



Shattered Dreams, Enduring Hope:

Community Voices on Mental Health and Psychosocial Well-being in Gaza

**Mental Health and Psychosocial Support
(MHPSS) Assessment Report
Gaza, 2026**

Acknowledgements

This assessment was made possible by the time, trust and openness of people in Gaza who shared their experiences under extraordinarily difficult circumstances. We are deeply grateful to the women, men, adolescents, children and older people who participated in focus group discussions and interviews while living with displacement, uncertainty and ongoing loss. Their perspectives and dignity are the foundation of this report.

We thank caregivers, youth and community members who spoke candidly about distress, coping and hopes for the future, shaping both the findings and the analysis presented here. We also acknowledge frontline service providers, including psychologists, social workers, health staff, community volunteers and camp focal points, who shared insights on service gaps, system strain and ethical challenges while continuing to serve under intense pressure.

This assessment was led by International Medical Corps in Gaza under the technical leadership of Maura Reap (MHPSS Coordinator, Gaza), with close collaboration from Ahlam Saleh and the International Medical Corps Gaza Mental Health and Psychosocial Support (MHPSS) team. We recognize the interpreters and field colleagues whose professionalism ensured that facilitation prioritized dignity, emotional safety and participant well-being, often while balancing roles as responders and survivors. We also thank International Medical Corps' Child Protection and Violence Against Women (VAWG) teams for support in identifying context-appropriate recruitment pathways for specific groups, and partner organizations, community-based actors and technical colleagues who supported coordination, shared contextual insight and facilitated access throughout the assessment period.

Finally, we acknowledge the strength of Gaza's communities. While this report documents profound distress and unmet needs, it also reflects the care, solidarity and perseverance that continue to sustain families and social bonds. This assessment is offered with respect and with the hope that it contributes to more coordinated, dignified and effective humanitarian action.

Table of Contents

Acknowledgements	2
List of Acronyms	5
I. Executive Summary	6
Overview of Study	6
Key Findings.....	6
Recommendations (see pages 70–73 for details)	7
II. Introduction	9
Why This Assessment Was Necessary	10
How to Read This Report.....	11
III. Methodology	12
Approach and Design.....	12
Data Collection and Analysis	12
Ethical Practice.....	13
Limitations	14
Strengths	15
IV. Context & Scenario Outlook.....	16
Contextual Overview	16
Displacement-linked instability and constraints on privacy and dignity	16
Food insecurity and deprivation as persistent psychosocial stressors	17
Children and family systems: erosion of protective structures	17
Protection risks, specific impacts and impediments to safe access	17
Service constraints and implications for feasible response design	18
Implications for interpretation of qualitative findings	18
Scenario Outlook (3–6 Months)	18
Population Groups of Concern.....	19
Children, especially younger children	20
Orphaned children.....	20
Unaccompanied and separated children	20
Adolescents.....	20
Caregivers, including caregivers of people with disabilities or chronic illness.....	20
Widows.....	20
VAWG survivors.....	20
Older people.....	21
People with disabilities.....	21
People with chronic illness or injury, or requiring continuity of medication.....	21
People requiring specialized or long-term psychiatric care	21
Former prisoners/detainees	21

V. Thematic Findings	22
Part 1: Foundational Stressors.....	22
Theme 1 — Displacement, Shelter & Environmental Hardship.....	22
Theme 2 — Basic Needs Stressors.....	24
Theme 3 — Loss, Grief & Bereavement.....	28
Theme 4 — Family & Social Support.....	30
Theme 5 — Protection Risks, Safety & Social Harm.....	34
II. Psychological & Emotional Impact.....	39
Theme 6 — Emotional & Psychological Impact.....	39
Theme 7 — Livelihoods, Income & Economic Hardship.....	43
Theme 8 — Health, Disability & Medication Access.....	47
Theme 9 — Faith & Spirituality.....	50
D. Community Adaptation & Future Trajectories.....	53
Theme 10 — Coping, Well-being & Life Skills.....	53
Theme 11 — Education, Learning & Aspirations.....	57
E. System Performance & Access To Care.....	60
Theme 12 — Access, Acceptability & Stigma in MHPSS Services.....	60
Theme 13 — Quality, Dignity & Safety Of Care.....	64
Theme 14 — Coordination, Collaboration & System Strengthening.....	68
VI. Integrated Analysis	72
VII. Recommendations	76
1. Stabilize basic living conditions as a foundation for mental health.....	77
2. Deliver MHPSS through community-based, mobile and integrated models.....	77
3. Protect children through structured safe spaces and caregiver support.....	77
4. Provide dedicated, developmentally appropriate support for adolescents and young adults.....	77
5. Protect education and learning as a stabilizing force across the lifespan.....	78
6. Integrate mental health with health, disability and medication continuity.....	78
7. Ensure access to specialized mental healthcare across the continuum, including inpatient capacity.....	78
8. Restore livelihoods and income pathways as a mental health-protective intervention.....	78
9. Safeguard quality, dignity and confidentiality across all services.....	79
10. Address protection risks as integral to MHPSS delivery.....	79
11. Invest in group-specific MHPSS programming.....	79
12. Strengthen coordination, referral pathways, and system coherence.....	79
VII. References	80
Annex 1. Qualitative Inquiry Framework and Discussion Domains (Gaza MHPSS Needs Assessment).....	80

List of Acronyms

CP	Child protection
FGD	Focus group discussion
IDP	Internally displaced person
IASC	Inter-Agency Standing Committee
INGO	International non-governmental organization
KII	Key informant interview
MHPSS	Mental health and psychosocial support
NGO	Non-governmental organization
PTSD	Post-traumatic stress disorder
UN	United Nations
VAWG	Violence against women and girls
WASH	Water, sanitation and hygiene

I. Executive Summary

Overview of Study

This assessment documents a population-wide mental health and psychosocial crisis in Gaza produced by repeated displacement, material deprivation, persistent insecurity, service disruption and cumulative loss across housing, health, education, and livelihoods systems. It is based on 12 focus group discussions and seven key informant interviews conducted across Gaza, engaging diverse populations including children, adolescents, young adults, men and women, boys and girls, community leaders, recent college graduates and clinical psychologists. Findings are contextualized within the operational realities of displacement and service disruption and reflect both community experience and provider perspectives in a context where ongoing instability continues to undermine recovery. The assessment identifies the most urgent mental health and psychosocial needs—especially among those most affected by trauma, displacement and loss—while highlighting gaps in available support. It explores key protection risks and how communities are coping, with the goal of guiding practical responses, improving coordination and keeping community voices at the center.

Mental health outcomes here do not stem primarily from individual vulnerability or isolated traumatic exposure. Rather, they reflect an environment in which safety, predictability, dignity and agency have been steadily eroded. Across the dataset, distress is widespread and persistent, shaped by interacting living conditions and structural stressors—chronic displacement, unmet basic needs, insecurity, disrupted education and livelihoods, protection risks, and health system disruption—compounded by cumulative loss and grief. These factors reinforce one another, producing layered MHPSS needs and progressively weakening the family and community systems that ordinarily buffer distress and sustain the social conditions necessary for psychological well-being. A comprehensive response therefore requires strong coordination across actors and sectors, with functional referral pathways and shared standards to reduce gaps, prevent duplication, and sustain quality, dignity and safety.

Key Findings

1. **Basic needs drive distress.** Food, water, fuel and shelter insecurity overwhelm daily life and exhaust coping capacity.
2. **Loss and grief are continuous.** Cumulative loss persists and is repeatedly reactivated by ongoing danger and renewed displacement.

3. **Education disruption destabilizes children and adolescents.** Loss of routine, learning and future orientation intensifies distress and hopelessness.
4. **Livelihood collapse undermines agency and protection.** Loss of income pathways deepens household strain and role disruption.
5. **Families are over capacity.** Survival demands and caregiving burdens weaken protective function and increase household conflict.
6. **Community cohesion is thinning.** Trust, mutual aid and informal support mechanisms have eroded under scarcity and displacement.
7. **Protection risks are embedded in daily settings.** Overcrowding, unsafe WASH, poor lighting and lack of privacy increase fear and restrict movement, especially for women and girls.
8. **Health system disruption amplifies psychosocial vulnerability.** Fragmented access and medication shortages increase suffering and caregiver burden.
9. **Coping strategies persist but are constrained.** Play, creativity, movement and peer connection remain protective but are sharply limited by insecurity and lack of safe space.
10. **Faith remains a stabilizing resource.** Prayer and belief support endurance and emotional regulation, even as communal worship and collective coping have been disrupted.
11. **Access barriers, service quality concerns, and coordination gaps increase harm.** Insecurity, cost, caregiving and time poverty limit uptake, while confidentiality breaches, weak referral pathways, and under-supported staff reduce continuity and trust.
12. **Distress spans the lifespan and is becoming more complex.** Providers report more severe and high-risk presentations alongside constrained coping options.

Recommendations (see pages 70–73 for details)

Improving mental health and psychosocial well-being in Gaza requires coordinated action across humanitarian sectors. The following recommendations reflect community priorities and align with the Inter-Agency Standing Committee (IASC) MHPSS framework, recognizing that psychosocial well-being depends on both specialized services and the broader social conditions shaping daily life.

1. Stabilize basic living conditions as a foundation for mental health.

2. Deliver MHPSS through community-based, mobile and integrated service models.
3. Protect children through structured safe spaces and caregiver support integrated with MHPSS services.
4. Provide dedicated, developmentally appropriate support for adolescents and young adults.
5. Protect education and learning as a stabilizing force across the lifespan.
6. Integrate mental health with health services, disability support and medication continuity.
7. Ensure access to specialized mental healthcare across the continuum, including inpatient capacity.
8. Restore livelihoods and income pathways as mental health-protective interventions.
9. Safeguard quality, dignity, confidentiality and safety across all services.
10. Address protection risks as integral to MHPSS delivery.
11. Invest in group-specific programming to ensure access.
12. Strengthen coordination, referral pathways and system coherence.
13. Strengthen community-based psychosocial support models grounded in local coping practices, social networks and cultural resources.

II. Introduction

Just before sunrise in one of Gaza's crowded displacement areas, the call to prayer moves through the settlement and people begin to stir. Whether or not they have rested, families wake and begin their day. Blankets are folded, water containers are gathered and children are coaxed into motion. Inside the encampments, women light small fires to prepare the first meal. Short on fuel or wood, they burn whatever is available. Before long, the air fills with smoke and the faint chemical scent of melted plastic. These tasks give shape to days that no longer resemble the lives people once knew.

Movement becomes a way to stay oriented in a life where meaning has thinned. People walk because there is water to collect, food to cook and shelter to reinforce. In a place with few destinations and even fewer choices, staying alive takes work. Families carry out these daily tasks while navigating a psychological world shaped by prolonged fear, accumulating grief and the erosion of the rhythms that once held life together. The conditions around them, such as overcrowding, food insecurity, displacement and constant scarcity, form the backdrop against which their emotional lives unfold.

Inside the rooms, clinics and community spaces where this assessment took place, participants arrived carrying the emotional weight of these realities. They described broken sleep, minds and bodies that remain constantly on alert, as well as worry that fills every waking moment. Many spoke of despair, of feeling overwhelmed or of losing their sense of self. They spoke about relatives who were lost or separated, destroyed homes, disrupted futures and the struggle to meet basic needs. Sometimes they shared openly. Other times they simply nodded when someone told a story that mirrored their own.

People also spoke about the loss of dignity. They described relying on humanitarian distributions for the first time in their lives, struggling for a place in line for scarce necessities, living without privacy and depending on others for survival. These experiences leave emotional marks that do not fade quickly, even in the quiet moments. Some described times when hope felt distant and the effort to continue felt too heavy.

Yet throughout these accounts, people reflected a strength that remained steady. Many spoke of faith as the anchor that carried them through the worst days. Others described the Palestinian spirit that values endurance, care for family and adaptation to impossible circumstances. This outlook appeared again and again, revealing the tenacity of a people forced to withstand more than most can imagine over two years of conflict.

Resilience, however, does not replace the need for support. People were clear that they want and deserve help, but they ask that support be delivered in a way that respects

dignity, identity, culture, history and their own ways of coping. They want services that welcome them as they are and allow them to heal in ways that honor their lived reality.

In this environment of disrupted lives, heavy grief and guarded resilience, we carried out this assessment to understand what people were facing as the ceasefire took hold. We asked questions that explored needs, fears and hopes for the future. People described what would help them access mental health and psychosocial support that feels relevant, responsive and humane.

This assessment reached across the Gaza Strip, seeking to understand experiences, challenges, needs and the remnants of people's dreams. It reflects three weeks of listening to families, youth, caregivers, older people and service providers who shared their lives with honesty and restraint.

The pages that follow examine the conditions of life in Gaza and the psychological world shaped by those conditions. They offer a concise view of people's concerns, survival strategies, resilience and their cautious return to imagining a future.

Why This Assessment Was Necessary

Two years of disruption and repeated displacement have reshaped the social and emotional landscape of Gaza. For many households, daily life has narrowed to immediate safety, shelter and basic needs, with recovery still distant. When the ceasefire took effect at noon local time on October 10, 2025, it created a brief but important window to listen, document needs and clarify service realities at a moment when people could speak with greater openness than is often possible during active escalation.

This assessment was necessary because distress in Gaza is being generated by conditions that cut across sectors and reinforce one another. Participants described repeated displacement, material deprivation, disrupted education and livelihoods, protection risks, and cumulative loss and grief as pressures shaping daily functioning, family life and coping. Understanding how these pressures are experienced in everyday life is essential for designing MHPSS that is feasible under displacement conditions and appropriately linked to the broader humanitarian response.

The assessment was also needed to understand the accessibility and current capacity of MHPSS services in a shifting operational environment. Many facilities have been damaged, closed or forced to relocate. Medication interruptions, reduced staffing and high caseloads have constrained service delivery. Participants and providers described uncertainty about where services exist, which organizations remain active and how to access specialized care—gaps that weaken continuity and disrupt referral pathways.

Finally, displacement patterns continue to change, making coordination central to effective response. Without shared understanding of priority needs, access impediments and practical entry points for service delivery across locations and population groups, there is a risk of efforts being uneven, duplicated in some areas and absent in others. This assessment was undertaken to support more coherent planning and coordination by grounding decisions in direct testimony from communities and frontline providers.

How to Read This Report

This report is organized as a set of thematic chapters reflecting the main domains of experience described across participants. Themes can be read sequentially to follow the overall narrative of how the crisis shapes daily life or individually based on areas of interest.

Each chapter opens with a brief synthesis, followed by patterns observed across groups and supported by direct quotations. Quotes appear as participants shared them, with light editing only for clarity or anonymization. They carry tone and nuance that cannot be captured through summary alone and serve as the evidentiary basis for the findings.

While themes are presented separately for clarity, they are intentionally treated as interconnected. Cross-cutting links, including displacement conditions, access constraints and service disruption, recur across chapters wherever they shape coping and help-seeking. System-focused sections provide additional interpretation for decision makers, planners, and technical teams.

Throughout, the emphasis remains on clarity, accuracy and respect for participants' testimony and lived experience.

III. Methodology

Approach and Design

The data were collected from 120 people who participated in 12 FGDs and 7 KIIs; the approach included field observations across displacement sites and health facilities in Gaza. The aim was to understand lived experiences, emotional needs, coping strategies and service gaps affecting children, adolescents, caregivers, older people and frontline staff.

A qualitative, thematic analytic approach was used to synthesize the dataset. Coding and interpretation focused on recurring patterns and domains of experience raised consistently across participant groups, while also attending to variation by age, gender, displacement context and role. Findings were compiled to reflect both the content of what was shared and the conditions shaping well-being and coping in a protracted crisis.

The report maintains an ethical, neutral and humanitarian approach. All information was collected in accordance with humanitarian principles. Personal identifiers were removed, and sensitive content was handled with care. The analysis does not assign political responsibility; it concentrates on humanitarian conditions and the needs of individuals, families and communities, using language intended to reflect respect for dignity, culture and lived experience.

Data Collection and Analysis

FGDs and KIIs were conducted by the lead researcher, supported by three interpreters, using a semi-structured, domain-based discussion guide (*see Annex 1: Qualitative Inquiry Framework and Discussion Domains*). The guide ensured analytical consistency across sessions while allowing participants to respond freely, shift between topics, and elaborate on issues most salient to them. Discussions were conducted in Arabic and facilitated in ways appropriate to the cultural norms and dynamics of each group. For sessions with younger children, facilitation incorporated developmentally appropriate, art-based activities to support expression of feelings and experiences.

A total of 113 participants took part in the FGDs, representing a cross-section of displaced families, adolescents, children (after obtaining consent from their caregivers), older people and those receiving MHPSS or health services. Seven KIIs were conducted with service providers and key stakeholders, including psychologists, community leaders and representatives from partner organizations. Participants were recruited using purposive sampling through community focal points, displacement site

contacts, and health and MHPSS service entry points, with attention to variation by age, gender, displacement context and service exposure. International Medical Corps' CP and VAWG teams also supported identification of context-appropriate recruitment pathways for specific groups. Recruitment emphasized voluntariness and confidentiality, and participation had no linkage to service eligibility or assistance. KIIs drew on the same analytic domains as FGDs, with probing tailored to respondents' roles and technical expertise.

