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Mental health of health professionals and their perspectives on mental health services in a conflict-affected setting: a qualitative study in health centres in the Gaza Strip during the COVID-19 pandemic

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ABSTRACT

Objectives To explore how primary care health professionals perceive their own mental health in a conflict-affected setting during and beyond the COVID-19 pandemic and to explore their perspectives on mental health services.

Methods The Gaza Strip faces a chronic humanitarian crisis and is suffering from the consequences of the COVID-19 pandemic; United Nations Relief and Works Agency (UNRWA) health centres were used to recruit participants for this study. Semistructured interviews were conducted with 29 health professionals in UNRWA health centres who were sampled using maximum variation sampling. Transcripts were translated, double checked and analysed via thematic analysis.

Results From the analysis, a thematic map was developed showing how health professionals perceive their mental health impacts. This included difficulties due to the COVID-19 pandemic, as well as the socioeconomic processes stemming from the on-going conflict. Another thematic map was developed showing the perceived strengths and challenges of the health services. The strengths included positive impact of the services to the service users and health professionals. In terms of challenges, health professionals identified socioeconomic processes and aspects of remote service provision during COVID-19.

Conclusions Based on the findings, we suggest that an improved signposting mechanism should be developed to address many of the challenges that emergencies bring about; in particular, this could support the health professionals' mental health, as well as improve the response to patients' socioeconomic challenges. We further suggest recommendations for improving mental health services when delivered remotely to increase their resiliency during various emergencies.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ To our knowledge, this is the first study exploring the perspectives of health workers working in a conflict-affected setting about their mental health during COVID-19.
⇒ The study design allowed us to explore in-depth about the experiences of a hard-to-reach population in the Gaza Strip and provide insights to the mental health services in conflict-affected settings.
⇒ Local authors and interpreters ensured that the data was collected and analysed rigorously.
⇒ The study took place within the workplace of the participants and the recruitment was conducted via their managers. It is therefore possible that the participants chose not to fully disclose their difficulties due to the societal stigma and fear of their workplace becoming aware of their difficulties.

BACKGROUND

It has been shown that the COVID-19 pandemic increased mental health problems, particularly among healthcare professionals.[1] However, the mental health of health professionals in low-income, conflict-affected settings during COVID-19 has been understudied, compared with high-income, non-conflict-affected countries.[2] Mental distress is a major public health concern for conflict-affected populations who make up an estimated 370 million worldwide.[3] Systematic reviews have shown high levels of poor mental health in conflict-affected settings, which is associated with demographic factors including gender, socioeconomic status and number of traumatic events.[4 5] Although reports on mental distress among conflict-affected populations during COVID-19 are scarce, one longitudinal study, which was conducted in conflict-affected Columbia, showed elevated depression, anxiety and parental stress among caregivers who had

been displaced due to conflict during COVID-19.[2] Other commentaries also suggest that COVID-19 added new mental health challenges to the already existing difficulties and generated multiple traumas; however, detailed illustrations are missing.[6] The studies call for in-depth understanding of mental health, not only a list of symptoms on a measurement scale, given that the variety of chronic stressors are presumably impacting individuals through complex processes in these settings.[7]

It is particularly beneficial to understand health professionals' mental health from their own perspectives since it has been shown that they experience higher psychological distress and also display higher likelihood of mood, anxiety, sleep and other psychiatric disorders than the general population.[8] During the COVID-19 pandemic and other viral outbreaks, studies from high-income settings have shown elevated levels of stress, anxious and depressive symptomatology among healthcare workers.[9–12] A few studies have also confirmed this in low-income countries.[13 14] This is concerning within itself and has shown to also be related to reduced service productivity and quality.[10–12] Nevertheless, studies in conflict-affected settings have not explored the health professionals' perspectives on their mental health stressors and coping strategies, particularly during COVID-19. It is particularly notable that health professionals are not only suffering from difficulties, but also coping with them. Moreover, health workers providing mental health services in conflict-affected primary care settings, due to their proximity to service provision and delivery, are also in a great position to provide perspectives on the advantages and challenges of the mental health services. A systematic review highlights challenges faced by health staff providing mental health support in low-income and middle-income countries in primary care settings such as heavy workload and stigma.[15] At the same time, they also highlight the need for qualitative studies on service provider perspectives as the current evidence base does not discuss contextual strengths and challenges for services.[16]

