyone living in the camps are Palestinian refugees, their group identity is cleaved by the country of origin, creating a PRL vs. PRS phenomenon. More importantly, before the arrival of the PRS, the camps in Lebanon were experiencing lack of stable electricity and inadequate water supply. The situation is now worse given as resources are split more ways. With an intense tension between the two groups, some PRS noted they tend not to engage or fight back and accept humiliation, as they are living under the mercy of the PRL.

**Safety:** Around 15% of the interviewed PRS cited safety inside the camps was creating significant psychological distress. Several female PRS had divulged knowing sexual assault cases that had occurred inside the camps. Given the gender violence, they stated they had been heavily relying on their male companion, often their husband. Some had given up seeking economic opportunities due to safety concerns. A male PRS indicated that the temporary tent that he set up in the camp's bazaar had been vandalized several times. Yet none of the interviewees endorsed reporting any incidents as they believed justice would not be sought, as discussed under Key Finding 3.

**Lack of support:** Several PRS attributed the lack of social support as an exacerbating factor to their psychological distress. Some PRS still had family members in Syria, and some lost their loved ones to the violence in Syria. Healthcare providers have noted that mothers of young children are particularly prone to lack of support. First, the social role demands that mother be the sole caretaker of the children even if the father is around. Second, as children were no in school, they spent even more time in the apartment taking care of them and less time outside socializing with peers.

**Unemployment:** PRS, especially men, discussed the lack of work as being a source of distress. PRS, previously had full employment rights in Syria, found themselves facing extremely limited work opportunities and high expenditures on food in Lebanon. Some noted there is a sense of shame for men as they are expected to provide for their family. Several healthcare providers also noted on the surveys that when men discuss their source of distress, unemployment came up often. While official assessment not available at the time of the research, an UNRWA staff member that the estimate percentage of families with at least one person who worked was slightly less than 50%, and nearly 100% of these employed workers held a temporary and not a permanent job.

In sum, despite leaving the active warfare in Syria, PRS are still experiencing factors that exacerbate their psychological distress. These factors share the commonality in that they are external -- outside of one's control, making it harder to mitigate without a systematic approach.



## Recommendations

Stress-related disorders pervading the Palestinian refugee from Syria (PRS) in Lebanon population is an undeniable fact. It is an established consensus in the medical community that the mind and the body are not two separate entities. A basic healthcare system therefore provides services not only limited for primary physical illnesses, but also psychological ailments.

Based on the lessons learned from the PRS patients and UNRWA healthcare providers, this section proposes recommendation for UNRWA to better help PRS with psychological distress. This paper does not seek to provide a list of mental health services UNRWA should provide, as it is best determined by the psychiatrist, psychologists, and social workers who specialize in mental health. Therefore, the recommendations are meant to serve as a guide for UNRWA to lay the groundwork in setting up the structural components of an initiative that provides services which address the mental health needs of PRS in Lebanon.

### A. Establishing an Initiative: Mission, Theory of Change, Common Ground

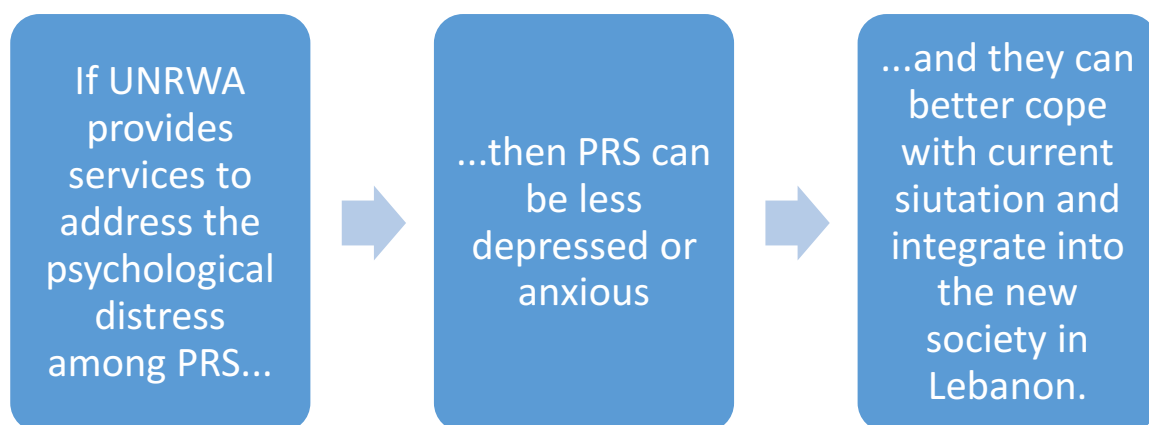
UNRWA healthcare providers in the camps saw first-hand how mental illnesses are damaging their patients. They want to provide mental health services to could alleviate patients' suffering. As the primary healthcare provider to Palestinian refugees, it is crucial that UNRWA Department of Health incorporates mental health into their services. Just as how non-communicative, maternal health, and pediatrics have their own team and a chair under the umbrella of the Department of Health, mental health deserves a dedicated team and a chair.

