

Living with the Covid-19 pandemic: adolescent experiences in the State of Palestine

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Introduction

As elsewhere, in the State of Palestine, the burden of COVID-19 morbidity and mortality has overwhelmingly fallen on older people. There is, however, growing recognition that younger people, including adolescents aged 10–19 years who account for more than a fifth of the population (1), are also suffering negative impacts on their health because of the COVID-19 pandemic. These impacts are multidimensional and are largely a result of closures of schools and other services, and significant disruptions to the economy brought about by multiple lockdowns. Given that nearly 40% of the population in the State of Palestine are refugees – of whom one sixth (around 800 000 people) currently live in camps¹ – it is important to distinguish between the experiences of the non-refugee and the refugee adolescent populations, and within the latter, those living in camp and non-camp settings. Such disaggregated evidence will help to inform national response plans by government and development partners to ensure that they are both adolescent-responsive and equitable.

This policy brief draws on findings of a questionnaire-based telephone survey involving just over 1000 adolescent boys and girls which was conducted as part of the Gender and Adolescence: Global Evidence (GAGE) longitudinal research programme. The telephone survey results are complemented by qualitative data obtained from a total of 46 in-depth virtual interviews with adolescents and 17 key informants. These more in-depth interviews sought to explore adolescent experiences during the pandemic in more detail, with a particular focus on the ways in which gender, stage of adolescence, disability and marital status shaped outcomes. The brief centres on findings related to adolescent health and nutrition, psychosocial well-being and mental health, age- and gender-based violence, education, and adolescents' ability to exercise voice and agency within their families and communities. It concludes with recommendations for policy and programming.

Background context

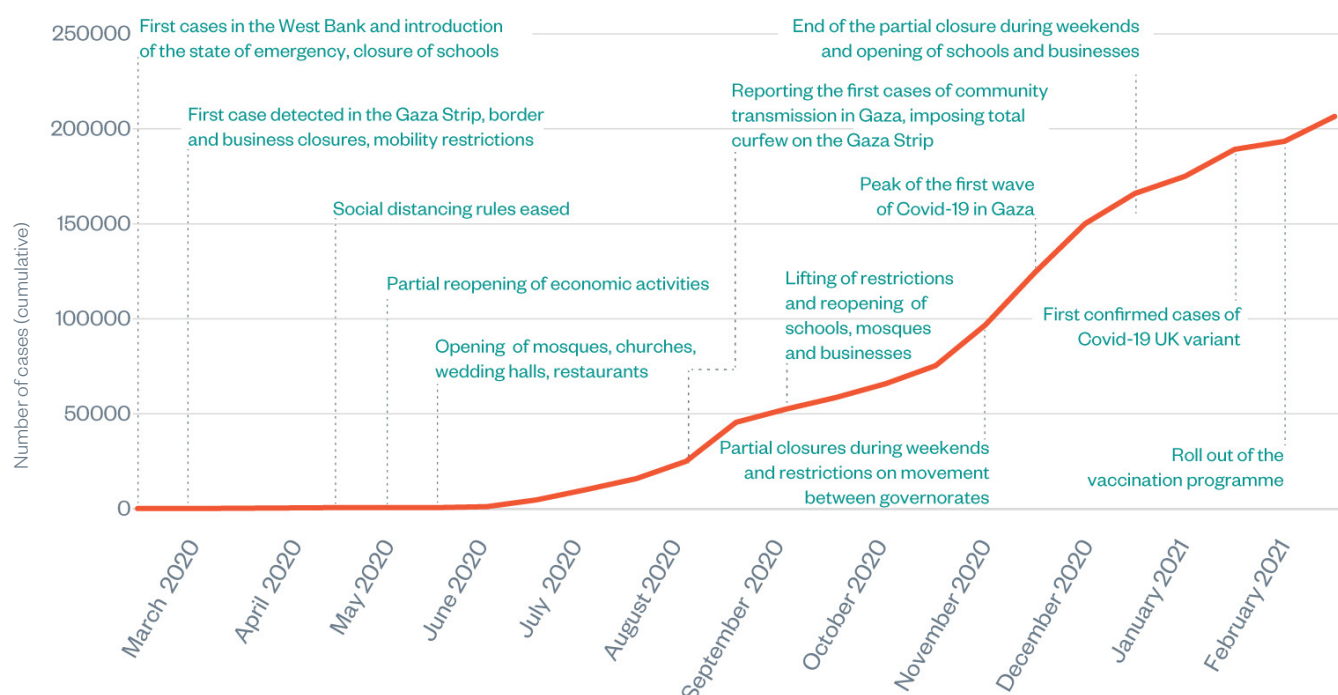
On 5 March 2020, immediately after the first cases of COVID-19 were reported in the West Bank, a state of emergency was declared which resulted in the closure of all schools and other educational facilities, restaurants, cafes, hotels, markets, wedding halls and religious places in both the Gaza Strip (hereafter referred to as Gaza) and the West Bank. Various lockdown measures were imposed, including 24-hour curfews, sometimes for several weeks at a time, night curfews (from December 2020), and restrictions on movement within and across governorates. Strict penalties for those who did not adhere to social distancing policies were also introduced (3). COVID-19 measures have also included redeploying resources to combat the pandemic, including closure of some primary health centres (4) (see Fig. 1).

Even before the first cases of COVID-19 were reported, serious concerns were expressed about the ability of the existing health service infrastructure to cope with the COVID-19 outbreak – especially in Gaza. Gaza, which has suffered from the negative repercussions of 14 years of a strict international blockade and deliberate de-development (5), is currently one of the most densely populated areas of the world.

There are in total 83 hospitals in the West Bank and Gaza (one third of which are managed by the health ministry) and 767 primary health care centres (6).² These provide around 6000 beds, which equates to a bed-to-population ratio of 1.3 per 1000 people (6,7). While people are generally able to access basic health services, outbreaks of conflict, checkpoints, the separation wall and settler violence can impair regular access to such services. Moreover, in both Gaza and the West Bank, access to advanced health services remains very challenging. There is a severe shortage of intensive care (ICU) beds and other resources needed to serve critically ill patients. For instance, the number of ventilators per head of population is only a tenth of Israel's (5).

1 According to the latest Palestinian Central Bureau of Statistics (PCBS) census conducted in 2017, the total population of the West Bank and the Gaza Strip is 4 780 978; the West Bank is home to more than half of this total (2 881 687) (2). However, Gaza is the more densely populated, where there are in excess of 5000 inhabitants per km² and where the average household size is 5.6 (4.7 in the West Bank) (2). Gaza also has a much higher proportion of refugees (66% of the population have refugee status) and a much lower gross domestic product (GDP), at just US\$ 1000 per capita compared with an average of more than US\$ 2000 per capita in the West Bank (1). Before the COVID-19 outbreak, the unemployment rate was 13% in the West Bank and 48% in Gaza (2).

2 The four major providers of health services in the West Bank and Gaza are: the Ministry of Health, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), nongovernmental organizations (NGOs), and private for-profit operators. The Ministry of Health is responsible for a significant portion of primary, secondary and tertiary health care (providing more than 50% of services). UNRWA plays an important role in the sector, delivering free primary health care services through its centres, and commissioning some secondary and tertiary services for Palestinian refugees. The NGO sector also plays a vital role, complementing the work of the health ministry and UNRWA.

Fig. 1: Timeline of COVID-19 infection rates and key developments in the State of Palestine

Source: WHO health emergency dashboard; 2021 (<https://covid19.who.int/region/emro/country/ps>, accessed 28 February 2021).

The course of the pandemic has followed different trajectories in Gaza and the West Bank, with the first case of COVID-19 community transmission in Gaza not reported until 23 August 2020, later than in the West Bank. This may be attributed to a number of factors. Firstly, of the two, the West Bank is the larger area and with fewer travel restrictions has always been more open to the rest of the world. This has likely contributed to the rapid evolution of the pandemic in the West Bank, while the blockade enforced by Israel since 2007 has played a protective role and delayed the reach of the virus in Gaza (5). Secondly, Gaza has only two entry points through which people can enter or leave the territory, while the West Bank has multiple entry points; many of the latter are not formal exits and, relative to the situation in Gaza, are more difficult for local authorities to control. Thirdly, many Palestinians living in the West Bank (an estimated 180 000 people) cross into Israel for work where they interact with large numbers of other people where adequate safety measures may not always have been place, at least not at the start of the pandemic (8). Finally, the local authorities in Gaza have generally been stricter in enforcing COVID-19 protective

measures than their counterparts in the West Bank, and where some areas are under Israeli control (area C) and not subject to the same level of COVID-19 safety measures as those applied in Gaza (9).

As of 18 March 2021, there have been 245 790 confirmed cases of COVID-19 across the West Bank and Gaza, and 2608 deaths, giving an estimated case–fatality rate of around 1.1%. The numbers for Gaza alone are 58 161 cases and 573 deaths (8,10,11). The highest number of daily cases was recorded during December 2020, when the pandemic and pressure on the health services was at its highest.³ At the time of writing (March 2021), the total number of active cases was 23 755, with 2505 in Gaza (8,10,11).

A COVID-19 vaccination programme commenced in late February 2021 in Gaza, and in March 2021 in the West Bank. The initial aim was to vaccinate 20% of the population, prioritizing frontline service providers and at-risk populations, with financial support the Gulf countries, international community and the COVAX initiative (11).

³ Due to limited resources, the amount of testing done, especially in Gaza, has been relatively low (around 2000) and at 16.6% the overall positivity rate is very high, indicating underperformance in testing (11). However, other available data suggest that the number of cases peaked in December 2020. The positivity rate reached 37.5% in the third week of December 2020, and WHO reports indicated that in early January 2021, total COVID-19 bed occupancy had dropped to 53%, compared with 76% in the third week of December 2020. High dependency and ICU occupancy rates were also lower in January (58%) than they had been during the third week of December 2020 (8,10,11).

Methods

This brief draws on the results of a mixed-methods study carried out between October 2020 and January 2021. The main part of study involved a telephone survey⁴ of over 1000 adolescents and their caregivers from socioeconomically vulnerable backgrounds, from both Gaza and the West Bank. Participants were asked questions about their experiences during the pandemic; these questions were designed to explore respondents' knowledge, attitudes and behavioural responses to COVID-19 and to assess the impact of COVID-19 on six adolescent capabilities (as defined by the Gender and Adolescence: Global Evidence (GAGE) longitudinal research study): health and nutrition, bodily integrity and freedom from violence, psychosocial well-being, education and learning, economic empowerment, and voice and agency.⁵

Selection of potential participants for the quantitative telephone survey relied on a sampling frame provided by the Palestinian Central Bureau of Statistics (PCBS). In addition, a snowballing approach was used to reach young people considered to be particularly vulnerable, namely adolescents with disabilities, ever-married girls and adolescents who had dropped out of school. Note that for the purposes of this report, adolescents with disabilities included those who either self-identified (in the case of those aged 15–19 years) or were identified by their female caregiver (in the case of those aged 10–14 years) as having “moderate to severe difficulties seeing, hearing, walking, remembering, communicating, or caring for oneself, such as dressing or washing all over” based on questions adapted from the Washington Group on Disability Statistics' Short Set on Functioning (WG-SS).⁶

To inform the survey instrument and complement the quantitative research findings, 46 qualitative virtual interviews were conducted with a separate group of adolescents aged 12–19 years. Nineteen such interviews were carried out in Gaza and 27 in the West Bank, and participants included married girls, adolescents with disabilities, and working and out-of-school children. In

addition, 17 key informant interviews, nine in Gaza and eight in the West Bank, were conducted with community leaders, education providers, and health and social workers.

Findings

A total of 1005 adolescents aged between 12 and 19 years participated in the quantitative telephone survey (90% response rate), approximately evenly distributed between Gaza and the West Bank. In Gaza, the sample included adolescent refugee and non-refugee boys and girls aged 12–19 years from both camp and non-camp settings, and in the West Bank the sample comprised refugee and non-refugee populations aged 12–19 years from three governorates: Hebron, Jenin and Ramallah, including adolescents living in the Jenin refugee camp (see Table 1).

In presenting the findings of our mixed-methods study, we have paid particular attention to similarities and differences between adolescents based on their age (where younger adolescents are those aged 14 and younger and older adolescents are those aged 15 and older), gender, place of residence (i.e. Gaza versus West Bank, refugee versus non-refugee, camp versus non-camp setting), as well as marriage and disability status. In this analysis, we have highlighted those comparisons between subgroups of adolescents where the findings are statistically significant (at a p-value of 0.05 or lower).

Our findings reveal that adolescents have experienced a wide range of adverse impacts due to the COVID-19 pandemic and the government's public health response to the pandemic. We have grouped our findings into five key domains or themes, which are based on GAGE's adolescent capabilities and which are as follows: health and food security, psychosocial well-being and mental health, protection from violence, education and learning, and voice and agency.

