FINAL REPORT

Project Evaluation of
"Health assistance and psychosocial support in Palestinian refugee camps in Lebanon"

Prepared for CCP Japan and their local partner National Institution of Social Care and Vocational training (NISCVT)

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Acronyms

ADHD	Attention-Deficit/Hyperactivity Disorder
BAS	Beit Atfal Assumoud (alternative name for NISCVT)
CCP	Campaign for the Children of Palestine (CCP Japan)
CHS	Core Humanitarian Standard
FGC	Family Guidance Center
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HH	Household
IASC	Inter-Agency Standing Committee
IDI	In-Depth Interview
INGO	International Non-Governmental Organization
JPF	Japan Platform
KII	Key Informant Interview
LEB	Lebanese (shorthand in tables/targets for vulnerable Lebanese households)
MHPSS	Mental Health and Psychosocial Support
MoU	Memorandum of Understanding
NFI	Non-Food Item
NISCVT	National Institution of Social Care and Vocational Training (Beit Atfal Assumoud / BAS)
OECD-DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
PFA	Psychological First Aid
PRL	Palestine Refugees in Lebanon
PRS	Palestine Refugees from Syria
PSEAH	Protection from Sexual Exploitation, Abuse and Harassment
SOP	Standard Operating Procedure
SRS	Syrian Refugees in Syria (in this report: Syrian Refugees in Lebanon)
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East

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JPF Evaluation Team

1. Gökhan Erkutlu – JPF MEAL Consultant
2. May Aoun – MHPSS Expert - Consultant
3. Soha Shaer – MEAL Expert - Consultant
4. Farah Fahed - Interpreter

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1 Executive Summary

This evaluation assessed the project *"Health assistance and psychosocial support in Palestinian refugee camps in Lebanon"*, implemented by CCP Japan in partnership with the National Institution of Social Care and Vocational Training (NISCVT/Beit Atfal Assumoud). The project was funded by the Japan Platform (JPF) and builds on the long-standing collaboration between CCP Japan and NISCVT *which has been ongoing in Lebanon since 2013. This latest project represents the continuation of that sustained partnership and commitment to addressing the needs of Palestinian refugees.*

The evaluation was conducted in July 2025 using a mixed-methods approach. Data collection included desk review, key informant interviews (KIIs) with CCP Japan and NISCVT management and staff, external stakeholders, in-depth interviews (IDIs) with beneficiaries, focus group discussions (FGDs), and two online surveys targeting dental and MHPSS service users. In total, 55 meetings were conducted with 82 participants, and survey responses were collected from 30 dental and 102 MHPSS beneficiaries. Data triangulation was applied to ensure validity and capture diverse perspectives across gender, age, and service type.

1.1 Key Findings

Component 1 – Dental Services:

The project filled a critical gap in dental care for kindergarten-aged children, who are not covered by UNRWA's school-based dental services. NISCVT's clinics provided urgent treatment, preventive education, and follow-up, integrated with kindergartens run both by NISCVT and other organizations. Beneficiaries consistently reported high satisfaction with the professionalism, hygiene, and accessibility of services. Families highlighted that dental care relieved severe pain, restored children's ability to eat and sleep, and improved school attendance. Preventive impact was also noted: awareness sessions encouraged better brushing habits, reduced sugar intake, and wider family-level changes in oral hygiene. While NISCVT provides dental services in multiple camps beyond the scope of this JPF project, the demand for free and accessible care continues to far exceed available resources. Families consistently noted that without NISCVT, affordable alternatives do not exist, underscoring the irreplaceable role of these services within the refugee community.

Component 2 – Mental Health and Psychosocial Support (MHPSS):

MHPSS services were widely regarded as indispensable. Families emphasized improvements in children's behavior, emotional regulation, and school participation, and as a direct result of these changes, they also reported an overall increase in their own wellbeing and quality of life. The program's strength lies in its multidisciplinary team, including psychiatrists, psychologists, speech, psychomotor, and occupational therapists, combined with social workers who bridge clinical interventions with home visits and trusted community relationships. This modality was repeatedly cited as a unique and effective approach. Despite long waiting lists for specialized therapies, beneficiaries valued the services as life-changing and often unavailable elsewhere. The recent escalation of violence in Gaza and Lebanon has further heightened demand, with parents reporting increased anxiety, nightmares, and aggression among children.

Component 3 – Capacity Building of Communities on Mental Health:

The mental health promoter model extended awareness and stigma reduction into neighborhoods and extended families. Promoters, mainly mothers of children who had benefited from services, shared personal testimonies while being backed by technical input from social workers and specialists. This peer-to-peer approach increased acceptance and encouraged earlier referrals, while also cascading impact. Promoters also gained confidence, modest income, and work experience, contributing to their empowerment. However, the number of promoters remained limited due to project budget constraints, which restricted the ability to expand coverage to all neighborhoods. Increasing the number of promoters in future programming could allow for broader community reach and deeper impact.

Cross-cutting Findings:

The decades-long CCP–NISCVT partnership remains a cornerstone of sustainability, rooted in trust and complementarity. NISCVT's reputation and embeddedness in camps continue to be central to delivery and were recognized externally by UNICEF, which recently partnered with NISCVT in its Mekani program. Beneficiaries praised staff for respectful and confidential services, but feedback mechanisms remain mostly informal and trust-based, with limited structured or anonymous options. Sustainability challenges persist, as both dental and specialized MHPSS services rely on external funding.

1.2 Key Recommendations

Component 1 – Dental Services:

Beneficiaries expressed interest in expanding the range of dental services, but the unique value of this project lies in providing urgent and preventive care as an emergency response where no alternatives exist. While NISCVT already offers dental services in several camps beyond this JPF project, demand for free and accessible emergency treatment continues to exceed available capacity. The recommendation is therefore to increase resources to reach more beneficiaries while keeping the focus on emergency dental needs and preventive awareness.

Component 2 – Mental Health and Psychosocial Support (MHPSS):

Increase specialist capacity to reduce waiting lists, particularly for speech and occupational therapy. Provide continuous professional development and learning and strengthen technical training and supervision for staff in autism, ADHD, and trauma care. Enhance outreach to fathers and caregivers to improve family-level impact. Staff and families emphasized that while many children improve within six months, more complex cases (e.g., trauma, severe anxiety, developmental or behavioral disorders) often require longer follow-up. CCP Japan and NISCVT acknowledged this need, but within the JPF framework, services are tied to one-year cycles and outcome indicators. Therefore, addressing longer-term or repeated care should be pursued through future advocacy and additional resource mobilization. Staff care and supervision should also be reinforced to prevent burnout, and awareness sessions for parents should be continued and expanded.

Component 3 – Capacity Building of Communities on Mental Health:

Provide refresher trainings and new modules (e.g., adolescent mental health, trauma, stress management) for promoters. Strengthen support in preparing materials and facilitation skills, while continuing close mentorship by social workers. Retain the promoters for more than one cycle to build on and invest in their expertise, while expanding their number to widen coverage across neighborhoods and sustain awareness beyond project cycles. Preserve modest compensation, which supports both motivation and women's empowerment.

Cross-Cutting Recommendations:

CCP Japan and NISCVT should formalize a joint process for assessing staff capacity needs at the start of each project cycle and create more structured technical reflection spaces. For sustainability, CCP Japan should invest more in public fundraising and campaigning in Japan and abroad to diversify their funding streams, while NISCVT continues to diversify its donor base. Both organizations should strengthen accountability by establishing clear, formal feedback mechanisms, such as complaint boxes, hotlines, and regular parent meetings, to complement existing trust-based practices.

2 Introduction

2.1 Context Background

Lebanon is home to one of the most vulnerable and marginalized refugee populations in the region: Palestine Refugees, many of whom have lived in protracted displacement for generations. As of February 2025, UNRWA estimates that around 222,000 Palestinians reside in Lebanon, including 195,000 Palestine Refugees from Lebanon (PRL) and 27,000 from Syria (PRS). While nearly half live in the country's 12 official refugee camps, the rest are spread across informal gatherings and urban neighborhoods. UNRWA's services reach an estimated 248,000 refugees and their family members, but these figures mask the chronic deprivation facing these communities.

Poverty levels are staggering. As of March 2023, 80% of Palestine Refugees were living below the national poverty line and without UNRWA's quarterly cash assistance (USD 18 million distributed in two rounds since December 2022), poverty would have climbed to 93%. Decades of structural discrimination, including prohibitions on working in certain professions regulated by syndicates and bans on property ownership, have stripped generations of Palestinians in Lebanon of opportunities to accumulate assets, secure stable livelihoods, or enter middle-income brackets. The result is systemic socio-economic exclusion now affecting the fourth generation of refugees.

The health situation is equally dire. Refugee households consistently identify hospitalization costs as a top concern. Many can no longer afford their share of medical expenses, and UNRWA's limited resources cannot fully meet health needs. Food insecurity compounds these challenges, households spend approximately 30% of their total expenditures on food, squeezing budgets for other essentials.

Protection risks in camps remain acute. The absence of formal governance, policing, and judicial mechanisms inside camps, coupled with Lebanon's broader judicial paralysis, has fueled insecurity. Violence against children and gender-based violence are reportedly high, yet underreporting persists due to stigma, lack of confidentiality safeguards, and fear of reprisals.

The escalation of the Gaza war since October 2023 has had a direct and destabilizing effect on Palestinian communities in Lebanon. Camps such as Rashidieh, Ein El Hilweh, and Burj Chemali have experienced heightened tensions, sporadic clashes, and movement restrictions. Emotional and psychological distress has deepened, particularly among children, as families watch the humanitarian catastrophe unfold in Gaza, where nearly the entire population has been displaced multiple times. Many in Lebanon have close family ties to those affected, intensifying feelings of grief, insecurity, and uncertainty.

These pressures are magnified by a deepening funding crisis. The U.S. suspension of USD 360 million annually to UNRWA created a massive service gap that no donor has been able to fill. UNICEF's Palestinian Programme, which complements UNRWA's work, has suffered a 50–60% budget cut, forcing the termination of more than 60% of partner agreements as of July 2025. New U.S. funding has returned only under strict conditions prioritizing "life-saving interventions," excluding critical areas such as mental health, education, child protection, and cash assistance.

The consequences are evident: essential services are shrinking just as needs are growing. Gaps are most severe in sectors such as mental health, where long waiting lists and persistent stigma limit access, and in dental health, which remains largely neglected despite its importance for children's overall well-being. As UNICEF's Chief of the Palestinian Programme noted, the situation for Palestinians in Lebanon is now among the worst of any major host country, with high unemployment, estimated at 60% for youth and the highest documented rates of violence exposure in the country (82%). Without sustained funding and coordinated service delivery, these overlapping crises will continue to erode the resilience and dignity of Palestine Refugees in Lebanon.

2.2 Project Summary

The project "Health Assistance and Psychosocial Support in Palestinian Refugee Camps in Lebanon" was implemented between 2 September 2024 and 1 August 2025 under the Japan Platform Iraq and Syria Humanitarian Crisis Response Program. It aimed to address urgent health and psychosocial needs among Palestine Refugees in Lebanon (PRL), Palestinian Refugees from Syria (PRS), Syrian Refugees (SRS), and vulnerable Lebanese individuals. Activities were delivered in partnership with the National Institution of Social Care and Vocational Training (NISCVT) across multiple locations, including Shatila, Beddawi, Ain el-Helwe, Nahr el-Bared, Al-Buss camps and surrounding camps and areas, through NISCVT's Family Guidance Centers and dental clinic facilities.

The intervention focused on three core components: *(1) Dental Health*, including check-ups, treatments, and education workshops; *(2) Mental Health*, offering child psychiatry consultations and psychosocial support for parents; and *(3) Community Capacity Building on Mental Health*, training mental health promoters and delivering awareness-raising sessions. Services prioritized accessibility for vulnerable groups facing financial, geographic, and institutional barriers. By combining direct clinical services with preventive outreach, the project sought to both alleviate immediate health and psychosocial distress and strengthen community resilience for longer-term well-being.