***Recommendation 1: Acknowledge the gravity of mental distress among PRS by establishing a task force.***

As a new initiative on an unchartered health topic, it requires a task force. Given the diverse options of mental health services, cultural sensitivity, and the systemic factors inducing psychological distress among PRS, this structured model provides opportunities to bring in diverse backgrounds, pool capital and knowledge, and foster collaborative cross-agency relationships. More importantly, it provides both a physical and metaphorical platform for that pushes forward a mission around one cause – alleviate the burden of mental health disease among Palestinian refugees in Syria. In addition, a formalized task force creates the credential to implement services, advocate on for policies, and garner funding related to mental healthcare delivery.

Once the task force has a mission statement, it needs to have a coherent and workable theory of change. A theory of change entails the identification of the central problem, an agreed upon intervention that promotes alleviation of the problem, and the expected impact that such intervention would bring forward. Below is a sample theory of change for the UNRWA mental health task force.

Figure 1: Theory of Change for UNRWA Mental Health Initiative

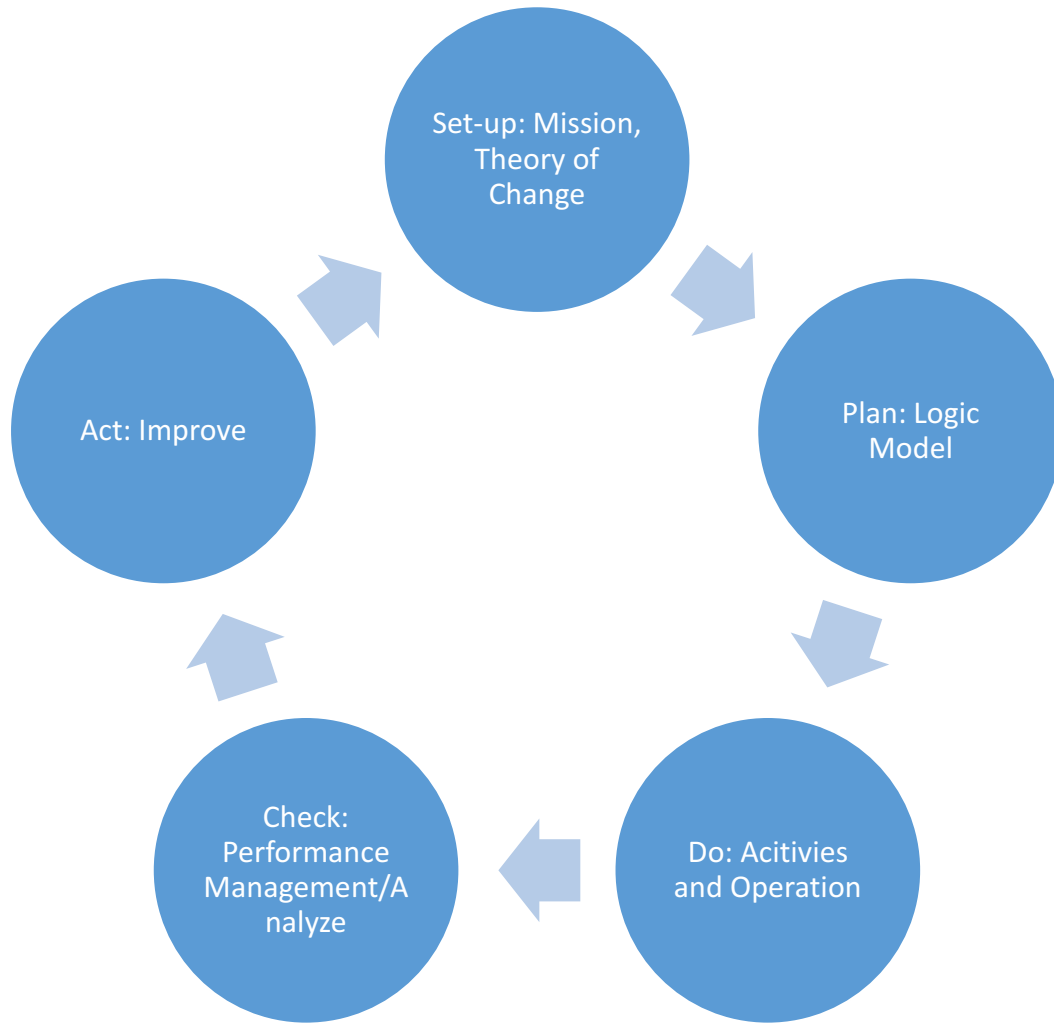


Moving forward with a unified mission and theory of change, tactics and interventions can be established in an agreed-upon fashion with a diverse background of expertise.

#### B. Measuring Success: A Culture Striving for Improvement

As with any initiative, measuring effectiveness of the services provided is essential to building a better mental healthcare system that better meets the needs of the patient. Organizations often use a working cycle similar to this.

Figure 2 The Working Cycle



A crucial aspect of starting a new initiative to foster a culture of performance evaluation. As healthcare providers, we are familiar with the scientific method, and thus we are familiar with this cycle of improvement. Starting a new initiative is no different.

**Recommendation 2: Develop measurements using a logic model**

Given that mental illness is stigmatized and hard to identify, progress in identifying and progress in providing treatment and support can be hard to measure initially. Therefore, innovative measurements can be used. Gathering data would be helpful to monitoring changes and effectiveness. An evaluation using the data would be helpful for further evolution of services provided.

Figure 3 Logic Model - Types of Measurement



Input measurement examples:

- How many full-time psychologists delivering care?
- How much can we allocate to the new mental health division/task force?

Process measurement examples:

- How many healthcare providers were seen before a diagnosis was made?

