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Impact of war on mental health of Syrian refugees in Southeastern Turkey - Northern Syria border

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I declare that the work contained in this assignment is my own, unless otherwise acknowledged. This study contains my personal perception and opinions that not necessarily reflect the opinion of the organisations here mentioned.

I want to dedicate this work to all the Syrians that, in spite of all the difficulties found on the way, are bravely giving a step forward on their journeys, so drastically modified by the stupidity of war. You are a life-long inspiration for me.

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ABSTRACT

Impact of war on mental health goes beyond direct exposure to violence and trauma-related consequences. With the conflict in Syria entering its 7th year and over 5 million of refugees, it is important for humanitarian aid providers to understand how it affects the mental health of Syrians living at both sides of the border. This professional work placement report retrospectively presents demographic and descriptive data of patients that attended individual counselling sessions in three border towns located in Turkey and Syria, from 2014 to 2016. Additionally, four mental health professionals currently working in the humanitarian response for the Syrian crisis were interviewed. The main complaint of 2,650 patients were analysed according to categories previously set by a data tool. Majority of patients were female (66%). The most reported complaint among all age groups were anxiety-related, while family-related being most common among women and physical complaints among men. The sources of anxiety among Syrian refugees were related to social and family factors present before and exacerbated by the war. Experience of conflict and violence, as well as forced displacement and the challenges of rebuilding life in a new environment were the other precipitating factors of anxiety. The social integration of Syrians in Turkey remains a challenge, as well as the strong stigma that affects access to care for both women and men.

Key words: humanitarian aid, mental health, refugees, Syria, anxiety.

RESUMO

O impacto da guerra na saúde mental vai além da exposição direta à violência e às conseqüências relacionadas ao trauma. Com o conflito na Síria entrando em seu 7^o ano e mais de 5 milhões de refugiados, é importante que os provedores de ajuda humanitária entendam como isso afeta a saúde mental dos Sírios que vivem em ambos os lados da fronteira. Este relatório profissional de colocação de trabalho retrospectivamente apresenta dados demográficos e descritivos de pacientes que participaram de sessões de aconselhamento individual em três cidades fronteiriças localizadas na Turquia e na Síria, de 2014 a 2016. Adicionalmente, quatro profissionais de saúde mental que atualmente trabalham na resposta humanitária para a crise Síria foram entrevistados. A principal queixa de 2.650 pacientes foi analisada de acordo com categorias previamente definidas por uma ferramenta de dados. A maioria dos pacientes era do sexo feminino (66%). A queixa mais relatada entre todas as faixas etárias foi relacionada à ansiedade, enquanto a relação familiar era mais comum entre as mulheres e as queixas físicas entre os homens. As fontes de ansiedade entre os refugiados Sírios estavam relacionadas a fatores sociais e familiares presentes antes e exacerbados pela guerra. A experiência dos conflitos e da violência, bem como o deslocamento forçado e os desafios de reconstruir a vida em um novo ambiente foram os outros fatores precipitantes da ansiedade. A integração social dos sírios na Turquia continua a ser um desafio, bem como o forte estigma que afeta o acesso aos cuidados tanto para mulheres quanto para homens.

Palavras-chave: ajuda humanitária, saúde mental, refugiados, Síria, ansiedade.

RESUMEN

El impacto de la guerra en la salud mental va más allá de la exposición directa a la violencia ya las consecuencias relacionadas con el trauma. Con el conflicto en Siria entrando en su séptimo año y más de 5 millones de refugiados, es importante que los proveedores de ayuda humanitaria entiendan cómo la guerra afecta la salud mental de los sirios que viven a ambos lados de la frontera. Este informe profesional de colocación de trabajo retrospectivamente presenta datos demográficos y descriptivos de pacientes que participaron en sesiones de asesoramiento individual en tres ciudades fronterizas ubicadas en Turquía y Siria de 2014 a 2016. Además, cuatro profesionales de salud mental que actualmente trabajan en la respuesta humanitaria para la crisis siria fueron entrevistados. La principal queja de 2.650 pacientes fue analizada de acuerdo con categorías previamente definidas por una herramienta de datos. La mayoría de los pacientes eran mujeres (66%). La queja más reportada entre todos los grupos de edad estaba relacionada con la ansiedad, mientras que la relacionada con la familia era más común entre las mujeres y las quejas físicas entre los hombres. Las fuentes de ansiedad entre los refugiados sirios estaban relacionadas con factores sociales y familiares presentes antes y exacerbados por la guerra. La experiencia de los conflictos y la violencia, así como el desplazamiento forzado y los desafíos de reconstruir la vida en un nuevo ambiente, fueron los otros factores desencadenantes de la ansiedad. La integración social de los sirios en Turquía sigue siendo un desafío, así como el fuerte estigma que afecta al acceso a los cuidados tanto para mujeres y para hombres.