Interpreters translated prompts and interpreted participants' responses in real time. While interpreter rotation may have introduced minor variation in phrasing or nuance, consistency was supported through shared briefing materials, brief reflection sessions and careful review of session documentation.

Sessions were held in tents, community spaces and health facilities, based on considerations of safety, privacy and accessibility. Participants were informed that participation was voluntary, that discussions would last approximately 60–90 minutes depending on the group's needs, and that they could skip questions or withdraw at any time.

Field notes were taken during each session and expanded into detailed write-ups immediately afterward. These write-ups formed the basis for thematic coding and analysis. Data were manually reviewed and organized into an Excel-based coding matrix, resulting in more than 650 coded excerpts organized across 15 core themes. Themes were derived inductively from the coded dataset and reflect the main domains raised across participant groups, including lived experience of displacement, basic needs and service disruption, protection and safety, family and community strain, coping, and impediments to accessing MHPSS support.

Ethical Practice

A strong ethical foundation guided every step of this assessment. Before each discussion, facilitators explained the purpose of the study, what participation involved and how information would be used. Verbal consent was obtained due to privacy concerns, literacy considerations and the practical constraints of displacement.

Emotional safety was prioritized. Facilitators were trained to recognize distress and respond using grounding, pausing or slowing techniques. On several occasions, discussions were briefly stopped to allow individuals to regain composure or comfort children who became upset. Participants showing acute distress were offered immediate psychosocial support and referred to services when appropriate.

Confidentiality procedures were explained to participants and followed throughout the assessment to protect privacy. All identifying details were removed during transcription.

Quotes were lightly edited to ensure anonymity without altering meaning or tone. Documentation was stored securely and accessed only by designated team members.

Sessions were conducted in Arabic, with interpretation support for an English-speaking lead facilitator, and were grounded in local expressions of distress, family dynamics and communication norms. Facilitators exercised particular care when discussing sensitive topics such as loss, safety concerns, trauma, marital conflict or displacement-related hardship.

A duty of care also extended to staff. Conducting FGDs and KIIs in an environment marked by grief, scarcity and instability carried emotional weight for facilitators. Internal debriefings were used to support staff well-being, identify challenges, and maintain quality across sessions.

Throughout the assessment, the team upheld principles of neutrality, dignity and respect. No political questions were asked, and participants were not encouraged to assign blame. The focus remained on humanitarian conditions, emotional well-being and community-identified priorities.

Limitations

Several constraints shaped the assessment:

Access restrictions. Movement limitations and security concerns prevented the team from reaching some remote or recently displaced areas. Although people with physical disabilities participated (particularly within the trauma hospital), individuals with significant cognitive or intellectual disabilities were less accessible.

Qualitative scope. This assessment prioritizes analytical synthesis over prevalence estimation due to access constraints. Findings should be interpreted as indicative patterns rather than representative estimates.

Compressed timelines. The ceasefire created a narrow window in which data collection could begin, but uncertainty about its duration constrained planning. Sessions had to be organized around community routines, facility operating hours and ongoing, unpredictable displacement patterns.

Population reach. Widows, highly isolated households, and some groups dispersed across informal sites were harder to engage. These gaps reflect contextual impediments rather than lack of effort.

Variation in interpretation. While the team followed shared guidance, using multiple interpreters introduced minor variability in phrasing or emotional emphasis.

Sector coverage. The assessment engaged primarily with MHPSS, health and protection stakeholders. Other sectors such as shelter, WASH, education and livelihoods were not directly interviewed, which may have limited opportunities for deeper multi-sector triangulation.

Despite these limitations, the consistency of themes across groups significantly strengthens the credibility of the findings.

Strengths

The assessment benefitted from several significant strengths that enhanced the credibility, depth and consistency of the findings.

Depth and openness of testimony. Participants spoke candidly about their emotional states, losses, coping strategies and expectations of services. The level of detail in their accounts provided rich insight into daily realities.

Cross-group convergence. Children, adolescents, caregivers, older adults and providers described highly consistent patterns of distress, disruption and need. This convergence validates the reliability of thematic findings.

Strong community trust. International Medical Corps' long-term presence in Gaza enabled facilitators to enter communities with an established degree of credibility. Participants engaged openly, even on sensitive topics.

Robust manual analysis. The dataset was coded manually, line by line, ensuring close engagement with participants' words and reducing the risk of misclassification or thematic drift.

Together, these strengths support a clear and accurate picture of the MHPSS landscape in Gaza at this moment, and the conclusions presented in the sections that follow.

IV. Context & Scenario Outlook

Contextual Overview

This qualitative MHPSS needs assessment was conducted in the context of a sustained, multi-layered crisis in which psychosocial distress is driven not by a single shock but by persistent exposure to insecurity, deprivation, displacement and disrupted services. The contextual overview below provides an evidence-based baseline to inform interpretation of the qualitative findings. It draws on recent humanitarian reporting and local documentation to summarize the scale of exposure, the weakening of protective systems and the constraints affecting psychosocial well-being and access to care.¹

Scale of exposure and breadth of protection and psychosocial needs

OCHA reports Gaza's current population at approximately 2.1 million (OCHA, 2026a). OCHA further reports that 2.1 million people are estimated to be in need of protection and MHPSS—including 1.1 million children—citing the Flash Appeal (December 2025) and UNICEF (December 2025) (OCHA, 2026a). In the same reporting, cumulative casualty figures reported by the Ministry of Health in Gaza and cited by OCHA include 71,824 fatalities and 171,608 injuries (OCHA, 2026a). These indicators collectively describe widespread exposure to loss, injury, displacement and disrupted services, with psychosocial consequences that extend across individual functioning, family systems and community cohesion (OCHA, 2026a; WHO, 2025).

Displacement-linked instability and constraints on privacy and dignity

Displacement and housing loss continue to shape daily living conditions and influence coping, caregiving capacity and help-seeking (GCMHP, 2025; OCHA, 2026a). OCHA reports extensive damage to the built environment, including 320,622 housing units damaged and approximately 81% of all structures destroyed or damaged (UNOSAT, as cited by OCHA) (OCHA, 2026a). OCHA also reports that approximately 1 million people require emergency shelter items (OCHA, 2026a). In MHPSS terms, overcrowding, limited privacy and unstable shelter conditions are associated with heightened family strain, increased protection risks and reduced feasibility of sustained engagement with services, particularly where discreet access and continuity of follow-up are required (GCMHP, 2025; UNFPA, n.d.).

¹ (GCMHP, 2025; OCHA, 2026a; UNFPA, n.d.; UNICEF, 2026; WHO, 2025).

Food insecurity and deprivation as persistent psychosocial stressors

The operating environment is further characterized by severe deprivation (OCHA, 2026a; WHO, 2025). OCHA reports that 77% (1.6 million people) of the analyzed population were facing or are projected to face crisis-level or worse acute food insecurity between December 2025 and April 2026 (IPC analysis, as cited by OCHA) (OCHA, 2026a). At the household level, OCHA reports that 55% of surveyed households relied on waste burning to prepare food (WFP Market Monitor, as cited by OCHA) (OCHA, 2026a). WHO situational analysis further describes severe disruption of access to essential resources and services under conditions of ongoing hostilities, which contributes to sustained stress exposure and reduced coping capacity (WHO, 2025). These conditions are expected to intensify caregiver burden and household stress, influence family functioning and constrain help-seeking through survival-driven trade-offs and reduced capacity to engage with services (GCMHP, 2025; OCHA, 2026a; WHO, 2025).

Children and family systems: erosion of protective structures

Children and caregivers are disproportionately affected through direct harm, bereavement and the prolonged disruption of stabilizing routines and protective systems (OCHA, 2026a; UNICEF, 2026). UNICEF reports that more than 64,000 children have been killed or injured (UNICEF, 2026). OCHA reports 637,475 school-aged children without sustained access to formal, in-person education (OCHA, 2026a). OCHA further reports that more than 58,000 children have lost one or both parents (UNICEF, December 2025, as cited by OCHA) (OCHA, 2026a). These indicators describe sustained disruption to core developmental and protective structures, including caregiving continuity, education, peer connection and daily routine (OCHA, 2026a; UNICEF, 2026). This context is expected to increase child distress and behavioral disruption and to intensify caregiver strain, while reducing access to stabilizing structures that support regulation and recovery (GCMHP, 2025; UNICEF, 2026).

Protection risks, specific impacts and impediments to safe access

Humanitarian reporting and MHPSS-focused situation analysis also highlight the ways protection risks and specific vulnerabilities are amplified in overcrowded and resource-scarce environments, with implications for psychosocial well-being and access to confidential services (UNFPA, n.d.). In practice, reduced privacy, movement constraints and insecure service environments can limit help-seeking and continuity, particularly for individuals who require discreet pathways to care (UNFPA, n.d.). These dynamics are central for MHPSS programming and service design, as they shape not only distress patterns but also the feasibility of safe support within integrated service platforms (UNFPA, n.d.).

Service constraints and implications for feasible response design

MHPSS needs are shaped not only by the severity of stressors but also by constraints affecting continuity of care and access to specialized support (GCMHP, 2025; OCHA, 2026a; WHO, 2025). OCHA reports that more than 18,500 critical patients, including 4,000 children, require medical evacuation outside Gaza (OCHA, 2026a). While not specific to MHPSS, this reflects a broader service ecosystem in which specialized capacity is constrained and continuity pathways are fragile (OCHA, 2026a; WHO, 2025). Local documentation from GCMHP indicates that survival priorities and instability frequently limit sustained engagement with psychosocial services, reinforcing the need for delivery models that are flexible, accessible and designed to function under interruption (GCMHP, 2025).

Implications for interpretation of qualitative findings

Taken together, this contextual overview indicates population-wide exposure to severe protection risks and psychosocial stressors; extensive destruction and shelter instability; crisis-level food insecurity; prolonged disruption of education and caregiving systems; and constrained service continuity (GCMHP, 2025; OCHA, 2026a; UNFPA, n.d.; UNICEF, 2026; WHO, 2025). This context provides the foundation for the qualitative FGD and KII findings that follow, which examine how these conditions are experienced in daily life, how families and communities attempt to cope under prolonged strain, what impediments shape help-seeking and access, and what response priorities emerge from community and frontline perspectives.

Scenario Outlook (3–6 Months)

This outlook synthesizes the humanitarian conditions summarized in the contextual overview and the operational constraints currently shaping displacement, essential services and continuity of care (OCHA, 2026a; WHO, 2025). Over the next three to six months, conditions will remain highly constrained even if hostilities decline. Continued population movement, fragile service delivery and limited household recovery capacity will sustain high psychosocial strain. Unless shelter conditions, service continuity and economic security improve in tangible ways, psychosocial pressures will deepen.

Living conditions are expected to remain crowded and unstable. Limited privacy, uneven access to safe water and sanitation, and poor lighting and security features in shelters will continue to erode dignity, increase fear and intensify family tension. Winter conditions will further compound stress, with cold, dampness and poor air quality worsening sleep disruption, fatigue and respiratory illness—particularly among children, older adults and people with chronic conditions.

Health and MHPSS services will remain under sustained pressure. High caseloads, medication interruptions and staffing shortages will continue to constrain access and

weaken follow-up, particularly for people requiring continuity of psychotropic or chronic disease medication. In periods of relative calm, demand is likely to become more visible as families regain enough psychological space to articulate distress, even while system capacity remains limited.

Education disruption will continue to destabilize children and adolescents. Prolonged gaps in structured learning reduce routine, social connection and developmental protection. For adolescents and young adults, continued disruption to exam pathways, training and employment prospects will further undermine future orientation and increase disengagement, isolation and hopelessness.

Economic recovery will remain out of reach for many households. Livelihood pathways will stay constrained, and caregivers will continue to face difficulty rebuilding income, securing basic supplies and managing daily costs. Ongoing financial strain will fuel household stress, role disruption and conflict, while sustained dependence on humanitarian assistance will reinforce uncertainty and loss of agency.

Social cohesion will remain under stress as prolonged displacement reshapes community life. Competition over space and resources, unfamiliar living arrangements, and ongoing insecurity will increase friction and misunderstandings, with implications for family functioning and protection risks, particularly for women and girls, children, older adults and people with disabilities.

Some localized stabilization is possible if mobility improves and coordination strengthens, enabling community spaces to reopen or adapt and allowing humanitarian actors to extend outreach. Even under incremental improvement, the operational reality remains that needs will be substantial and sustained. The next three to six months therefore require planning that assumes disruption: decentralized and mobile entry points, low-burden follow-up mechanisms that can withstand renewed displacement, strengthened referral pathways for higher-risk cases and consistent attention to privacy, dignity and safety as non-negotiable conditions of care.

Population Groups of Concern

Distress and need are widespread across Gaza. This section highlights groups facing compounded difficulties that increase their risk of harm or inability to access services during continued displacement, constrained services and limited privacy and dignity. These groups were identified through synthesis of secondary data and consistent patterns reported across FGDs and KIs. Across groups, the most consistent pressures relate to mobility and transport constraints, time poverty and caregiving burden, limited privacy and fragile continuity mechanisms in a disrupted service environment.

Children, especially younger children

Young children are vulnerable to regression, separation distress, disrupted routines and heightened dependence on caregiver stability. Overcrowding and limited safe play and learning spaces reduce protective structure and increase exposure to fear and distress, contributing to dysregulation where routine and safe space are limited.

Orphaned children

Children who have lost one or both caregivers face heightened emotional vulnerability, disrupted attachment and caregiving, and increased protection risks. Instability in living arrangements and reduced access to consistent adult support can intensify distress and hinder recovery, with increased risk of discontinuity in care where caregiving is unstable.

Unaccompanied and separated children

Children separated from caregivers face heightened emotional vulnerability, protection risks and instability in living arrangements, with limited continuity of care and support. They are at elevated risk of not being able to access services where consistent adult support is absent.

Adolescents

Adolescents describe loss of structure, disconnection from peers and uncertainty about their futures. Disruption to schooling and exam pathways has weakened identity development and future orientation, reduced protective routines and contributed to withdrawal, disengagement and hopelessness, with higher likelihood of disengagement when dignity, purpose and peer connection are disrupted.

Caregivers, including caregivers of people with disabilities or chronic illness

Caregivers report exhaustion, fear for their children and difficulty maintaining stability under conditions of scarcity and repeated displacement. High caregiving burden and time poverty constrain help-seeking and directly influence children's functioning, and caregivers are at heightened risk of not being able to access services when help-seeking requires time, travel or repeat visits.

Widows

Widows face compounded grief alongside practical strain, including intensified caregiving responsibilities, loss of household income, and increased social and protection vulnerabilities. Many experience isolation and reduced access to support networks under displacement and scarcity, with help-seeking further constrained where privacy and perceived safety are limited.

VAWG survivors

Survivors of VAWG face heightened psychological distress and protection risks, often compounded by stigma, fear of disclosure and lack of safe, confidential access to services. Overcrowding and limited privacy in displacement settings can further

constrain help-seeking and recovery, with disclosure and help-seeking suppressed where confidentiality cannot be assured.

Older people

Older adults face mobility difficulties, disrupted medical care and the loss of familiar environments. These factors increase the risk of isolation, depression, anxiety and unmet health needs, with access constrained by mobility difficulties and disrupted continuity of care.

People with disabilities

People with physical, sensory, intellectual/developmental, cognitive or psychosocial disabilities face compounded difficulties in displacement settings, including inaccessible environments, disrupted routines, limited assistive devices and challenges accessing services. Caregivers supporting people with disabilities often carry additional strain.

People with chronic illness or injury, or requiring continuity of medication

Individuals with chronic conditions, injury or untreated pain face heightened psychosocial stress when care is fragmented and medication access is unstable. Care disruptions also intensify caregiver burden and uncertainty, with psychosocial severity closely tied to interruptions in care and medication.

People requiring specialized or long-term psychiatric care

Individuals with severe mental health conditions face medication shortages, interrupted treatment and limited access to specialized care, increasing risk of deterioration and crisis when continuity cannot be maintained. In this context, interruption of medication and follow-up is associated with rapid escalation.

Former prisoners/detainees

People who were formerly imprisoned or detained were described as facing elevated psychosocial needs and reintegration challenges. Families also reported secondary strain as they attempt to support return and recovery under conditions of displacement, insecurity and constrained service access, with stigma and reintegration strain impeding help-seeking and recovery.

V. Thematic Findings

After two years of war, mental health and psychosocial needs are widespread across Gaza, but their severity is not evenly distributed. Across the dataset, participants described heightened strain where displacement has been prolonged, shelter conditions remain unstable and access to basic services and continuity of care is most constrained. Repeated relocation and chronic uncertainty further erode routines and coping capacity.

These findings sit within the broader conditions summarized in the contextual overview and show how those constraints are lived and navigated in daily life. Severity is also compounded for groups facing elevated protection risks, mobility impediments, high caregiving burden, disrupted learning, or interrupted treatment, including adolescents, caregivers, older people, people with disabilities and people requiring ongoing psychiatric care. The chapters that follow present findings by domain, grounded in direct participant testimony, and reflect how these pressures intersect to shape daily functioning, coping and help-seeking across settings and groups.