The Gaza Strip is a representative area where the population, including health professionals, are exposed to both conflict and the pandemic and are trained to provide mental health support in primary care. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) offers mental health and psychosocial support services (MHPSS) in its primary healthcare centres for nearly 1.5 million registered refugees in the Gaza Strip.[17] The territory is a narrow piece of land comprising a total of 362 km^2 and is considered as one of the world's most densely populated areas.[17] It has been facing a chronic humanitarian crisis impacting livelihoods and access to essential services for its inhabitants[18] since a complete blockade with severe restrictions to the flow of people and supplies was imposed by the Israeli occupation in 2007. In 2020, the unemployment rate in the area reached 49%,[19] reflecting the consequences of the prolonged blockade. The inhabitants of the Gaza Strip, primarily Palestinian refugees, continue to be exposed to regular airstrikes, with human lives lost and livelihood opportunities destroyed. Mental suffering, referring to feeling that one's spirit, morale and/or future was broken or destroyed, and emotional and psychological exhaustion in the context of protracted political conflict[20] has been used to describe the mental health impact of Gazans. Although studies have shown high levels of mental suffering, and high rates of medically defined mental distress including anxiety, depression and post-traumatic stress reactions in the population through time[21 22] health professionals as a subpopulation have not been studied; nor are we aware of any studies exploring the mental health during COVID-19 in this population. To address the afore-mentioned critical gaps, the setting provides us with a useful ground for the dual aims of: exploring how primary care health professionals perceive their own mental health in a conflict-affected setting during and beyond COVID-19 and eliciting their perspectives on the mental health services for informing service improvements.

METHOD

Study design

The explorative qualitative study was guided by interpretive and constructivist approaches and used semistructured video interviews to gain an understanding of the subjective mental health of the health workers and to elicit perspectives of the strengths and challenges of the mental health services during and beyond the COVID-19 emergency.

Study site, population and sampling

The study was conducted in 3 out of the 22 UNRWA health centres in the Gaza Strip. Each health centre was nominated by the UNRWA Gaza Strip management staff based on its location in different geographical areas of Gaza. This was done to achieve a maximum variation of different views that can arise due to external geographical variations, such as differences in the levels of bombing experienced, collective events in the area and demands of the work. Participants included health staff that had received the mandatory MHPSS training and were available and willing to participate. Staff that had newly joined or for other reasons had not yet completed the MHPSS training were excluded. Maximum variation of specific professions, gender and age range was sought in accordance with maximum variation sampling,[23] and then theoretical sampling was conducted until data saturation was reached.

Interview preparation and data collection

The interview topic guide was collaboratively developed by the authors and the health centre management staff of the three health centres through discussions. To ensure the guide's effectiveness, it was tested in a mock interview with a health professional who did not participate in the

study. The development process involved generating an initial list of interview questions designed to elicit information relevant to the research questions. The list was then refined through feedback from the health centre management staff and the mock interview. The interviews were semistructured, centred around the well-being of the health staff and their experiences providing the mental health services, both before and during COVID-19. The topic guide is available in the online supplemental file 1. Special care was taken not to probe into any potential trauma and to allow the participants to talk as little or as much about the topics as they felt comfortable. Although the preparatory work was done by the first author on the ground in Gaza, due to COVID-19, the study was fully conducted online via a video platform.