Health and food security

In terms of pandemic-related effects on adolescent health and food security, we include findings on self-reported health status and access to health care, food security

4 The GAGE survey instruments are available from the following links: <https://www.gage.odi.org/wp-content/uploads/2020/12/Covid-19-R2-Jordan-survey-CR-2.pdf> (adolescent questionnaire) and <https://www.gage.odi.org/wp-content/uploads/2020/12/Covid-19-R2-Jordan-survey-AF-2.pdf> (adult female caregiver questionnaire).

5 For more information about GAGE's Conceptual Framework and predefined adolescent capabilities, see https://www.gage.odi.org/wp-content/uploads/2020/01/Conceptual-Framework-2nd-Edition_WEB.pdf, accessed 26 April 2021.

6 Short Set on Functioning (WG-SS) survey accessible at: <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/>, accessed 26 April 2021.

Table 1: Study population characteristics

	Gaza No. (% of total)	West Bank No. (% of total)
Adolescent respondents		
Total	505 (100.0%)	500 (100.05)
Male	251 (49.7%)	258 (51.6%)
Female	254 (50.3%)	242 (48.4)
Younger adolescents (12–14 years)	201 (39.8%)	199 (39.8%)
Older adolescents (15–19 years)	304 (60.2%)	301 (60.2%)
Refugees	327 (64.8%)	158 (31.6%)
Non-refugees	178 (35.2%)	342 (68.4%)
Camp residents	147 (29.1%)	150 (30.0%)
Non-camp residents	358 (70.9%)	350 (70.0%)
Adolescents with disabilities	93 (18.4%)	68 (13.6%)
Ever-married girls	50 (9.9%)	48 (9.6%)
Out-of-school adolescents ^a	108 (21.4%)	109 (21.8%)
Adult respondents (female caregivers)		
Total	504	474

a "Out-of-school" adolescents is defined here as those who were not enrolled in school (including post-secondary education) in March 2020.

and dietary diversity, and coping behaviours with health impacts, which include changes in sleep patterns, levels of physical activity and substance misuse.

Health status and access to health care

More than 90% of all adolescents reported that their health, based on their own self-perception, was either "good" or "very good" at the time of the survey. However, 11% of respondents said that they felt that their health was worse since the onset of the pandemic. This proportion rose to 19% in Gaza. Among those adolescents who reported needing to see a health care provider since the pandemic began – 187 adolescents or approximately 20% of the total sample – more than one in five (23%) noted that they had not been able to see a health care provider because of the pandemic and the associated restrictions. Likewise, more than one in ten (11%) of the 250 adolescents who reported needing a medication had been unable to obtain it. These figures were again significantly higher in Gaza, where 31% of adolescents who needed to see a health care provider were unable to do so, compared with 10% in the West Bank (Fig. 2). As a 17-year-old refugee from a camp in Gaza explained: *"In the north of Gaza we have been affected a lot after discovering that the local hospital is an epicentre of the pandemic outbreak. After this, the hospital, clinics and the UNRWA [United Nations Relief and Works Agency for Palestine Refugees in the Near East] clinics all closed, even the private centres closed, so it has*

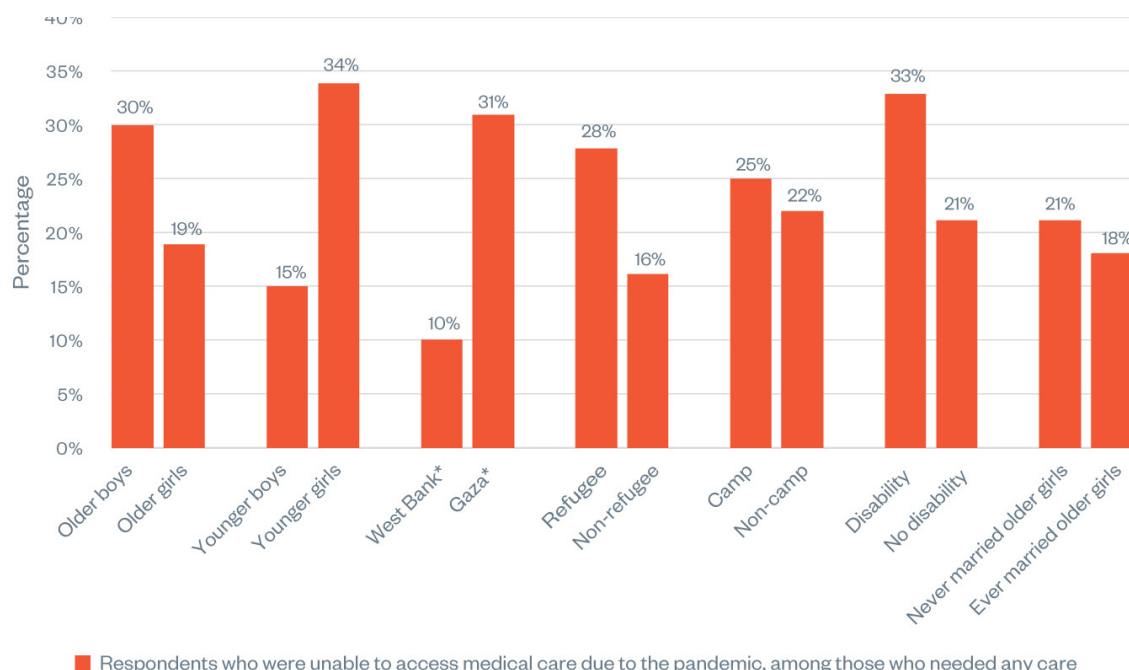
affected us greatly ... Only people with critical cases can access any services."

In terms of sexual and reproductive health services, none of the married survey respondents reported that they were unable to access birth control. However, out of the small number of the surveyed adolescents who experienced pregnancy during the pandemic (35 adolescent girls), nearly half (46%) said they had been unable to access health care during their pregnancy or delivery as a result of the pandemic.

Challenges relating to menstrual health management were more common. Around a quarter (25%) of all girls who had begun menstruation noted that they were fearful to ask family members for menstrual hygiene management support, while 36% said they were too embarrassed to do so. Girls under 15 years were more likely to report fear (37%) and embarrassment (51%) than those aged 15 years and over (22% and 32%, respectively). Young girls living in Gaza were much more likely to experience fear and embarrassment than those from the West Bank: whereas just 14% of girls in the West Bank reported that they were fearful about asking their family members for support, this proportion rose to 36% in Gaza. Likewise whereas only 15% of girls in the West Bank reported that they too embarrassed to ask for support, over half (56%) of respondents from Gaza answered yes to this question.

When asked about the challenges they faced in terms of menstrual hygiene management, 16% of all females who

Fig. 2: Percentage of adolescents who were unable to access medical care, among those who needed any medical care since March 2020



Notes: The percentages above are based on the total number of adolescents who reported needing any medical care since March 2020 (n=187). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level.*

had reached menarche reported experiencing at least one major challenge, including not having sufficient sanitary pads (13%), limited access to soap or water (10%) and lack of privacy (9%). Within this subgroup, 13% reported facing difficulties in accessing their preferred menstrual hygiene products during the pandemic, of whom 91% said that affordability (i.e. lack of money) was the main barrier. Again, the problems were more acute in Gaza, where 23% of girls reported difficulty accessing menstrual hygiene products of choice during the pandemic compared with just 3% of girls in the West Bank. Girls in Gaza were also more likely to report a lack of soap and water (16% compared with just 2% in the West Bank) and a lack of privacy for menstrual hygiene management (15% compared with 2% in the West Bank).

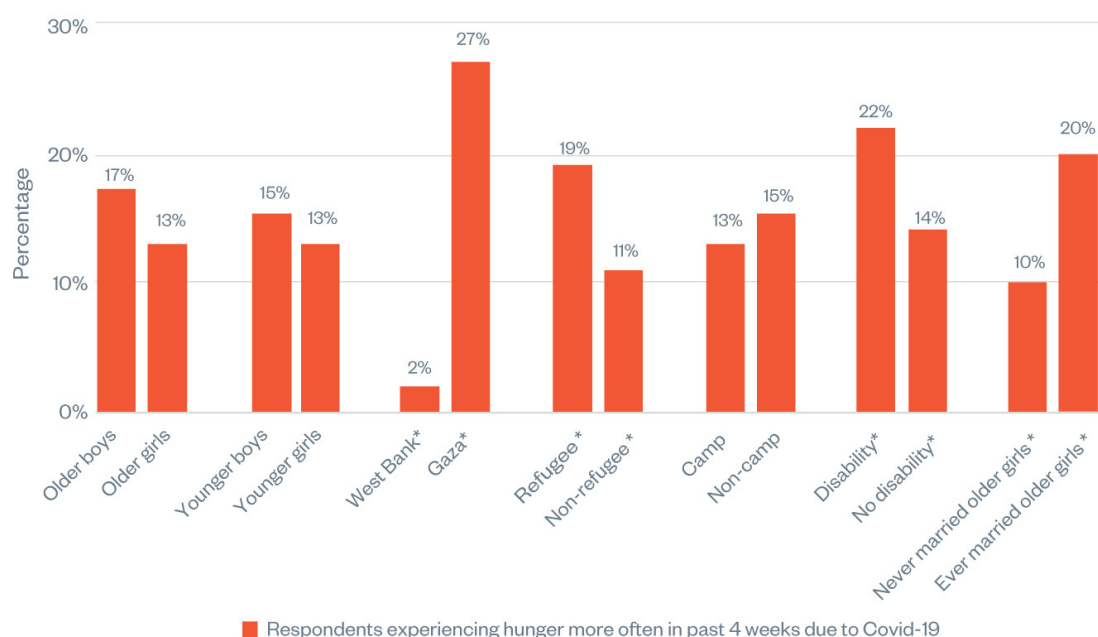
Around 6% of adolescents reported that they had experienced a serious injury — such as a broken bone, a sprain, a burn or cut, or a concussion or head injury — since the pandemic began, and more than a fifth (22%) thought that the risk of injury for adolescents of their gender had increased since the onset of COVID-19. Among those who had been injured (n=59), the most frequently reported injuries were cuts or open wounds, fractured or broken bones, and burns. There were significant gender differences in the prevalence of serious injury. Injuries were

more common in older adolescent boys, among whom 9% reported being injured compared with 3% of older girls. This gender differential is consistent with qualitative findings which indicate that older boys were not only more likely to be involved in work activities outside the home but also more likely to play in unsafe places or engage in clashes with peers and neighbours. The likelihood of serious injury was higher in Gaza, where 10% of adolescents experienced a serious injury compared with 2% in the West Bank.

Food security and dietary diversity

The results of our survey suggest that the impacts of the pandemic on adolescent food security have been considerable. Almost a quarter (24%) of all respondents reported having been hungry because there was not enough food to eat at least once during the 4 weeks prior to the survey (conducted in December 2020). Furthermore, 15% of all adolescents said that they had been hungry more often during the pandemic. Qualitative findings certainly support an absence of access to emergency food assistance. As a 16-year-old girl in Hebron in the West Bank underscored: “Many people say that they provide aid, but we don’t see anything ever. From the beginning of corona[virus], from March, we only received the regular

Fig. 3: Percentage of adolescents who report experiencing hunger more often in the past 4 weeks because of the impacts of the COVID-19 pandemic



Note: The percentages above are based on the number of adolescents in the survey who responded to this question, excluding those who responded "I don't know" or refused to answer (n=998). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level.*

UNRWA assistance. We are in need and they say they will help us but it doesn't happen!"

The prevalence of hunger was significantly higher in Gaza, where 40% of adolescents noted that they had experienced hunger at least once in the past month (versus 6% in the West Bank). Furthermore, 27% of Gazan adolescents (versus 2% in the West Bank) said that they experienced hunger more often in the past month because of circumstances created by the pandemic (Fig. 3). These pronounced differences are likely a reflection of the overall higher rates of poverty and food insecurity in Gaza, and the fact that the timing of the survey coincided with the first wave of the pandemic in Gaza, whereas by December 2020 the situation had already stabilized to some extent in the West Bank.⁷

Our findings also show that young people with disabilities are more vulnerable to hunger than their peers without a disability; 36% of respondents with a disability reported experiencing hunger at least once in the 4 weeks preceding the survey compared with 22% of those without a disability. Young people with disabilities were also more likely to report experiencing more frequent hunger as

a result of the pandemic than those without disabilities (22% compared with 14%; see Fig. 3). We also found that a higher proportion of married girls reported experiencing hunger more frequently as a result of the pandemic than unmarried girls (20% compared with 10%; see Fig. 3); qualitative findings suggest that this is because of the strong correlation between adolescent marriage and poverty.