Output measurement examples:

- How many training sessions we provided to the healthcare providers in clinic?
- How many counseling sessions did we provide to patients?
- How many diagnoses of stress-related disorders have been made in a given time?

Outcome measurement examples:

- Depression severity of patient receiving treatment
- School attendance and performance of a child with stress-related disorders

Impact measurement examples:

- Stress-related disorder incidence rate in a camp
- Suicide rate in a camp

### C. Identification of Patients: Who Needs Help and How Severe

Identification of patients with psychological distress is the central challenge, as patients may not know help is available, and may be unwilling or unable to seek assistance.

While this research project provided evidence of significant mental health distress among PRS screened in the UNRWA clinics, UNRWA still lacks a complete picture of who needs mental health services. Specifically, as women and elderly participated in the screening, the prevalence

of stress-related disorders among men and children remain unknown. Interviews revealed that children are believed to be a highly vulnerable subgroup. While men are less likely to seek assistance and express distress, it cannot be refuted that they are less prone to psychological distress. In addition, this research project only focused on PRS from two camps in Lebanon, despite carrying an evident gravity of the situation. The absence of data from other camps underestimates the extent and even severity of mental distress among the entire PRS population in Lebanon.

***Recommendation 3: Mandate the use of depression and PTSD screening at clinic visits.***

To remedy this problem, UNRWA should implement the use of PHQ-9 for depression for the initial primary care visit to establish a patient's mental status baseline, and subsequent visits to track their progress. Male family members should be encouraged to attend perinatal visits with their wife.

Screening should also be implemented at the initial intake when PRS provide their immunization record to the camp clinic.

***Recommendation 4: Utilize community health liaisons to reach out to male PRS***

As men are less likely to visit UNRWA clinics, UNRWA can go to them rather than waiting for them to come in. Community health liaisons are ideally peers who are PRS, of the same gender, and preferably with healthcare background, in order to establish relationships with PRS living in the camps. Liaisons will go to apartments of PRS to screen for stress-related disorders and educate them about mental health resources that would be made available. Such outreach program is meant to support PRS, particular men or those who might not actively seek medical attention. More importantly, it creates job opportunities for PRS when they become a community health liaison.