Palabras clave: ayuda humanitaria, salud mental, refugiados, Siria, ansiedad.

1. INTRODUCTION

1.1. War and mental health

“According to virtually any metric, grave concern is warranted with regard to the high global burden of mental disorders, the associated intransigent, unmet needs, and the unacceptable toll of human suffering.” (Patel, Saraceno & Kleinman, 2006)

Beyond genetic and individual factors, mental health is directly affected by social, economic and physical environments—its so-called social determinants.¹ When thinking about the impact of war on mental health, one can intuitively say that people exposed to the daily atrocities of war might eventually face mental problems. The atrocities with potential harm to mental health include all sorts and levels of violence against the individual, his/her family and community. People have their homes destroyed, witness the killing of others, lose family members and beloved ones, witness their villages and cities being heavily shelled and encounter the risk of death and physical injury themselves. When forced to abandon their homes and migrate to other areas, other challenges arise regarding recovery and adaptation to the new context.

In fact, there is an extensive literature that relates war and violence on a mass scale to precipitating events for psychological stress, mental disorders and to the worsening of pre-existent mental health conditions. It is clear these conditions will require adequate treatment and support.² The World Health Organization (WHO) estimates that after a major disaster like war, the prevalence of mild to moderate mental disorders, including depression and anxiety increases by 15%-20% or more.³

Contrary to common-sense thinking, not everyone among those exposed to war will develop a mental disorder. Thus, the problems go much beyond the diagnosis of post-traumatic stress disorder, which is too often overestimated in comparison with other common mental disorders. Once considered among experts as the top diagnosis for people psychologically traumatised, PTSD is now claimed to be a category fallacy. The assumption of a major disaster as a traumatic event for everyone may lead to a premature causal relationship between the event and the development of the syndrome. Furthermore, it makes room for an indiscriminate pathologization of people’s experience in those contexts, as well as mislead to undue and simplistic generalisations.⁴

Especially a short time afterwards, people who have gone through life-threatening events commonly report problems, such as difficult grief, acute stress, anxiety, physical symptoms, enuresis in children, sleep problems, social isolation and family problems. For part of the affected population, these may be normal and transitory reactions to the distressful context. Once the precipitating event is over, these complaints usually disappear without becoming a pathology and with no specialised intervention. However, depending on context, individual factors, intensity and duration of the exposure, some people are at higher risk of

developing a mental disorder. These cases do require special attention from mental health service providers.

It is important to highlight that the problems of the refugee community do not end once they leave the war zone and cross borders into other countries. Usually, this is only the beginning of a long journey searching for a new life that includes several difficulties, including economical, cultural, legal and others. These factors, as mentioned, will ultimately affect mental health, sometimes in a harsher and more enduring way than the direct exposure to war itself. At this point, we must be careful not to classify the social suffering as a pathology, what Pusseti⁵ calls “the pathologization of the migration experience”.

According to global estimates, mental disorders account for 13% of the burden of disease, representing a significant cost for public health. However, Vigo et al. (2016)⁶ suggest that this percentage is underestimated by more than one-third; thus, real figures might be higher. Yet physical injuries, disabilities and deaths directly caused by war are responsible for less than 1%, which varies according to the country and the region of the globe. The burden of war is higher (4%) in the Eastern Mediterranean region, where historically many chronic conflicts stand.

Known as one of the most devastating armed conflicts in place today, the Syrian war must be studied regarding its consequences in relation to the mental health of the affected people. It is important to analyse the burden of depression, anxiety and other mental disorders before and after the war to obtain an accurate measure of the impact so we can design better programs to attend the needs. In the section “Background”, the country profile of Syria and its mental health burden will be presented. However, it is necessary to consider the difficulty in gathering good quality data from official sources in the current circumstances of civil war.