The data collection took place during the COVID-19 pandemic, following an emergency mode functioning of the health centres, as soon as it was feasible in October and November 2020 over a period of 4weeks. Each health centre prepared a list of their health staff who had been trained in MHPSS. The trained Gaza field office staff approached appropriate health staff individually, fulfilling the maximum variation requirement. Potential participants were briefed about the study in conjunction with the information sheet and any questions were answered. Particular effort was made to ensure that no health staff felt obliged to participate. A private and quiet room with a computer was set up in the health centre for the online video interview. The first author and the third author, who is a trained Arabic-English interpreter, sought recorded informed consent prior to starting the interview.

Data analysis

The recordings of the interview were anonymised, transcribed and translated by two trained bilingual translators. The translations were double checked by the translators through independently reviewing each others translations and discussing any differences in opinion. A meeting between the first author and one of the translators took place to clarify any parts that were difficult for them to translate or agree on (eg, idioms) and explanations were given for such expressions to the first author. Deductive and inductive thematic analysis was then conducted on the English translations by the first author and involved the stages outlined by Braun and Clarke[24] and also included other authors at specified timepoints. This involved initially reading the translated transcripts at least two times. Initial codes were generated inductively by word-by-word, line-by-line coding across all transcripts. Initial codes were collated by similar features to form potential themes. Various thematic groupings were explored using inductively generated codes and deductively the research questions. The codes and thematic groups were refined with the third author and one of the translators by discussing different groupings. The themes were defined and named by the first author, and following that, the thematic maps were confirmed by the third author and discussed with the managements of the health centres and the Gaza Field Office Health Department.

Throughout the analysis, the first author reflected on her identity and discussed with the third author about potential ways their combined identities might have helped or hindered the participants' disclosure of difficulties.

Table 1 Participant characteristics

Profession	Participants, n
Doctor	9
Nurse	8
Midwife	4
Psychosocial counsellors	5
Head of the health centre	3
Geographical area of work	Participants, n
South	10
Middle	10
North	9
Sex	Participants, n
Female	21
Male	8
Age range*	Participants, n
30–40	16
40–55	11

*Two participants are missing data for age.

Patient and public involvement

A local assistant, the third author, was hired to assist with establishing locally appropriate methodology, data collection and for providing contextual insights for the analysis.

RESULTS

Interviews were conducted with a total of 29 participants, and their characteristics can be found in table 1. Through thematic analysis, two broad thematic maps were created in line with the research aims. The first thematic map showed aspects related to the mental health of health professionals in Gaza generally, and during the COVID-19 pandemic in particular. The second thematic map showed the perceived positive and challenging aspects of the MHPSS services in Gaza generally, and during the COVID-19 pandemic specifically.

Mental health and well-being of health professionals

The thematic analysis revealed five themes that health professionals perceived as contributing to their mental health difficulties. Two themes indicated that beyond COVID-19, health professionals are affected by the difficult psychological cases as well as personal and national events. During the COVID-19 emergency, health professionals faced additional burdens, including fears of

infection, increased workload and novel everyday struggles due to national measures. Despite this, our analysis identified three themes showing that mental health is supported through religion, work and positive activities and community. However, the majority of these supports, with the exception of religion, was reported to have somewhat diminished during COVID-19. Online supplemental table 1 provides a thematic map and evidence of these findings.

Participants discussed the long-standing difficulties faced by the population in the Gaza Strip due to successive wars, blockade and the resulting financial and societal burdens (superordinate theme I). This overarching theme highlights the challenging environment in which health professionals must work, treating patients facing unemployment, financial and food insecurity, which means that patients may be unable to even afford transportation to the health centres. The interviewed health professionals described that working with such difficulties contributed to their own emotional stress and feelings of helplessness (subordinate theme a). Cases where patients' root cause of distress is financial situation and unemployment, which the health professionals felt unable to solve, exacerbated feelings of helplessness.