***Recommendation 5: Ask about sexual abuse and safety concerns at the visits, and remind patient of confidentiality.***

Victims of sexual assault was recognized as a vulnerable group according to the healthcare provider surveys. More important, cases of sexual assault had been made known to both healthcare providers and PRS patients. Victims of sexual assaults from a refugee population deserves more services, such as safer living environment and law enforcement polices, besides the usual mental health care. Without proper identification, services cannot be provided. At the same time, without knowing the prevalence of sexual assault in the camps or any concrete evidence, it could be difficult to advocate for changes.

Therefore, it is crucial to ask questions about sexual abuse, domestic violence, and safety concerns during clinical visits. Given the barrier to reporting is repercussion and shame, healthcare providers should remind patients of confidentiality and establish a safe space for victims to divulge sexual trauma and seek help.

Several interviewed health providers accounted that that the victims of sexual assault that they were made known of involved young girls between the age of 15-25.

#### **D. Capacity: Identify and Engage Stakeholders**

Resources are needed to tackle the challenges on caring for patients with psychological distress. This section lays out recommendations for engaging new stakeholders.

***Recommendation 6: Hire professionals in mental health who are available to patients in the camp.***

Mental health is a specialty that requires the expertise of psychologists, psychiatrists and social workers. As a health topic surrounded by intense stigma and myths, mental health is an area that must be treated delicately with a great deal of cultural sensitivity. Therefore, these experts are a necessity.

As elicited from the healthcare provider surveys, patients are currently referred to private sectors or other NGOs. Yet, no service can be provided to these patients if they are inaccessible. Therefore, having an own team of psychiatrist, psychologist, and social workers solves the barrier of accessibility.

***Recommendation 7: Mental health training for UNRWA healthcare providers***

As professional service is provided in a referral manner, those who see patients first must be able to identify psychological disorders and at times provide counseling if patients refused to be referred. As healthcare providers cited in the surveys, more mental health training will be beneficial for them to provide mental healthcare delivery. Rather than relying on NGOs could not provide constant and intensive training, UNRWA could utilize the team of mental health professionals who will be hired per Recommendation 5 above to provide constant, impactful training to the primary healthcare providers. A stable and constant learning environment is necessary for training, and better training would yield better service.

***Recommendation 8: Engage non-medical stakeholder to grow capacity and provide services at various settings.***

Mental health is not only a medical issue; it is also a social issue. More importantly, it can be exacerbated by various factors as seen the findings. Intervention from different aspects of life can play a crucial role in alleviating mental distress beyond just medical settings. Specifically,

non-medical entities, such as faith communities, educators, school counselors, community workers and work agencies could all be engaged to help identify patients with psychological distress.

Here are a few examples of how these entities can be a stakeholder in alleviating psychological suffering.

- *Religious professionals:* Imams and other religious figureheads are often seen as a source of spiritual help. Given the trust that has been built, patients are likely to divulge feelings and troubles to a spiritual leader. In this aspect, they can help identify PRS with psychologist distress and normalize the stigma of mental illnesses. Moreover, spiritual leaders have the ability to reach out to a mass audience on a regular basis. Friday prayers would be an ideal place to educate PRS about psychological distress and the services available to them.
- *Schools:* Training in identification can be provided to educators and staff. Reporting protocols can be set in place. Wellness and mental health can be incorporated and thus normalized in curriculum for students.
- *Political Leaders:* Inside the camps, these political leaders are often the de-facto legal system. UNRWA should leverage their power as the caretaker of Palestinian refugees and their resource provider to demand changes in sexual assault reporting.
- *Patients turned community workers:* Peer-led support groups can build trust and gain access to populations in the camps that are otherwise difficult to reach, for example, mothers who take care of young children. The community could organize a pot-luck or social gathering with childcare provided, allowing mothers to join such peer-led support groups. Moreover, when it is led by Palestinian refugees from Lebanon, mutual understanding and trust can be built, tension between the PRS and PLS can be alleviated, and discrimination would be diminished.

#### E. Tackling Systemic Factors: Collaborate with cross-sector and non-UNRWA Agencies

Systematic factors that are out of one's control are cited as most common exacerbating agents to psychological distress. Medical health services are not the only variable in the function of alleviating psychological suffering. Other services, such as job security, housing, criminal justice, play an integral part in relieving one's psychological distress. Establishing partnership with governmental, non-profit, and private entities thus is required to tackle the systemic, external factors exacerbating the burden of disease.

