

“NAFSI TA'BANEH – MY SOUL IS SUFFERING”

How to develop a community-based mental-health programme
built on relationships with and acceptance by the communities
in and around the Bourj el-Barajneh camp
south-Beirut, Lebanon



Bourj el-Barajneh camp South Beirut, Lebanon
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Doris Burtscher
Social and Medical Anthropologist
MSF Adviser
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Executive Summary

The executive summary presents an overview of the most important findings of and comments on the study's question in general and answers specific points discussed with the Desk in Geneva, Muna Khalidi with whom I worked in Lebanon as well as the HoM and Field coordinator in Beirut in November 2009. This summary refers to the whole report; a complete description of the findings and recommendations can be studied in detail.

Findings on Health-Seeking Behaviour

Cultural perception of mental health and illness

- It appears that all matters related to mental health and mental illness are stigmatized
- 'Mental' is equated with 'crazy'. Mental health problems are denied. The community as such lacks knowledge and awareness of the different aspects of mental health. People are shy to speak about mental health issues and not used to expressing the need. In this sense stigma is very much linked to health-seeking behaviour, which is decidedly influenced by perceptions and attitudes of the population it serves
- When people express conditions related to mental well-being and distress they speak about how they feel in their soul, how they feel with themselves and use the Arabic word *nafsi Ta'baneh*¹, which could be translated as a disease of the soul, literally "My soul is tired or my soul is suffering"

Causes of mental health and illness

- Practically speaking most of the causes are related to poor living conditions in the camp and to the general situation of the Palestinian refugees
- Culturally speaking people refer to being possessed by Jinni or are pursued by Jinni and would try to get treatment from a *Sheikh*²

Health-seeking Behaviour – What keeps people from coming?

- Many simply do not know MSF
- Lack of visibility and awareness
- Lack of knowledge about mental health and illness and conditions related to poor mental health
- Lack of understanding of poor mental health and that something can be done
- Location of the MSF centre
- Opening hours of the MSF centre
- Targeting only therapy-related cases
- Targeting only adults

Findings on Community Involvement

How to approach the communities?

- We should approach the communities through the different NGOs inside and outside the camp. We should go towards the communities with an open minded and respectful attitude; to step back from ethnocentric behaviour and to try to understand why Palestinians are here and why Lebanese from the South are here.

Community Involvement – What does it mean?

- To be visible as an organisation and as MSF
- To be accessible
- To be available
- To network with the different NGOs in the communities by having regular meetings with them.

¹ *Nafsi* comes from the word *nafs* which means soul or self (Arabic dictionary). *Ta'baneh* literally translates as the female version of "TIRED" or "UNWELL" Muna Khalidi

² A *Sheikh* is a person trained in Islam, literally a man of old age; it gained currency as a religious term or as generally honorific in many parts of the world notably in Muslim cultures.

MSF Community-based mental health centre

- Remove the name 'mental' from the title
- Extend opening hours (men can come only after work and on weekends)
- Have MSF services inside and outside the camp
- Adopt the clinical and the community approach – treatment and social activities

Abbreviations

BeB	Bourj el-Barajneh
DRC	Danish Refugee Council
FGC	Family Guidance Centre
FGD	Focus Group Discussion
HSB	Health-seeking Behaviour
IMC	International Medical Corps
MH	Mental Health
MoPH	Ministry of Public Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
PRCS	Palestine Red Crescent Society
UNDP	United Nations Development Programme
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organisation
W.H.O.	Women's Humanitarian Organisation

1. Introduction

This report has been carried out in order to analyse the findings based on field research using interviews and observations made in the Bourj el-Barajneh camp from 4th to 28th November 2009. In-depth literature review and productive discussions with MSF teams are included in the analysis. Different internal reports from MSF and comprehensive discussions with Muna Khalidi, Head of Mission and Field coordinator, have been taken into account for the definition of the recommendations.

The main objective of the report is to assist the team in understanding the health-seeking behaviour of our beneficiaries and to develop a strategy for community involvement in and acceptance of the project.

Additionally this report discusses the specific objectives specified in the Terms of Reference:

Health-seeking Behaviour

- Cultural perception of health and illness (to better understand cultural perception of mental health)
- Cultural perception of mental health and illness
- Cultural perception of the causation of mental illness
- Influences on health-seeking behaviour (What keeps people from coming?)
- Decisions encompassing health-seeking behaviour

Community Involvement

- How to approach the communities?
- What does community involvement mean?
- Review existing current community relations and provide advice on how to strengthen them
- Review how we communicate within the community and provide advice
- Define which community participation is relevant to the project and what steps must be taken to involve the community?
- How to establish a Community Advisory Group (if deemed the best strategy)?
- How to set boundaries between MSF support and community involvement?
- Discuss the option of a "MSF drop-in centre" and if it is relevant to this project/context.
- Define which position/responsibilities (and background) are required to manage community involvement/activities
- Define an evaluation strategy for community activities/participation

1.1. Background Information on Palestinian Refugees

With the collapse of 400 years of Ottoman rule at the end of World War I, Palestine came under a British mandate. In the 1917 Balfour Declaration, the British promised a national home for the Jews in Palestine while referring to the indigenous population as the non-Jewish community. In 1947, Britain withdrew its mandate and turned the issue of a Zionist claim to Palestine over to the United Nations, hence the UN plan to partition Palestine into Arab and Jewish states. The partition plan was backed by the United States and the Soviet Union, while Britain abstained. The 29 November 1947 vote in favour of partition ignited the war for Palestine. With the subsequent defeat of the Palestinian and Arab forces and the expulsion and/or flight of Palestinians, a Jewish state was declared in Palestine on 14 May 1948³.

1.2. Local Context

The majority of Palestinian refugees registered with UNRWA in Lebanon (United Nations Relief and Works Agency) are those who arrived in the country in 1948-1949 and their descendants, subsequent to the defeat of the Palestinian and Arab forces and the expulsion and/or flight of Palestinians upon the declaration of a Jewish state in Palestine on 14 May 1948. (See Lebanon

³ Assessment Report Lebanon p. 49ff.

Assessment report for an elaborate analysis of the general context as well as health status of Palestinian refugees).

The initial arrivals were amounted to ten percent of the total Lebanese population. Lebanon is a multi-confessional country with 17 officially recognized religious communities; it found itself host to a large and overwhelmingly Sunni Muslim refugee population. Today, all refugee camps and gatherings have serious problems: no proper infrastructure, overcrowding, poverty and unemployment. UNRWA Lebanon takes care of the highest percentage of Palestinian refugees who are living in abject poverty and who are registered with the agency's "special hardship" programme.