Epidemiological data collection during times of turmoil is quite challenging. Civilian registration systems are the first to break down and data reporting may not be a priority for those parties involved in the conflict. In such situations and for political reasons, governments may not be interested on reporting data, which is a clear limitation for reaching an accurate source of information. Many times, the only available data is the one collected by non-governmental organisations, which is restricted to certain geographical or political areas to which they have access.⁷ That said, the data collected by Médecins Sans Frontières (MSF) and its partners in the field, although limited by the mentioned circumstances, are important to be brought to light and this study intends to contribute to this knowledge.

As well documented by the United Nations High Commissioner for Refugees (UNHCR),⁸ most of displaced people and refugees live in low-income countries. The world faces an unprecedented 64.3 million people forcibly displaced from their homes. This is astonishing. As the numbers related to Syrian war will be shortly presented in the next section, it is fundamental that we do not forget the real people behind these numbers with their unique stories, emotions and trajectories.

We should also not forget the children that are malnourished because of food insecurity, which is caused by the disruption of the food market and economy inside Syria. Moreover, the women giving birth at home with no health and social support—literally in destroyed

apartments—because the health system has collapsed. Going to the hospital sometimes means having to pass through targeted areas for shelling—when the hospital is not the target itself. There are people getting sick because there is no proper water and sanitation in sieged areas controlled by a certain group or faction. There are elderly people unable to flee the neighbourhoods in conflict due to their physical impairment, increasing stress and reducing their chance of survival. And the list goes on.

A small boy gets a job in slavery conditions in a border town between Turkey and Syria because his father is dead and he feels now responsible for his family's livelihood. This is dramatic from both human and social perspectives, but is not considered a "health case" until the boy is burned in a labour accident and he is no longer able to sustain his family. Moreover, such a simplistic overview fails to mention the psychological consequences of such occurrence.

Only after a significant event does the dramatic human and social problems become also a health and mental health issue. Risk factors for many health problems and common mental disorders are highly associated with social inequalities. Therefore, beyond being a duty of human rights, intervening in these risk factors before the individual reaches this health loss phase is certainly a public health measure.

We must think about the impact of war on health beyond the number of direct injuries and deaths in the battlefield and the headlines on mainstream media. Quoting Miller and Rasmussen,⁹ "A comprehensive understanding of mental health in war-affected population settings must go beyond direct exposure to consider the diverse and indirect pathways by which conflict affects psychological wellbeing".

It is a challenge to measure this comprehensive impact of conflict and war in people's life, which may last for many generations after the conflict. Indeed, the population in transit may keep moving in a migration journey for years. Thus, health problems, if registered somewhere, will not be considered for epidemiological effects as a direct consequence of war even though they are indisputably a consequence of it.

Reliable data are difficult to collect and track in these contexts, which makes the problem invisible for the public, policy makers, public health professionals and civil society. A lack of awareness and empathy for these people's dramatic living also turns the migrant or refugee's experience into something more painful. Having to flee from home, passing through all kinds of misfortunes, to end up being invisible to the eyes of society must be quite disturbing, to say the least. This is what refugees are experiencing in many different contexts around the world, and this has repeated throughout history. Moreover, it is evident that this is a complaint we will continue to hear in our humanitarian clinics if we do not improve the visibility of the cause.

Additionally, migration still raises unfounded fears within host countries, resulting in an alarming failure of the states to welcome refugees in a decent way. As Saraceno¹⁰ indicated, it is necessary to deconstruct the paradigm of "migrant emergency" that recently spread xenophobic speeches in Europe and led to the closure of borders, as if the emergency itself was the arrival of the refugees to the European countries and not the events causing them to flee from their home countries.

The aforementioned points lead us to think that the impact of war on health in general and mental health in particular is not only dramatically underestimated, but also not well understood. The already existing stigma around mental health problems is added as a heavy burden to the refugee's fight against stigma for being a refugee. Worldwide, resources to treat and prevent mental disorders remain insufficient, inequitably distributed and inefficiently utilised. Although affecting poor populations the most, this happens in every context and country. As a consequence of this alarming invisibility and lack of empathy, communities maintain a barrier for improvement of their own well-being and mental health when denying dignity and respect to refugees.