Adolescents also reported that they were consuming less diverse diets as a result of the pandemic; 32% of respondents said they consumed less protein, 28% ate less fruit and vitamin A-rich vegetables (29% in the case of fruit and other vegetables), while 28% stated that they consumed fewer milk products. Older boys in particular reported a reduction in their consumption of protein-rich foods (38% compared with 24% of older girls), as did adolescents from Gaza (39% compared with 25% in the West Bank). Among adolescents living in camp settings, 23% noted a decline in their consumption of grains and 32% mentioned a reduction in their intake of fruit and vegetables high in vitamin A; this compares with 16% and 26%, respectively for those in non-camp locations – a

⁷ It is important to note that Gaza's GDP is less than half that of the West Bank (2).

refection perhaps of the financial constraints experienced by UNRWA and its ability to distribute food aid to refugee camps. Young people with disabilities were also more likely to report reductions in dietary diversity, both in terms of protein consumption (39% compared with 30% for adolescents without disabilities), and fruit and vegetable intake (37% compared with 28%).

Coping behaviours with health impacts

Our findings are suggestive of discernible impacts on coping behaviours among adolescents living in Gaza and the West Bank. In particular, we found evidence of changes in sleeping patterns, with 15% of all participants reporting that since the onset of the pandemic they slept fewer hours. The proportion of adolescents sleeping fewer hours since the pandemic began was higher in Gaza, where 18% said they slept less well now, compared with 12% in the West Bank. Adolescents in Gaza were also more likely to report having slept for fewer than 8 hours during the previous 24 hours than their peers in the West Bank (23% and 13%, respectively).

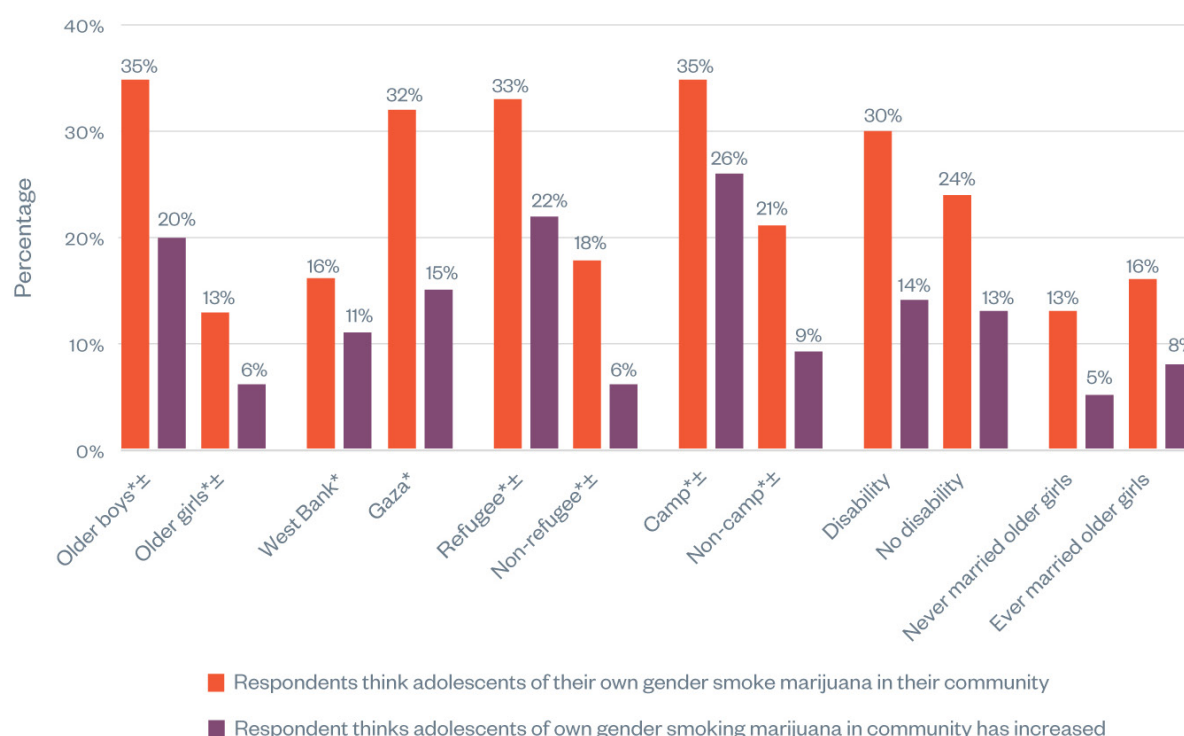
We also found evidence that the pandemic had impacted on physical activity: around a fifth of all adolescents reported that, relative to pre-pandemic levels, they now took less physical exercise. More specifically, 20% of respondents said that they now engaged in physical activity for 30 minutes or more on a fewer number of days than before the pandemic. Among boys, however, this figure was especially high (31% for older boys compared with 11% of older girls, and 26% for younger boys compared with 12% of younger girls). These findings are consistent with those from our qualitative work which indicate that boys generally had greater mobility prior to lockdown than their female counterparts, due to discriminatory gender norms, and thus, in terms of physical activity at least, the impact of the pandemic has been greater for boys. When asked about their levels of physical activity in the past week, older girls and boys reported a similar number of days engaged in at least 30 minutes of activity (2.1 days on average) and at least 60 minutes of activity (1.6 days on average). In contrast, younger boys reported taking physical activity lasting at least 60 minutes on approximately 1.9 days per week, a figure which compares with 1.2 days for younger girls, suggesting that younger boys continue to be more active than younger girls, despite the pandemic restrictions. As a 15-year-old from Jenin in the West Bank noted: *"I used to do sports before corona[virus]*

but during the corona[virus] period I've gained a lot of weight as I can't go anywhere to do any sports or exercise."

The impact of the pandemic on levels of physical activity was particularly striking in Gaza, where 31% of adolescents reported a reduction in the number of days on which they did physical activity of at least 30 minutes duration, compared with just 9% in the West Bank. Part of the Gaza–West Bank difference is likely to be due to the fact that the survey took place in December 2020 when Gaza was experiencing a strict lockdown and curfew (from 6 pm to 6 am). We also found – most likely reflecting the more crowded conditions – much lower overall rates of physical exercise among adolescents living in camps; on average, camp residents undertook physical activity lasting at least 60 minutes on just 0.6 days in the past week, whereas among those living in non-camp settings the average was 2.0 days. Rates of physical activity were also lower among young people with disabilities. Although adolescents with disabilities were not more likely than their peers without disabilities to report a reduction in physical activity relative to pre-pandemic levels, those with disabilities on average engaged in physical activity lasting at least 30 minutes on 1.6 days in the past week, compared with an average of 2.2 days among adolescents without disabilities.

Gender- and age-driven differences in other coping responses with significant health implications also emerged from our survey. Perhaps not surprisingly, we found that cigarette smoking was far more common in boys; 25% of boys aged 15 and older reported ever having smoked cigarettes, compared with just 0.3% of girls of the same age group. Moreover, among boys who were regular smokers (nearly one quarter of boys over the age of 15), 33% reported an increase in their smoking during the pandemic. As a 13-year-old refugee girl from Ramallah in the West Bank commented: *"Boys are smoking more after corona[virus] because they want to forget these conditions and to take care of themselves."* However, the survey findings also showed that 26% of regular smokers said that they had either reduced the number of cigarettes smoked or stopped smoking; qualitative data suggest that this is likely due to financial constraints.

Among older adolescents (15 and over), 11% reported ever having smoked a shisha pipe (16% of boys and 7% of girls in this age group). Among regular pipe smokers, 24% had increased their use of shisha pipes during the pandemic, but many more (46%) had decreased their use

Fig. 4: Adolescent perceptions of marijuana use among teenagers of their own gender in their community

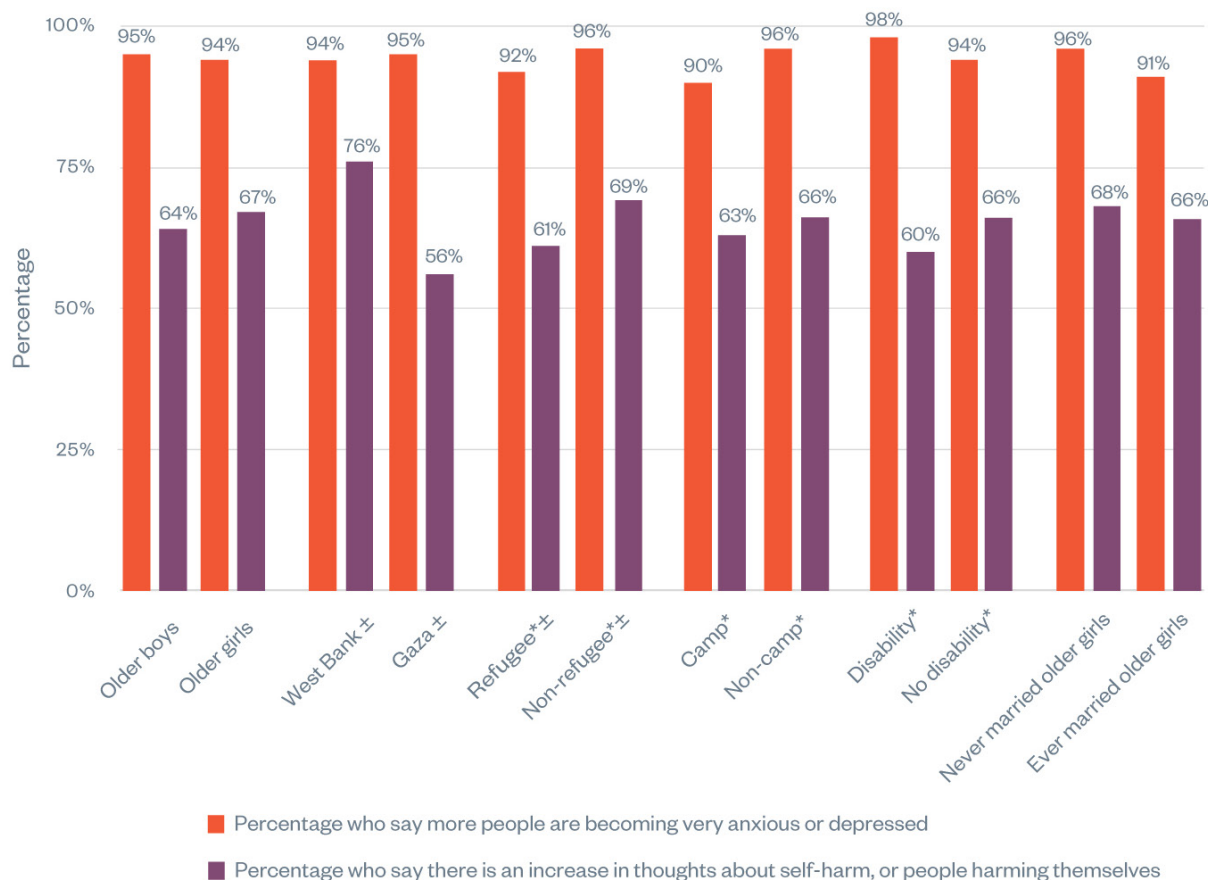
Notes: The percentages above are based on the number of adolescents aged 15 and older who gave a response to these questions, excluding those who responded "I don't know" or refused to answer (n=512). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for statement 1: "respondents reporting adolescents of their own gender smoking marijuana in their community." Categories noted with a "±" demonstrated statistically significant differences at the 0.05 level for statement 2: "respondent thinks adolescents of their own gender smoking marijuana has increased following the pandemic."*

or stopped altogether. The results of our qualitative work indicate that this decrease may in part be due to the closure of restaurants and recreational places. However, it appears that girls were more likely than boys to increase shisha pipe use during the pandemic; although there were fewer female adolescents who reported being regular shisha smokers, over half (52%) of girls aged 15 and over who were regular shisha smokers said they increased their shisha pipe use during the pandemic. In contrast, only 11% of boys who were regular shisha smokers admitted to increasing their use during the pandemic. There were also significant differences across locations; regular smokers in Gaza were much more likely to report reducing their shisha pipe use than their peers living in the West Bank (64% vs. 32%).

In terms of drug use, 13% of survey participants aged 15 and older thought that marijuana consumption had increased among adolescents of their own age and gender

in their community, and 12% thought that young people of the same age and gender had increased their use of other illicit drugs. Again, there were strongly gendered patterns: as shown in Fig. 4, 20% of older boys believed that boys of their age had increased their use of marijuana whereas only 6% of girls thought that girls of their age had done so. The corresponding figures for other illicit drugs are 18% (for older boys) and 6% (for older girls). Our survey also revealed that the proportion of adolescents believing that their peers were turning to marijuana during the pandemic was significantly higher among those living in camps (26%) than those from non-camp settings (9%); see Fig. 4). This camp–non-camp difference was again significant for use of other illicit drugs (24% compared with 8%).