These refugees have no social or civil rights, limited access to the government's public health or educational facilities and no access to public social services. Most rely entirely on UNRWA as the sole provider of education, health and relief as well as social services. Considered as foreigners, Palestinian refugees are prohibited by law from working in more than 70 trades and professions. This has led to a high rate of unemployment among the refugee population. The number of Palestinian refugees in Lebanon (all registration categories combined) is estimated to be 250,000⁴.

1.3. Population Bourj el-Barajneh Camp

Bourj el-Barajneh (Arabic for "Tower of Towers") is a municipality located in the southern suburbs of Beirut, Lebanon. The municipality is situated between the International Airport and the town of Haret Hreik. Its local population consists mainly of Shia Muslims. It has acquired a sizable Sunni, Kurdish, Iraqi and other refugee populations that reside mainly in and around the local Palestinian Camp.

The Bourj el-Barajneh refugee camp is located on the edge of the municipality. The league of the Red Cross Societies established the camp in 1948 to accommodate an influx of Palestinian refugees from Galilee in present-day northern Israel. The camp was besieged by the Israeli army and Lebanese Christian Phalangists in 1982, after Israel invaded Lebanon earlier that year. It was also besieged by Amal militia from February 1984 to February 1987 for the control of West Beirut. According to UNRWA more than 15,000 Palestinian refugees live in the camp today, though it was originally laid out to host only 10,000 on the one square-kilometre site. Another estimate puts the number of inhabitants at 20,000.⁵

1.4. Background of Médecins sans Frontières in Lebanon

MSF Switzerland had never been operational in the country except for the summer of 2006 (Israel/Lebanon war), yet there is a history of MSF interventions and explorations in the country that have led many in the movement to conclude that there is no space for our organisation in Lebanon. This was mainly due to existing high quality medical services and staff, an active local NGO environment and the absence of a life-threatening, crisis situation. Some MSF sections recently engaged in various assessments with regard to humanitarian needs, communications and recruitment possibilities. Currently only MSF Switzerland is operational in the country.

Lebanon has a population of 3.8 million (UN, 2005) belonging to various Christian groups, Sunni and Shia Muslims, Druze and others. With the deteriorating political situation, OCG thought it necessary for MSF to gain a better understanding of the current instability, marked by the series of high-profile political assassinations and monitor what might be the future impact on the population's health and the humanitarian situation.

An assessment mission was carried out from November 2007 to March 2008 which led to the definition of a community mental health project in Bourj el-Barajneh area.

The General Objective has been defined as: contributing to the alleviation of mental health suffering in the Bourj el-Barajneh area.

⁴ Project Proposal p.11.

⁵ Drawn from the Internet (Wikipedia) on 14th December 2009,

Specific Objectives

1. To improve the treatment of community members suffering from mental disorders
2. To promote mental health and reinforce coping mechanisms in the communities living within the catchment area
3. To advocate for the improvement of the social and economic status of the Palestinian refugees in Lebanon and the creation of objective grounds for a better mental health offer in Lebanon

1.5. MSF activities in the Bourj el-Barajneh area

MSF OCG started a Community-Based Mental Health Project in December 2008 for the community of Bourj el-Barajneh (BeB). The target population consisted of Palestinian refugees living in the Bourj el-Barajneh camp and Lebanese, Iraqi and other nationalities living within the municipality. In the initial phase, MSF was not registered in Lebanon to do a project and obtained special dispensation from the MoPH in order to begin. MSF received official authorisation to work in Lebanon in June 2009 and is currently completing the registration process.

With the need to start treating patients in December 2008, followed by internal HR constraints and gaps, the project has become a treatment-orientated centre with little or no community involvement in the project. This goes against the original concept of the project design, and there is interest shown by the municipality and community for participating in it. The project requests guidance and advice on how MSF can build community ownership of the centre and for understanding the needs of Mental Health Care for the longer-term continuation of services.

2. Research Methodology

The whole investigation is based on qualitative methods. After briefings in Beirut and discussion with Muna Khalidi, we started to meet with different international and national NGOs inside and outside the BeB camp. The main target groups were identified. With the help of NGOs inside the camp, home visits and Focus-group discussions (FGDs) could be arranged. The UNRWA clinic and the Palestine Red Crescent Society (PRCS) Haifa Hospital were visited; key persons were met and interviewed. Permission to do this study was sought from the popular committees in the camp (Fatah and Hamas) and with Hezbollah which controls the area outside the camp. This report represents investigations done only inside the camp as we were not allowed to pursue our study outside.

Semi-structured interviews and narrative interviews were conducted. Serving as a framework for the interviews, a questionnaire was compiled prior to the field study. Given that most of the population speaks Arabic, a translator was needed. MSF consultant Muna Khalidi⁶, who was hired to collaborate with the anthropologist, served as a translator at the same time.

The research team conducted discussions and interviews with the different NGOs mostly on their own premises. This gave us the opportunity to identify the NGO's location in the camp, to see their infrastructure, to learn about their programmes and to be able to better understand their context inside the camp and within the other NGO structures. Some members of the interviewed NGOs arranged home visits and FGDs. One FGD took place in the MSF office.

The study was placed in the field of applied medical anthropology which looks at the applied aspects of health care, mental health care and preventive care. Questions such as 'how people deal with mental health', 'what do people do when they feel mentally sick', 'where do they go and who takes the decision where and how a sick person has to be treated' were addressed in the interviews. Another important aspect is how far we try to understand and tolerate the health-seeking behaviour of our patients in a non-ethnocentric way.

The whole programme was planned as a community-based mental health programme. For that reason the study focused on what we mean by "community based".

⁶ Muna Khalidi already contributed to the initial assessment report.

Data validation will be achieved through triangulation, seeking evidence from a wide range of different sources (interviews, observations, literature reviews, etc.) and by comparing those findings.

2.1. Limitations

Limited time was allocated to this study and therefore only a few home visits and FGDs could be arranged. A visit to an NGO in another camp that has a similar mental-health programme inside the UNRWA clinic was not possible due to time constraints.

The selection of participants in the FGDs was not done by the study team but by the contact person in the NGO. Home visits were arranged by an NGO.

Finally it has to be mentioned that the camp population is used to being interviewed. In view of the fact that we did all the interviews through the NGOs we also have to keep the filtered message in mind.

2.2. Ethical Considerations

The research team explained the purpose of the study to the participants prior to any interview or discussion. The team offered information about the study, its purpose and its aim. No information was collected from the participants without prior consent. Participants in the study had the right to withdraw at any time during the discussion. Moreover, permission to take written notes was obtained before the start of the interview or discussion or focus group.