With the office of the United Nations High Commissioner for Refugees (UNHCR) alerting to a lack of funds for Syria regional response,¹¹ it is not difficult to imagine that if the broader humanitarian aid for refugees is under budgeted, mental health resources are certainly even more distant from ideal considering the needs. In this case, advocacy is more than necessary, it is mandatory.

Fortunately, some progress has been made. Over the last decades, the Global Mental Health movement has given more visibility to mental health needs among different actors, such as communities, public health professionals and policy makers worldwide.¹² Important programs, such as mhGAP by WHO,¹³ have been launched to cover the unmet needs of mental health in the Middle East, as well as in other regions of the globe. In addition, more Mental Health and Psychosocial Support (MHPSS) programs have been integrated to the classical response of emergency aid, along with food distribution, shelter, sanitation etc.

The projects mentioned in this study are operated by MSF together with the Turkish organisation Support to Life and other partners in the field and are an example of such initiatives. Introducing the data and experiences of humanitarian organisations to the academic and public debate is one way to promote findings and good practices that have been developed in the field to improve visibility of the topic. Such discussions also provide opportunities to reflect and learn from these experiences for everyone involved, organisations, workers, academics and the public.

Yet, there is much to be done. There is an unacceptable toll of human suffering occurring even while we have sufficient evidence for cost-effective treatments that should be available for people who need it. This gap is a moral issue that should push us to think about ethics beyond the relation with each of our patients: we have a moral issue to be solved globally, starting within our communities.¹⁴

As a field worker, I would like to share my insights based on what I witnessed on a daily basis at the MHPSS programs for refugees at the Turkish-Syrian border between 2014 and 2016. This study is a report and record of this experience, which proposes to reflect critically on how conflict affects the mental health of people who are going through many challenges that go far beyond the war itself.

1.2. Background

1.2.1. Syrian Arab Republic country profile

Prior to the beginning of the conflict in March 2011, the Syrian Arab Republic, commonly referred to only as Syria, was a multi-ethnic lower- middle-income country with a high literacy rate, urban population and good health indicator performance.¹⁵

According to the Mental Health Atlas country profile of Syria, in 2014,¹⁶ the burden of mental disorders was represented by a loss of health of 2,785 disability-adjusted life years (DALYs) per 100,000 population. Each DALY means one healthy year lost, either by premature death or lived with disability, adjusted for the severity of the disability.

The country profile data published by WHO in 2011 indicates that the mental health system in Syria was, previously to the war, centred in psychiatric care at mental hospitals and outpatient facilities. In 2007, a national mental health policy together with a mental health plan proposed a shift of services and resources from mental hospitals to community mental health facilities that integrate mental health services into primary health care, as recommended by the WHO. Up to 2011, however, still 93.59% of the total mental health budget was assigned to the mental hospital expenditures. Although having authorisation to prescribe psychotropic medications, primary health care doctors were not trained to identify and treat mental disorders and did not use any referral system to and from secondary/tertiary care.¹⁷

1.2.2. The war (2011-)

The Syrian conflict started in the context of the Arab Spring, a popular movement that occurred across different Arabic countries, with its citizens going down to the streets to protest against corrupt governments and conquer democracy. The Arab Spring started in Tunisia in 2010 and spread to other countries in North Africa and the Middle East from 2011 onward.

In Syria, the unrest started in March 2011 with discontent civilians demanding political reforms by protesting peacefully in the streets of Damascus. These protests were violently repressed by Bashar Al Assad's government forces and rapidly escalated to an armed conflict. The first insurgent group formed to fight Assad's government was the Free Syrian Army. In time, other factions entered into the scene, forming a multi-sided fight. The main groups consist of the majority-Kurdish Syrian Democratic Forces, the jihadist groups represented by al-Nusra Front and the Islamic State of Iraq and the Levant (ISIL), also known as Islamic State of Iraq and Syria (ISIS), Daesh (its Arabic acronym) or only Islamic State. In 2014, the Western coalition formed by the North Atlantic Treaty Organization (NATO) members, which was headed by the United States, started to launch airstrikes against ISIS.