Part 1: Foundational Stressors

Theme 1 — Displacement, Shelter & Environmental Hardship

Displacement is one of the most defining and destabilizing features of life in Gaza. Participants described it not as a single event but as an ongoing cycle of forced uprooting and adapting. Families move repeatedly, sometimes after being given only a few minutes of warning. Each relocation strips away routines, possessions and any sense of growing stability. Two participants described the cumulative weight of this disruption:

“We moved more than nine times. Some families have been displaced 12 times.” FGD 7

“The biggest challenge is constant displacement—we’ve moved so many times.” FGD 4

These repeated moves shape nearly every other stressor described across groups, including crowding, loss of privacy, exposure to harsh weather and the gradual erosion of dignity in daily life.

Overcrowding and the loss of private space

Crowding in tents and unfinished structures was one of the most frequently described daily hardships. Shelters often host far more people than they were ever designed to hold:

“Every tent has more than six people.” FGD 10

In these conditions, privacy has nearly disappeared. Ordinary tasks such as changing clothes, resting or speaking with family members now feel exposed and surveilled:

“The biggest challenge for me is privacy. There is none. There’s no space for the family. Everyone can see what you’re doing.” FGD 10

“All of us lost our homes.... We live in camps with no privacy. My neighbor overheard our private conversation through the tent.” FGD 11

Women and adolescent girls explained how this constant visibility affects dignity and daily functioning:

“These days, we’re always covered, always wearing hijab because there is no privacy.” FGD 8

Harsh exposure to weather and poor infrastructure

Shelters provide minimal protection from heat, cold, wind or rain. Tents trap heat during the day and become extremely cold at night:

“The tents get so hot, and it puts me in a very bad mood.” FGD 10

Electricity shortages heighten anxiety about the coming winter:

“For me, the absence of electricity is one of the hardest things, especially in winter. It will be so cold.” FGD 10

“We’re really afraid for the winter. We’re afraid for our children.” FGD 18

Even simple activities—such as cooking, resting or caring for children—become physically and emotionally exhausting under these conditions.

Environmental hazards

Many families described daily exposure to insects, rodents and other hazards that create ongoing health and safety concerns:

“There’s no one responsible for sanitation. There are insects, animals, even snakes and dogs.” FGD 10

“Yes, the insects are terrible. I even found worms on my baby one day.” FGD 10

These substandard conditions heighten vigilance and add layers of fear, disgust and exhaustion to daily life, particularly for caregivers who must constantly monitor children in environments perceived as unsafe and unhygienic.

Displacement as cumulative loss

Participants consistently described displacement as more than the loss of a physical structure. It is also the loss of the life built within, including privacy, independence, identity and a sense of belonging:

“We were bombed four times. We lost so much. Now, I live with my mother. I have nothing in this life.” FGD 5

For adolescents, displacement fractures social ties and leaves them emotionally unanchored:

“We’ve been displaced eight times. It’s hard to make new friends.” FGD 4

Crowding, instability and the erosion of familiar environments undermine autonomy and disrupt routines that once supported emotional regulation and a sense of continuity.

Destabilization and daily psychological strain

Taken together, these experiences show that displacement in Gaza is not a temporary disruption but a sustained condition shaping daily life. Persistent overcrowding, environmental exposure, unsafe sanitation and repeated movement between inadequate shelters erode routines, autonomy and emotional stability, leaving families physically exhausted and psychologically strained.

Within this environment of instability and exposure, the struggle to secure food, water, fuel and electricity becomes a dominant organizing force of daily life, intensifying distress and constraining the capacity to cope.

Theme 2 — Basic Needs Stressors

Against this backdrop of displacement and unstable shelter, shortages of food, water, fuel, hygiene supplies and electricity emerge as the most immediate pressures shaping daily life in Gaza. Across focus groups, participants described basic needs as a constant, organizing force governing how families spend their time, allocate energy and manage distress.

Much of each day is consumed by survival routines such as waiting in distribution lines, searching for water, securing fuel and adapting to shortages that disrupt cooking, cleaning and household functioning. These demands leave little space for rest, connection or emotional recovery. As one caregiver summarized:

“It’s exhausting... Every day we carry water, cook outside, search for things, stand in lines. There’s no break.” FGD 8

Food insecurity and irregular meals

Participants consistently described unstable and insufficient access to food. Many families rely on humanitarian distributions that are unpredictable or inadequate, while others skip meals so children can eat. The psychological burden of this uncertainty was repeatedly emphasized:

“For three days, we didn’t have a single piece of bread. My son is 8 years old. There was no food. I was so desperate.... I even tried to breastfeed him again! We ate anything we could find, even leaves and sand.” FGD 8

“The starvation period was devastating. Parents worried only about keeping their children alive instead of teaching them.” FGD 7

“We don’t have enough money. We don’t have gas to cook, and there’s no food.” FGD 8

“Starvation and malnutrition remain huge issues.” FGD 6

Women in several FGDs highlighted the emotional strain of not being able to feed their families or provide nutritionally adequate meals. For mothers responsible for preparing food without fuel or functioning kitchens, this burden was described as both practical and deeply distressing.

Water scarcity and hygiene challenges

Access to clean water remains limited and often requires long walks or repeated trips. Caregivers and older adolescents described carrying heavy containers across long distances:

“Water is always a problem. It runs out quickly, and we spend half the day trying to get more.” FGD 8

“Water, electricity, safety—we have none of them.” FGD 8

Water scarcity also undermines personal hygiene. Participants described being unable to bathe regularly, wash clothes or maintain basic sanitation. The discomfort and shame associated with these conditions intersect with health risks, protection concerns and emotional well-being:

“Taking baths is extremely hard. We use the tent itself, and I’ve worn the same clothes since the start of the war.” FGD 8

While hygiene-related health impacts are discussed further under “Health & Disability,” participants consistently identified the root of these challenges in the lack of safe, sufficient water.

Electricity shortages disrupting routines and connection

Electricity scarcity affects nearly every domain of daily functioning. Without consistent power, families cannot communicate, charge phones, refrigerate food, study or maintain routines. Adolescents in particular described feeling cut off and unable to complete even basic tasks:

“Without electricity, we can’t charge phones, we can’t cook properly, we can’t do anything.” FGD 8

“Electricity is a major need. We need to charge our phones to coordinate work. The lack of power creates so many problems.” FGD 11

The inability to study at night or keep food from spoiling adds further frustration and strain, especially for youth preparing for exams and caregivers managing households under constant uncertainty.

Fuel shortages and physical strain

Fuel scarcity has transformed one of the most basic routines of daily life. Cooking now requires open fires or improvised methods using debris, wood scraps or other burnable materials. Participants described meals taking hours to prepare under unsafe conditions:

“Cooking takes hours now. There’s no gas, and we have to burn whatever we can find.” FGD 8

“There’s no gas; everyone cooks with fire.” FGD 7

These methods expose families to smoke, fumes and prolonged heat. Women and children, who spend the most time near cooking areas, face heightened physical risk and exhaustion.

The burden of survival tasks

Across discussions, participants emphasized that securing basic needs dominates nearly every hour of the day. Time once spent on learning, rest or social connection is now absorbed by collecting water, waiting for food, searching for fuel or cooking under unsafe conditions:

“People spend their whole day trying to meet the basics. There’s no time for anything else.” FGD 7

Children are increasingly drawn into these routines:

“My children have lost their innocence. They’re always standing in line for water or food.” FGD 8

This constant labor leaves little space for routine, recovery or emotional processing. The burden falls especially heavily on women and girls, whose responsibilities for food preparation, water collection and caregiving intensify under scarcity.

Emotional consequences of unmet basic needs

Participants repeatedly linked unmet basic needs with emotional deterioration. Caregivers described feeling overwhelmed, ashamed and depleted when they could not meet their children's needs:

"They lack even the basics. Because of this, people are more anxious." FGD 7

"How can we have good mental health if the basics aren't available? My small child asks for something simple, like a piece of chocolate, and I can't even give it to her."
FGD 11

"We're seeing more stealing behaviors, more aggression and more isolation. People are adopting survival behaviors." FGD 12

These pressures feed directly into the emotional patterns explored in subsequent themes, including anxiety, irritability, withdrawal and strain within families and communities.

Basic needs as enabling conditions for recovery

All the key informants consistently emphasized that meaningful engagement in MHPSS is constrained when basic needs remain unmet:

"People can't focus on mental health if they don't have food or water." KII 1: Head of Protection Department, Local NGO

"If we could provide the basic needs first, that's the most critical thing." FGD 12

When survival dominates daily life

As shortages persist, daily life increasingly revolves around survival rather than stability. The effort required to secure food, water, fuel and electricity consumes time and energy, crowding out rest, routine and emotional recovery. What once felt ordinary begins to disappear.

Here, distress is not driven only by acute deprivation but by the gradual collapse of daily life itself. As meals, caregiving rhythms, dignity and choice erode, material scarcity begins to translate into broader forms of loss that shape how people relate, cope and endure.

Theme 3 — Loss, Grief & Bereavement

Loss emerged as one of the most pervasive elements shaping life in Gaza. Participants spoke not only of deaths, but of the disappearance of homes, familiar streets, livelihoods and the roles and identities that once organized daily life. Grief was rarely described as a single moment or event. Instead, it was portrayed as a continuous condition, repeatedly reopened by displacement, environmental hardship and ongoing uncertainty.

Loss influences how people function day to day, how decisions are made and how emotions are regulated. It is inseparable from the conditions that now structure life: unstable shelter, fragmented services, disrupted livelihoods and the weakening of community networks. Within this landscape, grief is not something that recedes with time; it accumulates.

Loss of family members and loved ones

Many participants referred to the deaths of close relatives. These disclosures were often brief, delivered with a restraint that reflected both emotional exhaustion and the normalization of bereavement.

“I drew a heart. It’s green. I made the heart, but I’m very sad because I lost my aunt, my father, my grandfather and my grandmother—so many people.” FGD 1

A young man spoke plainly about the scale of his losses:

“But I lost my mother, two sisters and one brother because of this war.” FGD 9

Service providers emphasized that grief rarely has space to be processed:

“People have been affected by so much loss... loss of so many loved ones. There’s a lot of unresolved grief that we’re all suffering from.” FGD 6

These accounts suggest a form of collective numbing that can emerge when bereavement becomes widespread and unrelenting.

Loss of home, community and place

For many participants, loss extended beyond people to the erasure of homes, neighborhoods and the sense of belonging tied to them.

“I have three children.... They spend most of their time crying because they lost everything.” FGD 8

“We lost our homes and our communities. Everything we knew before is gone.” FGD 7

The destruction of physical space was also described as a loss of orientation and continuity:

“We have to realize that what we had before we’ll never have again. Even our good memories are only in the past.” FGD 8

These experiences create dislocation in geographic terms and the deeper sense of where and how one belongs.

Loss of roles, dignity and place in the world

Alongside physical destruction, participants described a quieter but equally profound erosion of identity. The loss of livelihoods, routines and social roles destabilized how people understood themselves and their place in the world.

A psychologist described this rupture clearly:

“If the war ended, many people would heal naturally. But right now, they’ve lost their roles and sense of meaning.” FGD 8

An imam reflected on the collapse from professional life into survival:

“One woman I know used to be a lecturer and teacher; now she spends her days searching for food. This loss of role and dignity affects everything.” FGD 7

Here, loss is not only economic. It is emotional, relational and existential—shaping how people see themselves and what they believe remains possible.

Family fragmentation

Family separation—through death, repeated displacement or relocation to different shelters—emerged across nearly every FGD as a major source of strain. Fragmentation was described both as emotional rupture and as a practical breakdown of support systems.

“Another way stress shows up now is through marital problems. Divorce has increased a lot.” FGD 6

“We’ve been seeing a lot of violence between groups, and many families are separating. There are more divorces these days.” FGD 7

Others described isolation and conflict within families:

“I’ve had conflicts with my family. They’re not talking to me.” FGD 3

“Before the war, there were already social problems—depression, conflict—but now it’s much worse. There’s so much fighting, so much tension in families and communities.” FGD 6

As displacement scatters relatives across locations, caregivers are left with fewer emotional and practical supports, compounding daily strain.

Loss as a cumulative and collective condition

Although each experience of loss is deeply personal, participants emphasized that bereavement is now shared across households, neighborhoods and generations.

“Now, entire families are traumatized. Everyone has lost someone. The difference is in how deeply they’re affected.” FGD 12

“Before the war, there were many places to go, such as cafes, parks, friends’ homes. There were many activities and spaces for connection. Now those places are destroyed, and many people have lost the friends and networks that helped them cope.” FGD 6

Grief without closure

Loss in Gaza is unending and continuously unfolding. It is shaped by displacement, unfinished mourning, fractured families and the absence of conditions that allow grief to be settled or shared. Without space, safety or stability, sorrow is carried forward rather than integrated.

Therefore, even grief does not remain private. It reshapes roles, strains relationships and alters how families and communities function day to day. As loss accumulates without resolution, the emotional weight borne by households presses increasingly on the systems of care and support people rely on to endure.

Theme 4 — Family & Social Support

Family and social networks have long been Gaza’s strongest source of emotional stability, practical support and protection. Yet after months of displacement, overcrowding, scarcity and ongoing insecurity, these systems are carrying pressures far beyond what any household or community can sustain.

Across FGDs and KIIs, participants described a painful paradox: families remain the primary refuge for children and adults, but their capacity is eroding. Meanwhile, the broader social fabric that once buffered distress has fractured under the same pressures. The sections below illustrate how these strains interact across family life, peer relationships and community ties.

Family as the foundation

Across all age groups, participants described families as their first and most trusted source of comfort.

“This is my mama. Mama makes me happy. When I feel sad, I go to her.” FGD 1

“I go to my mom, my dad or my grandmother.” FGD 4

Adolescents echoed this reliance:

“I go to my sister, my mom or a friend.” FGD 2

“When I feel sad, I like to talk to my mother... or sometimes my sister.” FGD 5

Families continue to anchor children and adolescents in a context where nearly every other form of normality has collapsed. Yet sustaining this role has become increasingly difficult.

Household strain and the compression of emotional space

Prolonged scarcity, fatigue and constant threat have reshaped how families communicate and cope. Small stressors escalate quickly inside overcrowded shelters.

“Marital problems have increased dramatically. Sometimes it’s over small things—stress about missing items like diapers.” FGD 7

Service providers observed similar dynamics:

“Women are under extreme stress, and communication within families is harder.” KII 1: Head of Protection Department, Local NGO

Women also highlighted the strain men carry:

“The men are very stressed.” FGD 8

Community leaders described how quickly household strain can spill into harm, especially for children:

“Marital problems are increasing, and children pay the price.” Male, imam/lecturer, approx. 52

Households continue trying to protect one another, but daily survival demands leave little emotional space, thinning the buffer families once provided more reliably.

Role shifts and weakening of family functioning

Role changes appear in Theme 3 as a form of identity loss. Here, participants described the same shifts as forces that reorganize family life and impact caregiving, authority, responsibility and emotional availability within the household.

Participants described upheavals that strain family systems:

“Children have become caretakers for their families. Women have become heads of households. People trained as professionals are now working in bakeries or any job they can find.” FGD 12

For many women, grief and caregiving are inseparable:

“My husband was killed. I have to stand for hours in line for food and water. It’s extremely stressful. Every moment is consumed with tasks—washing clothes, caring for the children.” FGD 10

Families remain central, but the weight they are carrying is reshaping how they relate, communicate and endure.

Caregiving responsibilities that exceed what families can carry

Families are absorbing intensive caregiving for relatives with chronic illness, disabilities, trauma-related distress and war injuries, often without external support.

“One woman had three children. Her son couldn’t provide for the family, so he went to the aid center but was shot. Now he’s an amputee, and his parents must care for him.”

FGD 6

Adolescents described taking on adult responsibilities:

“I also have relatives with disabilities... one with a mental disability, another with amputated legs and another with a badly healed leg injury. Because of this, I had to take on a lot of household responsibility.” FGD 2

“I have a brother with special needs.... My mother stays home to care for him. We can’t take him out easily.” FGD 2

Others described irreversible loss:

“My brother also had special needs. He didn’t survive. He died from starvation.” FGD 2

These burdens deepen exhaustion inside households already struggling to meet basic needs, accelerating the erosion of family stability.

Peer relationships and the loss of childhood networks

The strain on families is compounded by the collapse of friendships and peer support. Children described how displacement has scattered the relationships that once shaped play, identity and emotional well-being.

“I’m happy when I’m playing with my friends. We live here in the camp, and we play in between the shelters.” FGD 1

*“I used to play in my backyard with my friends. We played *ṭanjīna*, hopscotch and hide-and-peek. We also played house with sugar plates.... I also like the rain because it makes the flowers. We pick the flowers, and we give them to each other.”* FGD 1

But repeated displacement has severed familiar ties:

“We’ve been displaced eight times. It’s hard to make new friends, and many of my friends have been killed.” FGD 4

Adolescents described growing isolation:

“These days I just like to be alone. I want to make new friendships, but sometimes I can’t.” FGD 2

With peers scattered and childhood routines lost, children and adolescents turn even more heavily to families that are already under extraordinary strain.

From household strain to community fracture

What happens inside homes mirrors what is unfolding across neighborhoods. Community routines that once absorbed stress—parks, prayers, social visits, barbecues, football matches—are no longer possible.