REFLECTIONS ON CULTURAL PERCEPTIONS

3. Health-seeking Behaviour

In order to find out how people for mental health care we have to explore some basic questions relating to health-seeking behaviour: how do people perceive mental illness? How do they deal with mental health and mental disorders? What do people do when they feel mentally sick? Where do they go? Who takes the decision as to where and how a sick person is to be treated?

3.1. Cultural Perception of health and illness

In every culture and society, religious and cultural values have a significant impact on health, education and social policy that drives the health care or care models that patients receive. Understanding cultural perceptions of health and illness requires understanding the spiritual and religious dimensions related to it.

The majority of the camp population is Muslim. Islam is a comprehensive way of life. Most Muslims believe that religion cannot be separated from social and political life, because religion informs every action a person takes. The West acknowledges that not every individual who seeks self-awareness, self-empowerment and self-actualizations pursues a particular religious belief or faith. According to Stoll et al. (1989) we can identify vertical dimensions of spirituality – that is the individual's relationship with the transcendent (God, Supreme Being or supreme values) and horizontal dimensions - that is the relationship with oneself, other people and the natural world. However, in Islam and according to the Koran there is no distinction between religion and spirituality. The concept of religion is included under the umbrella of spirituality. Generally in the Islamic context, there is no spirituality without religious thoughts and practices, and religion provides the spiritual path for salvation and a way of life.

The view of many Muslim patients on health and illness incorporates the notion of answering illness and death with patience, meditation and prayers. In general Muslim patients understand that illness, suffering and dying are part of life and a test of Allah. Athar (1993, 1998) stated that Muslim patients consider an illness as atonement for their sins, and death is part of a journey to meet God. It is argued that we should not necessarily consider illness as our enemy; rather, we should see it as an event, a mechanism of the body, that is as serving to cleanse, purify and balance us on the physical, emotional, mental and spiritual planes (Sheikh Moinduddin Chisti 1985). Health and illness become part of the continuum of being, and prayer remains the salvation in both health and in sickness⁷.

On the other hand, seeking treatment is not regarded as a sign of conflict with reliance on Allah for cure. The Prophet Muhammad said, "Seek treatment, because Allah did not create a sickness but has created a treatment, except of old age".

In many discussions it was mentioned that prayer helps the people to feel better and to find relief from stress. As a Doctor stated it,

Most of the patients get relief from praying. In Islam we say: rely on God. Everything that occurs to you, both good or bad, comes from God. Praying is personal.⁸

3.2. Cultural perception of mental health and mental illness

Each culture provides its members with ways of becoming 'ill', of shaping their suffering into a recognizable illness, of explaining its cause and of getting some treatment for it. Lay explanations of these conditions fall into aetiological categories: personal behaviour and influences in the natural, social and supernatural worlds. The cause of mental illness can therefore be explained by, for example, possession by a spirit, witchcraft, the breaking of religious taboos, divine retribution or

⁷ Rassool 2000: 1479

⁸ Interview 1, 2009-11-09, a male person

the 'capture' of the soul by a malevolent spirit. As with physical illness, culture influences the 'language of distress' in which personal distress is communicated to other people. When Palestinians express conditions related to mental well-being and distress, many speak of how they feel in their soul, how they feel with themselves and use the Arabic word *nafsi Ta'baneh*⁹, which might be explained as a disease of the soul and literally translated as "My soul is tired or my soul is suffering".

3.2.1. Somatization

A frequently encountered problem in making psychiatric cross-cultural diagnoses is somatization – the cultural patterning of psychological and social disorders into a language of distress, mainly physical symptoms and signs. As Swartz (1998) put it, somatization is a "way of speaking with the body". This phenomenon has been reported by numerous cultures worldwide and from a variety of socio-economic groups within those societies. It is particularly a feature of the clinical presentation of depression, and of personal suffering and unhappiness. In these cases depressed people often complain of a variety of diffuse and frequently changeable physical symptoms, such as 'tired all the time', headaches, palpitations, 'pains everywhere' and so on.

Kleinman (1981) points out how different cultures and social classes sometimes pattern unpleasant effects, such as depression, in different ways. For some, somatization represents a culturally specific way of coping with these effects; it functions to "reduce or entirely block introspection as well as direct expression". However the pattern of "speaking with the body" is probably much more common world-wide than expressing distress and anxiety in purely abstract, psychological terms.

3.2.2. Cultural somatization

Mumford (1993) proposed a useful model for understanding how somatization relates to cultural background. He suggests that there are three levels at which culture may shape the evolution of somatic symptoms, from first awareness to actual clinical presentation. They are as follows:

1. *Language and idiom*, without which the sensation cannot be expressed
2. *Concepts of health and disease*, without which the symptom cannot be interpreted
3. *Culturally sanctioned illness behaviour*, without which the symptoms cannot be presented to other people in order to obtain treatment of relief

In most communities, all three of these levels are necessary in order for cultural somatization to take place and to be recognized as such by all concerned. As a psychiatrist told us:

For women, unexplained somatic complaints are a symptom of depression – chronic depression¹⁰.

3.2.3. Belief systems of Islamic cultures related to mental health

The cultural perception of mental health and illness cannot be understood without having an understanding of the belief systems of Islamic cultures.

Islamic cultures transmit a number of beliefs that the local population accepts even though these beliefs are liable to be considered unlikely or even objectively disprovable by persons outside this culture region. The most important of these beliefs relate to supernatural agents such as the devil, jinn, sorcery and the evil eye¹¹. We will not go too far into the subject of supernatural agents, only to the extent of explaining the concept of *jinn* and the state of possession.

As a starting point for discussing the influence of these beliefs, we may take the Arabic word *wiswas*¹², which can refer both to the devil and to worrying thoughts. Unacceptable wishes, feelings and acts are projected onto the devil. Ruminations involving aggressive or unacceptable behaviour are also attributed to him, enabling people to doubt or to reject these and to avoid guilt feelings: such ideas are the devil's not one's own. States of possession permit such rejection as well. These

⁹ *Nafsi* comes from the word *nafs* which means soul or self (Arabic dictionary). *Ta'baneh* literally translates as the female version of "tired" or "unwell"; Muna Khalidi).

¹⁰ Interview 27, 2009-11-19, a male psychiatrist.

¹¹ El-Islam 1982:5

¹² The words and ideas that the *Shaitans* whisper into a person's heart to tempt them to do sinful things. (Arabic dictionary)

are thought to be the result of the individual's becoming overpowered by supernatural agents called *jinn*, and they are expected to lead to unreasonable or unpredictable behaviour for which the affected person claims unawareness and for which others do not hold him responsible. To relieve someone of a state of possession usually requires some ritual or at least a consultation with the *Sheikh*. Families of people with severe mental health problems (blamed on supernatural agents) often turn first to ritual healing. This may include consultations with a respected *Sheikh*, the use of amulets containing holy verses or purification rituals involving the drinking of or washing in water that has been used to rinse off Koranic verses that have been written on a plate. All interviewees that were asked about *Sheikhs* spoke about the important role they play in the people's traditional health-care concept.