Table 1: *Summary of project to be evaluated*

Project Summary				
Country	Lebanon			
Program Name	Humanitarian Response to the Iraq and Syria Crisis			
Project Title	Health assistance and psychosocial support in Palestinian refugee camps in Lebanon			
Implementing Partners	Campaign for the children of Palestine (CCP) Japan The National Institution of Social Care and Vocational training (NISCVT) known as Beit Atfal Assumoud (BAS)			
Project Locations	Shatila refugee camp (including Burj el-Barajneh and Mar Elias refugee camp) Beddawi refugee camp Saida (surrounding Ain el-Helwe refugee camp) Nahr el-Bared refugee camp Al-Buss refugee camp (including Borj Shamali and Rashidiya camps)			
Project Budget	30.640.085 YEN			
Project Duration	Start Date	2nd September 2024	End Date	1st August 2025
Project Overview	The purpose of this project is to address the urgent health and psychosocial needs of vulnerable populations residing in Palestinian refugee camps in Lebanon. These include Palestine refugees in Lebanon (PRL), Palestinian refugees from Syria (PRS), Syrian refugees (SRS), and economically vulnerable Lebanese individuals. The protracted crisis in Lebanon, exacerbated by economic collapse, infrastructure failure, and heightened insecurity due to ongoing armed clashes along the southern border, has placed enormous strain on the country's healthcare system and compounded mental health challenges among both refugee and host communities. In this context, the project seeks to mitigate the deterioration of physical and mental well-being among target populations by providing access to dental consultations and treatment, child psychiatry services, and community-based psychosocial support. The project is implemented in collaboration with the National Institution of Social Care and Vocational Training (NISCVT), a local NGO with decades of experience operating in			

	Palestinian camps across Lebanon. Service delivery takes place through NISCVT's existing facilities, including the Family Guidance Centers (FGCs), and is designed to reach vulnerable individuals who otherwise face significant barriers to care due to financial, geographic, or institutional constraints. By combining clinical services with preventive outreach and capacity building among community members, the project aims to contribute to both immediate relief and long-term community resilience.
Project Objective	To improve or prevent the deterioration of the physical and mental well-being of vulnerable individuals among refugee and host communities in Palestine refugee camps in Lebanon through the provision of medical, health, and psychosocial support. The project also aims to foster local ownership and empower community members so that preventive activities can continue sustainably beyond the project period.
Project Outcome	1. Dental health of the vulnerable PRS, SRS, PRL and LEB is improved, or its further deterioration is prevented through healthcare support. 2. Mental health of the vulnerable PRS, SRS, PRL and LEB is improved, or its further deterioration is prevented through healthcare and psychosocial support. 3. Human resources in the communities will develop more independence, and they will proactively cooperate with medical experts to continue prevention and awareness-raising activities even after the project ends.
Project Targets	<u>Component 1- Dental Health:</u> • Dental Check-Up: **2600 Beneficiaries** • Dental Treatment: **1500 Beneficiaries** • Dental Education Workshops: **1500 Beneficiaries** <u>Component 2 – Mental Health:</u> • Child psychiatry consultations: **250 Beneficiaries** • Parents Consultations by Social Workers: **300 Beneficiaries** <u>Component 3 – Capacity Building of the Communities on Mental Health:</u> • MH Promoter Trainings: **24 Beneficiaries** • MH Awareness Raising Workshops: **360 Beneficiaries**

Table 2: *Project Location vs Project Components Matrix*

Project Locations	Dental Health	Mental Health	CB of the Communities on MH
Shatila refugee camp (including Burj el-Barajneh and Mar Elias refugee camp)	Available	NOT Available under this Project	NOT Available under this Project
Beddawi refugee camp	Available	Available	Available
Ain el-Helwe refugee camp (Saida)	NOT Available under this Project	Available	Available
Nahr el-Bared refugee camp	NOT Available under this Project	Available	Available
Al-Buss refugee camp	NOT Available under this Project	Available	Available

** Services marked as 'Not Available under this Project' are provided by NISCVT in the respective camps through other donor-funded programs or institutional resources but were not included within the scope of this JPF-funded project.*

3 Evaluation Purpose and Objectives

The purpose of this evaluation is to assess the relevance, effectiveness, and quality of the project "Health assistance and psychosocial support in Palestinian refugee camps in Lebanon", implemented between September 2024 and August 2025 by CCP Japan in partnership with the National Institution of Social Care and Vocational Training (NISCVT). The evaluation seeks to generate evidence-based findings on the project's achievements, challenges, and lessons learned, while providing actionable recommendations to guide future programming under similar contexts.

The evaluation specifically aims to:

1. **Assess Relevance:** Examine the alignment of the project design and activities with the urgent health and psychosocial needs of targeted refugee and host communities.
2. **Evaluate Effectiveness and Quality:** Review the extent to which dental health, child psychiatry, and community-based psychosocial support services met intended outcomes and adhered to humanitarian principles and standards.
3. **Review Efficiency and Responsiveness:** Analyze implementation processes, coordination, and adaptability to contextual changes and emerging needs.
4. **Understand Beneficiary Satisfaction:** Explore perceptions of accessibility, quality, and impact of services from both beneficiaries and stakeholders.
5. **Identify Lessons Learned and Recommendations:** Provide practical insights to enhance future health and psychosocial interventions, with attention to sustainability, accountability, and community ownership.

The evaluation incorporates mixed-methods data collection, including document review, beneficiary surveys, interviews, focus group discussions, and direct observations, with gender, age, and location disaggregation to ensure diverse perspectives are captured.

3.1 Evaluation Design & Methodology

3.1.1 Methodology

The evaluation adopted a mixed-methods approach, integrating quantitative and qualitative data collection and analysis to provide a comprehensive assessment of the project's relevance, effectiveness, efficiency, and achievements. The methodology emphasized triangulation across multiple sources and methods to ensure reliability and depth of findings.

Data collection tools included:

- **Document Review:** Analysis of project design documents, progress reports, beneficiary selection criteria, and other relevant materials.
- **Beneficiary Survey:** Administered via the Kobo Toolbox platform, with built-in validation rules to ensure secure, high-quality data entry.
- **Key Informant Interviews (KIIs):** Conducted with project staff, partner organization representatives, and external stakeholders.
- **In-Depth Interviews (IDIs):** With beneficiaries from each project component to explore personal experiences, perceived outcomes, and service quality.
- **Focus Group Discussions (FGDs):** With beneficiaries from each project component to gather collective perspectives and identify common themes.
- **Direct Observations:** During field visits to Family Guidance Centers, dental clinics, and training sites.

To ensure inclusive representation, data was disaggregated by age and location. The Evaluation Matrix (Annex 1) served as the guiding framework, mapping each evaluation question to specific indicators, data sources, and methods, and aligning them with OECD-DAC and CHS criteria.

Field data collection primarily took place face-to-face during site visits, with interviews and discussions conducted mainly in Arabic and recorded (with informed consent) for transcription and analysis. For online engagements, the same consent and confidentiality protocols were followed. All transcripts were anonymized to protect participant privacy, names and identifying details of beneficiaries were removed, and staff were referred to by title unless reference to high-level positions was necessary for context.

The evaluation team adhered to ethical standards, including the Do No Harm principle, voluntary participation, and informed consent. Special attention was given to ensuring participant comfort and safety during data collection, particularly in sensitive discussions related to mental health and protection concerns.

3.1.2 Sampling Strategy

The evaluation employed a purposive targeted sampling strategy rather than random sampling, in order to ensure meaningful representation across key project components and beneficiary groups. An anonymous beneficiary list was provided by CCP Japan, containing demographic details of service users, which served as the basis for selection.

Given the project's design, the majority of direct respondents were mothers, as they are typically the primary caregivers responsible for following up on their children's participation in both MHPSS and dental services. Gender balance was therefore not a specific criterion in this evaluation, as the sampling naturally reflected the caregiving roles within households. Instead, the sampling considered the gender and age of the children who directly received services, ensuring that perspectives linked to different age groups were included.

Within service types, **MHPSS was prioritized** over dental services, given its central role in the project design. Equal representation was targeted among different MHPSS interventions, including child psychiatry consultations, parental support sessions, and community-based awareness activities. For dental services, beneficiaries were selected to capture experiences of both preventive and treatment-based care.

Geographic representation was guided by the **Project Location vs. Project Components Matrix** (Table 2). Accordingly, the evaluation team selected three sites:

- **Saida** – chosen because the Family Guidance Center is fully funded by CCP Japan and provides the full range of MHPSS services;
- **Beddawi** – selected as the only camp offering both MHPSS and dental services under one roof in this project, enabling comparative insights;
- **Shatila** – included for dental services in this project, as dental support is the only component funded here under the JPF project; however, CCP Japan also supports other activities in Shatila camp through different projects funded by other donors.

This approach ensured that the quantitative survey, IDIs, and FGDs reflected the diversity of project activities while capturing the perspectives of those most directly affected by the services. The sampling strategy therefore provided a balanced and nuanced basis for assessing the project's outcomes and identifying lessons learned.

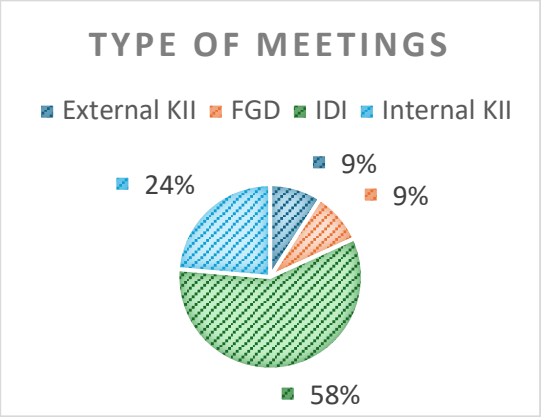
3.1.3 Data Collection Overview

The evaluation integrated both online surveys and in-person field activities to capture a broad range of perspectives from project beneficiaries, staff, and stakeholders. This multi-method approach ensured a balance of quantitative and qualitative evidence and strengthened the triangulation of findings.

Prior to the field visit, two online beneficiary surveys were disseminated by NISCVT colleagues at the camp level using Kobo Toolbox. While **138 responses** were initially collected, only those surveys that were fully completed, included consent, and confirmed receipt of services under this project were retained for analysis. This resulted in 132 valid surveys: **30 from dental service** beneficiaries and **102 from MHPSS service** beneficiaries. These surveys provided an initial quantitative dataset on accessibility, satisfaction, and perceived outcomes of the services.

Complementing the surveys, the evaluation team conducted an extensive round of **55 in-person meetings during the field mission**, reaching a total of **82 individuals**. These meetings included:

- **Key Informant Interviews (KIIs):** with CCP Japan staff, NISCVT management and technical staff, and external stakeholders (e.g., UN agencies, NGOs).
- **In-Depth Interviews (IDIs):** with service beneficiaries to capture individual experiences of accessing dental and MHPSS support.
- **Focus Group Discussions (FGDs):** with parents, community members, and mental health promoters to reflect collective perspectives.
- **Direct Observations:** during site visits to Family Guidance Centers and dental clinics.



The design ensured balanced representation across project sites and components, with **MHPSS prioritized** in Saida and Beddawi, and **dental services** covered in Shatila and Beddawi. Disaggregation by gender, age, and service type was applied wherever possible to highlight the diversity of experiences.

Table 3: *Breakdown of data collected per Location*

Location	# Meetings	%	Sum of # of People	%
Beddawi Center	15	27%	25	30%
Beirut	3	5%	3	4%
Online	3	5%	3	4%
Saida FGC	26	47%	37	45%
Shatila Center	8	15%	14	17%
Grand Total	**55**	**100%**	**82**	**100%**

Overall, the evaluation engaged more than 210 participants across surveys and field visits. Data from different tools were systematically triangulated to validate trends, identify challenges, and ensure that findings reflect the realities of both beneficiaries and implementing partners. Charts derived from the meeting statistics are included in this section to visualize participation across sites, tools, and service types.

3.1.4 Realization of Planned Data Collection Activities

The field data collection largely aligned with the targets established in the Inception Report, with only minor variances observed. A total of **56 activities were realized compared to the 51 planned**, reflecting an overall increase of five activities.