**Recommendation 9: Identify a list of entities that can help solve the external systemic factors causing distress.**

The first step to addressing systemic factors attributing to distress is to identify the corresponding entity who has the jurisdiction over the issue or has the power to promote changes. For example, in regards to crowdedness, the task force should identify:

- The entity that is responsible for housing
- An external relations arm within UNRWA who can work towards building temporary camps
- Private company has a philanthropist arm that can build temporary housing
- Entity who can help PRS apply for political asylum to other countries

With the local landscape of organizations and entities with the capacity and expertise to tackle these external systemic factors all mapped out, the task force can then approach these entities for concrete partnership.



## Conclusion

Starting an initiative to provide mental healthcare to a vulnerable population is going to be challenging, expensive, and time-consuming. It requires faith and courage to tackle a problem that is excruciatingly stigmatized and thus hard to identify in the region. Fundraising, awareness, education, partnership with other UNRWA divisions, non-medical entities, the government, other NGOs, cross-sector agencies are required to provide an effective healthcare system that alleviates refugees' psychological suffering.

Palestinian refugees from Syria in Lebanon were forced to face trauma and flee, becoming Twice Refugees. As healthcare providers, we have taken an oath to alleviate human suffering. We must recognize the existence of mental illnesses, and give mental wellbeing the same priority as we have given to physical wellbeing.

I sincerely hope this PAE is a helpful resource for the Department of Health of the United Nations Relief and Work Agency. As these recommendations laid the groundwork for an effective mental healthcare system, UNRWA can be the vanguard in making advances for treating mental health in the Middle East and giving refugees a better quality of life.

## Appendices

### Appendix A: Bibliography-Literature Review on PHQ-9 and CAPS

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Appendix B: PHQ-9 (English)

**PHQ-9 depression questionnaire**

<b>Name:</b>	<b>Date:</b>			
<b>Over the last two weeks, how often have you been bothered by any of the following problems?</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<b>Total ____ =</b>	____	+ ____	+ ____	+ ____
<b>PHQ-9 Score <math>\geq 10</math>: Likely major depression.</b>				
<b>Depression score ranges:</b>				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
$\geq 20$ : severe				
<b>If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</b>	<b>Not difficult at all</b>	<b>Somewhat difficult</b>	<b>Very difficult</b>	<b>Extremely difficult</b>
	____	____	____	____

Appendix C: PHQ-9 (Arabic)

الجنس \_\_\_\_\_ العمر \_\_\_\_\_ متى غادرت سوريا؟ \_\_\_\_\_ ما هي الامراض التي تعاني منها؟ \_\_\_\_\_

## استبيان حالة صنف المرضى - 9 (PHQ-9)

يُرجى أولاً إكمال تقييمك، إذا قررت من تعاليتي أن أترك اسمي؟ قم بتلطي				
لا أوافق أبداً	بعضاً من الوقت	كثيراً من الوقت	أوافق تماماً	
3	2	1	0	
3	2	1	0	1. أفتقد الاهتمام بما كنت أفعله سابقاً
3	2	1	0	2. أفتقد القدرة على التركيز
3	2	1	0	3. أفتقد الطاقة
3	2	1	0	4. أفتقد الاهتمام بالأمور الهامّة
3	2	1	0	5. أفتقد القدرة على التفكير بوضوح
3	2	1	0	6. أفتقد القدرة على الشعور بالمتعة
3	2	1	0	7. أفتقد القدرة على التفكير بوضوح
3	2	1	0	8. أفتقد القدرة على التركيز
3	2	1	0	9. أفتقد القدرة على الشعور بالمتعة

\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ = Total Score: \_\_\_\_\_ (FOR OFFICE CODING)

إذا تراءى عليك من أي من هذه الأعراض، فقم بتحديد عدد المرات التي تشعر بها في الأسبوع الماضي، والوقت الذي تستغرقه في التفكير فيها؟

تلبية لكثرة أو صعوبة <input type="checkbox"/>	لكثرة تباين حصة قديمه <input type="checkbox"/>	لكثرة بعض تفاصيلها <input type="checkbox"/>	لكثرة تباين وضعه ففأنيك لا تعقد <input type="checkbox"/>
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Appendix D: CAPS (English and Arabic)

PTSD Measure (CAPS)

Below are some statements regarding how you may have felt and acted during the past week. Please circle the number for each statement to indicate how often that feeling or behavior has occurred.