The *Sheikh* is also a counsellor for the people. He gives some assurance. *Sheikhs* and religion play a big role in releasing the Palestinian people from suffering. This is traditional medicine and healing. Epileptic patients go to the *Sheiks*, and they receive water that is blessed by the *Sheikh*¹³.

But some would reduce mental health problems to religion and say that people suffering from mental illness are sinners, non-believers.

3.2.4. Cultural Aspects of stress

In 1971 the World Health Organisation pointed out, that stress (and the diseases that result from it) represents an unsuccessful attempt on the part of the body to deal with adverse factors in the environment. Thus 'disease' is the body's failure to become adapted to these adverse factors rather than the effect of the factors themselves. Factors influencing the stress response include the following:

1. The characteristics of the individuals concerned (having control over their life or not, the individual's outlook on life, including hopes, fears and ambitions)
2. Their physical environment (living conditions)
3. The social support available to them (their relationship to the social environment, NGOs)
4. Their economic status (unemployment, deprivation and poverty)
5. Their cultural background (cultural factors may play a protective or pathogenic role)

In some societies it may be less socially acceptable for males to admit to and experience symptoms relating to stress¹⁴. The cultural values of a group can obviously be both a causal as well as a relieving factor. In our interviews cultural values were attributed with being a protection against stress – for example, by strengthening social and family cohesion and mutual support, which enable the individual to cope better with the transformations of life. "The camp is a big family, people help each other. It doesn't matter that everybody is needy and poor."¹⁵ While culture can protect against stress, culture can also stimulate it. Certain cultural beliefs, values, expectations and practices are likely to increase the number of stressors that the individual is exposed to. As examples, women feel the culturally induced pressure to help deal with daily expectations; while men feel the pressure of losing their roles as breadwinners.

3.3. Influences and decision-making in health-seeking behaviour

Factors influencing the health-seeking behaviour can be placed on different levels:

1. Social and cultural level: how ideas and beliefs regarding the nature of the given problem play a significant role in deciding to seek help
2. Practical level: identify if there are any institutions available to which the person may turn in case of mental health problems and how far or close they are
3. Economical or financial level: the patient will want to know if he is able to pay for the care
4. Empirical level: the experience of family members, friends and neighbours in a particular health institution may have an influence as well as the individual's own experience

¹³ Interview 1, 2009-11-09, male person

¹⁴ We will go more into the subject of gender roles and behaviour in the chapter on coping mechanisms.

¹⁵ Interview 3, 2009-11-09, a male political leader

5. Qualitative level: the care provided has to be adequate and appropriate

The family plays an important part in deciding upon the nature of the problem and the action to be taken in accordance with culturally shared concepts of illness. El-Islam (1994a) stated that the decision to seek professional medical help is often made by the family collectively. It is very unusual for a patient in communities with extended family systems to go to a psychiatric (or general medical) practitioner on his or her own. Interviewees told us that accompanying family members (e.g. parents, siblings, cousins, nieces) support patients by demonstrating interest in their well-being and helping to carry out treatment programmes.

Other influences on seeking health care are location, accessibility and availability of services. In relation to the camp population the location of the centre is not a major issue as such; the question is if the people know that the centre exists and if they know what kind of care is provided and how¹⁶.

¹⁶ Refer also to the chapter on the location of the MSF centre.

MAJOR FINDINGS

4. The Doctor-Patient relationship in the Arab cultural context

The therapist should support the values of the community to which the patient belongs. Patients' expectations of doctors are culturally shaped. Difficulties can arise if the therapist and patient belong to different cultures. Psychiatric patients expect psychiatrists to "remove" their suffering. Some patients expect and may insist on somatic treatment. They trust injections more than pills, paid medical service more than free service and may not accept conversational therapy as a treatment if it replaces prescription¹⁷.

When you pay for a service, you invest yourself, so if it is free, people do not take it seriously¹⁸.
Everything that is free is not good¹⁹.

Understanding the patient's cultural and social background should mark the doctor-patient relationship. What does it mean to be Palestinian, to be a refugee, living in the camp, living in the municipality? Finally, trust is the fundamental element for creating an atmosphere in which patients feel assured and comfortable and are therefore able to commit themselves to the "healing" process. This goes for psychological treatment in all contexts. Given the instable and challenging context of a refugee camp, trust is likely to be of even greater importance. The medical person should be aware of the cultural context of patient's verbal and nonverbal communication and be familiar with the family relationship patterns, which prevail in the culture.

5. Stigma related to "mental"

The stigmatisation of the word "mental" seems to be the major issue related to people's perception of and attitude towards the MSF centre. It looks as if the MSF centre with its name "community mental health centre" is already to some extent a stigmatizing label; therefore if people go there they get labelled as well. "Once individuals are labelled as 'mentally ill', they are subject to a number of cultural cues that tell them how to play their role; [...] Once labelled, individuals are dependent on the society at large for 'de-labelling' them and releasing them from the sick role ..."²⁰ It appears that all matters related to mental health and mental illness are stigmatized. Different NGOs working in the camp have mental health programmes but do not label it as such. All activities and support in the field of mental health is "camouflaged".

... there is a lot of stigma. If you plan a clinic and you call it MH clinic people will not come but if you put family medicine clinic everybody will come...²¹

"Mental" is equated with "crazy". Mental health problems are denied. But people need to know that they feel bad. The community as such lacks knowledge and awareness on the different aspects of mental health. People are shy to speak about mental health issues and are not used to expressing the need. In this sense stigma is very much linked to the health-seeking behaviour, which is decidedly influenced by the perceptions and attitudes of the population it serves.

6. Perception of oneself

How Palestinian refugees perceive themselves influences their perspective of seeking mental-health care. We can state that the whole camp population suffers from poor mental health. Reflecting on the description by the people, we may analyse five different categories:

1. People who are able to cope to some extent
2. People who do not cope
3. People who develop common mental disorders in need of psychological support
4. People suffering from severe mental disorders in need of psychiatric support

¹⁷ Refer also to El-Islam 2008:675ff and Helman 2000:170ff

¹⁸ Interview 25, 2009-11-18, a female psychologist

¹⁹ Interview 24, 2009-11-18, a female NGO employee

²⁰ Helman 2000:175.