Table 4: *Summary of the comparison between targeted and realized activities:*

Type of Data Source	Targeted	Realized	Variance (Realized-Targeted)
Observation Visit - Shatila Dental Clinic	1	2	1
KII Internal: CCP	3	2	-1
KII Internal: NISCVT	11	11	0
KII External:	2	5	3
IDIs - MH Child Psychiatry Consultations	11	10	-1
IDIs - MH Consultations to Parents	10	9	-1
IDIs MH Promoters	4	7	3
FGDs - MH Awareness Raising	4	4	0
IDIs -Dental Care Beneficiary	4	5	1
FGDs - Dental Care Awareness	1	1	0
TOTAL	**51**	**56**	**5**

In terms of site visits, the planned observation of the Shatila Dental Clinic was complemented by an additional visit to the Beddawi Dental Clinic, resulting in broader coverage of dental service delivery. While the number of internal KIIs with CCP Japan and IDIs with both child psychiatry beneficiaries and parents fell slightly below target (–1 in each case), these shortfalls were offset by increases in other categories. In particular, external KIIs (realized 5 vs. planned 2) and IDIs with mental health promoters (realized 7 vs. planned 4) exceeded expectations, **bringing in a wider range of perspectives** and strengthening the evidence base.

Overall, the realized sample is considered sufficient and robust for meeting the evaluation objectives. The balance achieved across KIIs, IDIs, FGDs, and observation visits ensured triangulation of data sources and provided a strong evidence base. The slight deviations from targets were operationally unavoidable but compensated through adaptive planning in the field. Importantly, the realized activities remained consistent with the **Evaluation Matrix** (Annex 1), ensuring systematic coverage of the evaluation questions related to relevance, effectiveness, and beneficiary perspectives.

In addition to the qualitative data collection, **two online surveys were conducted prior to the field mission with 30 respondents for dental services and 102 respondents for MHPSS services.** Only fully completed surveys with consent and confirmed receipt of services were retained for analysis. Respondents were predominantly women, reflecting the project's outreach to mothers as primary caregivers. These surveys provided a valuable quantitative complement to qualitative data collection, offering additional insights into demographic characteristics, perceived needs, and satisfaction with services. The detailed reports can be found as annexes to this evaluation report.

4 Findings

4.1 Partnership

The partnership between CCP Japan and the National Institution of Social Care and Vocational Training (NISCVT, known as Beit Atfal Assumoud) dates back to 1986. Since then, CCP Japan has maintained a continuous presence in Lebanon, working alongside NISCVT to provide humanitarian assistance to Palestinian refugees and host communities.

Over the years, this collaboration has grown into a long-standing and trusted relationship. NISCVT's role as one of the oldest Palestinian NGOs in Lebanon, with deep community roots and credibility, has made it a consistent and effective partner. For CCP Japan, Lebanon has remained one of the longest and most stable areas of engagement, and the cooperation with NISCVT has been central to ensuring continuity, quality, and impact in the delivery of services needed by the target communities.

Today, the partnership continues to be highly valued by both sides. Senior managers from both organizations emphasized that CCP Japan is regarded not merely as a donor, but as a true partner invested in sustaining NISCVT's services and building institutional capacity. Concrete examples highlight this: the **Family Guidance Center in Saida**, which provides a comprehensive package of MHPSS services, is fully funded by CCP Japan, while the **Beddawi camp center** offers both MHPSS and dental services under the partnership. These contributions have been particularly crucial during times of global funding shortfalls, ensuring continuity of essential care for vulnerable Palestinian and Syrian refugee families.

At the operational level, CCP Japan brings financial support and technical input, while NISCVT contributes access, long-standing community trust, and professional expertise. This complementary dynamic has allowed both organizations to adapt to changing needs and maintain accountability to affected populations. In the words of one senior NISCVT informant, CCP Japan is regarded "not just as a donor, but as a true partner in sustaining services and protecting institutional continuity." The history of the partnership demonstrates how solidarity-born initiatives can evolve into long-term humanitarian collaboration, continuing to serve communities across multiple generations of Palestinian refugees in Lebanon.

4.1.1 Capacity Assessment

There has been no formal or standardized capacity assessment framework[1] applied in the partnership between CCP Japan and NISCVT. Both organizations emphasized that, given the longevity of their relationship, there was no need for a checklist-style pre-award assessment. Instead, needs are identified jointly and informally, based on NISCVT's feedback and CCP Japan's observations during project design and implementation. As one senior manager noted, "CCP Japan listens to us, and if we raise a need for our staff or our services, they try to support within the scope of the project."

While CCP Japan has not established a systematic capacity-building approach[2], its support has been instrumental in sustaining NISCVT's ability to deliver services. For example, the partnership ensures funding for critical positions such as social workers and psychologists, and facilitates the introduction of new tools or approaches where gaps are identified. A social worker reflected: "They are not just donors who supervise us. They respect our role, they listen, and they give us space to propose what we need."

Capacity strengthening has also occurred through NISCVT's broader institutional model, which integrates the contributions of multiple donors. NISCVT senior staff explained that the organization deliberately combines the unique strengths of different partners: some donors provide financial continuity, others contribute

[1] A formal or standardized capacity assessment framework is a structured tool or methodology used to evaluate the skills, resources, systems, and performance of an organization or its staff. It helps identify strengths, gaps, and priorities for targeted capacity-building in a consistent and measurable way.

[2] Systematic Capacity Building Approach: A structured and consistent framework for developing skills and systems, relying instead on ad-hoc or one-off trainings without clear needs assessments, follow-up, or sustainability.
UNDP CA Methodology Guide: http://content-ext.undp.org/aplaws_publications/1670209/UNDP%20Capacity%20Assessment%20Users%20Guide.pdf

technical expertise, and others cover specialized services. “Every donor brings something different that the other cannot provide. Together they make it possible for us to offer a holistic package of services,” one NISCVT manager explained. Through this approach, CCP Japan’s contribution is seen as part of a larger mosaic, allowing NISCVT to maintain comprehensive child and family services that go beyond the scope of a single project.

Frontline staff repeatedly highlighted the value of continuous learning. They benefit from regular thematic trainings on child protection, stress reduction, and bullying delivered by international and local partners, and apply these within their multidisciplinary teams. However, while administrative support is strong, they emphasized the urgent need for structured clinical supervision to manage complex cases, particularly in the current context of heightened family stress due to financial insecurity and the impacts of the Gaza war.

Recommendations emerging from staff and management interviews pointed to several areas for further improvement:

- Developing a more structured joint process where CCP Japan and NISCVT systematically assess staff capacity needs at the start of each project cycle.
- Expanding opportunities for specialized training in areas such as autism, ADHD, and speech therapy.
- Extending the duration of support to beneficiaries receiving MHPSS interventions was highlighted as a need by staff and families, particularly for children with severe psychological or behavioral challenges. While many show progress within six months, complex cases (e.g., trauma, severe anxiety, developmental or behavioral disorders) often require longer-term follow-up. CCP Japan and NISCVT acknowledge this necessity; however, under JPF’s single-year funding framework, outcomes must be demonstrated within a limited timeframe. As such, this point is best considered for future advocacy and resource mobilization beyond the scope of the current project.
- Strengthening staff care and burnout prevention measures.

Overall, CCP Japan is perceived not as a distant donor but as a collaborator and peer. The partnership enables adaptive capacity-building that responds to evolving needs, even if it is not systematized. As one staff member put it, “They trust us and stand with us. That trust gives us the confidence to improve our work and to keep asking what more we can do for the children and families.”

4.1.2 Roles and Responsibilities

The implementation of the CCP Japan project in Lebanon is anchored in a three-tiered partnership model involving CCP Japan Headquarters in Tokyo, CCP Japan’s Lebanon Office, and the implementing local partner NISCVT. Each actor contributes according to their comparative strengths: CCP Japan HQ ensures donor compliance and strategic oversight; CCP Japan’s Lebanon Office serves as the operational link and coordinator with NISCVT; and NISCVT implements the project directly within the camps. Importantly, CCP Japan is not legally registered in Lebanon. As the country’s complex and lengthy registration procedures make it extremely difficult for INGOs to obtain legal status. As a result, CCP Japan cannot directly implement projects. This makes the partnership with NISCVT not only strategic, but also essential from a legal and operational perspective.

4.1.2.1 CCP Japan Headquarters: Strategic Oversight and Donor Accountability

HQ holds contractual responsibility with JPF, manages financial compliance, and ensures alignment with CCP’s strategic priorities. Tokyo staff also provide donor reporting and guide the overall framework of the project. Their role is primarily one of accountability and governance.

4.1.2.2 CCP Japan – Lebanon Office: Coordination and Monitoring

The Lebanon Office has been critical for facilitating day-to-day coordination, organizing access for evaluations, and ensuring smooth communication with NISCVT. Staff from NISCVT consistently highlighted the responsiveness of CCP Lebanon: *“They are not only checking the numbers. They listen, they understand our context, and they support us when we raise concerns.”*

The added value of the Lebanon Office lies in the complementary roles of its staff. The local Lebanese colleague, who has worked with CCP Japan for many years, provides continuity and deep contextual knowledge. With her long-standing engagement in Palestinian camps, she maintains the institutional memory of projects, understands the evolving needs of target communities, and ensures effective follow-up with NISCVT staff. She also conducts regular field visits, observes activities, and serves as a direct bridge between implementation in the camps and CCP's oversight.

At the same time, the presence of Japanese colleagues in Lebanon ensures a strong link with CCP Japan Headquarters. They follow up on high-level discussions with NISCVT management and ensure that project requirements such as reporting, finance, procurement, and compliance with policies and procedures which are consistently applied. Their presence also reinforces CCP's identity as a Japanese organization, facilitating accountability to the Japanese public and government. Importantly, Japanese colleagues translate documents and interpret contextual issues into Japanese, which enables CCP HQ staff to clearly understand developments without language barriers and minimizes communication challenges related to limited internet connectivity or technical infrastructure in Lebanon.

Together, the combination of local expertise and Japanese staff presence strengthens both operational coordination in Lebanon and accountability to stakeholders in Japan, ensuring that the partnership functions effectively across contexts.

4.1.2.3 NISCVT (Beit Atfal Assumoud):

NISCVT assumes full responsibility for direct project implementation through its centers and dental clinics. This includes management of multidisciplinary teams such as psychologists, social workers, psychiatrists, speech and occupational therapists, as well as the training and supervision of mental health promoters. As the legally registered entity in Lebanon, NISCVT provides the essential legal framework for project implementation, without which the CCP Japan project could not operate in the country. Staff emphasized that CCP Japan respects NISCVT's autonomy and role: *"They are not supervisors. They are partners who trust us to do the work we know best."*

4.1.2.4 Communication and Coordination:

Communication channels between the three entities are well established, with the CCP Lebanon Office acting as the bridge. Regular reporting from NISCVT is consolidated by CCP Lebanon staff and shared with HQ for donor compliance. Staff at all levels described communication as open and constructive, though several suggested that joint reflection spaces could be formalized further. As one frontline staff member put it, *"We want more technical discussions, not only about numbers and reports, but about how to face the difficult cases."* By "difficult cases," staff were generally referring to situations in the field that are complex or sensitive such as families facing overlapping vulnerabilities, children with multiple protection risks, or cases that do not fit neatly into program criteria where they seek not only internal support from NISCVT but also technical guidance from CCP Japan.

Table 5: *Summary of Roles and Responsibilities:*

Function	CCP Japan Tokyo	CCP Japan Lebanon	NISCVT
Donor communication & compliance	✅		
Legal registration in Lebanon			✅
Operational Coordination		✅	
Day-to-day liaison with NISCVT		✅	
Project implementation			✅
Monitoring		✅	
Financial & narrative reporting	✅ (final submission)	✅ (review & support)	✅ (field-level reports)
Safeguarding & accountability	✅	✅	✅

4.1.2.5 Conclusion:

Overall, the division of roles and responsibilities between CCP Japan HQ, the Lebanon Office, and NISCVT has been clear and complementary, ensuring both donor accountability and effective service delivery. NISCVT provides the community-based implementation, CCP Lebanon Office coordinates day-to-day operations and monitoring, and CCP HQ oversees compliance and reporting to JPF.