“Before the war, problems were not as severe. Children went to friends, people prayed and that helped release distress.” FGD 7

“People could still go to parks, have barbecues, eat fruit, play football or cards with friends.” FGD 7

As these shared routines disappear, stress rebounds inward, concentrating pressure inside the home.

Loss of trust and the erosion of traditional community support

Displacement and prolonged scarcity were influential factors that weakened neighborhood bonds and disrupted traditional mechanisms of trust and mediation. In unfamiliar settings, social relationships were described as guarded and fragmented.

“I’ve been displaced myself, and in the new area people don’t know me. I have to go to them, but no one really trusts anyone anymore.” FGD 7

Resource scarcity further fuels fear and tension, shifting everyday interactions from cooperation to competition:

“People are stealing from one another—even from aid trucks. It’s almost infectious. Everyone wants to be first to get water, food or aid. They’re afraid it will run out before they get there, and this causes pushing, fighting and more violence.” FGD 7

As trust thins, long-standing community support systems have weakened, changing how people seek support and resolve conflict:

“People can’t find anyone suitable to talk to. They carry more troubles and take it out on each other.” FGD 7

“Many people also faced marital problems, and they would come to the Mukhtar who could help them find resolution. Now they go to the therapist instead.” FGD 7

Problems once mediated collectively are now carried individually and spill into strained relationships.

Safe spaces as rare points of connection and emotional refuge

With family systems overstretched and peer networks disrupted, adolescents described safe spaces, particularly CP centers, as among the few remaining places where comfort, connection and a sense of being cared for are still possible.

“In the past, I would go and talk to my father. But now I come here when I am sad, and I feel better.” FGD 2

“When I come here, I see my friends. I feel safe and comfortable, and I can find people to talk to.” FGD 2

“I like to come here because I feel connected, and because of the activities.” FGD 2

“We have activities about how to talk to each other, make friends and build skills.” FGD 2

Support systems under strain

Family and social networks continue to hold people together, but they are doing so under conditions that steadily weaken their capacity to protect, absorb stress or repair harm. As displacement, loss and survival demands intensify, households are asked to carry more responsibility with fewer resources, less privacy and diminishing emotional reserves.

What once dispersed pressure across family, neighbors and community life now concentrates it inside households and a shrinking set of “safe enough” spaces. As these supports thin, the absence of safety becomes more visible—not only in physical environments, but in the narrowing margins where care, trust and protection once lived.

Theme 5 — Protection Risks, Safety & Social Harm

Protection risks cut across nearly every dimension of life in Gaza, shaping where people can move, how they sleep and whether they feel safe inside spaces meant to offer refuge. Participants consistently described living in conditions where physical safety cannot be assumed; protection mechanisms, whether actions taken by the family to protect its children or measures implemented by other parties, are weak or absent; and exposure to harm extends well beyond moments of active violence. Safety concerns permeate daily decision-making and constrain access to services, social life and recovery.

For many, the erosion of protection is not confined to a single location. Risk follows people across camps, streets, aid distribution points and even inside shelters. Adolescents, children, women, and people with disabilities—including those with

psychosocial and mental health conditions—face layered vulnerabilities shaped by gender, age, mobility constraints, and the absence of safe and protective infrastructure.

The absence of safe space

Across FGDs, adolescents articulated a stark reality: safety is no longer anchored to any specific place. Home, camp, street and service locations are all perceived as potentially dangerous.

“But really there is no safe space in Gaza. Maybe we’ll feel safe when we can finally go home, but for now, no place is truly safe.” FGD 2

This sense of pervasive insecurity was echoed by the same adolescent, who described the emotional toll of living without peace or predictability:

“I try to stay positive, but there’s no security. There’s no peace.” FGD 2

Younger adolescents reflected on how profoundly this reality departs from life before displacement:

“In the old days, the safest place was home.” FGD 2

Together, these reflections capture not only fear but the collapse of the idea that safety can be located anywhere in the present environment.

Exposure to danger beyond the camps: movement, aid and survival risk

Protection risks extend well beyond shelter areas. Movement itself carries danger, particularly when accessing aid and basic supplies, forcing families and adolescents to weigh survival needs against physical risk.

“I also have responsibility for bringing food and supplies to my family, so I have to go out for aid distribution. This is dangerous, and often there’s no food or supplies anyway.” FGD 4

This kind of exposure becomes routine, reinforcing fear, restricting mobility and shaping daily decisions for households already depleted by displacement and loss.

Physical insecurity of shelters: tents that cannot protect

While displacement and shelter conditions were discussed earlier as structural stressors, participants in this theme emphasized a distinct protection concern: tents do not provide security. Thin fabric walls, the absence of barriers and limited ability to secure entrances mean that shelters fail to function as protective spaces, particularly at night.

“It’s very important that we have locks on our tents and that we think seriously about our safety.” FGD 10

Without physical protection, families described constant vigilance:

“Our family has to stay awake most of the night to keep safe. We might get robbed if we fall asleep!” FGD 10

Nighttime alertness transforms rest into risk. Hypervigilance becomes a survival strategy rather than an exception, deepening exhaustion and emotional depletion across households.

Unsafe sanitation facilities and night-time exposure

Sanitation areas emerged as some of the most frightening locations within camps, particularly after dark. Poor lighting, distance from shelters and inadequate infrastructure expose women, girls and children to both physical danger and social harm.

“We’re afraid to go to the bathroom at night because of the dogs. The camp is filthy.” FGD 10

Families described coping strategies that reflect the severity of these risks:

“We’re living in camps without proper toilets. One toilet is shared by 40 families. We’ve even started using bottles inside the tents for privacy and safety. It’s unhygienic and causes illness. It also exposes us and our daughters to risks of abuse and sexual violence. There’s no one responsible for sanitation.” FGD 10

Men also linked inadequate sanitation design to increased VAWG risk:

“There’s been an increase in sexual abuse. All camps are different, but the lack of privacy—for example, men and women using the same toilets—has led to more... violence.” FGD 12

Here, infrastructure failure becomes protection failure, placing women and children at heightened risk in spaces intended to meet basic needs.

Children at heightened risk of harm, exploitation and loss of care

Children emerged as one of the most vulnerable groups within this protection landscape. Several participants described children being injured while attempting to meet basic needs or access aid.

“My husband and I have a 10-year-old son. He used to go to the humanitarian aid center, but he was shot. Now he’s an amputee above the knee.” FGD 8

Key informants reported broader patterns of exploitation:

“Children are exploited to steal or beg; one boy was beaten for stealing money to buy medicine for his sick father. Addressing these structural causes of violence is critical.”

KII 1: Head of Protection Department, Local NGO

The absence of stable protection systems places unaccompanied children and children with disabilities at extreme risk:

“Unaccompanied children are considered the highest-risk group. Many lack parental care, many are survivors of violence and a substantial proportion have conflict-related injuries or disabilities. Children with disabilities are another high-risk group.”

KII 3: CP Coordinator, UN Organization

Participants also emphasized the growing number of orphans without adequate care or oversight:

“We really need more care for the orphans. There are so many children who’ve lost their families, and no one is looking out for them.”

Together, these findings point to a protection environment in which children face compounded exposure: physical danger, exploitation, disability-related risk and the absence of consistent adult protection.

Family strain, violence and exposure to harm

Protection risks are closely tied to rising stress inside households. Caregivers and community leaders described how prolonged insecurity and deprivation are translating into conflict and violence, with children bearing the consequences.

“There are more family problems. Parents can’t provide for their children, and this sometimes leads to violence.”

Women described vulnerability when caregiving responsibilities fall solely on them, especially without partners or extended family support.

“This is also true for widows; we need to look out for them as well. They’re often excluded from services and must care for their children alone.”

These dynamics further erode protective family environments already weakened by displacement, grief and daily survival pressure.

Severe mental health needs and exposure in public spaces

Protection risks also surfaced for people whose psychosocial and mental health needs exceed what families and communities can safely manage. Participants described how

the absence of inpatient and specialized care leaves individuals exposed in public spaces, where safety risks increase rather than diminish.

“Right now, there are many people on the streets who need inpatient psychiatric care. Being on the street increases their safety risks.” FGD 12

This highlights a clear protection gap: without inpatient options, people with severe mental health conditions remain exposed to harm in public spaces.

At-Risk Populations with Hidden or Compounded Exposure

Participants and key informants identified specific groups facing acute protection risks compounded by low visibility, stigma and weak referral pathways. These include individuals recently released from captivity:

“Hostages who have been released are considered extremely at risk. We believe that all former hostages were exposed to sexual abuse, although this remains hidden and not widely disclosed.” KII 4: Director, Local Community Mental Health NGO

Concerns were also raised about the scale and urgency of unmet needs among other highly vulnerable groups:

“Gaza will face an explosion of mental health needs as the ceasefire continues. Particularly at risk are former prisoners, many of whom were tortured during detention; survivors of violence, including VAWG; and orphans.” KII 2: Senior Mental Health Official, Public Health Authority

These accounts underscore the need for targeted protection measures that go beyond routine community mechanisms, including safe and confidential identification, clear referral pathways and timely access to specialized care for individuals facing multiple layers of risk.

Safety as a prerequisite for access to services

Protection concerns directly limit access to support. Women described being unable to leave children unattended due to safety risks, preventing them from reaching activities or services without additional childcare or protection support.

“Women living in tents cannot leave their children unattended due to safety risks, preventing them from accessing services unless childcare or protection support is available.” KII 4: Director, Local Community Mental Health NGO

This reflects a recurring operational reality: service availability alone is insufficient when the pathway to services is unsafe.

Living without safety

When safety cannot be assumed, daily life is organized around vigilance rather than recovery. Movement, sleep, caregiving and access to services are shaped by fear of harm, exposure or loss of control. Tents, sanitation facilities, aid points and public spaces no longer function as protective environments, leaving people in a constant state of alert.

Living without safety does not remain external. It seeps inward, intensifying stress within households, limiting mobility, and constraining access to care and support. In this environment, emotional strain accumulates not only from what people have endured but from what they must continuously guard against.

II. Psychological & Emotional Impact

Theme 6 — Emotional & Psychological Impact

Emotional and psychological distress emerged across FGDs and KIIs as one of the most universal, severe and urgent dimensions of life in Gaza. Participants across age groups described a wide spectrum of reactions including persistent sadness, fear, anger, emotional numbness, withdrawal, exhaustion, irritability and despair. Service providers emphasized that these experiences are not isolated reactions but part of population-level mental health challenges shaped by prolonged exposure to violence, repeated displacement, unsafe living conditions, unmet basic needs and cumulative loss.

Across accounts, emotional distress was not framed as weakness or individual pathology. Rather, it was consistently understood as a predictable response to extreme and prolonged conditions that have eroded safety, stability and meaning in daily life.

A baseline of pervasive sadness and emotional depletion

Across FGDs, all the participants described sadness as a constant emotional baseline rather than an episodic state. Emotional pain resulting from conflict-related loss affected everyone and has become part of everyday life.

“But we didn’t feel this kind of stress or sadness before this war.” FGD 4

For many, sadness was inseparable from profound personal loss, articulated with striking directness and emotional fatigue.

“I lost my father and three sons. My daughter, too. All I know is sadness.” FGD 8

Women carrying sustained caregiving and survival responsibilities described distress as hollowing out daily life, leaving little space for rest, pleasure or emotional recovery.

“There is no life. It’s like being a zombie for women. We have nothing to make life good again.” FGD 8

Others situated this distress within a broader historical trajectory, noting a sharp deterioration since October 7, 2023.

“We are all in a severe psychological state. We’ve been living in war for decades, but since October 7th, it has been unbearable.” FGD 8

Together, these accounts reflect a deep erosion of emotional reserves, where distress becomes chronic and unrelenting rather than something that rises and falls in response to discrete events.

Heightened emotional fragility and loss of coping capacity

Several participants described a marked shift in emotional resilience compared to pre-war life. Situations that might previously have been manageable were now described as overwhelming, destabilizing and emotionally destructive.

“Before the war, we didn’t need psychologists, but now one situation can destroy a person. We need psychiatrists and psychologists now.” FGD 8

Young adults echoed this sense of internal collapse, using brief but heavy language to describe their state.

“I am very depressed and distressed.” FGD 11

People with disabilities and their caretakers were identified as particularly vulnerable to psychological strain, often experiencing sustained emotional exhaustion with limited access to support:

“The mental health needs are massive for people with disabilities and also their caretakers.” KII 6: INGO, MHPSS Coordinator

These accounts reflect a widespread erosion of coping capacity, where cumulative stress has narrowed people’s emotional buffer, making it harder to withstand daily pressures without significant psychological impact.

Escalating anger, irritability and behavioral changes

Service providers consistently reported increased irritability and behavioral dysregulation across age groups. These changes were described not as isolated behavioral issues but as manifestations of prolonged stress, overcrowding, insecurity and sleep deprivation.

“Everybody’s affected. For example, the children are so angry and irritable. You can see it in their behavior. There’s so much anger now, and it shows up everywhere.” FGD 6

“These days, people show their irritability very easily. We see new problematic behaviors. Suicide was rare before, but it’s increasing.” FGD 5

Irritability was frequently observed within families, schools and community settings already under strain, where limited space, constant threat and emotional exhaustion reduce tolerance and increase conflict.

Anxiety, fear and sustained hyperarousal

Fear and anxiety were described as pervasive and future-oriented, rooted in uncertainty, insecurity and the anticipation of further loss. Participants described living in a near-constant state of alertness, where the nervous system remains primed for threat.

“All children... in fact, almost 100 percent of Gazan people... are displaying symptoms of hyperarousal. When we hear a loud sound, we first look for our children and then for our belongings in case we need to run.” FGD 12

Others described how ordinary environmental sounds repeatedly reactivate fear and trauma.

“Every time we hear the sound of aid trucks, we relive the trauma.” FGD 8

These accounts reflect how distress is continuously reactivated by an environment saturated with reminders of danger, displacement and loss.

Severe and complex distress among children and adolescents

Clinical practitioners described a sharp rise in both emotional and behavioral disorders among children and adolescents. These presentations were described as more intense and complex than those seen before the war.

“There are many mental health disorders we’re observing, especially among children. We’re seeing a lot more aggressiveness, symptoms of ADHD, panic attacks and exaggerated startle responses. We’re also seeing enuresis.” FGD 12

Another clinician emphasized the depth of regression and despair observed among young people, particularly those who had experienced extreme loss.

“The symptoms we’re seeing are symptoms of regression.... Many are the only survivors in their families.” FGD 12

These observations suggest that children’s distress is shaped not only by exposure to violence but by the collapse of caregiving systems, safety, and developmental continuity.

Accumulated and unprecedented trauma

Mental health professionals repeatedly stressed that the trauma currently observed exceeds previous experiences in both scale and complexity. Several described difficulties even naming the nature of what they were witnessing.

“There’s a definite increase in PTSD, complex PTSD and depression.” FGD 12

“Before the war, maybe one in a thousand people had a mental disorder. Now, entire families are traumatized. Everyone has lost someone. The difference is in how deeply they’re affected.” FGD 6

“We don’t even know what to call this kind of trauma; it is something else. A Nakba PTSD is a name that was given to it recently.” FGD 12

These statements point to the cumulative nature of trauma in Gaza, where historical displacement, repeated wars and current mass devastation converge, rather than replace one another.

Somatic expressions of psychological distress

Psychological distress in Gaza was frequently described as being experienced and communicated through the body rather than through emotional language alone. Participants and health workers noted an increase in physical complaints that could not be explained solely by injury or illness but instead reflected the ways prolonged stress, fear and grief are carried somatically when emotional processing and verbal expression are constrained.

“People also complain more about physical symptoms, such as stomach aches, headaches, enuresis. They express psychological pain through the body.” FGD 5

“We’re seeing cases we didn’t ever see before. For example, 12 children with catatonic depression. A 19-year-old woman with PTSD whose hair turned white. A 5-year-old who lost all of his hair. The symptoms are manifesting in ways we haven’t seen before.” KII 2: Senior Mental Health Official, Public Health Authority

This pattern suggests that distress is not only psychological in form, but embodied and shaped by chronic hyperarousal, exhaustion and the absence of spaces where safety and rest can be restored.

Substance use as an escape from distress

Some service providers described substance use as an emerging coping response to chronic psychological pain, uncertainty and emotional overload. These accounts framed substance use not as a pre-existing pattern but as a reactive attempt to blunt distress in an environment where other forms of relief or support are limited or inaccessible.

“We’re also seeing more substance abuse and addiction. Even young girls are using medication and other substances, such as hashish, tramadol, ketamine and other narcotics, to escape from life’s problems.” FGD 12

This observation points to the limits of informal coping during prolonged crises, in which distress exceeds available containment, and individuals turn to numbing strategies without safety, structure or sustained support.

A sharp rise in suicidality and despair

Several participants and service providers described a troubling increase in suicidal ideation and expressions of despair, particularly among youth. These accounts reflected not only emotional pain but a collapse of future orientation and meaning.

“There’s also a significant increase in suicide, especially among youth.” FGD 12

“People can’t distinguish anymore between sacrifice and despair.” FGD 6

One young woman articulated a level of hopelessness that signals profound risk:

“If someone told me they were thinking of killing themselves, I wouldn’t do anything. I would just ask if I could go with them.” FGD 10

These statements underscore the depth of despair present in some communities, where suffering has stretched beyond individual endurance and into collective exhaustion.