Fig. 5: Adolescent perceptions on the impact of the COVID-19 pandemic on mental health in their communities



Notes: The percentages above are based on the number of adolescents aged 15 and older who gave a response to these questions, excluding those who responded "I don't know" or refused to answer (n=593). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for statement 1: "more people are becoming very anxious or depressed." Categories noted with a "±" demonstrated statistically significant differences at the 0.05 level for statement 2: "there is an increase in thoughts about self-harm, or people harming themselves."*

Psychosocial well-being and mental health

Experiences of depression and anxiety

Our findings suggest that up to 5% of young people living in Gaza and the West Bank may be experiencing moderate-to-severe depression, and around 10% may be suffering from moderate-to-severe anxiety. Depression was assessed as part of the telephone survey using the Patient Health Questionnaire (PHQ-8);⁸ using this tool around one in 20 of all adolescents who participated was rated as having a score indicative of moderate-to-severe depression (greater than or equal to 10). Higher PHQ-8 scores were more common among older adolescents (7% scored 10 or higher compared with 3% of younger

adolescents) and in Gaza (9% scored 10 or higher compared with 0.6% in the West Bank).

Our survey also revealed a relatively high prevalence of moderate-to-severe anxiety. Measured against the Generalised Anxiety Disorder 7 (GAD-7) scale,⁹ around 10% of all adolescents were assessed as having moderate-to-severe anxiety. Rates were significantly higher in the older participants (13% in those aged 15 and older versus 6% in those under 15 years), and in those living in Gaza (19% versus only 1% in those from the West Bank). This marked difference in levels of depression and anxiety between Gaza and the West Bank is perhaps partly explained by the protracted siege in Gaza and greater levels of extreme poverty, which other studies have linked to adverse mental health impacts (12). As a 19-year-old adolescent girl from

⁸ The Patient Health Questionnaire (PHQ-8) is a short screening tool for depression which scores patients on a scale of 1 to 24. A PHQ-8 score of 10 or higher indicates the presence of moderate-to-severe depression.

⁹ Anxiety was assessed using the Generalised Anxiety Disorder 7 (GAD-7) scale, a screening tool that is routinely used to test for various anxiety disorders. A score of 10 or higher on the GAD-7 indicates the presence of moderate-to-severe anxiety.

Gaza explained: *"Nothing would relieve my stress. I guess I haven't accepted this situation yet. I want life to go back to normal. I want university to open again and I want everything to come back! They just started the distanced electronic learning yesterday, I still don't accept it, I don't want the distanced learning. I mean we could do a lot of things trying to cope, but once you open your phone and see the news, you'd get depressed again."*

When asked about the mental health of people in their community during the course of the pandemic, an overwhelming majority (over 90%) of adolescents aged 15 and older said that they felt that people were becoming more anxious and/or depressed (Fig. 5). Furthermore, more than half of adolescents aged 15 and older believed that there was an increase in thoughts about self-harm or in the numbers of people harming themselves in their community since the pandemic's onset; in the West Bank this proportion was as high as 76%, which compares with 56% among the residents of Gaza.

Receipt of support since the start of the COVID-19 pandemic

To learn more about adolescent connectedness to supportive networks (friends and family members) during the pandemic, we asked adolescents how they felt the level of support¹⁰ they got from those in their lives had changed. Findings on whether adolescents believed that they were receiving more or less support from friends and family members since the pandemic began were mixed – 33% of all respondents reported receiving more support while 20% reported receiving less support. Younger adolescents were both more likely to report higher rates of support (38% compared with 29% of older adolescents) and less likely to report less support (16% vs. 22% of older adolescents). Among the older cohort, girls reported receiving more support since the pandemic started than did boys (34% vs. 23%). As a 16-year-old boy from Hebron noted: *"I used to ask my parents for things that I need but I feel shy now to ask them for any money. For example, if I need a phone card I used to ask them to pay for it but I don't do this anymore. I just refrain from calling my friends."* Those residing in the West Bank were more likely to report feeling less well supported by friends and family than their counterparts in Gaza since the pandemic began (23% compared with 13%, respectively), whereas a higher proportion of adolescents in non-camp settings felt that

they had received more support from friends and family (35%) than did adolescents living in camps (28%).

Trusting relationship with a friend or adult

Our survey also explored whether adolescents felt they were able to rely on a relationship with a friend or adult whom they could trust *"... and with whom [they] can talk about feelings and personal matters or call on for help."* Interestingly, peer support was more limited – only 41% of all participants said they had a friend they could trust, while nearly two thirds (65%) said they had an adult they could trust in their lives. In this respect, the younger cohort appeared to be especially disadvantaged, with only 37% of those aged under 15 reporting trusting relationships with a friend with compared with 44% of those aged 15 and over. A higher proportion of Gazans reported higher rates of trusted peer and adult relationships (56% and 69%, respectively than their counterparts in the West Bank (27% and 60%, respectively). Furthermore, adolescents living within the community were more likely than those living in a camp to report having a trusted peer (45% compared with 33%) or a trusted adult (67% compared with 59%).

Protection from violence

Household stress and violence

Almost half of all adolescents surveyed (49%) agreed that household stress had increased since the onset of the pandemic. This was especially noticeable among adolescents in the older cohort, 53% of whom believed that household stress had increased because of the pandemic compared with 43% of the younger cohort. This perception was held by both boys and girls, with no significant differences between the genders in the proportion reporting increased household stress since the start of the pandemic. When asked about particular stressors experienced by adolescents of their own age and gender in their community, respondents most often identified difficulties in obtaining household items as a source of increased tension. Over two fifths (41%) of unmarried adolescents and 60% of married adolescents identified a lack of money to buy non-food items as a contributory factor, while 17% of unmarried adolescents and 24% of married adolescents cited a lack of soap and water. The percentage of young people reporting greater

10 When responding to this question, participants were informed that by "support" we meant "helping you with problems, chores or your health needs."

household stress was more than twice as high in Gaza (67%) than it was in the West Bank (30%).

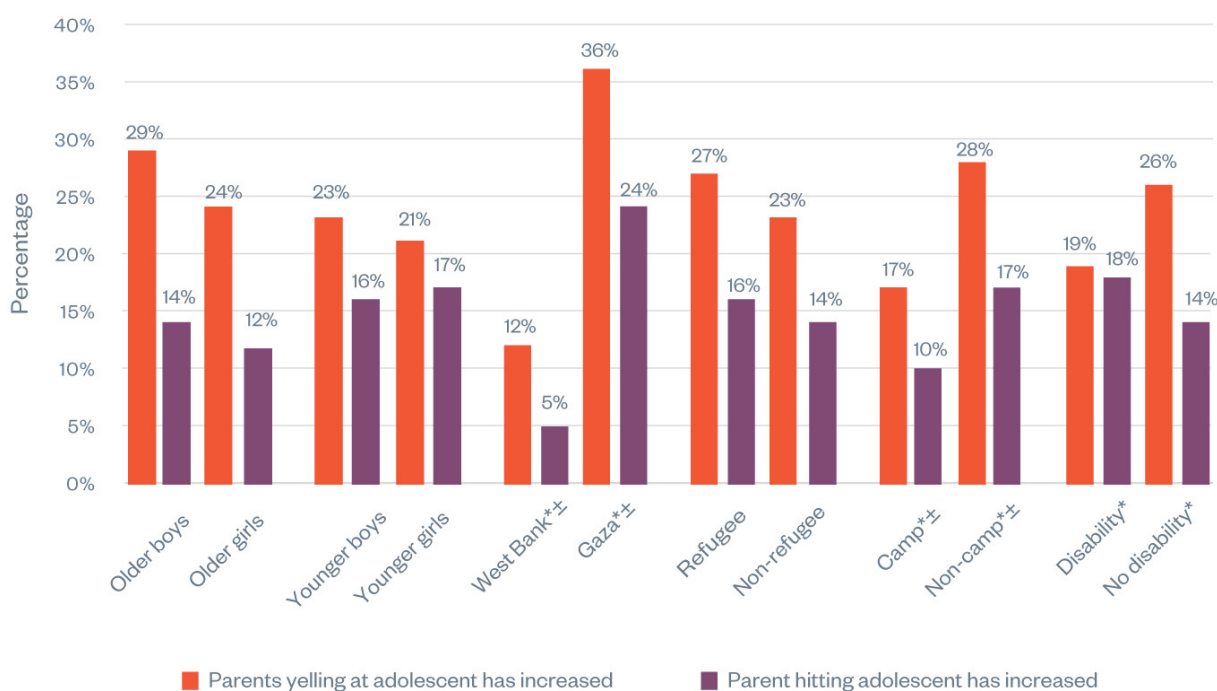
Our survey findings suggest that within households aggravated stress levels manifest in different forms – as physical and verbal abuse, as well as sexual violence. More than half of all respondents (60%) noted that members of their household had been getting angry more quickly or arguing more often since the start of the pandemic; again, this perception was shared equally by boys and girls, but also by both older and younger adolescents. However, among girls aged 15 and older, those who were unmarried were more likely to report increased levels of household stress – family members getting angry or arguing more often – than those who had ever been married (64% vs. 48%). When asked to think about their own community, adolescents aged 15 and older reported that household violence had increased since the pandemic against both boys (65%) and girls (62%); once again, there was no significant difference in this perception by gender. Older adolescents also observed that there was increased household violence against women from male family members (65%), but there was no significant differences

in these perceptions by gender of the respondent, nor by place of residence (West Bank or Gaza; camp or non-camp setting), or by refugee status.

When asked about challenges that adolescents like themselves might be experiencing during the pandemic, 25% of unmarried adolescents noted that being “yelled at” by parents had increased. This proportion was similar among both unmarried girls and boys. Furthermore, in this group, 14% responded that physical violence by fathers towards mothers had increased, 15% said parents hitting adolescents had increased, and 25% reported that bullying by siblings had increased, again with no significant differences between boys and girls (Fig. 6). A 15-year-old refugee boy with a disability living in a camp in Gaza explained that in his case, his father had become more anxious during the pandemic and was taking it out on his children: *“He has become nervous ... He shouts and slaps me if I forget to do something. Today I was slapped because I hadn’t filled the water tank.”*

When married girls were asked about the challenges they and other married girls in their community faced, 32% said that they believed that since the start of the pandemic

Fig. 6: Perceptions about the experience of household violence for “adolescents like themselves” among unmarried adolescents



Notes: The percentages above are based on the number of adolescents who have never been married, excluding those who responded “I don’t know” or refused to answer these questions (n=879). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for statement 1: “Parents yelling at adolescent” has increased as a challenge since the pandemic onset. Categories noted with a “±” demonstrated statistically significant differences at the 0.05 level for statement 2: “Parents hitting the adolescent” has increased as a challenge since the pandemic onset.*

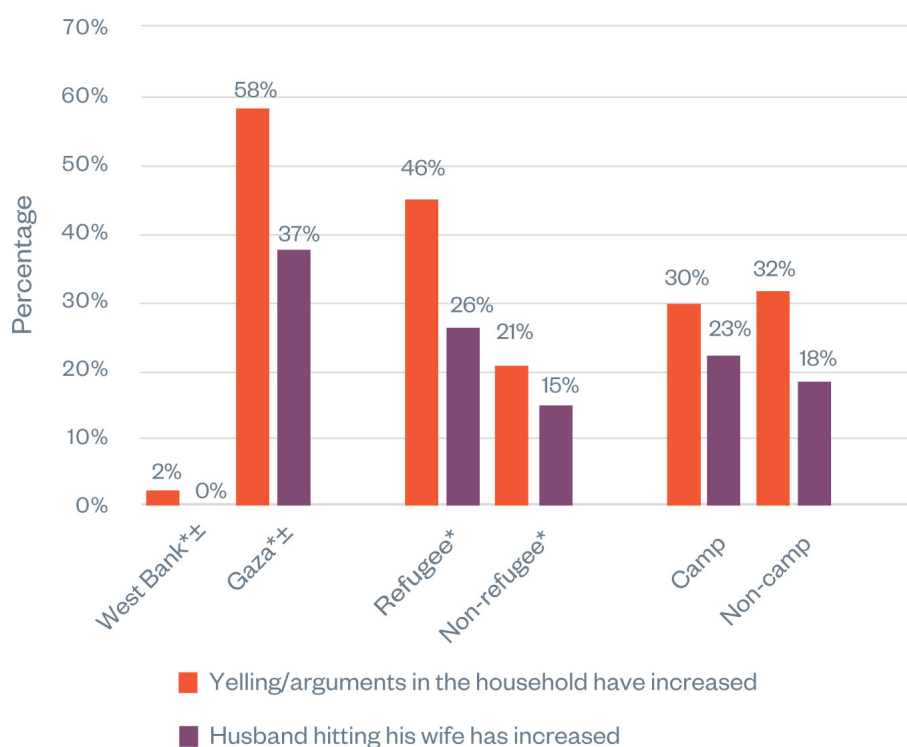
the level of yelling in households had increased. Nearly a fifth (19%) identified husbands hitting their adolescent wives as being more of a challenge now, and 8% were of the opinion that husbands forcing their adolescent wives to have intercourse was happening more frequently during the pandemic than before.