The presence of Japanese staff in Lebanon has added further value by strengthening communication between field operations and CCP Japan HQ, ensuring consistency in reporting, finance, and compliance, and maintaining the image and accountability of CCP as a Japanese humanitarian organization. Japanese staff also play a key role in translating documents, interpreting local realities for HQ colleagues, and communicating contextual information to the Japanese public. Together with the local Lebanese staff member in the Lebanon Office who brings long-standing knowledge of the context and communities, this arrangement enables close coordination with NISCVT while ensuring alignment with donor requirements.

At the same time, the evaluation notes that Japanese staff face restrictions on camp access due to security regulations imposed by the Ministry of Foreign Affairs of Japan. These restrictions are part of the conditions for project implementation and apply across all Japanese-funded projects in Lebanon. Despite these challenges, CCP Japan has continuously sought to advocate through the Embassy of Japan in Lebanon for increased access, in order to strengthen accountability and visibility of project activities. It will remain important for CCP Japan to continue this advocacy while making the most of staff presence in Lebanon by conducting field visits when possible, maintain strong communication with partners, and effective reporting to donors and the Japanese public.

4.2 Relevance

4.2.1 Project Design Process and Stakeholder Involvement

4.2.1.1 Initiation and Strategic Direction

The project design process was initiated by CCP Japan, in line with its ongoing engagement in Lebanon and its long-standing partnership with NISCVT. The strategic direction was framed by CCP Japan Headquarters in Tokyo, which aligned the proposal with the Japan Platform (JPF) Iraq and Syria Humanitarian Crisis Response Program. Senior staff from CCP Japan explained that the design of this phase built upon earlier cooperation with NISCVT in mental health and dental services, with the aim of maintaining service continuity while also responding to the deteriorating socio-economic and protection environment facing Palestinian refugees in Lebanon.

CCP Japan took the lead in drafting the project proposal for JPF submission, ensuring compliance with donor requirements. However, the inputs and field-level data that informed the design came largely from NISCVT, which provided detailed descriptions of needs, service gaps, and beneficiary profiles. One CCP Japan staff member emphasized that “the project idea is always shaped together with NISCVT, because they are the ones who know the ground and have access to the communities.”

4.2.1.2 Partner-Led Design and Field Consultations

NISCVT played a central role in shaping the project design, drawing on its direct service delivery experience in centers and dental clinics across multiple camps. NISCVT senior management confirmed that they provided CCP Japan with updated statistics on service users, lessons from previous project phases, and emerging needs observed by frontline staff. As one manager noted, “We know what children and families are struggling with every day, and this is what we bring into the design process.”

Community needs were incorporated indirectly through this mechanism. While no standalone baseline survey was conducted prior to this project cycle, NISCVT staff relied on ongoing monitoring data, social worker case reports, and beneficiary feedback sessions to highlight pressing priorities. In addition, both CCP

and NISCVT staff referenced external assessments by UNRWA, UNICEF, and other agencies documenting rising poverty, mental health challenges, and gaps in dental care. These sources were used to validate NISCVT's observations and to strengthen the case for donor funding.

The design process itself was iterative. NISCVT staff shared inputs and draft sections with CCP Japan, who then consolidated and adjusted the proposal to ensure compliance with JPF requirements. Coordination took place primarily through email exchanges and online meetings, with CCP Japan's Lebanon Office facilitating communication and consolidating feedback. NISCVT staff confirmed that they were consulted throughout the drafting stage, even if the final submission process was led from Tokyo.

Overall, the project design was both **continuity-based and adaptive**: continuity, in that it maintained the provision of core dental and mental health services already supported by CCP Japan in earlier phases; and adaptive, in that it integrated new priorities such as expanded awareness-raising through trained mental health promoters, reflecting both NISCVT's field insights and the evolving crisis context in Lebanon.

4.2.2 Relevance of the Project for the Beneficiaries

It is important to note at the outset that the interviews conducted for this evaluation were primarily with mothers of children already referred to NISCVT centers by UNRWA schools or through word of mouth, given the centers' excellent reputation and the scarcity of comparable free services. Many families also sought dental care only when urgent problems could no longer be ignored. What is clear, however, is that all the families interviewed were facing acute needs in psychosocial and dental health, and their perspectives should not be assumed to reflect the broader Palestinian community.

4.2.2.1 General Needs of the Beneficiaries

Across all interviews and focus groups, beneficiaries consistently described facing multiple, overlapping challenges in their daily lives. Poverty was the dominant theme: most families reported living far below the poverty line, struggling to cover rent, food, transportation, and education costs. One mother explained, *"We worry first about how to feed our children. Every month is a struggle between paying rent or buying medicine."*

Health was another pressing concern. Families reported difficulties accessing affordable medical care, including basic pediatric services, dental treatment, and specialized mental health support. Chronic conditions, disabilities, and untreated dental problems were common, often worsened by financial constraints. Mental health was frequently mentioned in connection to children's stress, fear, and behavioral changes due to economic hardship and exposure to violence. A caregiver noted, *"Our children carry heavy worries; they feel the tension at home and at school. We need help to manage this."*

Education also emerged as a top priority. Parents expressed strong concern about their children's schooling, dropout risks, and peer influence in camp environments. Overcrowded housing and insecurity in camps contributed to psychosocial stress, while lack of safe recreational spaces left children more exposed to negative coping mechanisms.

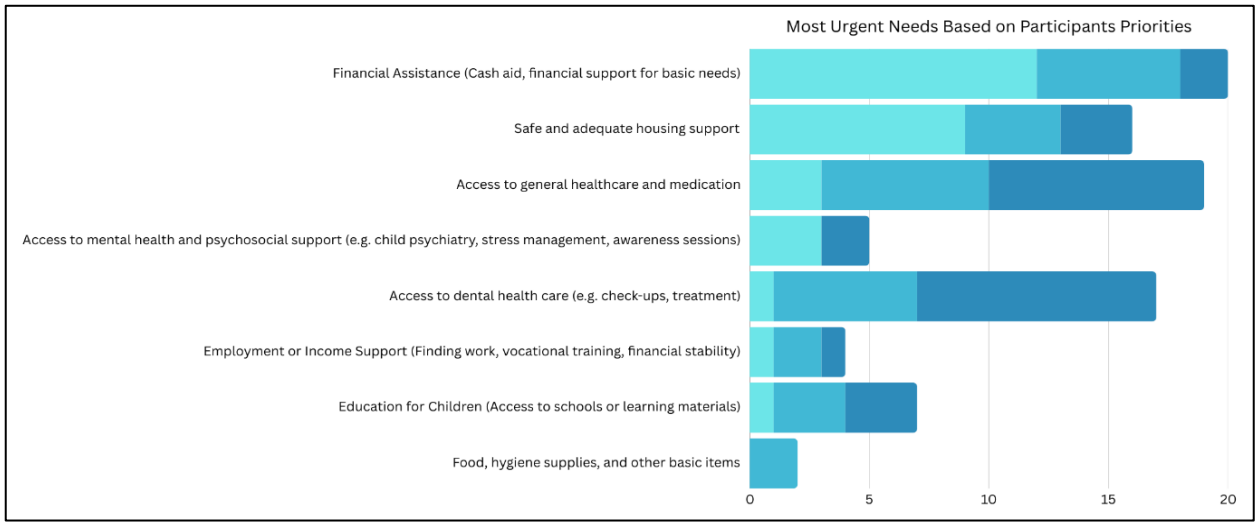
Overall, families portrayed their lives as a daily balancing act between survival needs (food, rent, medication), protection needs (safety and stability), and developmental needs (education and psychosocial well-being). Within this hierarchy, health services, including dental and psychosocial care, were viewed as critical but often inaccessible without external support.

4.2.2.2 Relevance of Dental Services

Dental services were described as **urgently needed but rarely accessible** without NISCVT's support. Parents reported that dental care is usually deprioritized in favor of food or rent, meaning problems accumulate until children are in severe pain. A mother explained, *"My son could not sleep from the pain. A private dentist was impossible for us. The clinic saved him."*

The relevance of dental services is also reflected in the beneficiary survey. Among 30 surveyed caregivers, when asked to rank their most urgent needs, **financial assistance emerged first, healthcare (general and dental combined) was second, and dental care specifically ranked third overall**. This finding reinforces the qualitative evidence that while survival needs such as food and housing dominate family priorities, access to dental health remains one of the top three urgent concerns, confirming that the program addresses a gap families could not otherwise cover.

Table 6: *Most Urgent Needs Based on Dental Care Services Beneficiary Survey*



NISCVT's dental clinics address a critical gap left by other service providers. While UNRWA covers basic dental care for school-aged children, **younger children in kindergarten receive no such support**. NISCVT fills this gap by ensuring that KG children, including those attending kindergartens run by other organizations, receive screening, treatment, and preventive care. This makes the service uniquely holistic and complementary.

The dental services were designed as **both treatment and prevention**, closely integrated with kindergartens. Children learned about oral hygiene while receiving check-ups and care, and teachers were also trained to reinforce healthy practices in classrooms. Over the years, this model expanded into fixed clinics and became a **core, holistic component of NISCVT's kindergarten programs**. NISCVT's dental services cover not only its own kindergartens but also those run by other organizations, ensuring that younger children, who are not covered by UNRWA dental care, can still access essential preventive and treatment services.

The Origins of NISCVT's Dental Services

The idea of providing dental care for Palestinian children in Lebanon dates back to the late 1970s. NISCVT's General Director, Kassem Aina, recalled how the initiative was inspired by his wife, a dentist, after observing preventive dental programs for preschoolers in Denmark. At that time, dental services in Palestinian camps were almost non-existent. NISCVT first launched **mobile dental units** to reach camps directly, before establishing its first permanent clinic in **Shatila camp.**

As recounted by NISCVT's General Director, *"It is not only treatment; it is education. Our clinics teach children and families how to prevent problems before they start."*

Beneficiaries confirmed this preventive value. Mothers noted improved hygiene practices at home, with children more aware of brushing and sugar intake, and in some cases correcting their mothers during brushing, highlighting the children's active role in reinforcing what they learned. External stakeholders echoed that very few actors provide free dental services in Palestinian camps, making CCP Japan - NISCVT's dental program an irreplaceable contribution.

4.2.2.3 Relevance of MHPSS Services

The MHPSS services offered by NISCVT were widely regarded as essential by beneficiaries, staff, and external stakeholders. Families emphasized the importance of addressing children's emotional and behavioral difficulties, often describing the services as a turning point not only for their children but for the whole family, as children's wellbeing had a direct impact on family dynamics and relationships. As one mother explained, *"I wanted my daughter to have someone professional to talk to, because at home we cannot always help her with her feelings."*

A major factor in the relevance of these services is the **referral pathway through UNRWA schools**. Teachers frequently refer children who present with learning difficulties, behavioral problems, or emotional distress. In some cases, schools request **IQ tests**, which NISCVT provides free of charge through its psychological specialists. These assessments are highly valued by parents, as the reports allow children to remain enrolled in mainstream schools rather than being diverted to UNRWA's special schools, which have limited capacity and are often avoided by families.