Distress without reprieve

Emotional distress in Gaza is not episodic or self-limiting. It is sustained by ongoing threats, repeated reminders of loss and the absence of spaces where safety and regulation can be restored. Fear, grief, exhaustion and hyperarousal accumulate as people remain exposed to instability with few opportunities to recover.

As coping capacity erodes, distress deepens and becomes more complex, shaping not only emotional experience but daily functioning, relationships and future orientation. The psychological impact documented here sets the conditions under which coping, caregiving, learning and recovery must now occur.

Theme 7 — Livelihoods, Income & Economic Hardship

Economic collapse is one of the central forces shaping psychological distress in Gaza. Across FGDs and KIs, participants described not only the loss of income, but the near-total breakdown of work, professional identity and viable economic roles. Livelihoods were consistently framed as a foundation of dignity, stability and purpose, and their absence as a source of profound frustration, shame and despair.

While shortages of food, water and fuel dominate daily survival (Theme 2), this theme captures a different rupture: the loss of pathways to earn, contribute and plan for the future. Participants emphasized that economic hardship is not simply about poverty, but about being unable to be who they once were, including providers, professionals, students or skilled workers, in a context where effort no longer leads to security or possibility.

Collapse of employment and income

Participants across age groups and professions described a landscape in which jobs have disappeared and income has become unattainable. Skilled professionals, laborers and service providers alike spoke of an economic environment with no functioning labor market.

A psychologist summarized the scale of unemployment:

“There’s so much unemployment. We have qualified social workers and psychologists but no jobs.” FGD 4

A camp leader echoed the broader impact:

“In the displacement camps there are many different actors and professionals, but most of them face a dark future themselves. People are exhausted, uncertain and struggling to sustain their work.” FGD 5

For many, the loss of income is compounded by the destruction of infrastructure and institutions that once made work possible.

Loss of professional roles and identity

Several participants described how war and displacement have stripped them of established careers and the ability to imagine returning to professional life. These losses were often described as permanent, extending beyond income to health, confidence and future orientation.

A woman in her 40s described the endurance of loss:

“Now the ceasefire is here, but the war continues. I lost everything—my job, my health. Even if there were jobs, I couldn’t work. And anyway, there are no opportunities, no salaries.” FGD 8

These accounts reflect livelihoods collapse as an erosion of identity and agency, where work is no longer a viable pathway back to stability or dignity.

Blocked pathways for skilled youth and new graduates

Young adults repeatedly described completing education or professional training only to find no avenues for paid work. This sense of being “stuck” emerged strongly in FGD 11.

“We volunteer with children because it helps our own mental health to stay busy, but we can’t be volunteers forever. Often organizations prefer to hire people they already know.” FGD 11

“I’m a speech therapist by training, but no one is providing these services now. So how can I find work?” FGD 11

Others emphasized the absence of even short-term opportunities:

“Even temporary jobs would help so we don’t stay volunteers forever without pay.” FGD 11

For these participants, unemployment is an active source of anxiety, frustration and loss of momentum at a critical life stage.

Survival economies and forced adaptation

Without formal employment, families described turning to informal and survival-based strategies. These activities rarely provide stability and often demand exhausting levels of effort.

Women spoke of wanting to work again, even in small or creative ways:

“We need to start working again and to use our senses. Many of us are creative; we just need materials.” FGD 8

A woman working with NGOs emphasized the untapped skills now lying dormant:

“In the past, women worked as tailors, in food preparation, mini-markets, bakeries, sweets and small manufacturing. Some made cosmetics—I did too. Reviving these skills would restore income and dignity.” FGD 6

These statements highlight that people are not lacking motivation or ability but rather opportunity, materials and safe conditions to work.

Children and adolescents assuming economic responsibility

In some households, the loss of adult income has pushed children into economic roles. Adolescents described balancing survival work with the abandonment of education and childhood routines.

One boy explained:

“I don’t have much time for this. I have too many responsibilities to put food on the table. I don’t have money, but I run a small ‘mini-market’ in front of my house to make money for my family. It takes most of my time.” FGD 4

Another shared:

“I also have responsibility for bringing food and wood and water for my family. I want to go to school, but I can’t. All I can do is try to provide for the family.” FGD 4

Although these experiences intersect with protection and education risks, participants framed them here as economic necessity. Children were filling critical income gaps left by the collapse of adult livelihoods.

Livelihoods, health and uncertainty about the future

Several participants linked livelihoods directly to recovery, meaning and hope. Even people receiving care expressed concern about returning to work.

One young man reflected:

“I’m a patient, but I keep thinking about how to rebuild my life. I’m a computer engineer, and I wonder how I’ll return to work.” FGD 9

Another stated:

“I want to be able to work, to feel like a human being again.” FGD 9

This illustrates how work remains central to identity and future orientation, even amid illness and displacement.

When livelihoods disappear

As livelihoods vanish, daily life loses one of its few remaining sources of structure and direction. Participants described days without work as long, uncertain, emotionally draining and marked by waiting rather than doing, dependence rather than contribution. The inability to earn, plan or provide reshapes how people see themselves and how they imagine the future, particularly for skilled adults and young people whose education or training no longer leads anywhere.

These conditions are not merely about economics; they also affect access to healthcare, medication, transportation and assistive devices. Moreover, uncertainty about work deepens stress inside households already stretched by displacement and caregiving demands. As livelihoods disappear, vulnerability increases, setting the conditions under which health and disability become harder to manage.

Theme 8 — Health, Disability & Medication Access

Health-related challenges emerged as one of the most pervasive and destabilizing stressors affecting families across Gaza. Across FGDs and KIIs, participants described how illness, injury, disability and unmet medical needs have become increasingly difficult to manage under displacement. What once involved routine care, follow-up appointments and stable medication access has now become a daily struggle marked by distance, shortages, refusals and uncertainty.

These disruptions interact directly with emotional distress, family strain, protection risks and economic hardship, placing health at the center of the current psychosocial crisis.

Collapse of continuity in healthcare access

Participants repeatedly described the breakdown of continuity in healthcare. Repeated displacement, damaged infrastructure, overcrowded facilities and unpredictable transport routes prevent people from reaching services they once relied on. Even when families manage to reach health facilities, care is often delayed, incomplete or unavailable.

“Now it’s very difficult to access services in general—even health services. For example, we got poisoned from something we ate at the sea. We went to the hospital, but they refused us. We had to wait a long time. Not all services or medications are available.”
FGD 5

For displaced families living in camps or informal settlements, the absence of nearby medical facilities and the instability of referral routes mean that access to care is often uncertain even when services nominally exist.

Health professionals confirmed that these impediments are systemic rather than incidental.

“The most urgent need observed is access to medical services, as many mental health problems currently stem from untreated medical issues. Medications are rare, and patients require a reliable referral pathway.” KII 4: Director, Local Community Mental Health NGO

Chronic illness under displacement

For people living with chronic illness, the collapse of care continuity carries immediate and sometimes life-threatening consequences. Participants described how conditions that were previously manageable now deteriorate rapidly due to interrupted treatment and lack of medication.

“For me, the biggest challenge is my health. I have cardiac disease and diabetes. I also need injections for a neurological condition, but I don’t have money for the medication or treatment.” FGD 10

Others described prolonged periods without essential medicines, leading to worsening symptoms and fear of complications”:

“Skin problems are everywhere—scabies, rashes. Chronic diseases are worsening, and there’s no medication. Even cancer patients can’t get treatment. I have hypertension and diabetes, and I haven’t had my medicine for three months.” FGD 7

The repeated search for care and medication itself becomes a source of emotional strain:

“For more than five months, I’ve been searching for medication. I have a health condition and need a gastroenterologist. Last week, I finally found some medicine. Not being able to access medical care has a terrible effect on our mental health.” FGD 8

Medication shortages and system instability

Medication shortages were described as widespread, unpredictable and destabilizing. Participants reported rationing doses, receiving partial prescriptions or being sent repeatedly to pharmacies with no stock.

“Sometimes, I don’t get my medication as prescribed. The staff doesn’t give it... probably because of shortages. They go to the pharmacy to collect it, but the medication isn’t there.” FGD 3

Camp-based providers confirmed that shortages extend even to basic pain relief and essential drugs.

“There’s a huge shortage of analgesics and basic medications.” FGD 6

At a system level, sudden changes in medication availability further destabilize care:

“Medication supply is severely disrupted. The essential drug list changed unexpectedly, forcing many patients off their regular medications.” KII 5: MHPSS Consultant, INGO

Health workers emphasized that these gaps place strain not only on patients but also on staff who are unable to meet escalating needs:

“Access to medication for chronic diseases is critical, and it’s becoming an even bigger challenge. This issue causes stress not only for affected individuals but also for staff who are unable to meet these needs.” FGD 10

Injury, disability and unmet specialist care

Alongside chronic illness, injury and disability emerged as major health stressors. Participants described living with untreated injuries, loss of rehabilitation services, and the absence of specialist referrals. For many, disability has become more disabling under displacement.

“I’ve had a deformity since birth. The doctor told me I’d need orthopedic surgery and physical therapy. As I grew, the deformity grew too. I have an urgent need for surgery.” FGD 9

Others spoke about unmet specialist care following injury.

“I’d also like to be referred to an ENT specialist.” FGD 9

Across FGDs, families described absorbing intensive care for relatives with injuries and disabilities in environments that lack rehabilitation services, accessibility or assistive support. Care responsibilities compound physical exhaustion, financial strain and emotional distress, particularly for caregivers already managing displacement and loss.

Structural and accessibility blockades

Key informants highlighted the scale of difficulty facing people with disabilities and injuries.

Approximately 30–40% of patients cannot reach hospitals because of distance, disability or financial difficulties. KII 4: Director, Local Community Mental Health NGO

“Many people with conflict-related-disabilities are very depressed. But without transportation support, they won’t come.” KII 6, ICRC, Mahmoud Ahmali

“People with serious injuries, particularly amputees, face ongoing medical and psychosocial vulnerability.” KII 2: Senior Mental Health Official, Public Health Authority

Displacement sites themselves often exacerbate disability-related risks:

“We need more accessible bathrooms for patients with disabilities.” Injured Male, age 35 (double amputee), FGD 3

Assistive devices were repeatedly identified as essential yet insufficiently available:

“Assistive devices are really important. We need to make sure that no one is excluded from getting them. When we think about access, this should be the first priority.” FGD 10

Service providers warned that older adults and people with disabilities are frequently overlooked:

“Spaces are also needed for older adults and people with disabilities, who are largely forgotten. Elderly and disabled people require assistive devices and regular support,

perhaps through static hubs or mobile teams equipped with appropriate supplies.” KII 1:
Head of Protection Department, Local NGO

Health deterioration and psychosocial impact

Across the dataset, participants consistently linked deteriorating physical health and lack of medical care to emotional distress, fear and exhaustion. Pain, untreated illness and uncertainty about survival place enormous strain on individuals and families.

“We need access to essential medication, vitamins and treatments for conditions like diabetes. We can’t get them anymore.” FGD 10

Health professionals emphasized that untreated medical needs frequently escalate into broader psychosocial crises:

“People with injuries and disabilities require tailored mental health services.” KII 5:
MHPSS Consultant, INGO

When health becomes a daily uncertainty

When access to care cannot be relied upon, illness and injury reshape daily life in persistent and destabilizing ways. Participants described living without assurance that medication would be available, that a facility could be reached or that a manageable condition would not become an emergency. Pain is carried longer, symptoms worsen and fear becomes a constant companion.

These conditions deepen vulnerability across households already strained by displacement and caregiving demands. As health becomes unpredictable, emotional distress intensifies and family resources are stretched further. The instability described here sets the stage for how people cope, seek support and engage with services. This underscores that without stabilizing health access, recovery in any other domain remains fragile.

Theme 9 — Faith & Spirituality

Faith and spirituality emerged as deeply embedded sources of strength, meaning and emotional regulation for many participants in Gaza. While displacement, loss and insecurity have dismantled physical spaces, routines and protective systems, religious belief remains a core part of personal and collective identity. Across focus groups and KIIs, participants described faith as a lived practice that includes prayer, remembrance, mosque attendance and trust in God, helping them endure fear, grief and uncertainty.

At the same time, participants emphasized that access to religious spaces and collective worship has been severely disrupted by insecurity and fear. Faith therefore exists in tension. It remains a central coping resource, even as the conditions that once supported communal religious life have been eroded.

Faith as a source of grounding and emotional relief

Many participants described prayer as a primary way of managing sadness, fear and emotional overwhelm. For adults and children alike, faith offered a sense of calm and inner stability in environments marked by constant threat and deprivation.

One young woman reflected on how mosque attendance had supported her mother's mental health before the war:

"In the past, we would go to the mosque to be close to God. My mother, for example, had depression. When she went to the mosque, it really helped her." FGD 5

Community leaders echoed this understanding, emphasizing that spirituality has long been woven into daily life:

"In the past, we went to the mosque. Spirituality has always been important for us." FGD 6

For many people, prayer remains a deeply personal coping mechanism, practiced wherever possible—even inside tents:

"Now, my relationship with Allah gives me peace. I feel most comfortable when I pray."
Female, age 30, FGD 8

"All I know is sadness. I pray to Allah." FGD 8

Children and young people also described prayer as a natural response to fear and loss:

"I like to pray, also. I pray for the war to end. I also pray for my uncle, who was lost in the war." FGD 1

"When I am sad, I pray in my tent. I pray all the time." FGD 1

"For me, I pray. I pray, I pray, I pray all the time." FGD 5

These accounts illustrate how spiritual practice functions as an accessible, internal coping strategy—particularly when other forms of support are unavailable.

Disruption of communal religious life and loss of spiritual spaces

While faith remains central, participants consistently described how fear, insecurity and the targeting of infrastructure have disrupted access to mosques and communal worship. This loss was described as both practical and symbolic: mosques were not only places of prayer but also spaces of guidance, connection and emotional release.

A religious leader explained how attendance has declined due to fear:

“Before, people came to me for advice—social, financial or religious issues. Now, because of fear from the bombings, people are anxious and don’t come to the mosques.”, FGD 7

An adolescent described the danger now associated with attending mosques:

“In the past, we could go to the mosques. But the mosques are targeted now; it’s dangerous. Maybe when there’s a ceasefire, we can go again.” FGD 4

The loss of these spaces has removed an important outlet for collective coping and reassurance, deepening isolation for those who once relied on communal worship and religious leadership for emotional support.

Faith as a framework for endurance and meaning-making

Many participants framed faith as a source of strength that enables them to endure ongoing hardship. Trust in God was described as sustaining hope and perseverance in conditions that otherwise feel unbearable.

“We all need strength in hard times. For me, it’s so important to pray to Allah. I have strong faith and believe he will help us resolve all problems.” FGD 5

Others emphasized faith as the primary force keeping them going:

“We were targeted, and the only thing that keeps us going now is our faith in God.” FGD 8

In these narratives, faith does not erase suffering. Rather, it provides a moral and emotional frame that allows people to continue despite fear, grief and uncertainty.

Faith alongside—not instead of—services

Participants and service providers were clear that spiritual coping, while vital, cannot substitute for material support or mental health services.

A young man working in service provision articulated this balance directly:

“We have the skills to provide these services but not the space. We take our strength from Allah, but we also need the services themselves.” FGD 11

This perspective reflects a consistent finding across FGDs and KIs: faith strengthens resilience, but it does not replace the need for safety, access to care and structured MHPSS support.

Holding on when structures fall away

Faith and spirituality remain among the few resources that displacement and insecurity have not fully stripped away. Prayer, belief and trust in God provide continuity when

homes, routines and institutions collapse. For many, faith offers a way to regulate emotion, endure grief and preserve a sense of meaning in conditions defined by uncertainty.

Yet the disruption of communal worship and religious spaces has narrowed the social dimensions of spiritual life, leaving faith increasingly practiced in isolation rather than together. In this landscape, belief sustains individuals, but it cannot compensate for the absence of safety, services and collective protection.

Faith, as participants described it, is not a replacement for care. It is a companion to it, and it must be recognized, respected and thoughtfully integrated within broader humanitarian and mental health responses.

D. Community Adaptation & Future Trajectories

Theme 10 — Coping, Well-being & Life Skills

Coping in Gaza has shifted from restoration to survival. Before the war, people drew on ordinary routines, movement, social connection and culturally familiar activities to regulate stress and re-establish equilibrium. Displacement, insecurity, overcrowding and the erosion of privacy have dismantled many of these stabilizing mechanisms. What remains are fragments: small practices that help people endure, even when recovery feels out of reach.

This theme examines coping as described directly by participants across age and gender. While family and social support remain central, they are addressed in Theme 4 and are not repeated here. Instead, this theme focuses on activity-based and skills-based coping, including play, creativity, movement, peer connection, reflection, structured safe spaces and formal psychosocial support—and what participants say is missing.

Children’s coping: play, imagination and nature as primary regulation

For children, coping was framed in concrete, sensory and relational terms. Play and peer interaction were repeatedly described as immediate pathways to relief, normalcy and emotional regulation within camp life.

“I like to play with my peers. We like to play football; we like to chase each other.” FGD 1

“I’m happy when I’m playing with my friends. We live here in the camp, and we play in between the shelters.” FGD 1

Children also described cultural and creative continuity as a form of comfort. Storytelling, particularly traditional forms, functioned as both entertainment and anchoring—a return to familiar rhythms and meanings.