The feelings of helplessness were also saturated in the health professionals' stories of facing collectively experienced disasters (subordinate theme b). This included describing the Israeli air attacks and its aftermath, as well as a recent gas-explosion caused fire where they did not feel they could help. The participants also reported experiencing significant distress from personal events and circumstances, which varied in their personal content and included, but was not limited to, dealing with the death of a family member, dealing with non-communicable diseases in the family and having caring responsibilities. As with the collective events, it was clear that the element of helplessness was a common thread causing distress. For example, due to the lack of resources in Gaza to address non-communicable diseases and developmental disorders in children, health professionals have limited opportunities to address these burdens.

According to health professionals, the COVID-19 emergency worsened the difficulties by intensifying the feelings of helplessness and adding extra stressors. They likened some of these difficulties to the experiences during increases in bombardments. They reflected that collectively experienced disasters have a negative personal impact, but extra pressure is added by increases in workload during these periods (subordinate theme c). Participants mentioned that whether it is an intensified bombardment, or COVID-19, the workload increases. The fear of infection was also discussed as a unique stressor, different from any prior fears including the intense fear during bombardment. The fear of infection centres on potentially becoming infected and passing the infection on to family members, rather than the potential impact of the infection on themselves.

Additionally, during COVID-19, new types of everyday stressors emerged (subordinate theme d). In the Gaza Strip, as in other areas around the world, restrictions to movement were implemented which resulted in the need for rapid adaptations to everyday habits and the need for additional efforts to complete everyday tasks. For example, public transportation availability was problematic due to curfew hours and resulted in problems in getting to work. Similarly, supermarket opening hours created issues with getting supplies. Home schooling was suddenly needed because of temporary, but lengthy school closures. This added extra stress, especially if there were many children in the family and limited technology. The health professionals emphasised how due to the unique COVID-19 restrictions, their usual self-care practices, such as going for walks and visiting friends and family, were not available. The latter are considered an essential part of the communal life in the Gaza Strip and typically supports mental health.

Importantly, in these extreme conditions, health professionals discussed how they cope (superordinate theme II). They reported universally finding relief in religion, which included religious activities such as praying and reading the Quran, as well as the dogma surrounding Gods will and destiny (subordinate theme e). Religion was seen as providing comfort, freedom and certainty during times of external restrictions and circumstances beyond their control, whether it be conflict, COVID-19 or other circumstances. Support from others, including work colleagues and managers, family members and friends, was seen as essential during times of distress (subordinate theme f). The health staff discussed that during COVID-19, management was helpful in trying to reduce the everyday struggles such as transportation issues promptly. Psychosocial counsellors that are usually supporting the patients are also employed to support colleagues when in need and this was seen as effective. The extended family and community were also supportive factors. The health staff described how they adapted their coping strategies during increases in infections and restrictions by reaching people via technology and scheduling leisure activities at home (subordinate theme g).

MHPSS perspectives

The analysis showed that the health staff perceived four main strengths of the MHPSS programme: the multiple success stories, positive personal impact, adapting and reducing resistance and signposting. Three themes were identified in regard to the reported difficulties that were perceived as significant challenges to the programme: societal stigma, economic problems faced by the patients and societal gender roles, as well as feelings of inadequate knowledge and skills. In addition to the cross-cutting challenges, three themes were identified as related to the COVID-19 emergency situation and having a negative impact on the delivery of the programme: privacy concerns regarding remote phone-based mental health work, loss to follow-up and loss of a trustful family health team relationship. The themes and evidence are presented in online supplemental table 2.

The health staff discussed how they have witnessed many success stories in supporting the mental health of patients in health centres (superordinate theme III, subordinate theme h). These success stories included, but were not limited to, assisting with anxiety disorders, suicidal ideation and postnatal depression. Health staff emphasised how the mental health programme has a ripple effect for improving non-communicable diseases care, particularly diabetes outcomes. Related to this, the health staff reported that signposting to other services can be helpful when the root cause of mental distress lays beyond the domains of the health centre. This included referring patients to employment workshops or financial institutions (subordinate theme k). Lastly, the participants narrated that the programme has also made them practice positive coping mechanisms in their private lives (subordinate theme i).