Already considered the worst man-made disaster since World War II, the war in Syria entered its 6th year in 2017. Out of a pre-war population of 22,505,091,¹⁸ half a million people

were killed, 6.3 million are now internally displaced—many fleeing inside the country from one area to another for the second or third time—and over 5 million became refugees, mostly in neighbouring countries like Turkey, Jordan and Lebanon.¹⁹ Turkey alone hosts 60% of all Syrian refugees who have fled abroad.

The UN, humanitarian organisations and the media also vastly documented the hundreds of thousands of refugees risking their lives in unsafe boats, sadly transforming the beautiful Mediterranean into the world's deadliest migration route. While closing borders may change the smuggled routes of migration, the war in Syria and the severe social problems that refugees suffer in the region persist, which have turned the agreement signed between the European Union and Turkey in 2016 a scandal. Instead of reducing the number of people risking their lives, it rather displaces and deepens the problem by trapping people in the war zone and neighbouring countries. The same outrageous strategies of containment were used in the recently imposed restriction of access of humanitarian ships to international waters off the Libyan coast in August 2017.

While borders are been closed, Syrians and other refugees and migrants fleeing war and famine have been arrested, extorted and raped—if they have not lost their lives on the way to these destinations.²⁰ Only a minority were safely resettled by UNHCR programs to the US, Canada, Australia and European countries. Still, they represent thousands of people who deserve the best of dignity in the countries to which they arrive.

The health system inside Syria suffered in many ways because of the war. Workforce flight, shortages of essential medicines and critical financing shortfalls are some of these aspects. Moreover, facilities have been either directly destroyed or disabled for lack of basic infrastructure, such as electricity and water supplies, leading to a dramatic scenario of up to 70% of its health facilities not functioning. Thus, with the fragmentation of the country by different ruling groups and enemies among each other, at least three parallel systems are currently in place, preventing the coordination of health response at a national level.²¹

As reported by Hoetjes,²² these constraints have been proven to affect health determinants and outcomes in Syria both directly and indirectly, ultimately changing the health needs and profile of the country. Similarly, the mental health needs of the population have certainly changed and, therefore, they must be understood to orient effective interventions.

1.2.3. Border cities of Kobane, Akçakale and Sanliurfa

The region consisting of the southeastern border of Turkey with northern Syria (Figure 1) has been dramatically affected by the on-going armed conflict in Syria. On the Turkish side, Sanliurfa, Hatay, Gaziantep, Kilis and Mardin are among the 10 Turkish provinces that host the most refugees, the region alone being responsible for half of the Syrians living in Turkey. Nationally, Istanbul has the largest refugee community and Sanliurfa (with a population of 1.940.627 in 2016), which has two of its districts in the scope of this study (Sanliurfa City and Akçakale), has the second largest. In August 2017, almost half a million (439,826) Syrians under

temporary protection of the Turkish government were living in Sanliurfa. Most struggle for a livelihood in the urban and rural areas of the province, whereas a minority (18%) live in the refugee camps provided by the Turkish government.²³



Figure 1: The border cities of Kobane in Syria, and Sanliurfa and Akçakkale in Turkey (Google maps).

Most Syrians have crossed the border into Sanliurfa on foot through its main gates in Akçakkale, which borders Tal Abyad in Syria and Suruç, which borders Kobane in Syria. The developments and impact of armed conflict in Kobane and Tal Abyad (within Raqqa Governorate) are of particular importance to explain such a concentration of refugees in the region. Sieged by the group ISIS during six months in 2014, Kobane witnessed violent clashes and massacres, displacing more than 400,000 people in a period of months. Kobane is a city of predominantly Kurdish ethnicity, with Arab, Turkmen and Armenian minorities. Sanliurfa city, which is inhabited by a majority of Kurdish, became a preferred choice for the Kurdish Syrians for settlement, whereas Akçakkale, a former Arab ethnicity stronghold, attracted Arab Syrians.