“Some of the activities I enjoy are storytelling, especially hakawati. These are old stories from old times. I like to hear them.” FGD 1

Nature emerged as a distinct stabilizing presence. Even limited contact with greenery, gardens or rain was described as calming and restorative, suggesting that children’s regulation remains deeply tied to sensory environments that signal safety and life.

“My mother takes us to the garden. In the garden, there are trees and flowers. I really like to be in nature.” FGD 1

“When the rain comes, the grass grows. In the rain, I like to plant trees and flowers.” FGD 1

Together, these accounts indicate that children’s coping relies heavily on space, safety and permission to play—all of which are increasingly constrained by displacement conditions and limited access to child-friendly environments.

Adolescents: coping through expression, peers and structured safe spaces

Adolescents described coping as more deliberate and multi-layered, combining private strategies (writing, drawing), social strategies (talking to trusted people) and embodied strategies (movement). Their narratives repeatedly emphasized the need for purposeful activity and a place to go.

“What helps me feel better when I am sad is talking to a trustworthy person.... It also helps to write things down. I also like drawing, running and swimming in the sea.” FGD 2

“I like to do creative things when I’m feeling stressed. I like to paint and draw.” FGD 5

Critically, adolescents described safe spaces not only as refuge but as active sites of coping acquisition, where techniques are learned, distress is processed socially and safety is experienced in real time.

“The staff here give me recommendations, and they teach me new techniques. We find people who want to give us a better future, and we get a lot of help.” FGD 2

Adolescents also linked coping to continuity of identity and future orientation, describing creative and social engagement as ways to resist emotional collapse and maintain a sense of self under prolonged disruption.

“I’d like more art workshops and opportunities to meet other people.” FGD 2

These accounts suggest that for adolescents, coping is inseparable from belonging, self-expression and access to consistent, structured spaces.

Men and boys: coping through movement, social normalcy and purposeful engagement

Across male discussions, coping was often framed through doing rather than talking, movement, routines and low-pressure social presence. Sport emerged as a recurring anchor, but the broader pattern was purposeful activity as regulation.

“Football, playing games, walking, shopping, visiting relatives. I like to see people and meet friends.” FGD 4

“For me, it’s about football. . . . It relieves stress and brings people together.” FGD 7

Men and boys also described creative modalities, such as art and music, as acceptable and meaningful sources of relief when embedded in activity-based settings.

“I come to International Medical Corps Field Hospital. I like the activities here, especially drawing, art and music.” FGD 4

A distinct subtheme was the desire for low-stakes communal environments—spaces that reintroduce normal rhythms (television, coffee, internet) without requiring disclosure of distress.

“Maybe we could also offer open days for men—a place with TV, internet and coffee, where we can watch football and relax safely.” FGD 11

Women explicitly linked men’s coping opportunities to household stability, underscoring the broader psychosocial value of male-friendly engagement spaces.

“We need dedicated spaces for men, with TVs for football matches, musical instruments, recreational sessions and classes on positive parenting. Activities for the men might help them even more than us. And this would then also help us.” FGD 8.

Together, these data indicate that coping support for men is likely to be most effective when delivered through movement, shared activity and socially acceptable entry points.

Women’s coping: creativity, privacy and the restoration of self

Women repeatedly described coping through creativity, reflection and the recovery of selfhood in conditions that have collapsed routine, privacy and identity anchors. Access to books and drawing materials was framed as a meaningful, concrete support.

“It would be great if we had books to read or drawing materials available.” FGD 5

“Is it possible to have a library? We’d like to borrow some books.” FGD 5

Women also described how the ability to engage in ordinary skills and roles, such as cooking, has been destabilized, with emotional consequences.

“I love to cook. I used to cook a lot before, but now it’s not easy.” FGD 5

“You have to discover your own self and skills to enjoy happiness. Before the war, I had many talents.” FGD 8

Privacy and dignity were not peripheral; they were presented as prerequisites for emotional regulation and social recovery.

“I need a space for myself, to sit with other women and talk. I need to be listened to.” FGD 8

“All I need is a dedicated space for privacy.” FGD 8

This pattern suggests that women’s coping is tightly tied to dignity conditions such as space, privacy and access to meaningful creative and relational practices.

Skill-building and psychoeducation as coping infrastructure

Participants did not frame skills-based activities as optional. They described life skills, psychoeducation and emotional regulation learning as mechanisms that restore daily function, rebuild agency and reduce distress.

“Learning life skills would be great—like learning photography or cooking.” FGD 5

“We’ve forgotten how to cook! I’d love to have cooking classes, maybe even a corner or small kitchen space where we could practice and share food together.” FGD 10

Skill-building was also described as a pathway back to dignity and humanity.

“We need someone to take care of us. It would be wonderful to learn new skills. I’ve forgotten how to cook. I want to learn again, to cook, to draw, to make handcrafts.” FGD 8

Participants explicitly linked skills-based learning to child behavior and regulation.

“Most kids are very aggressive now. They need someone to teach them how to self-regulate and manage their emotions.” FGD 8

Practitioners reinforced the importance of psychoeducation as a stress-release and coping amplifier.

“Psychoeducation is essential for men and older people. They need ways to release pressure and cope better. People must learn how to manage their distress and let it go.” FGD 6

Peer coping and mutual contribution as protective practice

Across groups, peer support was described as most valuable when structured around shared activity and mutual contribution—spaces where people help one another, exchange skills and regain social usefulness.

“Peer support groups would be wonderful. We love to play games and share skills.”
FGD 5

“Open days would be great... Each of us has skills to share. Dedicated times for these groups would help.” FGD 8

“Support groups and peer groups would be a good idea.” FGD 11

These reflections reinforce a key analytic point: coping is not only about receiving support. The ability to contribute appears to strengthen well-being and identity under prolonged crisis.

When endurance reaches its limits

Participants consistently acknowledged that current levels of distress exceed what informal coping can contain. While social and skills-based strategies help people endure, they are increasingly insufficient without safe space, materials, routine and accessible services.

“Before, people rarely sought mental health services. Now everyone needs them.” FGD 6

“We did awareness sessions before, but people didn’t come. We need to do more practical things, not just talk.” FGD 11

Coping in Gaza remains adaptive and resourceful, but it is being asked to carry an unsustainable load. As displacement persists and distress deepens, the line between endurance and exhaustion continues to narrow. The practices described here—play, creativity, movement, skills, peer contribution and structured support—offer clear pathways through which well-being can still be protected under prolonged crisis.

Theme 11 — Education, Learning & Aspirations

Education emerged across FGDs and KIs as one of the most urgent and deeply felt losses affecting children, adolescents and young adults in Gaza. Participants described the collapse of formal education systems, the disappearance of safe learning environments and the erosion of aspirations that once gave structure and meaning to daily life. Education was not framed as secondary but as a cornerstone of dignity, protection and recovery.

Across age groups, the loss of learning was described not only in terms of missed schooling but as a rupture in childhood development, identity formation and future orientation.

Collapse of formal education and impediments to access

Participants described widespread destruction of schools and learning centers, alongside severe access impediments to remaining options. Distance, cost, insecurity and transportation constraints were recurrent, particularly for displaced families.

“Now many schools are destroyed, and the few remaining are expensive and hard to reach. We need learning centers and schools for the children.” FGD 6

Caregivers emphasized that children have no stable pathway back into learning.

“For me, the biggest challenge has been the loss of education. All of my children now have nowhere to go to learn.” FGD 8

Even where learning centers exist, they are overwhelmed.

“Temporary learning centers are overcrowded. Most are well over capacity, and there’s no space. There are very few of them left.” FGD 10

Financial impediments were described as newly insurmountable, including at early childhood levels.

“Speaking of children, there’s no free education anymore. You have to pay a lot. Even kindergarten costs too much money.” FGD 10

Learning interrupted by survival demands and adult responsibilities

Participants emphasized that even when learning opportunities exist, children and adolescents often cannot attend because survival tasks have displaced education as a daily priority.

“Before the war, children wanted to study and get certificates. Now, they have to find food and water for their families. There’s no time for learning.” FGD 6

Adolescent boys described carrying adult responsibilities that block return to school.

“I want to go to school, but I can’t. All I can do is try to provide for the family.” FGD 4

Others framed access impediments as both structural and existential.

“Everyone in the world has access to education... but not us. Learning is our dream.” FGD 2

Online and alternative learning: attempted but structurally constrained

Some adolescents reported attempts to continue learning independently or online but described hard constraints related to internet access, electricity, devices and quiet space.

“I’m frustrated that there is no school. We can’t study. We use the internet to learn, but access is a problem.” FGD 2

“But there are so many challenges now. We had to stop learning.” FGD 2

These accounts underscore that alternative learning modalities cannot substitute for education when enabling conditions are absent.

Disrupted developmental learning in adolescence

Beyond academic interruption, participants described the collapse of developmental learning that normally occurs through schools, youth spaces, peer interaction and trusted adult guidance. Adolescents emphasized that topics related to bodily changes, identity formation, relationships and emotional development are no longer addressed safely or consistently.

Both boys and girls described unmet needs for guidance during critical developmental stages.

“We need awareness about the stages of development as girls. Our families are too busy to explain things like this now.” FGD 2

“At this age, many of us feel shy about our bodies. We are changing, and sometimes it is confusing.” FGD 4

This represents a disruption in structured developmental pathways that ordinarily support identity formation, self-understanding and psychosocial maturation.

Education as protection and psychosocial stabilization for children

Across the dataset, education was consistently framed as a protective factor for both daily stabilization and future attainment. Participants emphasized that structured learning activities help children regulate attention, reduce distress and regain predictable rhythms.

“For example, education activities make children happy. They give them something to do each day, a place to learn and focus, instead of listening to drones.” FGD 12

Education was also framed as essential for social recovery and community rebuilding.

“Education is critical for children; it’s how we must rebuild the future. Safe spaces must be inside our communities so children can reach them.” FGD 8

Aspirations and future orientation: education as identity and reconstruction

Despite prolonged disruption, children, adolescents and young adults consistently articulated strong educational and professional aspirations, frequently linked to rebuilding Gaza and restoring dignity.

“Learning is very important for me. I want to be an engineer and help rebuild this country.” FGD 4

When asked directly about their dreams, adolescent boys described a wide range of futures.

“I want to be an engineer.”

“I want to be a cardiac surgeon.”

“I want to be a doctor.”

“I want to be a businessman.”

“I would like to be a policeman.”

“I want to be an architect.”

“I want to study IT and technology.”

“I want to be a businessman. I already am!” FGD 4

Young women described ambitions blending learning with employability.

“I’d like to learn English, photography and office skills.” FGD 5

For young adults, returning to education was explicitly linked to dignity and personhood.

“I hope one day to continue my studies and rebuild my life. I want to return to learning, to be able to work, to feel like a human being again.” FGD 9

When learning disappears, the future narrows

The loss of education in Gaza has removed a central structure through which childhood, adolescence and early adulthood are ordinarily organized. Without safe learning environments, education can no longer perform its protective functions of anchoring routine, supporting development, offering social connection and sustaining future orientation.

Yet aspirations persist. Even as schooling collapses and pathways narrow, participants continue to imagine futures shaped by learning, contribution and rebuilding. In this context, education holds dual significance—not only as a right or service but as one of the remaining threads connecting present endurance to the possibility of a livable future.

E. System Performance & Access To Care

Theme 12 — Access, Acceptability & Stigma in MHPSS Services

Access to mental health and psychosocial support (MHPSS) services in Gaza is shaped by a complex interaction of physical, social, cultural and systemic impediments. Across FGDs and KIIs, participants consistently emphasized that the need for mental health support has grown substantially, yet the ability to reach, accept and sustain engagement with services remains constrained for many populations.

While stigma continues to influence help-seeking behavior, participants made clear that it is not the sole or even primary impediment to access. Instead, access challenges are embedded in daily survival realities, including displacement, insecurity, poverty, caregiving burdens, transportation issues, limited awareness and the organization and location of services themselves. Importantly, participants also articulated clear, practical recommendations for overcoming these impediments, grounded in lived experience.

Physical and logistical impediments to access

Across nearly all FGDs, distance, transportation, cost and safety emerged as dominant impediments preventing people from accessing MHPSS services. These challenges were particularly acute for displaced populations living in camps or informal settlements, where services are often located far from shelters and movement is restricted by insecurity.

Adolescent boys highlighted the cumulative impact of poverty, distance and fatigue on help-seeking:

“Some people are shy and it’s difficult for them to ask for help... Also, many people are poor, and there’s no money for transportation. For many people, International Medical Corps is very far away and difficult to get to.” FGD 4

Movement itself has become dangerous and costly, especially for young people:

“Transportation used to be good but now is very dangerous and expensive... We need safe, affordable transport.” FGD 4

Women described the physical toll of accessing services while displaced, often while caring for children:

“I’m originally from Gaza City, but we relocated here last month. I have to walk two kilometers to get here. It’s not easy, especially in the hot sun and with my baby.” FGD 5

Others emphasized that distance limits consistent engagement, even when motivation exists:

“The main problem for me is transportation. It’s a long way to come here. I’d like to attend more sessions, but it’s too far.” FGD 5

Service providers corroborated these experiences:

“Many children can’t reach International Medical Corps because of distance and transportation.” FGD 6

“Many people with conflict-related disabilities are very depressed. But without transportation support, they won’t come.” KII6: MHPSS Coordinator, INGO

Time poverty, caregiving responsibilities and competing priorities

Participants repeatedly emphasized that time constraints and caregiving responsibilities significantly limit access to MHPSS services, particularly for women and adolescents.

Adolescent boys described being unable to seek support due to adult responsibilities:

“I don’t have much time for this. I have too many responsibilities to put food on the table.” Male, age 15, FGD 4

Women highlighted how caregiving duties, household labor and safety concerns restrict mobility:

“If we could have childcare, it would make it so much easier to attend.” FGD 5

Participants stressed that service timing and location must reflect these realities:

“Services must be at reasonable times and in our communities. Transportation is a problem.... Many centers are too far.” FGD 8

Key informants echoed this constraint:

“Women living in tents cannot leave their children unattended due to safety risks, preventing them from accessing services unless childcare or protection support is available.” KII 4: Director, Local Community Mental Health NGO

Stigma, acceptability and social constraints

Although stigma was not consistently identified as the primary impediment, it remains a significant and unevenly distributed constraint, particularly affecting men, older adults and women living within extended family systems.

Adolescents noted persistent stigma and misunderstanding:

“People also think mental health isn’t important. There’s still a lot of stigma.” FGD 4

Women described fear of social judgment and reputational harm:

“People call us crazy if we say we’re seeing a psychologist.... I know a man who asked for help, and when his wife found out, she wanted a divorce.” FGD 8

Others described concealment strategies to avoid stigma:

“My mother tells them we’re going to a medical appointment when we come here.” FGD 5

Older generations were repeatedly identified as particularly stigmatizing:

“Our grandparents don’t understand and prevent us from seeking mental health services.” FGD 10

Key informants described entrenched misconceptions:

“They think mental disorders are inherited or contagious, that something is wrong with the person. They call them ‘crazy’ and avoid them.” FGD 12

At the same time, some professionals observed a shift:

“Stigma is no longer the main barrier. The war has weakened stigma, and people are now actively seeking mental health support.” KII 4: Director, Local Community Mental Health NGO

This suggests stigma has not disappeared but is contextual, group-specific and evolving.

Awareness gaps and misunderstanding of MHPSS

A recurring theme was limited understanding of what MHPSS services are, who they are for and how to access them.

“This is the first time we’ve really heard about mental health.” FGD 10

Participants and providers alike emphasized that many people equate MHPSS with illness or medication:

“People believe that if they go to a psychologist, they’ll be prescribed medication.” FGD 12

Others highlighted misconceptions within organizations themselves:

“Many organizations think MHPSS means playing with kids.” FGD 12

Pathways shaped by lived reality

Participants articulated concrete, experience-based strategies to overcome access impediments, emphasizing practical adaptations grounded in daily life and priority needs:

“How can I access mental health support when I’m hungry and my baby is crying?” FGD 11

Across groups, respondents emphasized that services must adjust to people’s physical and practical realities. Community-based and integrated approaches were repeatedly recommended, including linkage with other essential services to improve feasibility and acceptability:

“We should link MHPSS to other services like food or materials to reduce stigma.” FGD 4

Location and decentralization were described as critical, particularly for children and families who cannot safely travel long distances:

“Safe spaces must be inside our communities so children can reach them.” FGD 8

Participants also highlighted system-level gaps that make access uneven across governorates and communities:

“In all of Khan Younis, there’s only one psychiatric point, and it’s far from many people.”
FGD 12

Awareness-building through trusted messengers was viewed as essential to improving uptake and navigation of services:

“We need to raise awareness and involve community leaders, mukhtars and imams.”
FGD 12

Finally, privacy and dignity were framed as prerequisites for acceptability. Participants noted that integrating MHPSS with group activities can support engagement but only if confidentiality and safe space are protected:

“Link MHPSS to sports or art. And it’s important to ensure privacy and confidentiality, so people feel safe coming.” FGD 4

When need outpaces reach

Participants made clear that unmet need is not primarily driven by resistance to care but by the friction between daily survival and service design. Even where motivation exists, distance, insecurity, caregiving burdens and lack of information repeatedly interrupt access and continuity.