²¹ Interview 12, 2009-11-13, a male NGO employee

5. People suffering from severe mental disorders in need of hospitalisation

At the present moment MSF deals with category three and four but the majority of the camp population have mental health issues relating to category two. This group is not yet supported at all by the MSF programme.

As mentioned in the PP: "The majority of the camp residents whom we interviewed (whether diagnosed as 'mentally ill' or not) expressed a strong demand for better mental health services and/or a safe and agreeable space for meeting peers, learning something useful and spending time with others in a meaningful way²²."

6.1. Gender group perception: Men

Men's Health-seeking behaviour and their perception of stigma are linked to their identification of the traditional gender role as heads of families, i.e. being the one who should provide the family income. Men have to be strong and have to be able to care for their families. Since Palestinian refugees have very limited access to the job market (especially in skilled, usually male-dominated professions), many men can't fulfil their traditional role, although they still behave as if they could. While tradition puts men in the strongest position, the camp-reality puts them in the weakest. If a man seeks mental help, he is admitting weakness. Men accept only with difficulty that it is their women who work and bring in the money. They compensate by controlling their wives and putting all the pressure on them. Men set rules to overcome their lack of self-confidence and insecurity. It seems that the traditionally existing hierarchical rules have lost their reason with a real shift of power in the family.

For men it is double: he should be strong, so he will never say I am down. We should not fight men, the way we empower women is in a negative way²³.

Men seem to be the most fragile population group in Palestinian society. Culturally they do not have the 'right' to show their weakness and their suffering. It might be because of the above-stated reasons that men seem to be the most difficult target group to address.

6.2. Gender group perception: Women

It is not the women's perception of themselves that keeps them from seeking mental health care. The obstacle to their reacting freely and individually lies rather in their cultural background. They fear stigmatisation by their family, mainly by their husband who would consequently be seen as being married to a crazy woman. But women also state that they do not want to speak about their feelings and their well-being. In their view they would be understood to be complaining about their lives which once again would put pressure on the husband and on his self-esteem. Her moaning would highlight his weakness in not being able to care for his family, in being unable to make his family and wife happy. In this respect the women "protect" their husbands' dignity and "do not put an extra burden on them".

Since 1948 the families are uprooted from their lives. Women had to take up more and more responsibility to maintain their families, to give them hope. Women became stronger, and everybody is playing their traditional roles²⁴.

The burden of work seems to be another obstacle for women to seek care. Some women mentioned the fact that they have to look after their families and cook for their children when they come back home from school. Practical problems also prevent them from coming.

Women have problems with their husbands and families, there is a misconception; we have a male-centred idea of society. A woman is expected to receive help and assistance from the husband but the husband is not always able to provide this support. We still have the traditional image of men being the family leader and women taking care of the house and raising the kids. Also the role of sisters and brothers: the brother still has a role over the sister.²⁵

²² Refer to the PP written by Dalita Cetinoglu and Markus Fritz

²³ Interview 10, 2009-11-12, a female NGO employee

²⁴ Interview 4, 2009-11-10, a female NGO employee

²⁵ Interview 18, 2009-11-16 a male psychiatrist

6.3. Gender group perception: Youth

For young people it is very difficult to maintain a "healthy" life. If the family cannot afford studies, the children drop out of school. Jobs are difficult to find and future perspectives are hopeless. Similar effects that influence men's identities play a role on the boys' perception of self. Moreover they feel inferior to the girls because girls appear to be more successful in school and in managing their lives. Nowadays more girls enrol in high school and university than boys, a fact that traditionally was the opposite.

But if a young woman tried to seek mental-health care it would lower her marriage prospects, so their mothers tell them to keep silent.

Young men tend to be very depressed, they have bad jobs; they want to leave the camps and try to get married outside Lebanon, just as girls would. Migration is seen as a way out of their living situation.

According to an anthropologist who has worked in a Palestinian refugee camp masculinity changes through time and space. "Before 1948 the importance for a man was getting married and having a family and kids. Between 1962 and 1982 for the Palestinians living in Lebanon it was important to participate in the resistance movement and becoming a fighter. For young people now adulthood is linked to marriage."²⁶ But because of high unemployment rates it can take ten to twelve years for young men to be able to afford the dowry.

7. Coping mechanism in regard to the different generations and gender

Palestinians are out of their country since 1948. And the 4th generation living after 6 decades in the camps no longer has any hope of returning to Palestine. "According to Islamic culture, it is blasphemous to give up hope for relief of suffering because patient endurance is rewarded in the afterlife. There is evidence that this belief may shape the symptomatology of affective disorders. For instance hopelessness may not be a prominent symptom experienced by depressed patients."²⁷

The Palestinian refugees live in an environment that is difficult to adapt to. The Palestinians have lost their dignity, they feel they are not recognized as humans; they are always blamed and are the source of any troubles. Palestinians are afraid to go out of the camp. They have qualifications, but they do not find the opportunity to use these skills, which leads to depression and loneliness. They cannot go back to Palestine; they cannot travel to Arab countries. It is easier to travel to Europe. Some that go to the university, but they are not convinced of the sense of their studies because they will have difficulties finding a job. They start losing hope of returning to Palestine; they lose all hopes they have.²⁸

The first generation lived in hope of going back to Palestine. It was not only a hope but a conviction. When they had to leave their country they thought it would be for a short period only. When they realised that they were mistaken it turned into a trauma.

The second generation is the age group of the so-called "golden years". The women of this generation were very strong. They became directors and coordinators of the camp's NGOs. They benefited from scholarships. This generation had medical services and education; they had social support and could leave the camp. Today these services have stopped and scholarships are hard to get.

I lived the glory of the Palestinian revolution in the '70s; we had hope, we were more self-assured; we still have hope to return, we still carry the "cause" with us. The hope to return; our "cause" is a sacred "cause": to be refugees and to go back; socially there was more solidarity within the family and the extended family. The Palestinian leadership had money and we had income. The economic pressure was less; we had jobs, we had education, we were the golden age. My son speaks in a different way; he asks where is the leadership that will help us out of this. After 1982 when the PLO left Lebanon, the economic situation changed. But what should I

²⁶ Interview 33, 2009-11-23, an anthropologist

²⁷ El-Islam 2008:677

²⁸ Interview 12, 2009-11-13, a male NGO employee

do with my diplomas? You cannot sign up for an apartment, in your home. Migration is a hope, a hope for my son. My generation would never think about leaving.²⁹

The parents of today form the third generation; they are the children of the war. They perceive themselves as very unlucky. They find it difficult to leave the camp. These parents want their kids to learn and have a better life. This generation does not adhere to the goal of going back to Palestine, and they do not trust the leadership anymore. The fourth generation are the children of this already "lost" generation.