Use the following scale: 0 = not at all 1 = only once during the week 2 = 2 or 3 times in the week  
3 = 4 or 5 times in the week 4 = about once a day 5 = More than once a day

	not at all أبدا	Once during the week مرة خلال الأسبوع	2-3 times in the week 2-3 مرات في الأسبوع	4-5 times in the week 4-5 مرات في الأسبوع	about once a day مرة في اليوم	more than once a day أكثر من مرة في اليوم
1) Bad dreams or nightmares أحلام مزعجة أو كوابيس ليلية						
2) Being especially alert or watchful, when there was actually no need to be on guard. كنت شديد الانتباه والحذر عندما لم يكن موجبا لذلك						
3) Feeling in daze (ثنية غيبورية)						
4) Flashbacks of past unpleasant events. تكريرات مفاجئة لأحداث غير مسرة						
5) Unexpected or disturbing memories. تكريرات مفاجئة مؤلمة						
6) Feeling as my emotions were shut down or blunted الشعور أن عواطفني تيلدت						
7) Working hard to block out certain memories. بذل جهود عنيقة للحيلولة دون بعض التكريرات						
8) Violent dreams أحلام حافلة بأحداث عنيفة						
9) Trying to avoid reminders of painful past events محاولة تجنب ما يتكررت بالأحداث المؤلمة						
10) Checking to see that I was safe. أتأكد والتحقق من أرى أنني في أمان						
11) Jumping or being very frightened by sudden loud noises. انفزع (أفزع) لدى سماعي ضجعة عالية مفاجئة						
12) Acting or feeling as if I were re-experiencing some painful past events أتصرف أو أكن كأني أعيش الأحداث الماضية من جديد						
13) Distress caused by reminders of a painful past event ألم ويزن بسبب ما يتكررت بحوادث مؤلمة ماضية						
14) Efforts to avoid reminders of a painful past events. بذل الجهود لتجنب ما يتكررت بحادث مؤلمة من الماضي						
15) Feeling in danger...						
16) Feeling out of touch with my surrounding الإحساس بالابتعاد عن محيطي						
17) Feeling that things going on around me were strange, unfamiliar or not quite real. الإحساس وكان الأشياء المحيطة بي غير مألوفة أو غير واقعية						
18) Feeling as if I am watching myself from outside my body. الإحساس وكأنني أراقب نفسي من خارج جسمي						

## Appendix E: Interview Questions – PRS Relocated to Lebanon UNRWA camps (English)

1. Gender, age, when did you leave Syria, what, if any, illnesses do you have
2. How many times have you visited the clinic since you arrived?
3. What kind of health services did you receive when you first came to the camp?
4. What is the reason for today's visit?
5. How have you been feeling since the war has started? Since you moved to the camp?
6. Do you feel that your health providers here care about your mental wellbeing?
7. Do you feel that your health providers here fully address your mental needs?
8. If private counseling sessions are available, would you utilize it?
9. What do you hope for yourself in the near future?

## Appendix F: Interview Questions – PRS Relocated to Lebanon UNRWA camps (Arabic)

1. الجنس، العمر، متى غادرت سوريا، ما هي الامراض التي تعاني منها؟
2. كم مرة قمت بزيارة العيادة منذ قدومك الى المخيم؟
3. ما هي الخدمات التي تلقيتها في المرة الاولى عند قدومك للمخيم؟
4. ما هو سبب زيارتك اليوم للعيادة؟
5. ما هو شعورك منذ بداية الحرب؟ خصوصا عندما انتقلت الى المخيم؟
6. هل تشعر ان مقدم الخدمة في العيادة يهتم بصحتك النفسية؟
7. هل تشعر ان مقدم الخدمة في العيادة يخاطب احتياجاتك النفسية بشكل كامل؟
8. اذا توفرت جلسات تقديم مشورة/نصائح خاصة هل ستشارك فيها ؟
9. ما ذا تامل / تتوقع لنفسك في المستقبل القريب ؟

## Appendix G: Survey Questionnaire – UNRWA Health Providers (English)

Job title \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_ Years working with UNRWA \_\_\_\_\_