In addition to reporting witnessing success stories for improving mental health and physical health, as well as positive personal impact, the health staff also noted that the programme allows for enough flexibility to respond to the accessibility barriers (subordinate theme j). Although there are many barriers which can stop a person from attending appointments, such as stigma and gender roles, the participants suggested that the programmes flexibility allows them to counter some of these challenges. This includes reassuring the patient about confidentiality and going beyond their duty to make follow-up calls private in environments where family members live in close proximity. For example, by adjusting the time of calling or not stating the purpose of the call when a family member would answer the call. The family health team approach, where one patient always sees the same doctor, was seen as helping to increase trust and adherence to follow-up appointments.

However, several challenges to the programme were voiced by health professionals (superordinate theme IV). The devastating effect of stigma was highlighted (subordinate theme l). For example, a person who seeks mental healthcare is generally viewed negatively, and it is not believed that help is available for mental health conditions. This also means that people who would benefit from help do not want to seek it for fear of societal consequences, such as hindrance to their marriage potential or destruction of family relations. Stigma was reported not only among patients, but was also observed among the health staff themselves. One proxy measure of that was that the health staff who had experienced mental health difficulties and received help from outside UNRWA, had not disclosed it to close family or workplace. In addition, the interviewed psychosocial counsellors discussed that there is resistance among other staff to refer patients to them as the cases were not perceived as severe enough to warrant help.

Besides mental health stigma, economic problems and gender roles were seen as hindering the programmes success (subordinate theme m). Health staff reported observing that the financial situation and unemployment in the Gaza Strip are the root cause of a lot of distress and common mental health problems. Participants felt that a health programme is unable to adequately address the root cause for the majority of patients. Health staff reported that patients may not have enough money to pay for transportation to come to the health centre. While this was sometimes solved by collecting money internally among the health staff to pay for the transportation of the patient, it was reported as being only a temporary solution. Additionally, participants also reported rigid gender role expectations prevent many females from attending the health centre for their appointments or from talking in a private space over the phone.

The health staff, with the exception of psychosocial counsellors, identified that they would need more training on specific issues, such as domestic violence, and support to manage the time-constrained health centre environment (subordinate theme n). Health staff also felt overwhelmed by their workload and reported not having enough time to adequately provide basic psychosocial care, as it requires more time than other tasks.

The health staff discussed two novel interlinked challenges that emerged for the services during the COVID-19 pandemic (subordinate themes o and p). On 25 August 2020, when COVID-19 cases were detected in the area, the health centres started functioning in accordance to the emergency plan. This meant that MHPSS services were only provided via telemedicine, a system that had been implemented in April 2020. Due to safety concerns, face-to-face services were limited. According to the UNRWA emergency plan, initially no psychosocial care was offered except through telemedicine and hotline phone numbers, which the clients could use to reach doctors and psychosocial counsellors. Screening for new cases was stopped, and the medications were distributed by home delivery to the clients. Once it became possible, from the 13th of September 2020, psychological support was offered face to face for critical and urgent cases, as well as over the phone to existing clients. On 7 October 2020, screening for new cases was resumed but only for a limited number of high-risk individuals.

The health staff discussed difficulties in detecting new cases and establishing rapport over the phone. They explained that due to the nature of phone calls, they were unable to employ the typical mechanisms of observing the person's body language, which made psychological screening challenging (subordinate theme o). The health staff also reported that patients who previously had a good follow-up record because of the established trusting relationship with their doctor, suddenly had reduced attendance for follow-ups. The health staff attributed this to the fact that during the emergency situation, different doctors were conducting follow-ups. Therefore, the trust-based relationship which existed previously was no longer present, leading to reduced attendance.

The health staff also expressed concerns about the effectiveness of treatment and the privacy when care is provided via telemedicine (subordinate theme p).