When it comes to coping, there are not many opportunities to offer to support them in their suffering. There is denial and unawareness. Coping can take different forms: active coping or denial and repression. Active coping means that an individual feels able to decide on a course of action to deal with his or her suffering; that implies that the individual knows where to go. Denial takes place when people feel powerless towards the problem and do not see any solution. Repression is a reaction mostly from women. They would like to do something but culture and tradition do not allow it, consequently they have no control over their wellbeing.

When questioned about how people deal with their situation and their poor mental health the answer is always the same. People have no idea what to do or where to go, but they have a desire to get assistance. Some try to find relief in prayer, and some go to the *Sheikh* for help .

One coping mechanism is self-medication and heavy drug consumption in the camp. One interviewee stated that Lebanon is the country with the highest consumption of psychotropics³⁰. They give the refugees the impression of finding relief from their suffering and feeling better. At the same time drug abuse worries the whole community. The problem is already on the political agenda. Drug abuse is the main coping mechanism for young people. In the interviews we received few details about which drugs were used, but it was pointed out that all kinds of drugs are easily available in the camp. Among others, smoking cigarettes, smoking a *nargile* (the water pipe), drinking alcohol, sniffing glue and drinking cough syrup and alcohol mixed with pills are common.

Men go outside of their homes but do not speak about their problems. They engage, as the young ones do, in self-medication with heavy painkillers, extreme smoking and alcohol drinking. One repercussion is that drug abuse may lead to violence, specifically domestic violence.³¹

In several interviews women mentioned that they are not allowed to speak about their mental-health problems. Women suffer silently. They are told to hide, because complaining is a shame and would dishonour the family. Again this is related to the perception of "mental" being equated with "crazy". In general women do not speak but expressed frankly that they would like to talk to someone they can trust. Some can talk to friends, but the majority repress their problems. Taking the problems outside the nuclear or extended family could be perceived as disloyal and even as betrayal.

8. Perception of medication and drug use in relation to quantity and quality

At a consultation the patient will always expect the doctor to give him drugs. If the doctor does not prescribe drugs, he is seen to be a bad doctor. Even if the patient is not sick he expects "something", which means drugs. People are not used to seeing a doctor just for "conversation" and receiving mental treatment without drugs. Like one interviewee put it, "It is not that people love their medication; they have a passion for their medication"³².

Some people came to the MSF centre with clear expectations of the drugs they "needed". These people came with the idea of receiving free drugs. On the other hand, several interviewees mentioned the fact the "free care is not good care". In the same way if the patient expects "something", he feels he should pay "something". It was also mentioned that free care can result in carelessly adhering to appointments.

²⁹ Interview 7, 2009-11-11, female NGO employee

³⁰ Interview 12, 2009-11-13, male NGO employee

³¹ There is one NGO in the camp that has a listening centre for victims of domestic violence.

³² Interview 12, 2009-11-13 a male NGO employee

When you pay for a service you invest yourself; so if it is free, people do not take it seriously. Many patients do not adhere to appointments, and the reason is because they do not pay³³.

9. Perception of the MSF community-based mental-health centre

9.1. General population

We found both misconception of the MSF programme as well as a perception of wrongly focused attention by MSF.

In one discussion it was mentioned that people link the name Médecins sans Frontières to doctors that treat everything. The name "without borders" suggests that you can come with any health problem. "... you have all the doctors and specialists"³⁴. Most of the people who come by the centre are surprised that it treats "only" mental health problems. People expect a dentist, a general practitioner, etc. Parents coming with their sons and daughters below the age of eighteen are disappointed that MSF serves only adults.

When we gave information about the MSF services in FGDs, people started to discuss the basic needs they wanted to have covered before going to solve mental-health problems. In all cases the general living conditions were discussed, lack of water, lack of electricity, unemployment, worrying future perspectives etc. In this respect mental health is only at the end of a long list of problems that have to be tackled before. One interviewee suggested that mental-health problems could be prevented by solving the economical problems and improving the living conditions by guaranteeing basic needs³⁵.

Another major point was that people need to build trust in MSF and this takes time. People fear a lack of confidentiality when speaking about their very personal and intimate concerns.

Besides basic trust issues, some interviewees had the impression that the MSF centre was for the Bourj el-Barajneh municipality only.

One interviewee got to the point, "[...] for the general population we are accessible but we are not available"³⁶.

9.2. Other camp NGOs

As an international humanitarian medical organisation, MSF has a high reputation. MSF stands for good-quality care and for its principles of impartiality and independence. It has to be mentioned here that the NGOs displayed a more critical view of MSF as an organisation and the MSF's approach regarding its services.

For the NGOs, MSF does not make enough effort of coming into the camp and cooperating with the NGOs present there. All the NGOs emphasized their eagerness to work with MSF. One NGO employee expressed it frankly:

MSF has a beautiful centre and does good work, but one thing I am hearing is that if you expect people to come to you, you have to go to them. Reciprocity is needed. I heard this from the NGOs. You are expecting people to come and you complain 'they don't come'. Go to the people. E.g. there was a meeting on drug abuse; all the NGOs were there, but MSF wasn't. It should have been. People asked, and MSF said they received the invitation late, but that does not change the fact that MSF was not there. There are many events in the camp, national events. MSF should show up, if you want to be present and get into contact with the people.³⁷

One NGO stressed on the fact that since the municipality had a much higher population than the camp, it is logical for MSF to receive more Lebanese patients. 60,000 people are living in the municipality while 20,000 live in the camp. Having a ratio of two patients from the municipality for every patient in the camp correlates with the population distribution. Furthermore it was specified that families would only come with their sick members when they feel that the situation becomes problematic. That means they are coming in a later stage, and they are coming mostly with severe cases.

³³ Interview 25, 2009-11-18 a female psychologist

³⁴ Interview 24, 2009-11-17 FGD with women

³⁵ Interview 30, 2009-11-20, FGD with men

³⁶ Interview 38, 2009-11-24 male psychiatrist

³⁷ Interview 21, 2009-11-17 female NGO employee

9.3. Awareness of MSF and the MSF centre

Activities during the mental health day had a great impact on raising awareness of the MSF centre and its services.

People who know the centre and MSF have a high opinion; they appreciate the staff, they like the place and they like the idea. People feel that they are getting good quality service.

But the majority do not know of our existence. That the centre is lacking patients from the camp is simply because the communities do not know of MSF and the services provided.

9.4. MSF centre located outside the camp

First and foremost, it's not the centre's location outside the camp which constitutes the problem. The matter is that MSF is not inside the camp.