1. What physical evaluations do you provide when Palestinian refugees from Syrian (PRS) first come to the camp?
2. What psychological evaluations do you provide when these refugees first come to the camp?
3. What is the most common chief complaints, both physical and psychological, that you encounter from these newly arrived patients?
4. Do the chief complaints change as people stay in the camps over time? In what way?
5. What percent of this refugee population do you estimate is experiencing significant psychological distress that requires clinical attention (PTSD, depression, and anxiety disorders?)
6. How much training have you received in detecting and diagnosing stress related mental health conditions, specifically PTSD, depression, and anxiety disorders?
7. Would more training be helpful to you in providing care to these patients?
8. Which subgroup of refugees do you believe is most vulnerable to psychological distress? Why?
9. How is this manifest?
10. What situations do you see in the camp that could lead to or exacerbate psychological distress?
11. When you suspect that a patient has significant psychological distress, what do you do?
12. How are diagnoses made and documented?
13. What services and resources are available?
14. What mental health services do you perceive as immediate needs?
15. Do victims of sexual assault typically seek medical care following the assault? If not, why?
16. What medical services are available for victims of sexual assault?
17. What psychological services are available for victims of sexual assault?
18. What physical and mental health services do you perceive as immediate needs for victims of sexual assault?



## Appendix H: Consent Form (English)

### Verbal Consent Form

You are invited to participate in a research study assessing the needs for psychological counseling and mental health services. The goal of this research study is to work towards the design of effective interventions to provide services address the mental health of Palestinian refugees from Syria (PRS).

This study is being conducted by Samia Osman. The Harvard Medical School and UNRWA has provided funding for this study and monitor the progress of this study.

To be qualified to participate in this study, you must be a 1) healthcare provider of a UNRWA clinic, 2) a Palestinian refugee who migrated to Lebanon from Syria due to the conflict

Participation in this study is absolutely voluntary. If you agree to participate in this study, you would be asked a series of questions of your attitude on mental health services.

Participating in this study may benefit you directly. Your participation will help the community and us to assess the need for mental health services and protection programs for Palestinian refugees from Syria (PRS). You may find answering some of the questions upsetting, but we expect that this would not be different from the kinds of things you discuss with family or friends. You may skip any questions you don't want to answer and you may end the interview at any time.

The information you will share with us if you participate in this study will be kept completely confidential to the full extent of the law.

If you have any questions about this study, please contact Samia Osman, Health Consultant at the UNRWA Headquarter at [s.osman@unrwa.org](mailto:s.osman@unrwa.org).

Are you willing to participate in this study?

## Appendix I: Consent Form (Arabic)

أنت مدعو للمشاركة في دراسة بحثية لتقييم احتياجات الإرشاد النفسي وخدمات الصحة النفسية. الهدف من هذه الدراسة البحثية هو العمل على تصميم الخدمات وتوفير التدخلات الفعالة لمعالجة الصحة العقلية للاجئين الفلسطينيين القادمين من سوريا.