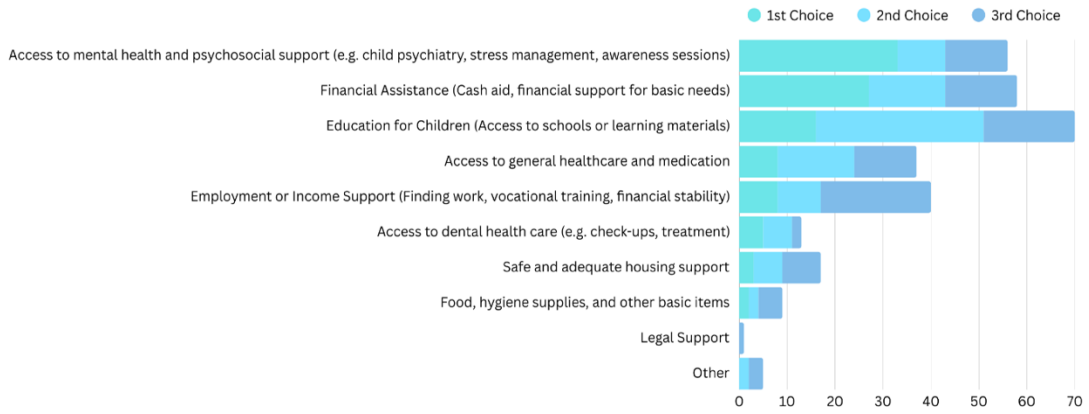
Multidisciplinary Approach to MHPSS

NISCVT's centers operate through a multidisciplinary model that brings together specialists in psychiatry, psychology, speech, psychomotor and occupational therapists. Weekly case meetings allow staff to jointly review children's situation, ensuring that interventions are tailored and integrated across disciplines. This collaborative approach enhances both accuracy of diagnosis and continuity of care, making the services highly relevant.

Beyond assessments, the strength of NISCVT's MHPSS program lies in its **multidisciplinary team of specialists**, which allows for a holistic response to children's needs. This team includes a psychiatrist, psychologists (including an IQ test specialist), two speech therapists, a psychomotor therapist, and an occupational therapist. Together they address developmental delays, speech and learning difficulties, behavioral challenges, trauma, and family stress. As one senior NISCVT staff member explained, *"What makes the program unique is the multidisciplinary team and the weekly case discussions. Every child is seen not just by one professional, but through a team approach that makes the intervention more holistic and effective."*

Survey data further validate the centrality of these services. Among 102 respondents, MHPSS support itself was ranked as the top priority by the largest share of families, ahead of financial assistance and education. As the mother of one beneficiary explained, *"We can always find some support to get food, but mental health services are extremely important as no one else can provide them."* Cumulatively, financial support and education followed closely, confirming the heavy weight of survival concerns but also demonstrating that psychosocial well-being is viewed as a core family priority, not a secondary issue. This reinforces the finding that, despite poverty dominating daily life, families consistently identify mental health care as indispensable for their children's ability to cope, learn, and thrive.

Table 7: *Most Urgent Needs Based on MHPSS Services Beneficiary Survey*



The relevance of these services is also reflected in the **high demand and long waiting lists**. Families and staff alike reported that many more children in the community need therapy than current capacity can cover. A psychologist noted that waiting lists are particularly long for children with speech and learning difficulties, highlighting the urgent need for expanded resources. Parents confirmed that seeing positive changes in their neighbors' and relatives' children often encouraged them to register their own, while stigma still deters some families. Mental health promoters and social workers emphasized that awareness campaigns have gradually reduced stigma, but demand continues to exceed supply.

Taken together, these factors underline the centrality of MHPSS services in the Palestinian refugee context. By offering free, specialized, and community-based interventions, NISCVT addresses needs that are not covered by UNRWA or other providers. As one senior NISCVT staff member explained, *"Mental health today is not secondary; it is a priority. The waiting lists at all our centers show how urgent and relevant this service is for families."*

4.2.3 Conclusion – Relevance

The evaluation finds strong evidence that the project is highly relevant to the urgent needs of Palestinian refugee families in Lebanon. Both dental and MHPSS components directly address gaps in services that would otherwise remain unmet, and are perceived by beneficiaries as essential rather than optional support.

For dental services, the program filled a structural gap by providing treatment and preventive care to **kindergarten-aged children not covered by UNRWA**, while also extending access to kindergartens run by other organizations. Families consistently described relief from severe pain, improved oral hygiene, and the importance of awareness sessions for children and parents. The historical roots of NISCVT's dental program, and its unique integration into kindergartens, underline its continued relevance in today's context where no other comparable free services exist.

For MHPSS, the services were equally indispensable. Families, schools, and external actors emphasized the critical role of NISCVT's **multidisciplinary team** in providing psychological assessments, counseling, therapy, and awareness sessions. The provision of free **IQ tests** ensured children's continuity in mainstream education, while referrals from UNRWA schools and long waiting lists demonstrated the scale of unmet need. The community-led awareness work of mental health promoters further confirmed the relevance of outreach activities in reducing stigma and broadening access.

External stakeholders, including UNICEF and UNRWA, validated that both dental and MHPSS services are rare yet essential in the Palestinian refugee context. The impact of the Gaza war and the recent escalation in Lebanon has only heightened the urgency, with children showing increased anxiety, aggression, and fear. Against this backdrop, access to specialized psychosocial care and basic dental treatment was described as a lifeline by parents and staff alike.

In sum, the project aligned strongly with beneficiary priorities by addressing both urgent health problems and longer-term psychosocial well-being. While poverty and survival needs dominate daily life, beneficiaries repeatedly confirmed that dental and MHPSS services are not secondary but **core to the dignity, health, and resilience of their families**.

4.3 Impact

4.3.1 Component 1: Dental Care Services

4.3.1.1 Access and Implementation Practices

Beneficiaries consistently reported that the dental services were **easy to access** in terms of location and language, since clinics were situated inside the camps and staffed by Arabic-speaking dentists and assistants. Waiting times varied: some parents noted that urgent cases were seen quickly, while others mentioned delays due to high demand. Despite this, families emphasized that they preferred waiting at NISCVT rather

than seeking costly private alternatives. *"Even if we wait, at least we know our child will be treated without asking for money we don't have,"* one mother explained.

Privacy and comfort were also highlighted. Parents described the clinics as hygienic and welcoming, with staff creating a reassuring environment for children. Mothers particularly valued that explanations were given clearly before and during treatment: *"The doctor explained each step to my son so he would not be afraid. They also told me what to expect after the filling."*

4.3.1.2 Satisfaction with Services

Satisfaction levels with the dental services were very high. Parents praised the professionalism of the staff, the cleanliness of the clinics, and the quality of the treatment. They appreciated being informed about procedures and options, with many noting this was different from their experience at private dentists. Several mothers said the trust they developed with staff was as important as the treatment itself: *"They treated us with respect, not as if we were receiving charity. That gave us confidence."*

4.3.1.3 Impact on Dental Health

Parents described clear improvements in their children's dental health after treatment. Many reported that pain was fully resolved, infections healed, and children were able to eat and sleep better. *"My daughter could not chew on one side before. After the filling she eats normally and does not cry from pain anymore,"* said one mother. While a few noted that problems sometimes reappeared if children developed new cavities, the overwhelming majority said the condition was **better than before** and treatment outcomes were positive. Importantly, no cases of serious complications after treatment were reported.

4.3.1.4 Behavioral and Preventive Impact

The **FGD with dental beneficiaries in Shatila** highlighted changes in family practices after awareness sessions. Parents described children brushing more regularly, using toothpaste, and even reminding siblings and parents about oral hygiene. One mother explained, *"Before, my children didn't brush. Now they remind me every night, and I bought them each their own toothbrush."* Mothers also reported adopting preventive habits themselves, such as reducing sweets in children's diets and planning regular check-ups.

Teachers in kindergartens, supported by dental staff, confirmed that awareness activities created a cultural shift toward prevention. Dental care was no longer seen as only emergency treatment but also as part of daily health practices.

The survey results provide further evidence of behavioral change. **Nearly half of respondents (47%) reported adopting new oral health habits at home after receiving dental services or attending awareness sessions**. Caregivers most frequently cited that their children began **brushing more often (14 mentions), showing greater awareness of healthy and unhealthy foods (10), and reducing sugar consumption (7)**. All respondents identified at least two positive changes. These quantitative results corroborate the focus group findings, where parents described children reminding siblings to brush or insisting on healthier food choices, showing that preventive impact is being sustained within households.

Table 8: *Changes in Caring for Teeth After Receiving Dental Services or attending an Awareness Session*

4.3.1.5 Counterfactuals and Alternatives

When asked what they would do if NISCVT's dental services were not available, almost all parents said they would either **go without treatment entirely** or rely on over-the-counter painkillers. A few mentioned private clinics but emphasized these were unaffordable: *"If this clinic did not exist, my child would suffer. Private care costs more than our monthly income."* This demonstrates the critical role of the program in ensuring access for the poorest families.

4.3.1.6 Field Staff Reflections

NISCVT dental staff and social workers highlighted that dental problems were among the **most visible and urgent needs** in the community. They described how untreated pain affected children's school attendance, concentration, and behavior, often leading to wider family stress. One staff member noted, *"When dental pain is treated, we see not just healthier teeth, but calmer families and children able to return to school."*

4.3.1.7 External Validation

External stakeholders reinforced the impact of the dental component. UNRWA staff acknowledged that their own dental coverage is limited to school-aged children, leaving younger children without services. UNICEF and other external actors pointed out that few humanitarian programs prioritize dental health, even though untreated conditions can contribute to malnutrition, speech difficulties, and systemic illness. In this context, the NISCVT–CCP Japan dental program filled a **critical service gap** while also setting a model for integrating preventive education with treatment.

4.3.1.8 Summary of Impact

Overall, the dental component of the project has had a clear and meaningful impact at multiple levels. Services were accessible and delivered with professionalism, with parents repeatedly emphasizing the hygiene of the clinics, the clarity of explanations, and the respectful treatment they received. The most immediate benefit was the relief of children's pain and infections, which allowed them to eat, sleep, and return to school more comfortably. For many families, this was described as a transformation in daily life, as the stress and anxiety caused by untreated dental problems affected not only the child but the entire household.

In addition to urgent treatment, the project also generated longer-term preventive impact. Through awareness sessions in kindergartens and direct counseling with parents, children developed healthier oral hygiene practices and began to take responsibility for brushing and diet. Mothers explained that these changes spread across households, with siblings and even parents adopting better habits. Teachers

confirmed that dental health became part of daily routines in classrooms, showing how the program influenced behavior beyond the clinic.

The project has also created important indirect benefits for the community. By employing Palestinian dentists and nurses, the clinics provide livelihood opportunities to highly educated professionals who are otherwise restricted under Lebanese law from working or opening their own practices. This not only helps sustain their professional skills and income but also builds an additional layer of trust with families, as community members feel more comfortable receiving care from professionals who share their lived experience and understand their daily realities.

Families were clear that, without these services, most would simply have gone without treatment or relied on painkillers, as private dental care remains far beyond their means. This counterfactual demonstrates that the project filled a gap that no other provider currently addresses, especially for younger children not covered by UNRWA. Staff reflections and external stakeholders reinforced this finding, emphasizing that the program not only prevents long-term complications but also serves as one of the very few accessible dental services available in Palestinian camps.

Taken together, the evidence shows that the dental component of the CCP Japan – NISCVT project was not only relevant to urgent needs but also delivered a significant and lasting impact. It relieved suffering, improved family well-being, strengthened community trust in services, and introduced preventive practices that will continue to benefit children and their communities in the future.

4.3.1.9 Key Recommendations for Dental Care Services

Interviews with beneficiaries confirmed their satisfaction with the quality and accessibility of dental services, but they also raised suggestions for improvement. Several parents noted that long waiting times could discourage families, especially when children were in pain, and recommended expanding clinic hours or adding more dentists where possible. Others emphasized the importance of continued awareness activities, asking for more frequent sessions on healthy diet, brushing, and preventive care, both in kindergartens and for parents.

From the perspective of NISCVT's dental staff, more structural and programmatic improvements were identified. Dentists highlighted the **urgent need to expand services geographically**, with one senior dentist recommending the establishment of a second clinic in Burj el-Barajneh camp to meet the growing number of children in need. Staff also noted that while beneficiaries occasionally request additional types of dental services, the CCP Japan supported project is designed to focus on emergency treatment and preventive care for kindergarten-aged children, where the gap left by UNRWA and other actors is most acute. Although this project focuses on emergency and the most urgent assistance within limited resources, staff suggestions highlight needs that could inform future advocacy and resource mobilization efforts beyond the scope of the current project.