Our survey suggests that interpersonal and domestic violence associated with the pandemic is particularly acute in Gaza. All forms of violence were identified as having increased since the onset of the pandemic by a significantly larger proportion of adolescents in Gaza compared to the West Bank (Fig. 6 and Fig. 7). The most striking differences were noted for parents hitting adolescents (24% compared with 5%; see Fig. 6) and husbands forcing intercourse (15% compared with 0%). Furthermore, adolescents who lived in non-camp settings were more likely to view parents hitting adolescents as an increasing challenge than those who resided in refugee camps (17% compared with 10%).

Pressure to marry

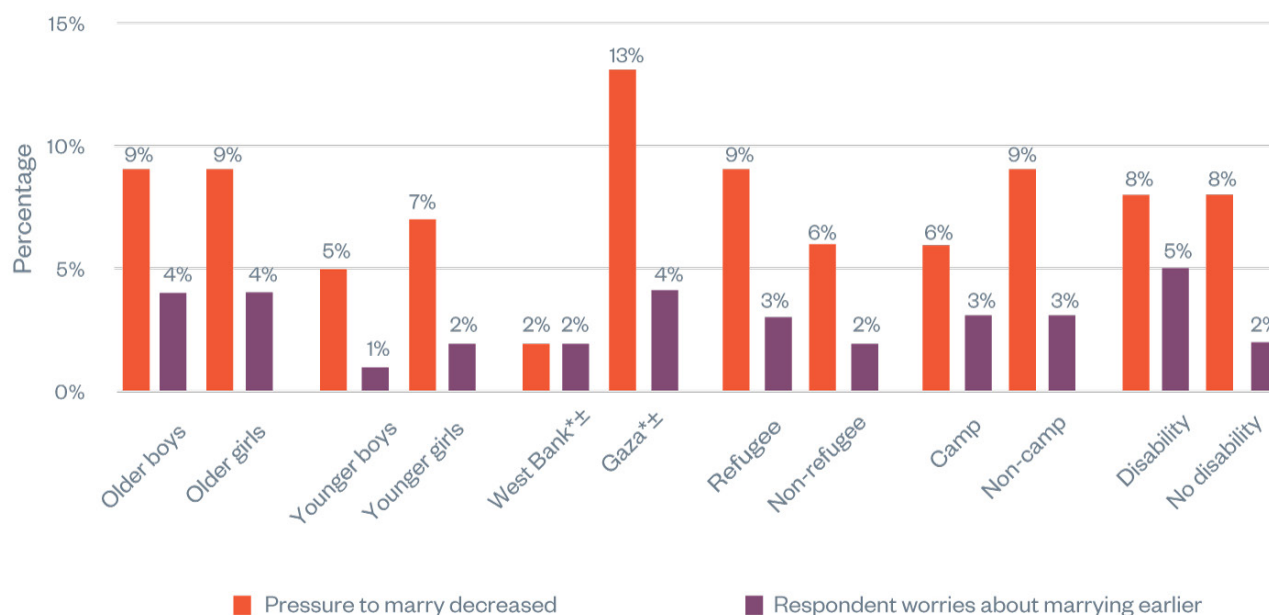
The survey also explored whether adolescents felt increased pressure to marry since the start of the pandemic. Overall, just 3% of adolescents reported that they worried about marrying earlier because of the pandemic. In fact, a larger share of adolescents – albeit still a minority – reported feeling less pressure to marry as a result of the pandemic (8%) (Fig. 8). Perhaps reflecting higher rates of poverty and more conservative gender norms (13), the proportion of young people worrying about earlier marriage due to the pandemic was slightly higher in Gaza compared with the West Bank (4% vs. 2%). By contrast, our qualitative data suggested that this may be a result of underreporting on a culturally sensitive issue. A key informant working for a nongovernmental organization (NGO) that operates a counselling hotline explained that cases of child marriage were increasing during the pandemic: *“The father prefers to marry his daughter early because he is afraid of major closure and is afraid about her future ... Some parents, because they fear the*

Figure 7: Perceptions about the experience of household violence for “adolescents like themselves” among married older girls (aged 15 and older)



Notes: The percentages above are based on the number of older female adolescents (aged 15 and over) who have ever been married, excluding those who responded “I don’t know” or refused to answer these questions (n=96). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for statement 1: “Yelling or arguments in the household” have increased as a challenge since the pandemic onset. Categories noted with a “±” demonstrated statistically significant differences at 0.05 level for statement 2: “Husbands hitting their wife” has increased as a challenge since the pandemic onset.*

Fig. 8: Adolescent perceptions about the pressure to marry during the pandemic



Notes: The percentages above are based on the number of adolescents who have never been married, excluding those who responded "I don't know" or refused to answer these questions (n= 899). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for statement 1: "The pressure to marry has decreased." since the pandemic onset. Categories noted with a "±" demonstrated statistically significant differences at the 0.05 level for statement 2: "I worry about marrying earlier" since the pandemic onset.*

pandemic, are forcing their daughters to leave school in order to get married – the marriage ceremony is limited to the family only without a large wedding hall."

Education and learning

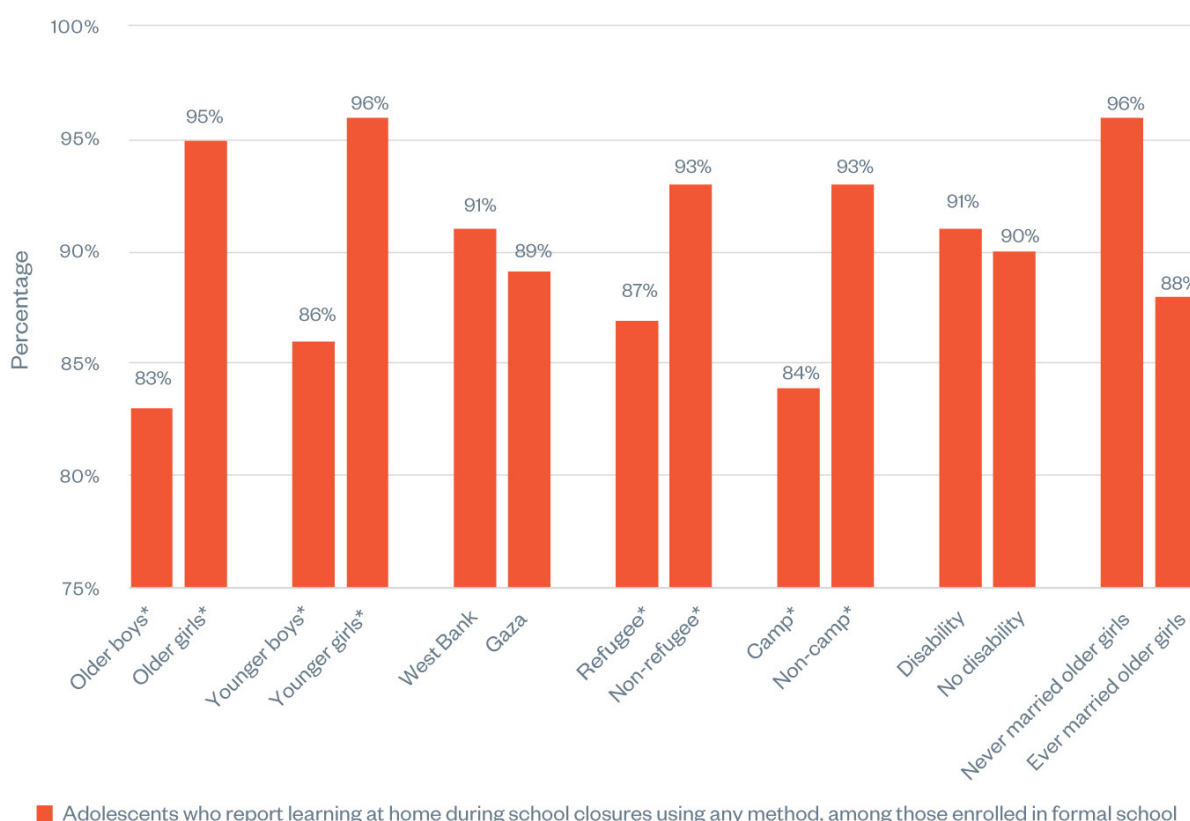
Continuity of learning

Over three quarters (78%) of adolescents who were surveyed were enrolled in school prior to the pandemic in March 2020, and almost as many (76%) re-enrolled in school at the start of the current school year. Our survey findings reveal that most adolescents (90%) who were enrolled prior to the start of the pandemic were able to continue their learning in some way. In this respect, girls were at a slight advantage, with 95% of older girls and 96% of younger girls continuing to learn from home, compared with 83% of older boys and 86% of younger boys (Fig. 9). While there were no significant differences in our measures of continuity of learning between Gaza and the West Bank, there were significant differences between the refugee and non-refugee subgroups and between camp and non-camp settings, with non-refugees and non-camp adolescents doing better than refugees and adolescents in camps, respectively (Fig. 9).

The vast majority (92%) of adolescents said that they wanted to return to school after closures, a view that was generally shared by both boys and girls. Adolescents in the West Bank, however, were less likely to want to return to school (87%) than their counterparts in Gaza (97%). Approximately 6% of the surveyed population expressed concerns that they might not be able to return to school when the COVID-related restrictions were lifted; this proportion rose to 8% among adolescents from the West Bank but reduced to 4% among those in Gaza. As many as 15% of adolescents living in camps feared that they would not be able to return to school, compared with just 2% of those in non-camp settings.

Challenges in accessing distance education

A sizeable number of respondents said that their ability to access distance education was impaired by connectivity problems, resource deficits and/or time constraints. When asked about their own experiences, just over a fifth (20%) reported a lack of (or unreliable) internet connections, 5% cited unreliable electricity supply and 5% identified not having enough devices for all family members who needed one as a barrier to accessing learning during the pandemic shutdowns. For instance, a 14-year-old Gazan

Fig. 9: Continuity of learning (by any method) among adolescents enrolled in formal school

Notes: The percentages above are based on the number of adolescents who were enrolled in school in March 2020 and/or had re-enrolled in school in the school year following the summer break, excluding those who responded “I don’t know” or refused to answer this question (n=788). Categories noted with an asterisk (*) demonstrated statistically significant differences at the 0.05 level.

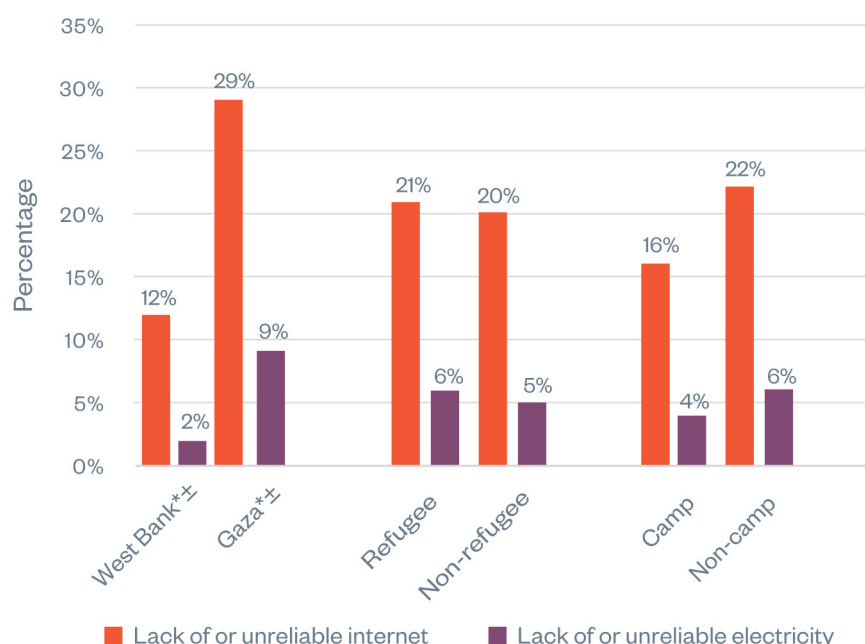
girl in a refugee camp commented: “I do not have a phone but we have a laptop. I and my three siblings use it ... Sometimes we take turns on the laptop so we can at least access some lessons. After we all use it, the laptop breaks down and no one admits who broke it so my father starts yelling and he prevents us from touching it again because we always break it. Each time one of us breaks something. Sometimes the battery, other times the charger ... and it costs money. And sometimes the electricity cuts when a lesson is about to start.”

Resource deficits and internet connection issues were more likely to be the main challenge to accessing e-learning among the adolescent population of Gaza. Here, more than one in four adolescents identified a lack of reliable internet as their greatest challenge to learning (29%), whereas only around one in 10 or 12% of students in the West Bank cited internet connectivity as a key barrier. Another 9% of Gazan students reported that the lack of electricity was their greatest challenge, which compares with 2% of students from the West Bank (Fig. 10).