Improving access to MHPSS in Gaza therefore requires more than expanding services. It demands rethinking *where*, *how* and *with whom* care is delivered and ensuring service pathways are aligned with the realities of displacement, scarcity and social constraint. Only when services move closer to people’s lives can acceptability, continuity and impact begin to follow.

Theme 13 — Quality, Dignity & Safety Of Care

Quality of care in Gaza is not merely a technical concept. Participants described it through concrete, immediate conditions, such as whether a service space protects privacy, whether confidentiality is respected, whether staff speak with basic humanity and whether people feel physically and socially safe enough to engage in support. In a setting shaped by overcrowding, displacement, surveillance and chronic insecurity, these dimensions become more than “good practice.” They become the difference between care that is accessible in theory and care that is trusted, usable and psychologically safe in reality.

Across FGDs and KIIs, participants emphasized that dignity is a core determinant of whether people seek services, whether they return and whether services are experienced as supportive or exposing. What follows illustrates how privacy, respectful

treatment and safety conditions shape both perceived quality and ethical integrity of care.

Privacy and confidentiality as prerequisites for psychosocial support

Participants repeatedly emphasized that psychosocial support requires environments where people can speak without being overheard, exposed or publicly identified. In crowded settings, privacy is not assumed; it must be intentionally created.

One young mother highlighted how privacy intersects with service attendance and continuity:

“It would make it easier for me to attend sessions if there was a private place to breastfeed my baby.” FGD 5

Frontline providers reinforced that privacy is not a comfort feature but a foundational requirement for ethical psychosocial work:

“Psychosocial support needs private spaces. We need rooms where psychologists can work safely and confidentially.” FGD 6

Participants also emphasized privacy needs beyond in-person sessions, particularly when movement is restricted or when attending services feels unsafe:

“We also need private spaces to protect dignity and a hotline for remote support.” FGD 11

One woman described how a breach of confidentiality caused lasting harm and prevented her return to services:

“I also lost all my family. After that, I was referred to another NGO, but I had a bad experience. The doctor called my name and told others I was there for mental health support. I didn’t feel safe to return.” FGD 11

In Gaza’s current context, confidentiality violations can trigger shame, social exposure and complete loss of trust, undermining both continuity of care and perceived safety of services.

Dignity in service environments: being seen, protected and treated as human

Participants described dignity through lived experience: being respected, not being exposed, and not being treated as a problem to manage. Several accounts underscored how respectful care can function as a psychosocial intervention in itself, restoring personhood amid collapse.

One participant described how the quality of interaction shaped the therapeutic impact:

“The psychologist here helped me understand my emotions better. At first, I felt hopeless, but through the sessions I started to feel seen and respected.” FGD 9

Others pointed to the harm caused when care is delivered with harshness or humiliation, particularly in overstretched health settings. Injured participants described disrespectful conduct as a direct violation of dignity:

“I want to mention one doctor in particular. . . . He did not respect me at all. He shouted in a very bad way. Others saw this and tried to intervene.” FGD 9

“We need the doctors and nurses to be more respectful. Sometimes the way they talk to us feels harsh. The behavior should be kinder and more humane.” FGD 9

These accounts demonstrate that quality of care is not defined solely by availability. Where systems are strained, the risk of dehumanizing interactions rises, and services themselves can become distressing rather than supportive.

Dignity, identity and privacy for women and girls

For women and adolescent girls, privacy was repeatedly described as inseparable from dignity and emotional safety. Participants framed private space not only as a requirement for disclosure but as a requirement to feel like themselves again.

“We need someone to help us feel like women again. We need hairstyles, makeup, time for ourselves. We need a private space where we can remove our hijab and be ourselves.” FGD 8

Displacement collapses boundaries between public and private life, leaving women without space for bodily autonomy, self-care or relief from constant visibility. In this context, dignity-supporting spaces are not aesthetic additions—they function as psychosocial protection.

Women and girls also described dignity needs through concrete resources that signal care and normalcy:

“We are young ladies. We need dignity kits—maybe even more than the married women.” FGD 5

Key informants emphasized that dignity needs extend across gender and age:

“Dignity kits remain essential. Men also need dignity kits; many lack clothes or even razors.” KII 1: Head of Protection Department, Local NGO

A community leader captured how even small dignity-related supports carry emotional meaning:

“Now we just have small dreams. One organization provided dignity kits, and people were so happy. Even small gestures matter.” FGD 7

Safety within care pathways: caregiving realities and fear of repercussions

Participants described safety as a practical condition for engagement. This included safety in leaving children, safety in moving to services and safety from repercussions in the home environment.

One woman described fear associated with repeated attendance:

“I would like to come for services more often, but I feel unsafe. I have two other children, 2 and 3 years old. If I keep coming, I have to leave them with their father, and then I get yelled at when I come home.” FGD 5

Others emphasized how camp design and basic security measures enable participation:

“If activities could be organized inside the camps, it would make things smoother and safer. If there were fences, I would feel safe leaving my children in the tent while I attended activities.” FGD 10

These accounts show that quality and safety extend beyond the consultation room. If care exposes children to risk or women to backlash, services exist in name but not in practice.

Dignity in aid-linked and public-facing practices

Participants also raised dignity concerns related to public-facing aid practices. Being photographed or publicly identified during aid distribution was described as culturally violating and harmful.

“Photographing recipients during aid distributions must stop. It is against our culture and violates dignity.” KII 1: Head of Protection Department, Local NGO

Dignity here is procedural, embedded in how services are operationalized and how people’s presence in care is handled in public spaces.

Older adults and dignity-centered service design

Participants emphasized that dignity-centered care must also account for older adults, who face compounded impediments and are frequently overlooked.

“Elderly people especially need comfort and dignity. I recommend elderly centers inside the camps.” FGD 6

This recommendation speaks directly to quality: when service models assume mobility, stamina or social access that older adults lack, care can become difficult to access.

When care itself must feel safe

Across these accounts, quality, dignity and safety emerge not as abstract principles but as enabling conditions. Privacy makes disclosure possible. Respect preserves humanity

in overwhelmed systems. Dignity-supporting spaces and resources restore identity under constant exposure. Safety within camps and households determines whether care can be accessed without fear.

In Gaza's current reality, services that fail to protect dignity risk reproducing harm, even when well intentioned. Ethical care, as defined by participants, is care that people can enter without being exposed, can return to without shame and can engage with without endangering themselves or those they care for.

Theme 14 — Coordination, Collaboration & System Strengthening

Coordination, collaboration and system strengthening emerged as critical determinants of whether mental health and psychosocial support in Gaza can remain safe, effective and responsive as needs continue to escalate. Across FGDs and KIIs, participants emphasized that the scale, complexity and duration of the crisis have surpassed the capacity of isolated services or stand-alone programs. It is not enough merely to provide more activities. Rather, what is needed is a coherent, integrated system capable of absorbing rising acuity, sustaining quality and protecting both service users and providers.

Participants consistently framed system strengthening not as a technical or administrative concern but as a condition for safety and continuity of care. As one senior stakeholder warned:

“We will see many more mental health problems in the coming months. What we need now is collaboration, all humanitarians working together. MHPSS is not an add-on; it must be complementary. We need to focus on hope, on rebuilding lives.” KII 2: Senior Mental Health Official, Public Health Authority

This framing situates coordination as a core component of humanitarian protection and recovery, rather than a parallel process.

Fragmentation and the limits of stand-alone services

Participants across roles underscored that the current mental health burden cannot be managed by individual organizations operating independently. While many actors are providing valuable services, fragmentation has created gaps, duplication and uneven coverage that undermine both efficiency and safety.

“We need to focus on rebuilding the sense of safety. All organizations must work together. One organization alone can't meet the scale of the needs.” FGD 12

Camp-based actors echoed this concern, noting the sheer volume of need relative to existing services:

“Maybe we can separate services inside IDP camps to cover the huge numbers. Collaboration and coordination is key. The needs are so large.” FGD 6

These observations reflect a system operating at—and beyond—its functional limits, where lack of alignment increases the risk of people falling through gaps in care.

Referral pathways and continuity of care

Weak referral pathways emerged as one of the most persistent system-level vulnerabilities. Participants described confusion about where to seek care, inconsistent linkages between service levels and fragile coordination between mental health, medical, protection and nutrition services.

“The referral system between organizations remains weak. People wanting care often do not know where to go, and partners are not consistently connected.” KII 4: Director, Local Community Mental Health NGO

Service providers emphasized the need to strengthen connections across the IASC MHPSS Pyramid, particularly between community-based services and specialized care:

“Strengthening referral pathways between Level 2, Level 3 and Level 4 services is another area of opportunity.” KII 3: CP Coordinator, UN Organization

Health and medication access were also cited as critical components of referral integrity:

“The most urgent need observed is access to medical services, as many mental health problems currently stem from untreated medical issues. Medications are rare, and patients require a reliable referral pathway.” KII 4: Director, Local Community Mental Health NGO

Without predictable referral routes and guaranteed access to follow-up care, participants warned that even well-designed programs risk contributing to frustration and loss of trust.

Coverage gaps and the need for mobile and community-based models

System strengthening was also linked to geographic equity. Participants highlighted persistent coverage gaps, particularly for people living in informal or remote displacement settings.

“Coverage must extend beyond UNRWA camps. I want to stress the importance of including informal camps to ensure equitable access.” KII 3: CP Coordinator, UN Organization

Mobile teams were identified as an essential system adaptation rather than a temporary workaround:

“A third urgent need is expanding mobile teams to ensure that displaced and remote populations are reached consistently. These teams used to provide psychological first aid but now offer more comprehensive support.” KII 4: Director, Local Community Mental Health NGO

Transportation support was similarly framed as a system function:

“Many people cannot reach static service points. GCMHP currently contracts a transportation company to help people who cannot afford travel, but additional support is needed.” KII 4: Director, Local Community Mental Health NGO

Workforce capacity, training and supervision

Participants consistently identified workforce development as a cornerstone of system strengthening. Capacity gaps persist across levels of care, particularly in specialized child protection, VAWG-related case management and advanced clinical services.

“Capacity gaps persist in specialized child protection case management, especially in cases involving VAWG survivors and children with complex protection needs.” KII 3: CP Coordinator, UN Organization

At the same time, stakeholders emphasized that Gaza has substantial untapped local expertise:

“Local expertise should be leveraged. Gaza has hundreds of psychologists and strong institutions such as Gaza Community Mental Health.” KII 5: MHPSS Consultant, INGO

Participants suggested closer collaboration with universities and structured training pathways:

“Graduates from psychology departments should be empowered... either recruited for jobs or engaged as volunteers. It’s easy to work with universities and train students in psychological first aid, so they can then support their families and communities.” FGD 12

However, several respondents stressed that training without supervision undermines service quality:

“We also lack supervision and regular training for staff, which affects service quality.” KII 1: Head of Protection Department, Local NGO

Providers as survivors within a strained system

A defining feature of the current system is that providers themselves are operating under conditions of displacement, loss and chronic insecurity. Participants repeatedly

emphasized that staff well-being is not a peripheral concern but a system-level risk factor.

“Service providers themselves are now experiencing social distress, and no one is taking care of them.” FGD 12

Camp leaders echoed this reality:

“In the displacement camps there are many different actors and professionals, but most of them face a dark future themselves. People are exhausted, uncertain and struggling to sustain their work.” FGD 7

Without adequate support, participants warned that burnout and emotional numbing threaten both staff retention and client safety.

Caring for carers as a system protection measure

Participants framed supervision, peer support and staff care not as wellness initiatives but as essential protections against system failure.

“Supervision is urgently needed. Mental health workers are burned out—even psychologists. We need programs that take care of us, too.”, FGD 6

Institutional leaders emphasized that sustained crisis response requires structured professional support:

“To recover, we need specialists, case managers and people who can refer to specialized centers. To get through this crisis, our institution is training psychologists, helping them build experience and master how to deal with mental health problems across the lifespan.” Participant, approx. 42, FGD 7

When systems cannot hold acuity

Several participants highlighted the ethical and clinical risks that arise when system capacity is exceeded. The absence of inpatient and stabilization options was repeatedly cited as a critical gap.

“We really need an inpatient psychiatric facility. Right now, there are many people on the streets who need inpatient care.” FGD 12

“There is a massive need for specialized care and an inpatient unit. The destruction of the MOH facility was a big loss for Gaza.” KII 6: ICRC, November 24

Specialized pediatric services were identified as particularly insufficient:

“There is a critical gap in pediatric psychiatry. Over 1 million children require support, and an estimated 38 percent may need specialized services.” KII 5: MHPSS Consultant, INGO

These gaps place disproportionate burdens on families and frontline staff, increasing the risk of harm even when services are nominally present.

Coordination mechanisms and shared governance

Participants acknowledged the role of existing coordination platforms, while noting the need for more consistent information sharing and alignment.

“Active participation in the MHPSS Technical Working Group, the Case Management Working Group and the Child Protection group helps organizations stay updated on training opportunities, program standards and new developments. Coordination is improving, but partners need to share information more consistently and remain aligned with technical standards.” KII 3: CP Coordinator, UN Organization

Community and camp leaders were also identified as critical system actors:

“Community and camp leaders are key to community recovery. They can be trained in VAWG prevention, suicide prevention and psychosocial awareness. They can also help identify people with special needs in their camps.” KII 1: Head of Protection Department, Local NGO

When coordination becomes protection

Coordination, collaboration and system strengthening are foundational requirements for safe and sustainable MHPSS services in Gaza. Fragmented services, weak referral pathways and under-supported workforces place both service users and providers at risk as mental health needs continue to intensify.

Participants consistently emphasized that effective system strengthening must integrate mental health across sectors, reinforce referral and supervision structures, expand mobile and community-based models, and recognize providers as survivors whose well-being directly affects quality of care. In this context, collaboration is not merely a principle; rather, it is the primary mechanism through which access can be expanded and dignity, continuity and protection can be preserved.

Without a coordinated and supported system, even the most committed individual services will remain insufficient to meet the scale and complexity of needs.

Strengthening the MHPSS system as a whole is therefore essential not only for recovery but for preventing further harm in the months and years ahead.

VI. Integrated Analysis

Together, the contextual overview and qualitative findings converge on the same core constraints, with the qualitative data clarifying how these conditions translate into

distress patterns, access impediments and service feasibility on the ground. In Gaza, mental health outcomes do not stem from individual vulnerability or isolated traumatic exposure. Rather, they are produced by an environment characterized by repeated displacement, material deprivation, persistent danger and the progressive dismantling of the structures that ordinarily sustain daily life. Across the dataset, distress emerges as a predictable response to prolonged instability in which safety, predictability and agency are consistently absent.

Displacement functions as the primary organizing condition of this crisis. Participants describe displacement as an ongoing cycle of uprooting that prevents stabilization at any point. Each forced move erodes routines, fragments social ties and strips away the physical and relational environments that support regulation and recovery. Over time, repeated disruption diminishes autonomy and exhausts adaptive capacity, leaving individuals and families in a permanent state of contingency.

Conditions within displacement sites intensify this destabilization. Overcrowding and the severe loss of privacy collapse boundaries between public and private life, with direct consequences for dignity, emotional regulation and family functioning. Women and adolescent girls described constant visibility that constrains bodily autonomy and heightens stress. Adolescents articulated how the absence of private space during a critical developmental period disrupts identity formation and increases vulnerability to shame, withdrawal and irritability. For families, crowding accelerates emotional fatigue, amplifies conflict and reduces tolerance for stress, weakening the household's protective capacity.

Environmental exposure further compounds these pressures. Inadequate shelter, extreme temperatures, poor sanitation and persistent hazards create a background of physical discomfort and vigilance that leaves little opportunity for rest or recovery. Caregivers described the mental toll of continuously monitoring children in environments perceived as unsafe and unhygienic, transforming ordinary caregiving into sustained anxiety. These conditions normalize hyperarousal and exhaustion and constrain recovery from loss and fear.

Protection risks permeate daily life and are embedded in the physical and social environment. Insecure shelters, unsafe sanitation facilities, poor lighting and dangerous aid distribution points create constant exposure to harm. Movement itself becomes risky, restricting access to services, education and social connection. These risks are unevenly distributed. Women, girls, children, older adults and people with disabilities face layered vulnerabilities shaped by cultural norms, mobility limitations and reliance on caregivers who are themselves overwhelmed. The absence of safe space undermines not only physical security but emotional safety and trust, further constraining help-seeking and participation in services.

Within this context, unmet basic needs dominate daily life and structure emotional experience. The continual search for food, water, fuel and electricity consumes time, physical energy and emotional bandwidth. Survival tasks displace routines that once supported learning, social connection and emotional regulation. Caregivers described daily trade-offs that generate guilt, shame and despair, particularly when children's needs cannot be met. Children's growing involvement in survival labor reflects accelerated role reversal and the erosion of childhood protections. When deprivation persists, distress becomes sustained rather than episodic, reinforcing a cycle in which coping capacity steadily narrows.

Disruption to education further compounds psychosocial distress, particularly for children and adolescents. Repeated displacement, unsafe conditions and prolonged school closures have removed one of the few remaining sources of routine, structure and forward momentum in daily life. Participants described how the loss of schooling erodes a sense of normalcy and progress, leaving children without predictable rhythms or developmental markers. For adolescents, the absence of education weakens future orientation and contributes to feelings of stagnation, withdrawal and hopelessness. For caregivers, the inability to keep children in education adds to guilt, anxiety and a sense of failure, intensifying household stress already shaped by survival demands.