The comments relating to the question whether the centre should be outside or inside the camp were diverse. One part of the population would have preferred MSF to be inside the camp with its own infrastructure; to have a pure MSF centre inside the camp. Another part said that MSF should be located inside the camp but in the UNRWA clinic and/or in the PRCS Hospital. Others suggested that MSF should provide services from inside the different NGOs within the camp. A fourth group stated clearly that they would prefer the centre outside the camp.

The current MSF centre is not too far from the camp and it is easily accessible and reachable. The discussion of accessing the centre inside or outside the camp focused on two points: confidentiality and self-confidence.

Confidentiality

Being situated outside the camp has two major advantages: First it provides a greater sense of confidentiality. Being inside the camp, inside the UNRWA clinic or PRCS, people fear being seen by relatives. Considering the stigma attached to mental health this is something they want to avoid. Therefore, those who favour the centre's being outside the camp do so for the sake of privacy. As a secondary side effect, leaving the camp to go to the centre holds a symbolic meaning for the people. They are, at least for a short time, leaving their own difficult living conditions.

Self-confidence

In opposition to confidentiality stands self-confidence. Some people, especially women are not used to leaving the camp; they do everything inside the camp, and they feel more secure in seeking mental health care inside the camp.

The majority of women shop in the camp; they do not feel comfortable leaving the camp. They feel insecure, and they do not feel confident enough to go out. You have to take the women to the centre. We have to overcome the fear. Ask the women if they need help getting there. Sometimes they do not feel comfortable taking public transport; women may be afraid. They are out of the context they are used to. They are always with their husbands and they are not used to do things alone. They would need help to leave.³⁸

³⁸ Interview 10, FGD with women

RECOMMENDATIONS

The following recommendations are drawn from analysing the field research, discussing with MSF staff – national and international, working in Lebanon, conversations with the Cell in Geneva, discussions with the MSF consultant in Lebanon, Muna Khalidi, and medical anthropologists, experienced in the Lebanese Palestinian Refugee camps. Finally my own field experience with MSF leaves its mark on data analysis and the recommendations.

The MSF centre with its "community-based mental-health programme"

People have poor mental health because of the living conditions. The ones with mental illness are a smaller part of the population, and they get good quality care if they come to the centre.

What happens with the population? People are suffering from poor mental health. We have to be frank with the people and tell them that we cannot work on the causes but we can work on the consequences, and we can help them to deal with their difficult situation and to cope better by facilitating and empowering their strengths. We should give the people opportunities for leisure. We take that for granted, but they do not have pleasure in their lives.

To use an old catch phrase: the programme needs a paradigm change. The MSF centre is not a community-based mental-health programme as its objective, but rather a mental health clinic with outreach activities. MSF's approach became medical, it is not people-centred but patient-centred.

As we have learned with this study, it is not external factors like accessibility that keeps people from coming. People stay away because the centre is a clinic and not a place promoting well-being. We learned that MSF's treatment is very well perceived, but the issue is if we really address the needs of the population.

As stated in chapter 6, MSF concentrates on patients with severe mental disorders and common, fairly severe mental disorders. We have clinical patients, we provide therapeutic services and we are recruiting more patients through our outreach activities. But the whole population is suffering from poor mental health. We are leaving out all those who are not within the afore-mentioned categories. We are trying to reach more "patients" but not more "people"; we are recruiting sick people from the community but not inviting people when they suffer from poor mental health. We have many people with a potential of developing mental-health problems, but we are not offering services in our centre to prevent those problems.

Now we have a clinic with outreach activities targeting new patients, but we need a more comprehensive approach: a clinic that is proactive for reaching people with poor mental health.

Treatment and community involvement are two separate operations that need different approaches. The two paths have to be tackled in different ways. As we have seen throughout the report, the treatment part works very well. Now MSF has to make a major effort in working on the social part.

For a community-based mental-health programme the staff needs to have knowledge of the community, i.e. they should know the problems in the community. It is a matter of TRUST. MSF needs in-depth knowledge of the community and its families.

In order to reach the objectives of a community-based mental health-care programme, we have to create the atmosphere for such a programme within the building and among the staff.

The whole team has to be on the same wavelength with the same convictions and with the same aims. It is a need expressed by the people.

This is reflected in community work. Although we use that title, we don't do community work; we are recruiting but not involving the community.

Overview of the core issues

Acceptance

- Lack of knowledge and understanding of MH conditions
- Lack of understanding of poor MH and the possibility of preventing the development of MH problems
- Lack of knowledge that MH problems can be treated
- People do not see the "sense" in coming to the centre
- The fact that people relate MH problems to being possessed by *Jinni* may prevent some people from coming to the centre and prefer to seek treatment from a *Sheikh*, but this is only a small part of the population

Leverage

- The centre's location: outside the camp, but this is a barrier only to part of the target group. It is ambivalent, for some would appreciate its being inside while others would appreciate its remaining outside because of the space and confidentiality
- The centre's opening hours
- The centre only targets clinical cases
- The centre only targets adults

Visibility

- Lack of visibility and awareness
- Lack of knowledge that the MSF centre exists
- Lack of knowledge of the services we provide

Practical recommendations

	Recommendations	Decisions: (Rejected/Accepted)
Acceptance		
1	Team building Do a team-building workshop for the entire staff. E.g. play team games. ³⁹	
2	Orientation and awareness-raising for the entire project team. Their professional education is very much clinically focused. Their approach is very much individually focused and not community centred. The awareness of the entire staff needs to be raised, and they must be briefed and oriented to the population's needs, community work and the situation of the Palestinian population in the BeB camp. Expose them to the concepts and tools of community work as well as of preventive mental-health work.	
3	Culture: All staff need to know Palestinian society, culture and historical context. Do a dialogue workshop: explain to the team why the Palestinians are in Lebanon. Discuss the whole complexity of their situation. Raise team awareness on each other situation – Lebanese and Palestinian.	
4	Visit all the organisations (NGOs, etc.) and discuss the problems (youth group Ahlamouna, W.H.O, Soumoud, Najdeh, Active Aging House, Qaderoon Project (Qaderoon means the capable ones, they reach the men. Ali, the social worker, already has contacts with men, the adults, the children's parents).	
5	Everyone working in the project should read the Project Proposal	
6	Remove "mental" from the title and if necessary rename the centre	
7	Be open to people from other NGOs. Have meetings once a month with	

³⁹ A list of professional persons who could facilitate these team-building workshops can be had from Muna Khalidi.