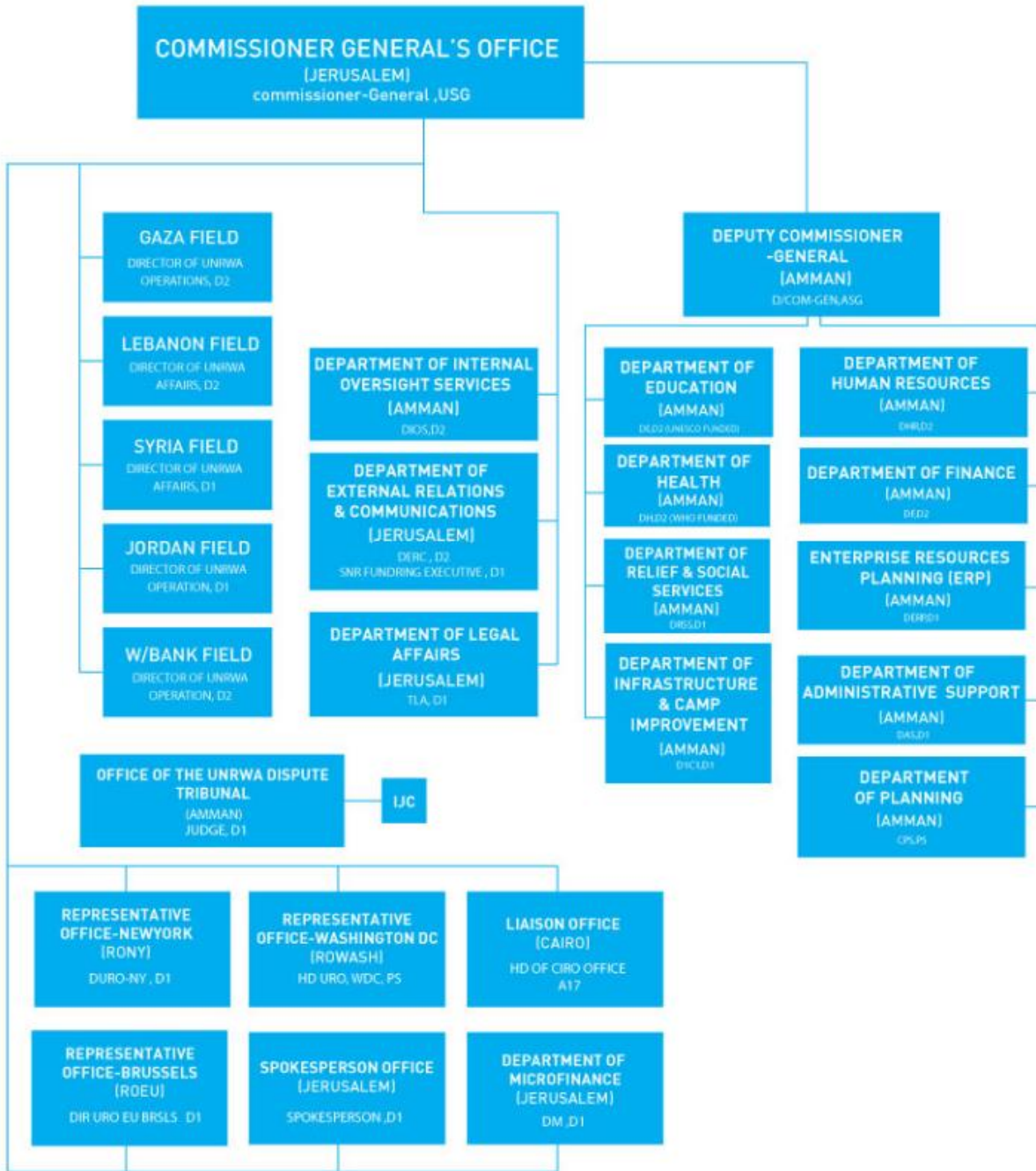
لنتكون مؤهلاً للمشاركة في هذه الدراسة، يجب أن تكون (1) مقدم الرعاية الصحية من عيادة الأوروا، (2) لاجئ فلسطيني من الذين هاجروا إلى لبنان من سوريا بسبب الصراع

المشاركة طوعية على الاطلاق في هذه الدراسة. إذا وافقت على المشاركة في هذه الدراسة، سوف يطلب منك سلسلة من الأسئلة حول موقفك على خدمات الصحة النفسية.

المشاركة في هذه الدراسة سوف تصب في مصلحتك مباشرة. مشاركتكم ستكون بمثابة مساعدة للمجتمع ولنا لتقييم الحاجة إلى خدمات الصحة والنفسية وبرامج الحماية للاجئين الفلسطينيين من سوريا. قد تجد الإجابة على بعض الأسئلة مزعجة، ولكن نتوقع أن هذا لن يكون مختلفاً عن المواضيع التي تناقش مع العائلة أو الأصدقاء. يمكنك تخطي أي الأسئلة التي لا ترغب في الإجابة عليها ويمكنك إنهاء المقابلة في أي وقت.

هل أنت على استعداد للمشاركة في هذه الدراسة؟

Appendix J: UNRWA Organization Structure



## Appendix K: Participant Breakdown

Between the two camps in Lebanon, we conducted PHQ-9 and CAPS screenings on 224 Palestinian refugees from Syria.

	Female	Male	Total
Participants	171 (76.34%)	53 (23.66%)	224 (100%)
Age (average)	32.4	47.2	
Age (median)	28	48	

Month(s) since left Syria at the time of screening	% of PRS screened
0-6 months	68.3%
7-12 months	24.6%
More than 12 months	7.1%

42 Healthcare provider surveys were collected: 10 physicians, 25 nurses, 7 midwives. 8 out of the physicians are men, two and all the nurses + midwives are women.