Practical challenges were also underlined, suggesting that child-friendly adaptations of clinic environments such as waiting-room activities and gradual exposure methods, should continue to be strengthened to overcome children's fear of treatment remains a barrier

Finally, staff stressed that dental services should remain **free of charge and uninterrupted**, as families have no viable alternatives. As one dental staff member explained, *"If we stop, these children will simply not be treated. Their parents cannot pay, and the problem will only get worse."*

In summary, the main recommendations for dental services include:

- Expanding services to other camps, particularly Burj el-Barajneh.
- While the project prioritizes emergency and preventive dental care, staff suggestions to broaden the scope of services highlight needs that could inform future advocacy and resource mobilization.
- Maintaining and increasing preventive awareness programs for children and parents.
- Ensuring continuity and free access, given the lack of alternatives for refugee families.

4.3.2 Component 2: Mental Health Services

4.3.2.1 Access to Services

Beneficiaries generally reported that MHPSS services were accessible and welcoming. Family Guidance Centers (FGCs) were located inside or near camps, making them easy to reach. Sessions were delivered in Arabic, which parents appreciated for comfort and clarity. Privacy was highlighted as a strength; mothers felt that consultation rooms provided a safe and confidential space. Waiting times were sometimes long, especially for specialized therapies like speech therapy, but families said they were willing to wait because of the quality of services. As one mother explained, *"Even if it takes time, we know this is the only place where our child can get proper support."*

4.3.2.2 Satisfaction with Services

Parents expressed high satisfaction with both the professionalism of staff and the clarity of explanations they received. They consistently said staff explained the goals and steps of therapy in simple language, helping them understand how sessions would benefit their children. Mothers emphasized that staff followed up regularly and provided advice for home, which made them feel supported beyond the clinic. *"They don't just see my daughter and send her away. They tell me what I can do with her at home. That makes a big difference,"* one participant in an FGD said.

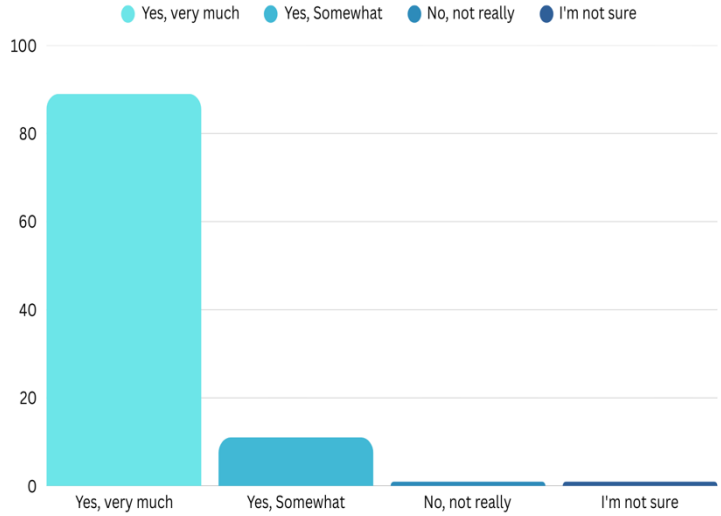
4.3.2.3 Impact on Children and Families

Families reported significant improvements in their children's behavior, emotions, and social functioning. Parents described children becoming calmer, more communicative, and better able to focus in school. One mother explained, *"My son used to isolate himself and refuse to go to school. After sessions, he is more confident and speaks more."* Another mother said, *"Before, my daughter had constant nightmares. Now she sleeps peacefully most nights."*

Improvements extended beyond the child to the family as a whole. Mothers felt more hopeful and less overwhelmed, with some saying they could manage daily responsibilities more effectively. Fathers, though less directly engaged, also benefited when family tensions decreased. Several parents said that after receiving guidance, they changed their approach to discipline, shifting from shouting to listening and communicating.

The quantitative survey reinforces the qualitative testimonies. **87% of surveyed beneficiaries reported that their own or their family's emotional well-being was significantly improved** through the services, with a further 11% noting partial improvement. Parents highlighted that after receiving support, children were calmer, more communicative, and better able to manage emotions. This aligns with mothers' testimonies in interviews, such as "my daughter had constant nightmares, now she sleeps peacefully." The survey confirms that such positive changes were not isolated, but widely experienced across the 102 families who participated.

Table 9: *To what extent have the MHPSS services affected your or your family's emotional well-being or mental health?*



4.3.2.4 Changes in Behavior and Coping

Many parents said the services gave them new coping strategies for dealing with stress—both for themselves and their children. Mothers explained that they learned to talk with their children about emotions, provide

reassurance during times of stress, and manage their own frustration more constructively. *"When my son misbehaves, I used to only shout. Now I try to understand what he feels first,"* said one mother.

Survey results also underline the program's success in equipping both children and caregivers with coping mechanisms. **86% of respondents (88 out of 102) said they can now use helpful methods to cope with stress and difficult situations**, and **81 families reported feeling more able to handle emotional or stressful situations** after receiving support. Importantly, the impact cascaded beyond individual families: **92% indicated they often or sometimes shared what they learned with others in their family or community**, demonstrating a multiplier effect of the program. These quantitative results echo mothers' narratives that they shifted from "shouting to listening," and that children became more confident in expressing feelings.

Table 10: *After attending an MHPSS session or receiving support, did you notice any changes in how you or your family cope with stress or difficult situations?*

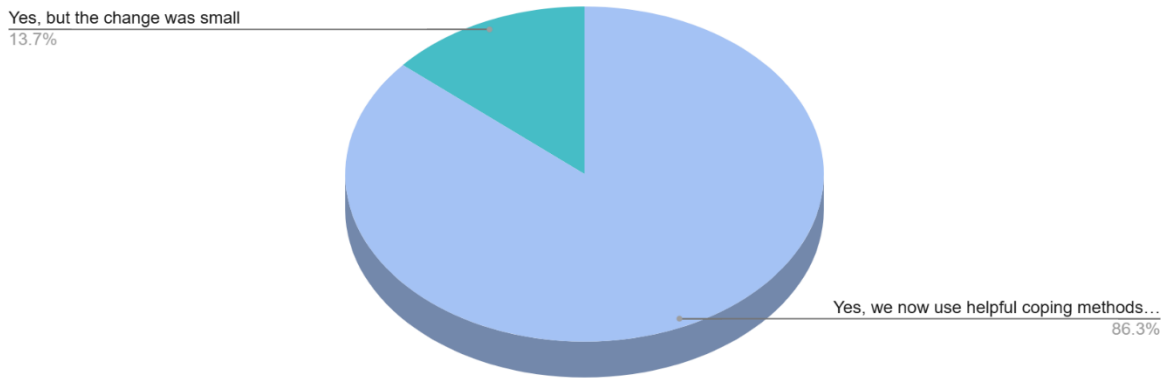
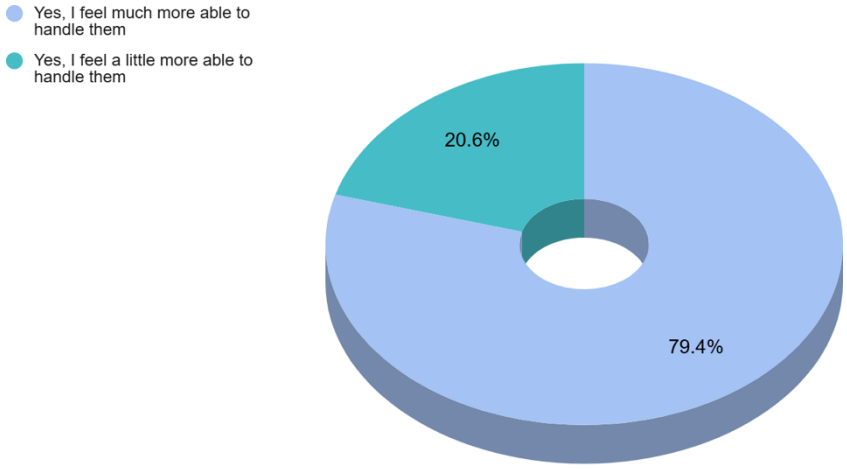


Table 11: *Do you feel more able to handle emotional or stressful situations after participating in the MHPSS services?*



4.3.2.5 Community Reaction and Stigma

Social stigma around mental health remains a barrier, but staff and families observed a clear shift toward greater openness. Parents noted that seeing improvements in neighbors' or relatives' children encouraged them to seek support themselves. *"At first my husband refused. But when he saw our neighbor's child improve, he agreed,"* a mother reported. Staff said that referrals from UNRWA schools remain a strong driver of participation, while awareness-raising sessions by social workers and promoters help reduce stigma over time.

While social stigma around mental health remains a barrier, families engaged in MHPSS demonstrated strong acceptance, prioritizing their children's wellbeing over social perceptions. Parents noted that seeing improvements in neighbors' or relatives' children encouraged them to seek support themselves. As one mother explained, "At first my husband refused. But when he saw our neighbor's child improve, he agreed." Referrals from UNRWA schools and awareness sessions by social workers and promoters further reduced stigma. For parents already receiving MHPSS services, stigma was not a major concern, most caregivers, including fathers as mothers reported, understood the importance of mental health and valued access to professional support. However, fathers were often reluctant to come to the centers themselves; aside from some success stories, most preferred to remain in the background, though they expressed appreciation for the improvements in their children.

4.3.2.6 Staff Perspectives and the CCP–NISCVT Modality

A central strength of the MHPSS program lies in the **modality developed jointly by CCP and NISCVT**, which combines the technical expertise of a broad multidisciplinary team with the community-embedded role of Social Workers (SWs). Specialists such as psychiatrists, psychologists, speech, psychomotor, and occupational therapists provide highly technical interventions. These are then **reinforced and translated into daily practice by SWs**, who conduct home visits, follow up with families, and deliver practical suggestions.

During the field visits, evaluators observed the strong, friendly, and trusting relationships between SWs and families. Beneficiaries repeatedly emphasized that **trust in the SWs was the key reason they felt comfortable engaging in mental health services**. As one mother put it, *"We open our doors to them because they are from us, from the camp. They understand our life."* Because SWs are themselves Palestinian and part of the community, they are uniquely placed to gain insights into children's home situations and to reflect this back to the specialists, ensuring a holistic response. A senior NISCVT staff member summarized: *"The expert team gives the technical direction, but the social worker is the bridge. Without that bridge, the impact would not be possible."*

This modality has not only improved clinical outcomes but also reduced stigma and built long-term trust between service providers and the community, something that would be far more difficult for external or Lebanese NGOs to achieve at this level.

4.3.2.7 External Validation

External stakeholders reinforced these findings. UNICEF noted that Palestinian refugee children face particularly high levels of psychosocial distress due to poverty, overcrowding, and repeated exposure to violence. UNRWA staff emphasized that their capacity to provide psychosocial services is limited, making NISCVT's centers essential referral points. The recent escalation of violence in Gaza and southern Lebanon has intensified children's anxiety, with parents and staff reporting higher levels of fear, nightmares, and aggression. In this environment, the presence of trusted, accessible mental health services was described as more vital than ever.

4.3.2.8 Summary of Impact

The evidence demonstrates that the MHPSS component of the project produced substantial benefits for children and families including improvements in family dynamics and couple relationships. Services were accessible, clearly explained, and delivered with professionalism. Families reported improved emotional well-being, reduced behavioral problems, and greater resilience in daily life. The unique **CCP Japan –NISCVT modality**, combining highly technical expert support with the trusted interface of community-based SWs, has been a decisive factor in the program's impact. This dual approach ensured both the depth of specialized therapy and the breadth of community trust, making services more acceptable and effective. External actors validated these findings, noting that in the current environment of heightened insecurity, such services are not just relevant but indispensable.

4.3.2.9 Key Recommendations for MHPSS Services

Beneficiaries expressed high satisfaction with the MHPSS services, but they also raised several suggestions for improvement. Many parents noted that waiting lists for specialized therapies, especially speech and occupational therapy, were long and at times discouraging. They recommended expanding the number of specialists or clinic hours to reduce delays, particularly for younger children in critical stages of development. Mothers also emphasized the importance of continuing awareness sessions for parents, asking for more frequent workshops on stress management, child behavior, and coping strategies that they can apply at home.