Specifically, they emphasised that treating mental health conditions over the phone may not be as effective as face to face for some patients, and that face-to-face treatment should be resumed as a priority as soon as possible. They reported that due to the sensitivity of the topic of mental health, the patient may sometimes need to hide their conditions from the family. Phone consultations could not always ensure the level of privacy needed, particularly as private spaces are often not available in the home environments. Although a minority of health staff reported that privacy was not a concern as they could call patients at a suitable time, the majority reported the opposite, raising concerns for the patients' safety and comfort if they happen to receive a call at an inconvenient time.

DISCUSSION

The study results shed light on various aspects of the mental health of health workers in UNRWA health centres in the Gaza Strip, as well as the positive and challenging aspects of the UNRWA MHPSS programme from the perspectives of the health staff. The interviews revealed that the health staff perceived that their mental health is generally impacted by the difficult psychological cases that they work with, as well as personal and national events. During the pandemic emergency situation, they perceived that novel aspects negatively affected their mental health, particularly fears of infection, increased workload and struggles related to the COVID-19 restrictions. Their mental health continued to be supported by religion, work, personal leisure and the community. In terms of services, the health staff recognised the positive impact of mental health services on both patients and themselves personally, and saw the ability to adapt the services as an advantage. However, the participant' stories also highlighted challenges including societal stigma, persistent economic problems and gender roles, and the need to improve their knowledge and skills. The emergency situation compounded these challenges, particularly with interlinked concerns about phone-based mental health work.

The findings elaborated on aspects that may be unique to conflict-affected settings, such as how distress in such a setting continues beyond the confined pandemic period. One prior commentary suggested how in conflict-affected settings, COVID-19 adds new mental health challenges including worsening the already existing mental health difficulties and adding multiple traumas[6]; however, there is a gap in literature exploring this in conflict-affected settings qualitatively. One qualitative research from a low income country, although not in conflict setting, has suggested that the high workload of health providers can adversely impact mental health during COVID-19.[25] The health staff highlighted two central aspects which show how burdens accumulate during a pandemic. However, they also highlighted these aspects as not unique to the pandemic but are common in other emergencies including conflict escalations. First, the workload increases were perceived as distressing and typically occurring with any emergency. Second, the national restrictions to counter COVID-19, although needed to counter the spread of the virus, added new distress to everyday life including difficulties with food supplies and home schooling responsibilities. Everyday stressors are also heightened during conflict escalations. The study also demonstrated an increased fear of infection that has been found in medical professionals in other settings during the COVID-19 pandemic.[26 27] Importantly, the study showed that health staff cope with the feelings of helplessness, and burdens imposed by the conflict and/or COVID-19, by relying on religion and community which can be seen as durable positive coping strategies.[28 29]

Signposting

Our findings regarding signposting have implications for other settings. They highlight the importance of universal signposting to supportive community services that can address not only the patients' needs beyond the healthcare sector but also improve the mental health of health professionals who feel unable to address some of the root causes, such as financial difficulties, of the patients' distress. By signposting to community services that can address these issues, healthcare professionals can better support their patients and improve their own mental health. One of the cross-cutting principles of the WHO mental health action plan 2013–2030 is multisectoral approach, collaborating between health, education, employment, social and other sectors to provide comprehensive support.[30] Previous studies from other settings recommend to have clear guidance on signposting in primary care[31 32] and to include support from various community sources in the efforts of addressing mental health.[33] Our study adds essential nuances to this recommendation in conflict-affected settings.

We found that signposting is seen as a valuable approach by the health staff, which should be used comprehensively by all health staff, particular considering the multitude of social determinants which can negatively impact patients' mental health, including economic problems, gender norms and societal stigma. Therefore, we recommend, as a first step, mapping the available community resources and local services. This is particularly important in a setting frequently experiencing escalations in conflict, where partnerships should be made with durable services that are providing, for example, phone or online support. This should be followed by establishing strong links with the community resources and local services and establishing guidelines on signposting for the staff that is involved in screening for the mental health services. This would allow for comprehensive mental health support, addressing not only the patients' needs but also the feelings among the health professionals that they cannot do enough to address social problems. Ultimately, this could have a dual effect of improving the comprehensiveness of support and addressing at least partially the mental health concerns of health professionals themselves.