Overall, more than half of all adolescents surveyed (57%) noted that they were having to spend more time on household chores and sibling care since the start of the pandemic, restricting their time for study. This extra burden fell more heavily on girls; 71% of older girls and 68% of younger girls said that since the start of the pandemic they were spending more time on childcare and doing household chores compared with 44% of older boys and 44% of younger boys. A 16-year-old refugee girl in a camp in Gaza explained that: “I feel psychologically depressed and stressed. My parents control when and where I can go at all times, my mother and brother are shouting at me and I’m expected to do many more chores than before the pandemic – for boys and men they stay at home and they don’t do anything – it is normal for them but it’s very different for girls who are expected to cover all the domestic work.”

Pressure to contribute more to household chores and childcare was significantly more common among adolescents living in Gaza than among those in the West Bank (72% vs. 41%); adolescents in non-camp settings

Fig. 10: Barriers to distance education among adolescents enrolled in formal school



Notes: The percentages above are based on the number of adolescents who were enrolled in school in March 2020 and/or had re-enrolled in school in the school year following the summer break, excluding those who responded “I don’t know” or refused to answer these questions (n=788). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for lack of access to reliable internet. Categories noted with a “±” demonstrated statistically significant differences at the 0.05 level for lack of access to reliable electricity.*

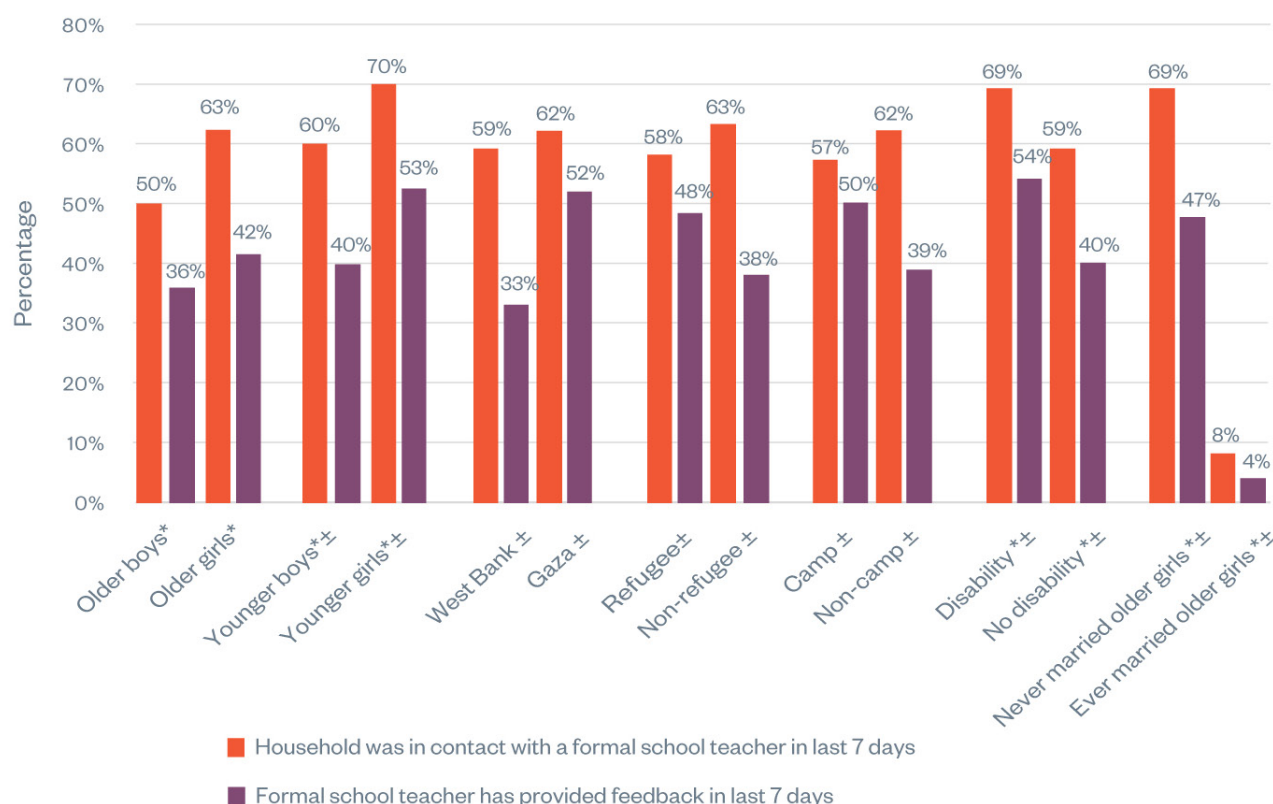
also experienced increased pressure to contribute to the running of the household relative to those living in camps (60% vs. 47%). Adolescents without disabilities also reported greater time constraints compared with those with disabilities on account of increased domestic and care work pressures (60% vs. 44%), as did married girls compared with unmarried girls (89% vs. 63%). Around 1 in 10 (11%) of adolescents reported that since the pandemic began, they had increased their paid work hours. Boys were more likely than girls to work outside the home, with 26% of older boys saying they now spent more time doing paid work, compared with 3% of older girls.

Support from family and teachers

Our survey findings showed that almost three quarters (73%) of in-school adolescents received some form of support from their family to enable them to continue with their formal schooling during periods of school closures. Among those who received any support from their family, over half (57%) noted that they received help with schoolwork, 70% said they were helped by being given a space to study and 60% reported that they were given a device or access to a device with internet access, while a fifth acknowledged that their family was reducing their

chore load so that they could keep up with their studies. Younger as opposed to older adolescents were more likely to identify family support for their education needs (78% vs. 69%). The proportion of adolescents who were supported in education by their families was higher in Gaza (80%) than in the West Bank (67%), and higher in non-camp settings (79%) than in the camps (60%). However married girls – already significantly less likely to be enrolled in formal school than unmarried girls (25% vs. 94%) – fared less well in terms of family support for continuity of learning; only 46% of married girls enrolled in school reported receiving support whereas 76% of unmarried older girls were helped by their families to continue their schooling.

Among those enrolled in school, 61% said that they had some form of contact with their teacher in the 7 days prior to the survey; however, only 43% had received feedback from a teacher in the same period. However, these overall figures mask some significant differences between subgroups. For example, there were notable differences in the experience of boys and girls; younger girls were more likely to receive feedback compared with younger boys (53% vs. 40%) and older girls were more likely to report any contact with a teacher than older boys (63% vs. 50%); see Fig. 11. Overall, younger adolescents were more likely

Fig. 11: Teacher contact and feedback in the 7 days prior to the survey among adolescents enrolled in formal school

Notes: The percentages above are based on the number of adolescents who were enrolled in school in March 2020 and/or had re-enrolled in school in the school year following the summer break, excluding those who responded “I don’t know” or refused to answer these questions (n=784). Categories noted with an asterisk (*) demonstrated statistically significant differences at the 0.05 level for any form of contact with a teacher. Categories noted with a “±” demonstrated statistically significant differences at the 0.05 level for receiving feedback from a teacher.

to have been in contact with a teacher in the past week than older adolescents (64% vs. 57%), a reflection perhaps that UNRWA supports younger adolescent education up to grade 10 but not beyond. Additionally, reporting of feedback from teachers was higher among Gazan adolescents than among those in the West Bank (52% vs. 33%), and also among adolescents in camp as opposed to non-camp settings (50% vs. 40%) – again, perhaps reflecting more proactive relationships between students and teachers within UNRWA education settings relative to government schools. For example, a 13-year-old refugee girl living in a camp in Gaza and attending an UNRWA school explained that she has good interaction with her teacher and feels supported: “I am accessing lessons on Google classroom daily and if I face any challenges, I tell the teacher in the chat and she responds immediately.”

Voice and agency

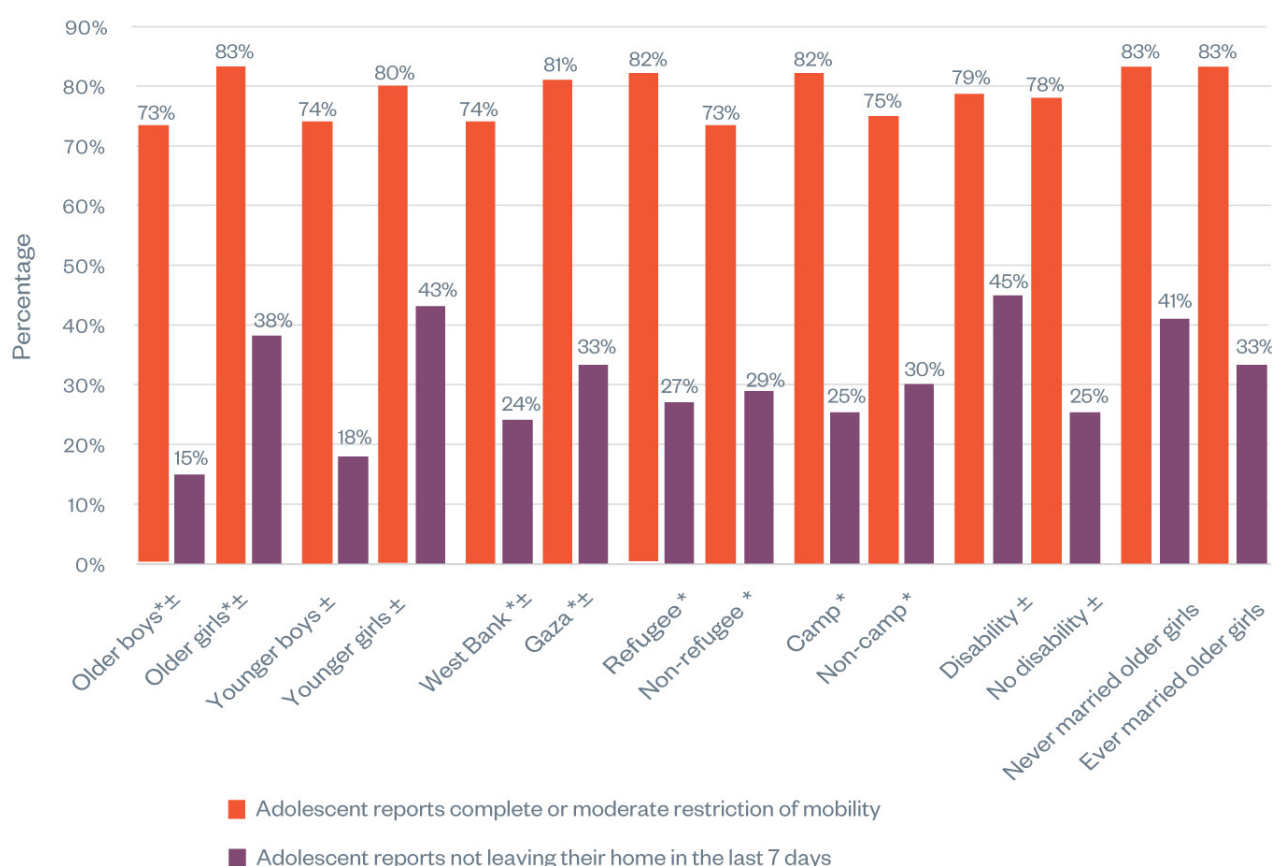
Our findings highlight that overall, adolescents’ ability to exercise voice and agency during the pandemic was

restricted, particularly for girls and adolescents with disabilities.