From the perspective of NISCVT staff, structural and programmatic improvements were identified. Senior staff underlined the importance of further investing in **specialized technical training** for psychologists, social workers, and therapists, particularly in areas such as autism spectrum disorders, ADHD, and trauma-focused care, where demand is increasing. They also highlighted the need to enhance outreach to fathers and male caregivers, and to develop creative strategies and stronger advocacy to engage them, as they are often less involved in psychosocial support. Increasing fathers' participation would help strengthen the impact of MHPSS on entire families.

Staff and families also raised the issue of duration of support. While many children improve within six months, complex cases such as trauma, severe anxiety, or developmental and behavioral disorders often require longer follow-up. CCP Japan and NISCVT recognize this need but clarified that, within the JPF framework, support must be provided within a single-year cycle and tied to outcome indicators. For this reason, the issue of extended or repeated care is best approached as a topic for future advocacy and resource mobilization, beyond the scope of the current project.

Social workers, who play a bridging role between technical experts and families, stressed that their workload is heavy and emotionally demanding. They recommended more support for **staff care and supervision**, to reduce burnout and maintain service quality. They also emphasized the need to strengthen home-visit follow-ups, which parents described as one of the most valued aspects of the program. As one mother explained, *"The visits to my home helped me trust the process. It showed me they cared not just about the child in the center, but about our whole family."*

Finally, both staff and families stressed the importance of maintaining services free of charge and uninterrupted. With limited alternatives in the camps and persistent stigma around seeking mental health care in private settings, NISCVT's centers remain the only realistic option for most families. A senior NISCVT staff member summarized, *"If we stop, the children will not find this support elsewhere. What we built here cannot easily be replaced by another organization."*

In summary, the main recommendations for MHPSS services include:

- Expanding service capacity to reduce waiting lists, especially for speech and occupational therapy.
- Strengthening technical training and supervision for staff in specialized areas such as autism, ADHD, and trauma.
- Increasing outreach to fathers and wider family members to enhance family-level impact.
- Addressing the need for extended or repeated support in complex cases through advocacy and resource mobilization beyond the current JPF framework.
- Providing staff care and support to address workload and prevent burnout.
- Continuing and expanding awareness sessions to strengthen coping strategies at home.
- Ensuring continuity and free access to services, as families have no viable alternatives in the camps.

4.3.3 Component 3: Capacity Building of the Communities on Mental Health

4.3.3.1 Implementation Practices

The MH promoter model was built on the principle of selecting trusted community members, mainly mothers of children who had received or were receiving MHPSS services. This ensured that promoters could speak from personal experience while being backed up with technical information. Promoters consistently described that their involvement began with a **selection process based on motivation and community standing**, followed by structured **training sessions** led by NISCVT psychologists and social workers.

The training covered topics such as stress management, child protection, bullying, parenting, and mental health awareness. Promoters highlighted that what made the training effective was the **practical and participatory approach**, where they could share their own stories as mothers while learning technical knowledge to present to others. *"They gave us the information, but also encouraged us to speak about our own lives. That is why people listen to us,"* one promoter explained.

Preparation and delivery of awareness-raising sessions were carried out with close support from NISCVT staff. Promoters emphasized the role of **social workers and psychologists in guiding them step by step**—helping them design sessions, preparing materials, and debriefing after each activity. Several noted that without this ongoing guidance, they would not have felt confident to lead sessions on their own.

4.3.3.2 Support from NISCVT Staff

The role of NISCVT staff, particularly social workers, was described as **critical for building confidence and capacity**. Promoters reported that SWs not only provided technical input but also accompanied them during home visits and community sessions, ensuring credibility and helping manage difficult questions. As one promoter put it, *"When I felt nervous, the social worker was there. She supported me and made sure I could continue."*

This close mentorship was cited as one of the main strengths of the program. It allowed promoters to gradually step into leadership roles, while ensuring technical accuracy and safeguarding principles were maintained.

4.3.3.3 Impact and Community Reaction

Promoters and participants alike reported that the awareness sessions had a **positive effect on communities**. Families became more open to discussing stress, children's emotions, and parenting practices. One promoter noted, *"At first people laughed when we talked about stress. Now they ask questions and want to know how to deal with it." Another beneficiary shared, "We are practicing breathing activities when we feel stress, and we are encouraging our children to do the same," and many others confirmed adopting similar coping techniques introduced through the awareness sessions.*

Because promoters were themselves mothers from the camps, their personal stories made the sessions relatable and credible. This peer-to-peer approach significantly reduced stigma: families that might resist professional intervention were more willing to listen to someone from their own neighborhood. Promoters also identified families in distress and referred them to NISCVT centers, strengthening the referral pathway between the community and specialized services.

As repeatedly emphasized by NISCVT staff and promoters during interviews, the program's effectiveness rests on a chain: **experts provide the technical knowledge, social workers build trust with families, and promoters extend this impact deep into the community**. Together, these layers ensure that specialized support does not remain within the clinic but reaches families and neighborhoods at the very core of camp life.

4.3.3.4 Challenges

Promoters acknowledged challenges, particularly in overcoming stigma and reluctance to participate in sessions. Some families still feared being judged if they attended activities related to mental health. Confidence-building among promoters themselves was also an initial challenge; several said they needed repeated practice before feeling comfortable speaking in front of groups. Preparing materials and adapting them to different audiences was another difficulty, though mitigated by ongoing SW support.

4.3.3.5 Summary of Impact

The MH promoter approach expanded the program's reach from the clinic to the **very core of the community such as extended families, neighbors, and peer networks**. It created a bridge between professional expertise and community realities, ensuring that mental health awareness was not confined to service centers but spread organically within daily life. The fact that promoters were mothers with lived experience gave authenticity to the sessions, while the backing of NISCVT's technical staff ensured accuracy and continuity.

The model demonstrated that capacity building at multiple levels, technical specialists, community-based social workers, and grassroots promoters, can reinforce each other to generate a **larger impact than any single layer alone**. Families reported greater openness to seeking support, reduced stigma, and improved knowledge of how to manage stress and children's emotional needs.

4.3.3.6 Key Recommendations for MH Promoter Work

Beneficiaries and promoters themselves expressed high appreciation for the MH promoter model, while also offering suggestions for strengthening its effectiveness. Promoters consistently noted that their training was useful and that the ongoing support of social workers was essential for building their confidence. Several highlighted the need for **more structured support in preparing materials** and additional guidance on facilitation skills to feel more confident when leading sessions. Mothers attending sessions also asked for **more frequent awareness activities** on parenting, stress, and children's emotional well-being, noting that these topics resonated strongly with their daily concerns.

From the perspective of NISCVT staff, the promoter model is a cornerstone of the broader CCP - NISCVT approach because it brings mental health awareness into the most intimate spaces of camp life. Staff emphasized that promoters' personal stories resonate strongly with other families, helping to overcome stigma and encouraging earlier referrals to Family Guidance Centers. They recommended providing **refresher trainings** and adding new modules on trauma, adolescent mental health, and stress management so promoters can respond to evolving community needs.

An additional dimension raised by both promoters and staff is the **economic empowerment aspect** of this role. Promoters receive modest financial compensation, which for many women represents their first independent income. This was described as giving mothers both confidence and valuable short-term work experience. As one promoter explained, *"For the first time, I feel what it means to earn something myself."* This dual benefit, social empowerment through community leadership and personal empowerment through income, was seen as an important outcome of the model.

From the perspective of the **evaluation team**, however, the number of promoters remains limited relative to the scale of community needs. Expanding the number of promoters in future phases would allow for broader community coverage and help sustain awareness-raising beyond the project duration. This observation is supported by the fact that promoters often rely on their extended family and neighborhood networks, but the current small group cannot reach all areas consistently.

In summary, the main recommendations for MH Promoter work include:

- Providing refresher trainings and specialized modules (e.g., trauma, adolescent mental health, stress management).
- Strengthening material preparation, use of visual material support and facilitation skills support for promoters. Continuing close mentorship by social workers to ensure technical accuracy, confidence, and safeguarding.
- Retaining mental health promoters beyond a single cycle of implementation, building on their expertise to scale the initiative (currently they usually work for a limited period and then stop, in order to give the newcomers the opportunity to benefit).
- Recognizing the added value of modest compensation, which not only motivates promoters but also contributes to women's economic empowerment and independence.
- (Evaluation team observation) Expanding the number of promoters to widen community coverage and sustain long-term impact.

4.4 Sustainability

The sustainability of the project's outcomes and approaches can be assessed across several levels: the long-standing partnership between CCP and NISCVT, NISCVT's institutional commitment to holistic services, the ripple effect at the community level through promoters and awareness work, and the prospects for future funding and donor diversification.

4.4.1. Partnership between CCP Japan and NISCVT

The collaboration between CCP Japan and NISCVT has been one of the most enduring features of the project. Both partners emphasized that their relationship goes beyond donor–recipient dynamics and is grounded in trust, shared values, and decades of joint experience in the Palestinian camps of Lebanon. This strong institutional partnership has been a key factor in the project's continuity over multiple phases. Staff from both organizations confirmed during interviews that CCP is seen not only as a funder but as a partner that provides stability and strategic continuity. The longevity of the partnership is itself an asset for sustainability, as it allows both organizations to build on institutional memory, established systems, and tested modalities.

4.4.2. NISCVT's Institutional Commitment and Complementary Programs

Even beyond CCP funding, NISCVT has a track record of sustaining its core services, particularly dental and MHPSS, through other donor partnerships. Staff highlighted that dental and psychosocial support have long been pillars of NISCVT's holistic approach to child well-being, integrated with its kindergartens and family guidance work. NISCVT expressed willingness to continue these activities as much as resources allow, underscoring that the complementary design (linking dental, psychosocial, education, and awareness) is too valuable to abandon. Evidence from KIIs and FGDs confirmed that this integrated model is now seen as part of the organization's identity, not just as a donor-driven project.

A concrete example of this institutional anchoring came from the UNICEF key informant interview, UNICEF has recently selected NISCVT as one of its partners for the **Mekani Program**, citing the holistic community-based model as a strength. According to the evaluation team, CCP's long-standing investment in strengthening NISCVT's programs was an enabling factor that contributed to this recognition and partnership expansion. This demonstrates that donor diversification, anchored in NISCVT's reputation, is already taking place.

4.4.3. Sustainability from the Perspective of Beneficiaries

From the perspective of beneficiaries, the sustainability of services is viewed differently across components. Families consistently expressed concern that without external support, they would have no alternative for specialized dental or MHPSS services, as private care is unaffordable and UNRWA coverage is very limited. However, the **mental health promoter model** has left a deeper mark in terms of community ownership.

Promoters themselves described gaining confidence, skills, and recognition that extend beyond the duration of the project. Mothers attending awareness sessions said that promoters' personal testimonies helped reduce stigma and encouraged them to seek support.

This ripple effect, spreading knowledge, normalizing conversations about mental health, and embedding awareness at household and neighborhood levels, was highlighted by both promoters and staff as one of the most sustainable aspects of the project. Promoters also emphasized that they felt equipped to continue sharing knowledge in their communities, though they would require periodic technical refreshers and support to stay confident and accurate.

The Ripple Effect of Mental Health Promoters
One of the clearest signs of sustainability identified during the evaluation is the ripple effect created by the mental health promoter model. Mothers who were once service users became promoters, sharing their personal stories with neighbors and relatives while delivering awareness sessions backed by technical guidance from social workers and psychologists. This peer-to-peer approach reduced stigma, encouraged families to seek professional support, and created lasting community resources. The MH promoter model shows potential to **sustain impact at the community level** long after project funding ends.

4.4.4. Future Funding and Strategic Outlook

As this was the last phase under JPF funding, the sustainability of activities now depends heavily on CCP Japan's ability to diversify its fundraising base. It is important to note that the shrinking of available funding poses a challenge to all actors. However, while NISCVT is well positioned to continue attracting some donors thanks to their well-established programs and wider network of partners globally, CCP's role in Lebanon requires a clearer strategy.

From the perspective of the **evaluation team**, CCP Japan would benefit from investing more systematically in **campaigns and public fundraising in Japan** to build a stable source of unrestricted income for its Lebanon program. This approach could complement efforts to secure institutional donors in Japan and internationally. Building on the visibility created by the long-standing NISCVT partnership, CCP could position itself as a trusted intermediary that channels support from Japan to locally embedded Palestinian institutions.