Remote mental health work

The findings also suggest the importance of strengthening remote mental health work that would be resilient to escalations in conflict and the pandemic. This includes not only improving the ways in which support is delivered by the health staff, but also strengthening the way mental health support is provided for the health staff.

In our study, health workers reported that they regularly work with cases that are difficult to process emotionally, and this has been a persistent issue even before the COVID-19 pandemic due to the prolonged siege. We recommend to always keep the mental health of health professionals at the forefront through multiple mechanisms to ensure that the support can be maintained through different types of emergencies. Although well-being activities are regularly conducted for the staff in UNRWA, more benefits can be gained through professional supervision by a senior psychologist or psychiatrist, monthly reflective spaces and peer supervision. These activities should also be carried out remotely during times when face-to-face support is not possible. Considering the high levels of distress that can be experienced, access to counselling and therapies should also be provided in an online format, as well as outside of the organisation, for example, by partnering with other local organisations and the Ministry of Health. The proposed measures would not only assist in improving the mental health of health workers but also enhance their ability to handle emotionally impactful cases.

Taking into account the central challenges conveyed by the health staff regarding the remote phone-based mental healthcare, there are ways to improve phone consultations that are offered in emergency situations. Although these recommendations were developed in the context of COVID-19 emergency restrictions, they may be applicable to other emergencies when face-to-face support is not possible such as during conflict escalations. To improve the general resilience of the service and prepare for unexpected events, we first recommend to develop a clear framework for phone-based care which includes guidance on improving privacy mechanisms. The framework should give clear guidance on how to improve therapeutic relationship and assess symptoms and risk of harm via the phone, as has been suggested to be important by research covering telehealth mental health services during COVID-19.[34] The framework could also include guidance on innovative ways to address privacy, including for example, providing the clients with a private space which they can access for the phone appointments, as well as set boundaries for phone-based work to avoid staff feeling overwhelmed by workload, as these were some of the challenges highlighted by the health professionals. Similar frameworks would potentially be beneficial for other conflict-affected settings and other types of community organisations wanting to sustain mental health support during crises.

The study had some limitations stemming from the study design and decisions made for analysis. First, the research team was hired by UNRWA during the research design, data collection and analysis phases. As the participants were also working for UNRWA and the study took place in their workplace, it is possible that the participants chose not to fully disclose their difficulties or primarily reported positive information about the MHPSS programme. Further, the first author of the study, who conducted majority of the analysis, is a foreign researcher, relatively unfamiliar with the local language and culture. The data analysis occurred in the English language, potentially missing nuances of informative body language and phrases that would have improved the quality of the analysis. It is therefore important to acknowledge that even though the third author, a local Palestinian, was involved in interviews and parts of the analysis, and translations were checked, the analysis might have been richer if conducted in Arabic.

CONCLUSIONS

The study provided insights into the mental health of health workers and the mental health programme in the conflict-affected Gaza Strip, during the sensitive time of the COVID-19 emergency. We showed the first-person perspectives of health professionals on their mental health, as well as the strengths and challenges of the mental health services, both during and beyond COVID-19 pandemic. The study generated insights which may be useful to also other settings experiencing strain, including which face the duality of the pandemic and conflict. This included recommendations for implementing a framework for signposting that would improve both the mental health of health professionals as well as help to meet the needs of the patients. The study also shed light on how to better use phone support, both for improving the services during disease outbreaks, but also for using it to support health professionals during conflict escalations when other support systems might be unavailable.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by Palestine Health Research Council (ref.PHRC/HC/671/19) and London School of Hygiene and Tropical Medicine Research Ethics Committee (ref.18045). Participants gave informed consent to participate in the study before taking part.

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