	them to discuss issues: invite people to come but first let them see what you are doing. This is networking.	
8	Offer the social workers of the camp organisations (e.g. NGOs) support for their work. The NGO staffs in the BeB camp are camp residents themselves and all of them suffer from the same problems as the users of their services. They need debriefing and supervision. Give relaxation session to the staff of other NGOs. This gives a positive image of MSF as givers and not only as receivers.	
9	Use the space in the MSF centre for the communities to use. It seems that it is more for the MSF staff and does not seem inviting for the people who we wish to reach. The MSF centre is currently made for the MSF staff.	
10	The appointment system is something new we aim at our target population. Clearly explain the appointment system in such a way that people can accept it: to maintain confidentiality, to decrease the waiting time, i.e. it is for their own good. At the moment people perceive it as a barrier.	
11	Health promotion Do not promise anything if you cannot meet expectations. If you do not have any recreation centre do not speak about it.	
Leverage		
12	Extend the age range of our target group. Open the centre to children and adolescents in order to be able to reach the men; men are fathers. It is difficult to reach men but not difficult to reach fathers. Youth have drug problems – everybody speaks about this problem on all levels: political, in the NGOs, people in the community and in families. Children: women could bring their children; they may be an umbrella, an excuse for women who would not otherwise be able to come for their own sake.	
13	Have flexible working schedules to accommodate and meet the reality of the target population, including the possibility of later opening hours and weekends when needed.	
14	It is still too early to establish a community advisory group. Identify potential organisations and individuals that are interested in participating. It is important for the process to be a slow and cumulative one.	
15	Being inside the camp: We can start by entering through the UNRWA clinic and provide services through it. PRCS Haifa hospital was not very interested having us in their place. Another option would be if an NGO proposes we be present in their organisation. We could respond by saying we have a psychologist who can work one day in the NGO providing mental health services to the community. e.g. W.H.O. has a gynaecologist who comes once a week.	
Visibility		
16	Propose activities ⁴⁰ for the different target groups (not therapy related): <ul style="list-style-type: none"> • Women Yoga, relaxation, stress management, dancing, beauty, handicrafts, broidery, bead work, cooking and baking, food preservation e.g. making pickles, marmalades, how to freeze; cine club, literacy, painting, drawing, jewellery design, language courses, computer courses, trips outside the camp ... • Men Lectures or workshops for men, skills workshops (men teaching their skills to youths), stress management, language courses, computer courses, sports, handicrafts, cultural movies and discussions (movie club), music, trips outside the camp ... • Youths Stress management, sports, roller blades, ping pong, dominos and games, body building, computer skills and computer games, computer 	

⁴⁰ These activities should be discussed with the communities and NGOs before proposing to find out which ones would be preferred by the different target groups. The ones listed here were mentioned in various interviews.

	<p>graphics, photography, ...</p> <ul style="list-style-type: none"> • Parents <p>Prevention workshops for parents e.g.: How do you help your children with their homework? How do you choose toys for your kids? How does a child develop?</p>	
17	Discuss the activities for the different target groups for the centre with the organisations. Advertise the activities clearly and with maximum visibility.	
18	Make a weekly schedule of the different activities that take place in the centre and announce these activities. Also ensure that this schedule is clear and simple and is widely circulated.	
19	<p>Raise visibility with posters for community involvement. We have leaflets and a fact sheet for the clinical target population, our patients.</p> <p>Keep poster simple with simple messages; an A3 poster of a woman talking to another woman (psychologist), Palestinian men talking to another man/woman (psychologist). A youth talking to someone. Use something similar like the "Persepolis" cartoon style for the people and keep the message simple.⁴¹</p>	

Other:

- The entrance hallway is too "clinical", the entrance desk in the centre is too high; it is like a barrier. Have a desk where the person who comes can sit down and be welcomed. Have some reading materials for people to leaf through as they wait.
- Have a television in the waiting area.
- Have a discrete smoking area for the staff – not in the entrance of the MSF centre.
- Have more Palestinians in the team

⁴¹ A list of addresses of illustrators can be found in the appendix.

Concluding Remarks

Success and failure of health programmes depend on how well they adapt to the characteristics and needs of the population. Potential difficulties in fieldwork can be avoided with a deeper knowledge of the local society involved. To train health personnel to be responsive to and respectful of the populations' traditions, religion and customs in the environment they want to work should be a basic prerequisite in the preparation phase.

The success of a project depends on its being accepted by the population. Being close to the people is meant literally, not only in a metaphorical sense.

Wherever we went, both inside and outside the camp, MSF was very welcome. Let us respond to this welcome with respect and openness and encourage the Palestinian refugees and the people living in the municipality to continue to cooperate with us.

We have to avoid ethnocentric behaviour by the expatriate and national staff. And we have to try understanding patients' worries and concerns and not assuming that our understanding of things is the right and only one.

Acknowledgements

Carrying out this study for MSF in the Bourj el-Barajneh refugee camp in South Beirut was a great challenge for me. I gathered a lot of new and interesting information and was able to add many aspects to my ethnomedical and cultural knowledge with this special focus on mental-health care. As the various missions with MSF add up, I can enhance and improve by doing comparisons of the different countries and experiences. I obviously realise that every mission is distinct but it is of utmost interest to find numerous similarities that support understanding and proving the results.

I would like to thank all the people who have been working with me in order to make my intervention possible and constructive. It was an enriching and often touching experience to speak with them. I would especially like to thank them for all the openness with which they shared personal issues such as their mental health.

A researcher cannot give immediate assistance, but I hope that the information I gathered and the conclusions I have drawn will enable us to strengthen our intervention and create a successful community-based mental health programme for the BeB area.

I would like to thank the MSF Team in Lebanon and at Headquarters in Geneva and Vienna for their support, professionally and personally. Especially I want to thank Muna Khalidi for her professional attitude, her in-depth knowledge of the country and its people and our enlightening discussions. In particular I thank the Palestinian people for all the knowledge and wisdom, the problems and worries they shared with me. They are the experts of their culture. Me, I can only learn from them and transcribe their knowledge onto paper with my analysis as a medical anthropologist.

I would not have liked missing my experiences with MSF, my colleagues and the people in Lebanon; with all my respect for them and for their ability to cope with difficult living conditions and their consequences. To all those who may continue to work in Lebanon.

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Posters

Three posters for different target groups

Messages:

For women: Do you need someone to talk to?

Men: Do you need to breathe?

Young people: Do you need to release?

MSF Logo

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Possible Illustrators to contact:

Karim Al-Dahdah: www.karimaldahdah.com

Lena Merjeh www.lenamerhej.com

Mazen Kerbaj: mazenkerblog.blogspot.com

Meiroun: Meirounblogspot.com (a young Palestinian refugee woman)

Lebanon Map



Map of Palestinian Refugee camps in Lebanon