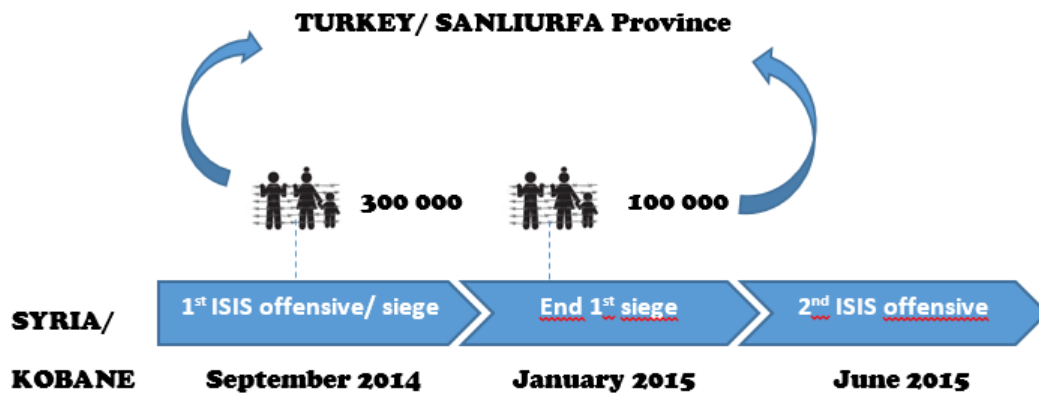


Figure 2: Timeline of the main events in Kobane affecting the influx of refugees into Turkey.

In January 2015, Kurdish forces backed by US-led airstrikes and opposition groups retook control of the city. Clashes again provoked an influx of refugees into Turkey, overburdening public structures and demanding a rapid response from Turkish government and non-governmental organisations, such as MSF. A second attack from ISIS to Kobane occurred in June 2015 with a massacre of civilians, which again prompted new influxes of people fleeing into Turkey, staying mainly in Sanliurfa Province and its districts.

1.3. Study context

This monograph is a professional work placement report of mental health and psychosocial support interventions performed in the context of humanitarian response to the Syrian crisis. The narrative is built upon the author's experience of two years as a mental health worker at the Turkish-Syrian border, from November 2014 to November 2016. This experience comprehended two phases: working as a national staff for the Turkish organisation Support to Life (STL) for one and a half years in Sanliurfa city, and working as an expat mental health officer for the international organisation MSF for four months in the same project in Sanliurfa city and Akçakale district, both belonging to Sanliurfa Province in Turkey.

STL and MSF are partners in the MHPSS project for Syrian refugees living in the urban settings since august 2014. While MSF provides financial and technical support for the project, the partner organisation is responsible for its complete implementation in the field.

The high number of people displaced by the violent clashes in Tal Abyad and Kobane from 2014 led many international and national organisations to provide emergency humanitarian response in the region. MSF, through its operational centre in Amsterdam, started its mission in 2013, named Turkey/ North Syria, in partnership with different organisations and local authorities. Included in the scope of this study are the projects developed by MSF in

partnership with the organisations Support to Life and International Blue Crescent in Turkey, and with Kobane Health Authority (KHA) in Syria.

The experience conveyed in the present dissertation reflects only part of the framework of humanitarian response provided by MSF, STL and International Blue Crescent (IBC) in the region.

MSF is a medical humanitarian organisation delivering emergency aid to people affected by armed conflicts, epidemics, healthcare exclusion and natural or man-made disasters. Founded in 1971, MSF operates programmes in 71 countries.

Support to Life is a humanitarian aid organisation delivering emergency relief aid since 2003 in different Middle East countries, with its current broader program in Turkey. Areas of intervention include shelter provision, food security, water and sanitation, child labour and psychosocial care.

International Blue Crescent is a relief and development foundation operating in the fields of relief and rehabilitation, housing and reconstruction, rural development, community development, education and health in different countries around the globe.

1.4. Objectives

The main objective of the present work placement report is to describe and discuss the impact of war on the mental health of Syrian refugees living in the border cities of southeastern Turkey and northern Syria. The specific objectives are:

- 1) Report demographic profiles of patients attending MHPSS services in three border towns (Kobane in Syria, Sanliurfa and Akçakale in Turkey) during the two-year period of 2014-2016;
- 2) Analyse the main presenting complaints and precipitating events as reported by patients attending individual counselling in the period;
- 3) Increase the visibility of MHPSS needs of Syrian refugees among field workers, policy makers, organisations and researches involved in humanitarian response.