Mobility outside the house

Overall, a sizeable majority (77%) of surveyed adolescents said that their mobility had been moderately or completely restricted by the pandemic. As shown in Fig. 12, girls were more likely than boys to report restricted movement, especially older girls; while this gender-based difference was also apparent in the younger age group, it was not statistically significant. The mean number of days spent at home without leaving the house during the week preceding the survey was also higher for girls (5.2 days for older girls and 5.0 days for younger girls) than boys (3.1 days and 3.5 days, respectively). Most notably, 39% of older girls reported not leaving the house or receiving any visitors in the 7 days prior to participating in the survey, compared with 15% of older boys. Young people with disabilities were also less mobile, staying home for an average of 4.8 days in the preceding week, while their counterparts without

Fig. 12: Freedom of movement among adolescent survey participants



Notes: The percentages above are based on responses from the full sample of adolescents (n=1005). However, two participants responded “I don’t know” or refused to answer the question relating to the level of restriction on their mobility. Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for adolescents reporting complete or moderate restrictions in mobility. Categories noted with a “±” demonstrated statistically significant differences at the 0.05 level for adolescents reporting not leaving home at all in the 7 days prior to the survey.*

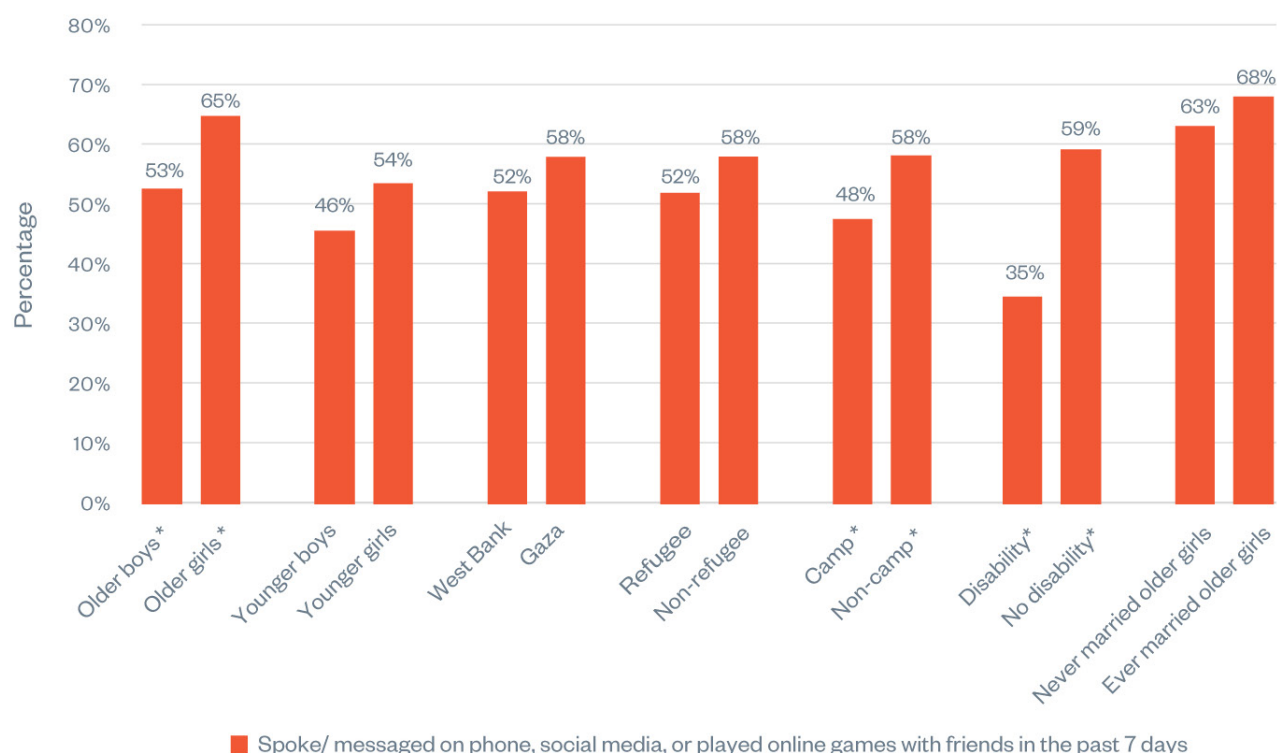
disabilities remained at home on average for 4.1 days. A 15-year-old girl with a disability from Gaza reported: “The young people with a disability are more affected by corona[virus] because they used to go to the centres where they do activities together, communicate with other PWDs who are similar to us, but now they can’t! They feel alone and afraid!”

Interactions with friends in the past week

Three quarters of adolescents (75%) said that they had had some interaction with friends in the week prior to the survey, either virtually or in person. Overall, 28% reported “hanging out” or playing with friends in person in the previous week; this percentage rose to 49% among older boys and 44% among younger boys. In contrast, only 7% of older girls and 11% of younger girls said they had met up with friends in person in this period. More than half (55%) of adolescents had interacted with friends virtually in the past week, either through text messaging on a phone,

connecting over social media, or playing online games. Girls, and older girls in particular, were more likely to rely on virtual methods to connect with their friends; see Fig. 13.

Given the importance of peer interactions during the adolescent years, the finding that a quarter of all adolescents (25%) had no interaction with friends, neither in person nor online, is very concerning. Younger girls were significantly more likely to have no contact with friends than younger boys (37% vs. 21%). This perhaps reflects younger girls’ general lack of independence in terms of mobility outside of the home, compounded by lack of access to a personal device with internet access (just 31% of younger adolescents had their own internet-enabled device, compared with 61% of older adolescents; see below). As a 15-year-old girl in Gaza explained, the isolation from friends is taking a heavy toll: “We have stopped going to school, we haven’t seen our friends and we haven’t gone out of the house ... I feel suffocated and frustrated.”

Fig. 13: Percentage of adolescents who interacted virtually with their friends in the last 7 days

Notes: The percentages above are based on responses from the full sample of adolescents (n=1005). Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level.*

Adolescents with disabilities appear to be experiencing particularly high levels of social isolation, with 46% reporting no interaction with friends in the past week, neither online nor in person, compared with just 20% of adolescents without disabilities. Young people in Gaza may also be disadvantaged in this respect, although part of the difference in the percentage of respondents reporting in-person interactions in the past week between Gaza and the West Bank (25% vs. 31%) is likely due to the timing of the survey (during the peak of the first wave in Gaza).

Internet connectivity and online experiences

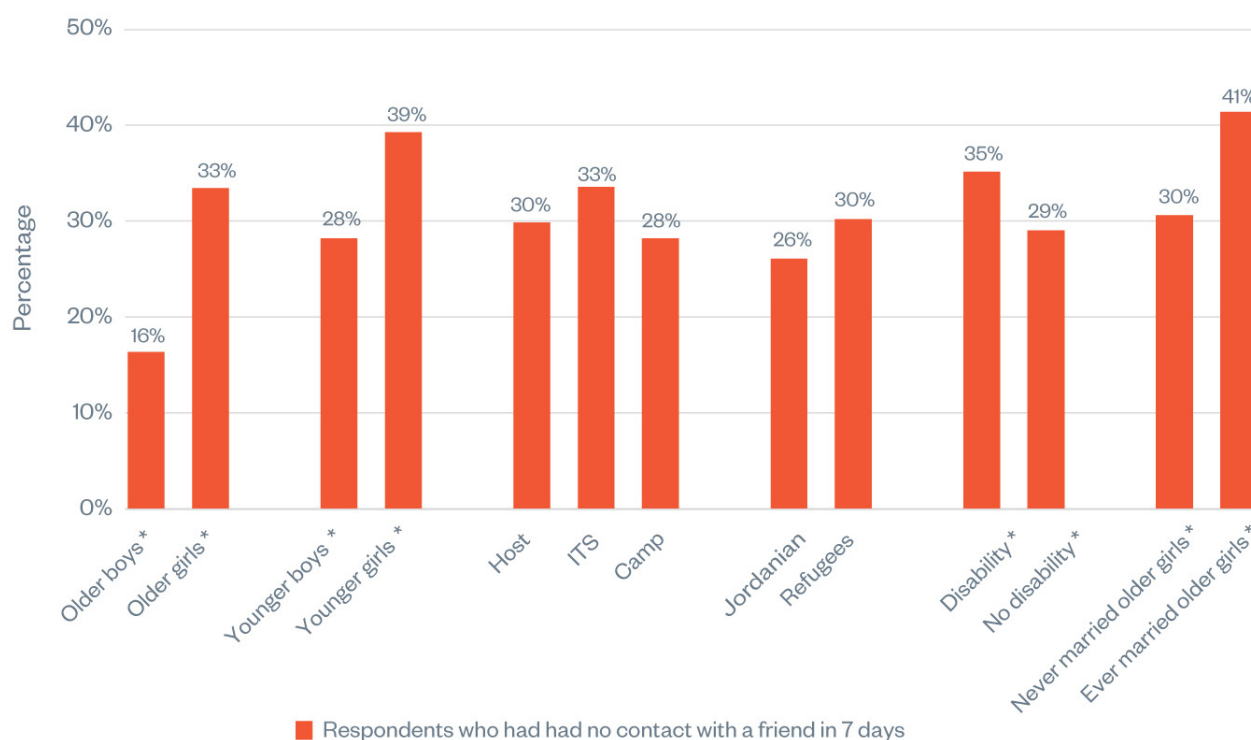
Adolescents who participated in the phone survey acknowledged that technology had become an important part of life during the pandemic. At the time of the survey, 49% of all adolescents had their own personal device with internet access; older adolescents were more likely to have exclusive access to an internet-enabled device than younger adolescents (61% vs. 31%) but access did not differ significantly between boys and girls (Fig. 14). Two thirds (66%) of all respondents reported that they had increased their access to technology since the start of the pandemic, a trend that was particularly noticeable

among older girls who were more likely to report increased access to technology than their male peers (72% vs. 60%; see Fig. 14).

More than half (55%) of all adolescents reported engaging with friends online in some way in the 7 days prior to taking part in the survey. The proportion of older girls who engaged with friends online was higher still, and at 65% considerably greater than that for boys (53%) (Fig. 13). There was also a noticeable difference in online engagement between those living outside of camps and those living in camps (53% vs. 48%). Young people with disabilities appear to be disadvantaged in both mobility and online connectivity; their peers without disabilities were much more likely to interact with friends online (59% compared with 35%). As shown in Fig. 14, young people with disabilities were also less likely to have their own device with internet access (37% compared with 51% in those without disabilities).

Of the online users, 11% reported having negative or uncomfortable online experiences in the 12 months before the survey, an occurrence that appeared to be more common among young people in Gaza (14%) than in the West Bank (9%) but consistent with the finding that adolescents in the West Bank are more likely to report

Fig. 14: Access to technology, including internet-enabled devices, among survey participants



Notes: The percentages above are based on the full sample of adolescents (n=1005); however, five participants responded "I don't know" or refused to answer the question relating to access to technology. Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level for adolescents reporting complete or moderate increase in technology access. Categories noted with a "±" demonstrated statistically significant differences at the 0.05 level for adolescents who report having their own mobile device with internet access.*

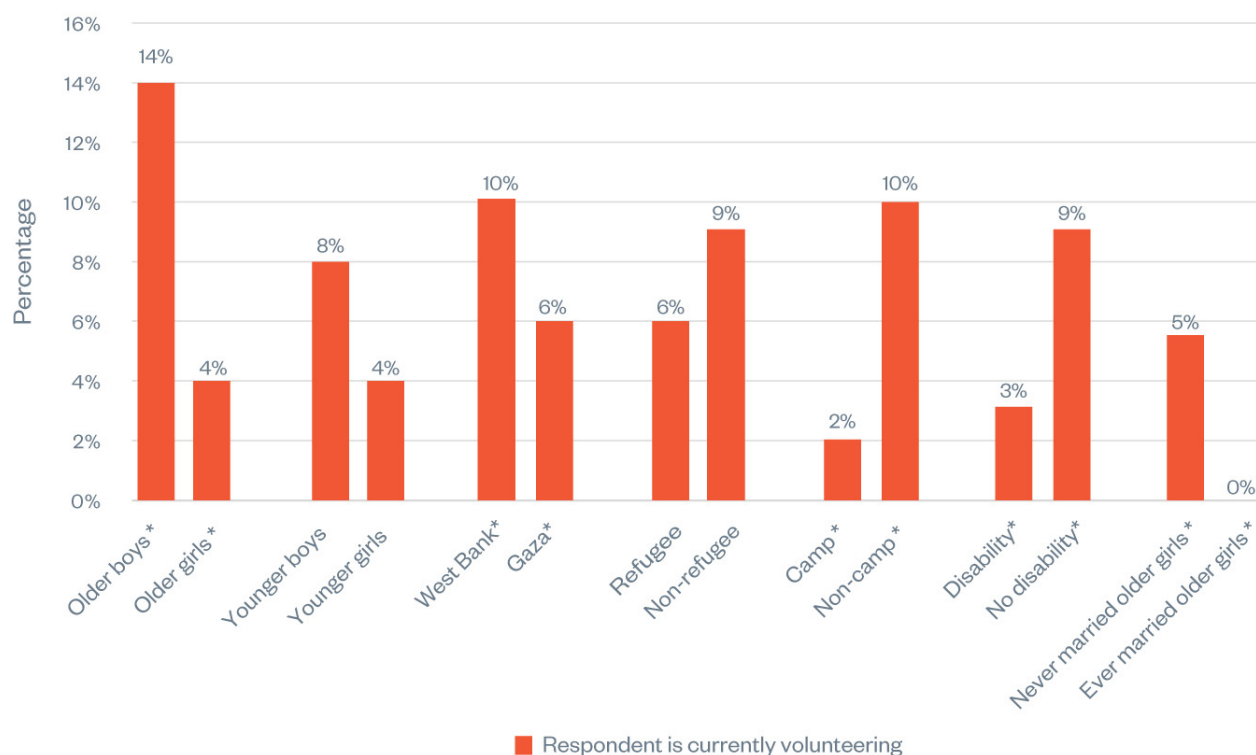
that they know how to be safe online (92%) than their peers in Gaza (85%). Younger adolescents and those with disabilities emerged as the subgroups most likely to have negative online experiences: younger adolescents were less likely to report knowing about online safety than older adolescents (84% vs. 92%) and a lower proportion of adolescents with disabilities reported knowing how to be safe online, compared with their peers without disabilities (78% vs. 90%).