4.4.5. Conclusion on Sustainability

In conclusion, while the dental and technical MHPSS services cannot be sustained without external funding, the program has created **pathways of sustainability at multiple levels**:

- The CCP - NISCVT partnership, anchored in decades of trust and collaboration.
- NISCVT's institutional commitment to holistic programming, now recognized by other donors such as UNICEF.
- The ripple effect of mental health promoters and reduced stigma, embedding awareness in households and neighborhoods.
- The potential for CCP to strengthen fundraising in Japan and diversify its donor base to secure continuity.

The evaluation finds that the project's design, linking high-level expertise with social workers and community promoters, has not only produced immediate outcomes but also built lasting structures of trust and knowledge that can sustain impact well beyond the current funding phase.

4.5 Accountability to Affected Populations

4.5.1. Feedback and Complaint Mechanisms

Across KIIs and FGDs, it emerged that NISCVT has **informal but functioning channels** for feedback. Most beneficiaries said they felt comfortable raising concerns directly with **social workers** or other frontline staff, as they had built trust and frequent contact with them. Several mothers emphasized that the close

relationship with staff made it easier to share complaints: *"We see them every week. If something is wrong, we tell them."*

However, very few families reported being informed of **formal complaint procedures** (such as written mechanisms or complaint boxes). Most feedback is shared verbally during sessions, home visits, or at the clinic. While this allows for responsive follow-up, some beneficiaries pointed out that a more **anonymous option** could encourage participation, especially for sensitive topics. In one FGD, mothers explained that they would feel more comfortable if there were a **suggestion box or a phone line** for complaints, since not everyone wants to speak face to face.

From the staff side, NISCVT confirmed that feedback is usually addressed immediately through discussion with the relevant staff member or manager. When issues are raised, they are handled internally, though systematic documentation of complaints was not reported.

The online survey conducted with Dental Care Beneficiaries, confirms that, out of the 30 dental beneficiaries who completed the survey, **25 reported being informed about how to provide feedback**, and all respondents said they felt comfortable doing so. When asked about preferred mechanisms, **77% indicated a suggestion box**, while **23% preferred raising concerns directly with staff**. Three respondents had already provided feedback, and each reported that their concerns were addressed satisfactorily. These findings highlight both the trust families place in NISCVT staff and the opportunity to strengthen accountability through more formalized and anonymous feedback channels, such as suggestion boxes, which were strongly preferred.

The MHPSS beneficiary survey confirmed these findings: while most families felt able to raise issues directly with trusted staff, **only a minority were aware of any formal feedback procedures**. Respondents emphasized their reliance on informal, relationship-based channels, consistent with the strong trust described in KIIs and FGDs. At the same time, families indicated that **anonymous options such as suggestion boxes or hotlines would increase comfort**, particularly for sensitive complaints.

4.5.2. Comfort in Expressing Concerns

Most beneficiaries indicated they felt comfortable sharing concerns because of the **trusting relationships with NISCVT staff**. Many described staff as approachable and respectful: *"They listen to us, not only about the child but about the family situation."* Still, there were some barriers. A few mothers admitted they had **never been informed directly** about how to provide complaints, and therefore relied on personal initiative. Others said they would hesitate to complain if the issue was about a staff member they interacted with regularly, fearing it might affect the support their child receives.

This indicates that while **trust and proximity** are strong enablers of accountability, there remains a need to **formalize safe channels** that do not depend entirely on individual relationships.

Online survey results showed that **the majority of beneficiaries felt comfortable sharing concerns informally**, largely due to the approachability of NISCVT staff. However, the lack of structured information about how to give feedback means that comfort is dependent on individual relationships rather than institutional systems.

4.5.3. Respect, Privacy, and Safety in Services

Beneficiaries and staff consistently highlighted that services were delivered with **respect, privacy, and confidentiality**. Mothers reported that consultations took place in private spaces where they felt safe to speak freely. They also said that information about their children was not shared outside the sessions. Social workers and psychologists confirmed that they place a strong emphasis on creating safe spaces and respecting confidentiality.

Although terms like *"safeguarding"* or *"PSEAH"* were not mentioned explicitly by staff or beneficiaries, the practices described and observed during fieldwork; confidentiality, respect for families, privacy of sessions,

and sensitivity to children's needs, are consistent with safeguarding principles. Importantly, **no complaints of misconduct or breaches of confidentiality** were reported by beneficiaries, staff, or CCP during this project phase or in past phases.

4.5.4. Beneficiary Perspectives on Improvement

Beneficiaries provided concrete suggestions on how accountability could be improved. The most frequently mentioned ideas included:

- Establishing **anonymous feedback boxes** in clinics and centers.
- Providing a **phone number or WhatsApp line** for complaints.
- Ensuring beneficiaries are **regularly informed** about how to give feedback during awareness sessions.
- Creating **feedback sessions with parents** every few months to discuss progress and challenges collectively.

Mothers also stressed that accountability is not only about raising complaints, but also about being kept informed. As one participant explained, *"It helps when they tell us what will happen next, what kind of therapy, what steps. We want to feel part of the process."*

When asked for suggestions, online survey respondents echoed FGD findings: they recommended **introducing anonymous mechanisms** (e.g., suggestion boxes, WhatsApp lines), **regular reminders during awareness sessions** about how to provide feedback, and **group discussions with parents** to share progress and concerns collectively.

4.5.5. Summary on Accountability

The evaluation found that **accountability is strongly rooted in trust-based relationships** between beneficiaries and NISCVT staff, particularly social workers. Families feel comfortable sharing concerns directly and see staff as responsive. However, accountability remains largely informal and dependent on personal relationships. There is limited evidence of structured or anonymous mechanisms, and many beneficiaries reported they were not explicitly informed about complaint procedures.

For sustainability and safeguarding, it is recommended that CCP and NISCVT:

- Formalize and communicate clear feedback channels (e.g., suggestion boxes, hotlines, regular parent meetings).
- Ensure beneficiaries are regularly informed about their right to provide feedback and complaints.
- Introduce simple mechanisms for documenting and reviewing feedback systematically.
- Strengthen safeguarding and protection oversight by aligning existing privacy and respect practices with formal safeguarding standards through training and periodic monitoring.
- Establish confidential, accessible reporting channels specifically for SEA, in addition to assigning female and male PSEA focal points, and regularly informing beneficiaries about zero tolerance for SEA and how to report safely.

5 Recommendations

The evaluation identified strong appreciation for both the dental and MHPSS components of the CCP Japan - NISCVT partnership, while also surfacing areas for improvement and opportunities for future programming. It is important to note at the outset that some of the recommendations voiced by beneficiaries, staff, and external stakeholders may go beyond the current financial or operational capacity of CCP Japan and NISCVT. Nevertheless, the evaluation team considers it valuable to document them in this report, as they reflect genuine demand from the community and provide insight into needs and aspirations that remain unmet. Capturing these perspectives not only highlights the relevance of the program but also offers direction for potential future resource mobilization and collaboration.

5.1 Dental Services

- **Expand geographic coverage**: Families and dental staff highlighted the urgent need for a second dental clinic, particularly in Burj el-Barajneh camp, to meet rising demand.
- **Broaden service scope (future advocacy)**: While the project rightly prioritizes emergency and preventive dental care for children within limited resources, staff and parents highlighted unmet needs beyond the current scope. These suggestions, although outside the focus of this project, could inform future advocacy and fundraising to address wider gaps in dental care.
- **Strengthen preventive education**: Parents asked for more frequent awareness sessions on diet, brushing, and oral hygiene, both in kindergartens and for parents. Teachers confirmed the positive impact of these activities and recommended their continuation.
- **Guarantee continuity and free access**: Families stressed that if dental services were interrupted, children would simply go untreated. Staff underlined that services must remain free and consistent to prevent long-term deterioration in children's health.

5.2 Mental Health and Psychosocial Support (MHPSS)

- **Reduce waiting lists**: Both parents and staff emphasized the need for more specialists or extended clinic hours, particularly for speech and occupational therapy, where demand far exceeds current capacity.
- **Strengthen technical training**: NISCVT staff recommended more advanced training for psychologists, social workers, and therapists in areas such as autism spectrum disorders, ADHD, and trauma-focused care.
- **Enhance family involvement**: Several staff highlighted the need to better engage fathers and male caregivers, whose participation remains limited but could strengthen family-wide impact.
- **Support staff well-being**: Social workers flagged heavy workloads and the emotional demands of their role. Staff care, supervision, and structured debriefing mechanisms should be expanded to prevent burnout and maintain service quality.
- **Sustain awareness sessions**: Parents requested more frequent workshops on stress management, child behavior, and coping strategies. Awareness sessions should remain a core part of the program.
- **Maintain free access**: With no viable alternatives in the camps, families stressed the importance of keeping MHPSS services free and uninterrupted.

5.3 Mental Health Promoters and Community Awareness

- **Expand the promoter model**: Both staff and beneficiaries emphasized the effectiveness of the promoter approach in reducing stigma and reaching families at the neighborhood level. The number of promoters, however, remains too limited to cover all communities. Expansion in future phases would strengthen impact and sustainability.
- **Retain experienced promoters:** Promoters highlighted the need to work beyond a single cycle. Retaining them and building on their experience would allow scaling of both content (by adding new topics) and coverage, while also enabling experienced promoters to mentor new ones and support their development.
- **Provide refresher trainings**: Promoters requested additional sessions on trauma, adolescent mental health, and facilitation skills to keep their knowledge updated and confidence high.
- **Strengthen material preparation support**: Promoters noted that preparing materials for awareness sessions was a challenge; more structured guidance would enhance quality and consistency.

- **Recognize empowerment aspects**: The modest compensation for promoters not only motivates participation but also provides women with valuable work experience and confidence. This dual empowerment (social and economic) should be retained.

5.4 CCP Japan – NISCVT Partnership and Program Management

- **Systematic capacity review**: While the partnership is built on trust, it is suggested to have more structured joint assessments at the start of each project cycle to identify technical and capacity-building needs.
- **Clarify cost–benefit of expatriate presence**: Given restrictions on camp access for Japanese staff and the relocation of personnel during crises, CCP Japan should evaluate the added value of maintaining permanent staff in Lebanon versus organizing regular, well-planned field visits with special permits. CCP Japan should also advacate on accessibility to target project locations during the field visit.
- **Strengthen joint reflection spaces**: NISCVT staff suggested more opportunities for technical discussions beyond reporting, where difficult cases and evolving needs can be addressed jointly.

5.5 Sustainability and Donor Diversification

- **Invest in fundraising in Japan**: Several CCP informants acknowledged the need for stronger public campaigning and donor outreach in Japan to secure unrestricted income for Lebanon programs.
- **Leverage NISCVT's recognition**: NISCVT's recent partnership with UNICEF under the Mekani Program demonstrates the credibility of its holistic approach. CCP Japan can position itself as a bridge, highlighting its long-standing investment in NISCVT to attract additional donors.
- **Consolidate sustainable practices**: The ripple effects of the promoter model and reduced stigma around mental health should be reinforced as sustainable elements beyond direct donor funding.

5.6 Accountability to Affected Populations

- **Formalize feedback channels**: Beneficiaries suggested anonymous complaint boxes, hotlines, or WhatsApp lines to make feedback easier and more private.
- **Communicate rights clearly**: Families said they were not always informed about how to provide complaints. Regular awareness about feedback mechanisms and PSEA should be integrated into sessions.
- **Strengthen documentation**: Feedback and complaints are currently handled informally. Systematic documentation and follow-up would improve accountability.
- **Continue respectful, trust-based approaches**: Beneficiaries consistently praised the respectful, confidential, and approachable nature of staff. This trust must remain the foundation of accountability systems.

6 Annex List:

Annex 1: The Evaluation Matrix
Annex 2: List of Meetings Conducted During the Field Visit
Annex 3: Dental Care Services Beneficiary Online Survey Results
Annex 4: MHPSS Services Beneficiary Online Survey Results