Loss and grief intersect with these conditions in ways that prevent resolution. Participants described cumulative loss not only of loved ones but of homes, livelihoods, roles, social status and imagined futures. Grief was rarely framed as something that could be processed or completed. Instead, it persists alongside ongoing displacement, insecurity and deprivation, repeatedly reactivated by new stressors. Without safety, stability or social space to mourn, loss becomes a continuous condition rather than a discrete experience, causing prolonged emotional numbness, irritability, despair and withdrawal across age groups.

Livelihood disruption similarly shapes emotional distress by eroding purpose, agency and social role. The loss of work was described not only as economic hardship but as a collapse of identity and dignity, particularly for adults who once structured daily life around providing for their families. Without stable or meaningful work, feelings of helplessness, frustration and shame intensify, and stress reverberates through family relationships. These pressures intersect with displacement and scarcity, narrowing coping options and reinforcing a sense that effort no longer leads to stability or recovery.

Families remain the primary buffer against this accumulation of stress. Yet, the findings show that they are absorbing burdens far beyond their capacity, often without the wider social and community structures that once shared this load. Households are simultaneously managing displacement, food insecurity, caregiving for injured or disabled relatives, untreated mental health conditions and economic collapse. Profound

role shifts have occurred: children assume adult responsibilities, women carry intensified caregiving and emotional labor with little respite and men experience the loss of provider roles that once structured identity and purpose. As family systems strain under these pressures, conflict increases, and protective capacity weakens, placing children, older adults and people with disabilities at heightened risk.

At the same time, the data point to a broader thinning of community cohesion that intensifies this family-level strain. Displacement, prolonged scarcity and the loss of shared routines have weakened neighborhood ties, trust and traditional mechanisms for mediation and mutual support. As collective spaces and informal social regulation disappear, pressures that were once dispersed across community life rebound inward, concentrating stress within households and reducing opportunities for connection, shared coping and conflict resolution.

Across age groups, distress presents as an expected response to prolonged, intersecting stressors rather than individual pathology. Participants described pervasive sadness, fear, anger, emotional exhaustion and hyperarousal. Children exhibit regression, aggression and somatic symptoms. Adolescents report isolation, hopelessness and disruption of identity and future orientation. Adults describe emotional depletion, irritability and despair linked to the loss of agency and role. Service providers reported a rise in severe and complex presentations, including suicidality and substance use, reflecting the erosion of informal coping mechanisms under sustained pressure.

Health system disruption further intensifies psychosocial vulnerability. The collapse of continuity in medical care, medication shortages and limited access to specialist services place individuals with chronic illness, injury and disability at heightened risk. Physical suffering, untreated pain and uncertainty about survival amplify emotional distress and deepen caregiver burden. The findings consistently demonstrate the bidirectional relationship between physical and mental health, particularly in displacement settings where access to care is fragmented and unpredictable.

Alongside these constraints, participants also described the few remaining sources of emotional anchoring. Faith and spirituality remain among the most consistent stabilizing resources across age groups. Prayer and belief provide meaning, comfort and emotional regulation in an environment stripped of predictability. At the same time, the disruption of communal spaces limits collective coping and social support, shifting practice into more isolated forms. Faith sustains endurance, but participants emphasized that it cannot substitute for safety, privacy, food or access to care.

Coping strategies described across the findings reflect adaptation under constraint. Play, creativity, movement, peer connection and access to open and natural spaces have historically supported emotional regulation and resilience, especially for children and adolescents. These mechanisms are now severely constrained by displacement,

environmental destruction, overcrowding and the absence of safe spaces—narrowing opportunities for regulation and restoring agency.

Access to MHPSS services is shaped by the same structural realities that generate distress. Distance, transportation costs, insecurity, caregiving responsibilities and time poverty frequently prevent engagement, even when motivation exists. Stigma persists, but participants more often emphasized structural blockades as the primary constraint. Where services are distant, exposed or disconnected from basic needs, continuity remains fragile.

Quality, dignity and safety emerge as decisive determinants of whether care is experienced as supportive or harmful. Privacy breaches, lack of confidentiality and disrespectful treatment undermine trust and deter help-seeking. For women and adolescent girls, dignity-supporting spaces are essential for emotional safety and participation. For older adults and people with disabilities, challenging environments result in inaccessibility. In this context, the conditions of care shape not only access but the likelihood that services are experienced as protective.

Finally, the findings demonstrate that system-level coordination functions as a form of protection. Fragmentation, weak referral pathways and under-supported workforces increase the risk of people falling through gaps in care. Providers themselves are operating under displacement and loss, facing burnout and emotional exhaustion. These realities reinforce the extent to which continuity, coordination and workforce support influence both safety and service effectiveness.

Overall, the findings depict a population living under conditions in which distress is continuously produced and rarely stabilized, and in which service feasibility is shaped by the same constraints that drive need.

VII. Recommendations

These recommendations reflect a consistent reality across the findings: psychological well-being in Gaza cannot be separated from the conditions in which people are trying to survive. An effective MHPSS response must address emotional distress directly while also strengthening the social, material and structural conditions that shape it. The recommendations below are grounded in community testimony, provider experience and field observation, and are intended to support a coordinated, realistic humanitarian response in a protracted crisis.

1. Stabilize basic living conditions as a foundation for mental health

Overcrowding and a lack of food security, safe shelter, lighting, locks, electricity and safe sanitation are primary determinants of psychological distress across the population. Interventions to improve shelter conditions, WASH infrastructure, privacy and safety should be treated as mental health-protective measures for all age groups, not only as parallel sectoral activities. Improving daily living conditions reduces chronic stress, fear and exhaustion and enables engagement with MHPSS services.

2. Deliver MHPSS through community-based, mobile and integrated models

MHPSS services should be brought closer to where people live, particularly in high-density, informal and remote displacement sites. Mobile teams and community-based services are essential for reaching people who cannot travel, including caregivers, older adults and people with disabilities. MHPSS should be discreetly integrated within primary healthcare, nutrition, child protection, VAWG services and aid distribution points to reduce stigma and promote access. Engagement of trusted community leaders, camp focal points and local volunteers is critical for outreach, awareness-raising and facilitating safe access to services.

3. Protect children through structured safe spaces and caregiver support

Structured child-friendly spaces with predictable routines, trusted staff and opportunities for play, expression and peer interaction should be scaled as a core protective intervention. These spaces provide emotional containment and developmental protection in environments where homes and communities no longer reliably offer safety. Caregiver support, including stress management, positive parenting and non-violent discipline adapted to displacement, is essential to sustaining children's mental health under prolonged crisis conditions.

4. Provide dedicated, developmentally appropriate support for adolescents and young adults

Adolescents and young adults face distinct risks related to identity disruption, loss of peer networks, blocked transitions to adulthood and diminished future orientation. Dedicated programming should address emotional regulation, peer belonging, life skills and meaningful participation, alongside psychosocial support. Services for this group must be predictable, dignified and accessible, recognizing the importance of agency, social connection and future pathways in psychosocial recovery.

5. Protect education and learning as a stabilizing force across the lifespan

Access to safe, structured learning for children, adolescents and young adults should be treated as a psychosocial stabilization measure. Education provides routine, cognitive engagement, social connection and future orientation, all of which are closely linked to mental well-being. Interventions should include safe learning spaces, alternative education pathways, tutoring and learning centers, and support for access to devices, electricity and internet, where feasible.

6. Integrate mental health with health, disability and medication continuity

Mental health support should be embedded within primary healthcare and outreach services, including psychological first aid elements, stress management and brief supportive interventions. Strengthened referral and follow-up are needed for people living with chronic illness, injury and disability, recognizing the bidirectional relationship between physical health instability and psychological distress. Access for people with disabilities must be embedded across service design, including accessible spaces, assistive devices, outreach follow-up and tailored psychosocial support for injured people, amputees and caregivers.

7. Ensure access to specialized mental healthcare across the continuum, including inpatient capacity

The absence of specialized and inpatient psychiatric care leaves individuals with severe mental health conditions vulnerable. The response should ensure access to specialist consultations, consistent medication supply and referral pathways for complex conditions, alongside the establishment of a rights-aligned, short-stay inpatient psychiatric stabilization unit. Inpatient care should be time-limited, dignity-based and fully linked to outpatient and community MHPSS services to ensure continuity rather than isolation. Remote or hotline-based support should complement in-person care where movement is unsafe or restricted.

8. Restore livelihoods and income pathways as a mental health-protective intervention

Livelihood collapse has stripped households of income, dignity and stable social roles, intensifying distress, family tension and hopelessness. Livelihoods should be treated as a core determinant of mental health, not as a secondary or post-recovery activity. Priority actions include integrating MHPSS considerations into cash-for-work and income-generation initiatives; supporting women's safe, home-based or collective

economic activities; restoring dignified income pathways for men; and developing transitional livelihood options for adolescents and young adults. Livelihood recovery stabilizes households, reduces chronic stress and restores agency and identity.

9. Safeguard quality, dignity and confidentiality across all services

Privacy, confidentiality and respectful treatment are prerequisites for effective care. Services must ensure private consultation spaces, discreet client flow and non-stigmatizing communication, particularly in crowded settings. All staff, not only mental health specialists, should be trained to protect confidentiality and dignity. Practices that undermine trust, such as public calling-out or photographing of aid recipients, should be avoided. Ethical, humane care is central to service utilization and continuity.

10. Address protection risks as integral to MHPSS delivery

Camp safety measures, including lighting, safe WASH facilities for women and girls, secure access routes and mitigation of nighttime risks, should be treated as part of the MHPSS response. Strengthened identification and referral pathways are needed for high-risk groups, including unaccompanied and separated children, VAWG survivors, widows and female-headed households, people with disabilities, orphans, former hostages and individuals with severe mental health conditions. Clear, shared protocols for managing acute risk, including suicidality and psychosis, are essential.

11. Invest in group-specific MHPSS programming

Findings highlight the need for gender-segregated and group-specific programming. Women require safe, private spaces and targeted support addressing caregiving burden, grief and protection concerns. Men benefit from low-stigma entry points that restore purpose, social connection and provider identity. Tailored services are also needed for widows, orphans, VAWG survivors, torture survivors, people with disabilities and older adults to ensure access and appropriate care across the population.

12. Strengthen coordination, referral pathways, and system coherence

Effective MHPSS delivery depends on strong coordination across health, protection, education, livelihoods and humanitarian actors. Shared service mapping, clear referral pathways across the IASC pyramid and consistent communication among partners are essential to reduce gaps and duplication. Coordination mechanisms should prioritize continuity of care, geographic equity and protection of high-risk individuals, while supporting providers who are themselves operating under displacement and chronic stress.

VII. References

Gaza Community Mental Health Programme. (2025). *Mental health crisis report 2025*.

Gaza Community Mental Health Programme. <https://www.gazamentalhealth.org/wp-content/uploads/2025/10/Mental-Health-Crisis-Report-2025-2.pdf>

United Nations Children’s Fund. (2026). *Children in Gaza need lifesaving support*.

UNICEF. <https://www.unicef.org/emergencies/children-gaza-need-lifesaving-support>

United Nations Office for the Coordination of Humanitarian Affairs. (2026a, February 4).

Reported impact snapshot: Gaza Strip (4 February 2026 at 15:00) [Snapshot]. OCHA

oPt. <https://www.ochaopt.org/content/reported-impact-snapshot-gaza-strip-4-february-2026>

United Nations Office for the Coordination of Humanitarian Affairs. (2026b, January 29).

Humanitarian situation update #355 | Gaza Strip [Situation update]. UN

OCHA. <https://www.unocha.org/publications/report/occupied-palestinian-territory/humanitarian-situation-update-355-gaza-strip>

World Health Organization. (2025, September 10). *Hostilities in the occupied*

Palestinian territory (oPt): Public health situation analysis (PHSA) [Situation analysis].

WHO. https://cdn.who.int/media/docs/default-source/documents/emergencies/who-phsa-opt-100925.pdf?sfvrsn=367c45e4_1

Annex 1. Qualitative Inquiry Framework and Discussion Domains (Gaza MHPSS Needs Assessment)

Purpose and facilitation approach

This assessment used a semi-structured qualitative approach grounded in shared analytic domains rather than a fixed question schedule. Discussion prompts were used flexibly to facilitate a participant-led narrative while ensuring consistent coverage of core domains across groups. All discussions were facilitated by a single facilitator. Question wording, sequencing and emphasis were adapted based on participant group, developmental stage, role, safety considerations and group dynamics. Not all prompts were asked verbatim or exhaustively in every discussion; however, the core domains below were consistently explored across the dataset through open discussion and targeted probing as needed.

For confidentiality and consistency with the main report, stakeholders are presented by institutional category and role, rather than by organization name.

Core analytic domains and illustrative prompts

The domains below reflect the common analytic backbone used across key informant interviews (KIIs) and focus group discussions (FGDs). Prompts are provided as illustrative examples of how domains were initiated and explored.

Domain 1. Lived experience of current conditions and priority stressors

Illustrative prompts included:

- How has life changed for you/your family over the past year?
- What feels hardest right now in daily life?
- What are the biggest challenges or stressors people are facing at the moment?

Domain 2. Distress presentation and impacts on daily functioning

Illustrative prompts included:

- How is distress showing up for people day to day (feelings, behavior, physical symptoms, relationships)?
- What changes have you noticed in yourself, your children or people around you?
- How are these conditions affecting family functioning, caregiving and daily routines?

Domain 3. Coping strategies and sources of emotional support

Illustrative prompts included:

- What helps you cope when you feel sad, stressed or overwhelmed?
- What helps children and adolescents cope?
- Who do people usually turn to for support (family, peers, community, faith, services)?

Domain 4. Help-seeking pathways and obstacles to access

Illustrative prompts included:

- When people need support, where do they go first? Where do they go now?
- What makes it difficult to seek help or continue care (mobility, cost, insecurity, time, stigma, privacy)?
- What prevents people from accessing services even when they want support?

Domain 5. Protection, dignity, privacy and safety considerations

Illustrative prompts included:

- What makes people feel unsafe or exposed in daily life or when accessing services?
- What makes it easier or harder to talk about sensitive issues in this context?
- What conditions are needed for services to feel safe, respectful and confidential?

Domain 6. Experience of available services and perceived gaps

Illustrative prompts included:

- What support is currently available, and what is missing?
- What has been helpful, and what has not worked well?
- Where do people fall through gaps in the current system (referrals, follow-up, continuity)?

Domain 7. Priorities for support and service feasibility

Illustrative prompts included:

- What kinds of support, activities or services would be most helpful right now?
- What would make services more accessible and realistic under current conditions?
- What should be prioritized over the next three to six months?

Domain 8. Future orientation, hopes and meaning

Illustrative prompts included:

- As we finish, what is your hope, dream or prayer for the future?
- What would help people feel more hopeful or able to keep going?

Group-specific facilitation adaptations

While the same analytic domains guided all discussions, facilitation approaches were adapted to ensure developmental appropriateness, ethical sensitivity and feasibility:

- **Children (approximately ages 9–12):** Creative methods were used as entry points to support expression and reduce pressure for verbal disclosure. For example, children were invited to draw something that makes them happy when they feel sad; the discussion then explored meaning, coping, safety and support-seeking through the child's narrative about the drawing.
- **Adolescents:** Discussion emphasized peer connection, dignity, privacy, identity and role disruption, future orientation and impediments to support-seeking, using age-appropriate language and probes.
- **Adults and caregivers:** Discussion emphasized caregiving burden, household stress, service access and continuity, and practical impediments to help-seeking under displacement and deprivation.
- **Protection-sensitive groups:** Questions were framed to avoid forced disclosure, with emphasis on safety, confidentiality and non-identifying descriptions of impediments and needs. Probing was adjusted based on participant comfort and group dynamics.

Key informant interviews: stakeholder categories

KIIs were conducted with stakeholders across the following institutional categories: **local NGOs, local community mental health NGOs, international NGOs, UN**

organizations and public health authorities. The same analytic domains guided KIIs, with probing tailored to respondents' institutional roles and technical areas of expertise.

Note on documentation and consistency

Across discussions, facilitators prioritized participant-led narrative and used targeted probing to ensure coverage of the domains above. Where participants addressed domains spontaneously, prompts were not repeated. This approach reflects standard qualitative practice in protection-sensitive humanitarian contexts and supports analytical consistency without imposing a rigid or uniform question schedule.



To learn more about the assessment report and our MHPSS program in Gaza and the Middle East, contact:

Maura Reap

Gaza MHPSS Coordinator

International Medical Corps

mreap@InternationalMedicalCorps.org

Abdelkarim Khader

Global MHPSS Advisor for the Middle East

International Medical Corps

akhader@InternationalMedicalCorps.org

To learn more about International Medical Corps' Gaza program, contact:

Javed Ali

Senior Director, Emergency Response Unit

International Medical Corps

jaali@InternationalMedicalCorps.org

To learn more about International Medical Corps' global MHPSS programs, contact:

Claire Whitney

Senior Global MHPSS Advisor

International Medical Corps

cwhitney@InternationalMedicalCorps.org