Participation in volunteer activities

Only 8% of all adolescents reported being engaged in volunteering during the pandemic. There were stark gender differences – just 4% of older girls participated

in volunteer work compared with 14% of older boys (see Fig. 15). Volunteering was more popular in the West Bank, where 10% of adolescents were engaged in some form of volunteer activity, whereas only 6% of Gazans did any voluntary work. Similar differentials were observed between adolescents in non-camp and camp settings (10% vs. 2%), and between young people without disabilities and those with (9% vs. 3%) (Fig. 15). The qualitative findings highlighted the fact that poverty was a constraint on participation for many. As an 18-year-old girl from the West Bank remarked: "People here don't have money to buy food. How will they do volunteer work?"

Fig. 15: Percentage of respondents currently engaged in volunteer work



Notes: The percentages above are based on responses from the full sample of adolescents (n=1005), excluding one participant who did not answer this question. Categories noted with an asterisk () demonstrated statistically significant differences at the 0.05 level.*

Recommendations for policy and programmatic actions

We conclude by summarizing the key findings on the intersecting impacts of the COVID-19 pandemic on adolescents in the West Bank and Gaza Strip. In each thematic domain, we identify priority policy and programming actions in line with a rights-based approach to address these impacts and to promote adolescent health and well-being during the pandemic itself and then in the post-pandemic response period. It is important to underscore that some groups of socially disadvantaged young people – those in refugee camps, adolescents with disabilities and, to a lesser extent, girls but especially married girls – appear to be disproportionately affected by the pandemic. In keeping with commitments to “leave no one behind” and the 2030 Sustainable Development Agenda, it is critical that these subgroups be placed at the forefront of any targeted or socially inclusive pandemic response.

1. Promote equitable health care access for adolescents

More than a fifth of all adolescents reported that they had not been able to access health care and medications when they needed to during the pandemic. This figure was higher among young people with disabilities, adolescents in Gaza, pregnant girls and adolescent mothers. It is recommended that adolescents’ health and well-being needs, including sexual and reproductive health, nutrition, violence and injury prevention, mental health and psychosocial support, are explicitly integrated into the national COVID-19 response, as well as in humanitarian preparedness and response plans more broadly. To support related health service outreach efforts, it is also recommended that the database of vulnerable adolescents be updated and government agencies, civil society organizations and NGOs work together to promote access of these groups to health services.

2. Support food security and dietary diversity

Hunger and a reduction in dietary diversity affected almost a quarter of all adolescents surveyed, and more than 40% of those resident in Gaza. This indicates an urgent need to improve shock-responsive social assistance systems so that support can be rapidly expanded during crises, and

effectively targeted at the most vulnerable adolescents, including those with disabilities and married girls.

3. Ensure menstrual health and hygiene management

A third of adolescent girls reported facing challenges with menstrual hygiene management. While this is partly due to cultural taboos surrounding menstruation, these challenges were exacerbated by pandemic-induced financial constraints and the lack of privacy during the lockdown. It is recommended that public health officials in partnership with other stakeholders act to address the stigma and taboos surrounding menstruation, and coordinate with humanitarian actors to ensure the availability of, and accessibility to, water, sanitation services and menstrual hygiene supplies.

4. Promote injury prevention

Almost 6% of adolescents had suffered a serious injury during the pandemic and more than a fifth identified the COVID-19 outbreak as a factor that increased their risk of injury. It is therefore important that public health measures are taken to identify and mitigate those risks that are likely to be exacerbated during lockdown scenarios, and to raise awareness among community members, service providers and employers of such risks and how best to manage them. Such measures require multisectoral collaboration, including with the ministries of education, health, transportation and social development, as well as municipalities and local governments.

5. Support positive coping repertoires, including measures to mitigate risks of substance abuse and inadequate physical activity

Adolescent coping behaviours and strategies in the context of the pandemic differed by gender. While relatively few girls smoke, among the 25% of boys aged 15 and over who were regular smokers, one third were smoking more during the pandemic. In terms of physical activity, 20% of all adolescents reported that they now have fewer days in which they are engaged in physical activity of 30-plus minutes duration than before the pandemic. However,

among older boys who are usually more engaged in physical activity than girls- this proportion rose to 31%. Gendered cultural norms impose severe restrictions on girls' free movement, physical activities and participation in sport activities.

Public health and mental health services that can provide support to reduce the risks associated with unhealthy lifestyles are essential, and should focus on those most at risk. Adolescents and their caregivers need targeted information about where and how to get support and care. In addition, it is important to promote healthy lifestyles, for example, by providing guidance on physical activity with particular emphasis on promoting girls' engagement in physical exercise that can be undertaken in the home and school using information sheets or online video links, as well as engaging with United Nations agencies and partners to facilitate availing open spaces for physical activities for both boys and girls with social distancing measures. In addition, schools need to make sure that online timetables include sufficient time for physical education with options for home exercises for both boys and girls. In terms of substance misuse, more specific measures could include – building on lessons learned from the subset of the adolescent population who have stopped or reduced their smoking due to financial constraints – shaping public health messaging around economic savings, not just the health benefits.

6. Promote adolescent psychosocial well-being and mental health

Findings suggest that 5% of the sample had possible moderate-to-severe depression while 10% of the adolescents are experiencing moderate-to-severe anxiety as a result of the pandemic. Community-based and online counselling services should be prioritized to support these young people, especially in the Gazan context where the pandemic is layered on multiple and intersecting long-standing vulnerabilities on account of the siege and economic malaise. A large number of young people in both Gaza and the West Bank lack trusted peers and family members and could therefore also be vulnerable to mental ill-health in the medium to longer term, indicating an urgent need to invest in community-based peer support groups that can be maintained through innovative mechanisms during crisis episodes. A multi-layered, multisectoral approach is recommended, one which includes responses ranging from targeted campaigns for tackling stigma and discrimination, through to community-based interventions,

as well as the integration of mental health in primary health care and general health care and the strengthening of specialized services to promote mental health and provide care for adolescents and their families with mental health disorders.

7. Tackle risks of intra-household violence

Adolescents highlighted that household stress had increased since the start of the pandemic, manifesting itself in increased intra-household abuse and violence. Approximately one quarter of adolescent respondents reported being affected by some form of abuse more frequently now than during pre-pandemic times – typically verbal abuse but also physical and sexual abuse. The reported prevalence of intra-household violence was higher in camps and in Gaza, where living circumstances are already precarious. This suggests an urgent need to address the underlying stressors, especially economic constraints, through scaled social assistance, and to ensure that hotlines and counselling services are adequately resourced, and that there are community services available for adolescents to turn to when required. It is also recommended that health care providers are made aware of the increased risks for intra-household age- and gender-based violence, and that they understand the specific challenges that adolescents face in reporting abuse. Health workers must also be trained and supported to detect abuse and to make appropriate referrals when needed.

8. Adopt disability-inclusive approaches

Relative to their peers without disabilities, adolescents with disabilities are already experiencing additional vulnerabilities and challenges, many of which have increased as a result of the pandemic. Actions should be taken to ensure all efforts related to promoting adolescent health and well-being during and beyond the pandemic are inclusive of adolescents with disabilities and take count of any related considerations. This should be done in full consultation with adolescents with disabilities, their families, caregivers and representatives to ensure that implemented policies, actions and measures are truly inclusive on the ground.

9. Ensure continuity of learning

While large numbers of young people were able to continue learning in some way, internet connectivity, electricity and/or infrastructure constraints affected approximately one

fifth of adolescents; increased pressure to spend more time taking care of siblings and helping with domestic work also negatively affected their ability to engage in distance education. Lack of opportunities for teacher engagement was also cited as an impediment: less than half of young people had had recent feedback from a teacher. In light of these findings, it is important to strengthen linkages between teachers and students during distance learning, and to provide alternative means of learning – for example, paper-based learning for those with electricity and internet connectivity challenges – so as to minimize education disadvantage for the most vulnerable. Moreover, it is critical to facilitate, as early as possible, the safe reopening of schools and consider it a priority for governments and partners, and to prioritize adolescents with disabilities in related outreach activities.

10. Support adolescent voice and agency in the community

Limited mobility and difficulties in maintaining interactions with friends in person during the pandemic were highlighted by girls and young people with disabilities in particular. This suggests a need to support peer interactions in appropriately socially distanced ways and, where interaction is online, to ensure that adequate safeguarding measures and online safety awareness are in place to minimize risks. Currently less than 8% of young people are participating in local volunteer activities to support the pandemic response, but if efforts to “build back better” are to be youth responsive, it is essential that there are opportunities for adolescent girls and boys to participate actively. To this end, examples of promising practices within the West Bank and Gaza, as well as internationally, should be shared and adapted at scale.

References

1. Palestine in figures 2019. Ramallah: Palestinian Central Bureau of Statistics; 2020 (<https://pcbs.gov.ps/Downloads/book2513.pdf>, accessed 29 June 2021).
2. Preliminary results of the Population, Housing and Establishments Census 2017. Ramallah: Palestinian Central Bureau of Statistics; 2018 (<https://www.pcbs.gov.ps/Downloads/book2364-1.pdf>, accessed 29 June 2021).
3. Occupied Palestinian Territory. Emergency type: chronic conflict and outbreak. Health Cluster Bulletin. 2020(April): 1–12 (www.un.org/unispa/document/health-cluster-bulletin-opt-april-2020, accessed 29 June 2021).
4. Assessment report: Impact of COVID-19 counter measures on the SRHR sector in Palestine. Palestine: United Nations Populations Fund; 2020.
5. Hamad S, Abu Hamra E, Diab R, Abu Hamad B, Jones N, Małachowska A. Listening to young people's voices under COVID-19. Exploring the impacts of COVID-19 on adolescents in the Gaza Strip. Policy brief. London: Gender and Adolescence: Global Evidence; 2020 (<https://assets.publishing.service.gov.uk/media/5f31510c8fa8f57ac3af2e07/Exploring-the-impacts-of-covid-19-on-adolescents-in-the-Gaza-Strip.pdf>, accessed 29 June 2021).
6. Palestine 2030. Demographic change: opportunities for development. Palestine: United Nations Population Fund; 2016 (<https://palestine.unfpa.org/sites/default/files/pub-pdf/Palestine%202030%20Full%20Report%20English.pdf>, accessed 29 June 2021).
7. Health annual report. Palestine 2018. Nablus: Palestinian Health Information Center, Ministry of Health; 2019 (https://healthclusteropt.org/admin/file_manager/uploads/files/1/Health%20Annual%20Report%20Palestine%202018.pdf, accessed 29 June 2021).
8. CORONAVIRUS – COVID-19 Surveillance System [web page]. The Palestinian National Institute of Public Health, Ministry of Health; 2021 (<http://site.moh.ps/index/covid19>, accessed 30 June 2021).
9. Asi Y. Occupation in the time of COVID-19: Holding Israel accountable for Palestinian health [web page]. Al-Shabaka [the Palestinian Policy Network], 15 November 2020 (<https://al-shabaka.org/briefs/occupation-in-the-time-of-covid-19-holding-israel-accountable-for-palestinian-health>, accessed 30 June 2021).
10. COVID-19 Cases in the Gaza Strip. Weekly Epidemiological Bulletin from (07/03 TO 13/03 2021) AND (14/03 TO 20/03). The Palestinian National Institute of Public Health, Ministry of Health and Geneva: World Health Organization; 2021 (http://www.emro.who.int/images/stories/palestine/documents/COVID-19_Gaza_epidemiological_bulletin_21March2021.pdf?ua=1, accessed 30 June 2021).
11. Coronavirus disease (COVID-19). Situation report 68'. Geneva: World Health Organization; 18 March 2021 (<https://who18createsend.com/campaigns/reports/viewCampaign.aspx?d=j&c=99FA4938D049E3A8&ID=A633917DD1B-D52992540EF23F30FEDED&temp=False&tx=0&source=Report>, accessed 30 June 2021).
12. Abu Hamad B, Jones N, Samuels F. Mental health and psychosocial challenges facing adolescent girls in conflict-affected settings: the case of the Gaza Strip. *Arab J Psychiatry*. 2020;31(2):169–180
13. Abu Hamad B, Gercama I, Jones N, Abu Hamra E. *No one told me about that. Exploring adolescent access to health services and information in Gaza*. London: Gender and Adolescence: Global Evidence; 2017 (<https://www.gageodi.org/wp-content/uploads/2017/12/GAGE-Health-Briefing-revised-cover.pdf>, accessed 30 June 2021).



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Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org.uk for more information.

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