2. METHODOLOGY

As a professional work placement report, the methodology of the present study has the following elements:

- 1) A descriptive narrative of the author's personal testimony and insights on the impact of war concerning the mental health of refugees, in the context previously detailed in the *Study Context*;
- 2) Presentation of demographic and descriptive data of patients attending individual counselling sessions and psychosocial activities at the three locations of MSF MHPSS project within the Turkey/North Syria mission. Data presented was retrospectively analysed from September 2014 to December 2016. From the beginning of each project until the end of 2016, 2,650 patients started counselling in the three locations. Data of 1,466 patients in Kobane, 800 patients in Akçakale and 384 patients in Sanliurfa were compiled. A detailed description of the data collected and its methods is presented below, as well as the main variables analysed.
- 3) Semi-structured interviews were conducted with one Turkish and three Syrian professionals working in the MHPSS services for refugees in the three different locations.

2.1. Data collection and ethical considerations

The dataset used to illustrate this dissertation is part of the database of MSF and was kindly shared by that organisation through a data-use agreement signed between MSF Holland and the author. The terms of use have, above all, the purpose of protecting the confidentiality of the patient as a core medical ethical principle.

The dataset is part of the regular data collection done as a routine task of the projects with the purpose of monitoring and evaluating (M&E) the program by its managers in the field and the headquarters. Therefore, none of the mentioned data was collected with the specific purpose of this study. Instead, retrospective data was analysed with the purpose of illustrating this narrative and providing insights on the topic of this report.

As per principle, no confidential information of patients, such as name, contacts and session content, were stored in the data tool. All digital information remains protected by password and accessible only to the project supervisor and the data encoder of each location. Instead of name, codes were attributed to each patient. Only the counsellor and supervisors had access to the complete files of the patients, which were stored in locked cupboards at each

location of the project. All patients were asked to give consent to have their contacts and names registered in the file.

The concern about confidentiality has special sensitivity in the humanitarian context, zones of conflict and politically unstable areas, such as Kobane and Tal Abyad (Syria). It is worth mentioning that high stigma present in such contexts is one of the barriers for people to access care. Particular is the situation of women and children who struggle to access care in a hostile environment where they tend to be isolated at home or at refugee camps. Being strict to confidentiality principles have been one of the key enablers to guarantee access to mental health and psychosocial care to the beneficiaries in such settings.

2.2. MHPSS data tool

The digital tool, here named “MHPSS data tool”, was developed by MSF Holland and shared with its partner organisations in the field who were co-responsible for data entering and reporting. Each team had one person assigned per location to complete data entering and reporting. The main sources of data entered into data tool were team reports and the patient files filled by the counsellors of the projects (see Annex 1). The main variables selected from the data tool to be presented here were:

- Age and gender of patients;

- Main presenting complaint, defined as the main reason reported by the patient to come to the counselling service, categorised by the counsellor into one of the 10 groupings according to the data tool and Mental Health Monitoring guidelines developed by MSF.²⁴ In the patient’s file, the wording of the patient to express his complaint is registered in the field “presenting problem” on page 2 of the form, and the correspondent code and category is chosen from a list with the types of complaints, located in the same section of the file. See patient file model in Annex 1. “Main presenting complaint” is categorised as follows:
 1. Age-related problems
 2. Physical complaints
 3. Social functioning
 4. Family-related problems
 5. Economic functioning
 6. Behaviour related
 7. Anxiety-related complaints
 8. Mood-related problems
 9. Loss/Mourning
 10. Other serious mental health condition(s)

For further specification of details of each complaint, a subdivision of the above categories must be registered through a code in the field “presenting complaint detailed code” (see subdivisions in Annex 2).

- Precipitating event, which is defined as the event that precipitates the main complaint, as reported by the patients and categorised by the counsellors into the following categories:
 1. Psychological violence (Intentional)
 2. Physical violence (Intentional)
 3. Intentional abuse during detention
 4. Sexual trauma or abuse
 5. Witnessing abuse, injury or death
 6. Deprivation and discrimination
 7. Domestic discord or violence
 8. Displacement, migration and related problems
 9. Separation and isolation
 10. Non-violence related
 11. OTHER
 12. Traumatic experience linked to natural disasters

The complete list of precipitating events, its details and codes can be consulted in Annex 3.

2.3. Interviews with staff in the field

A semi-structured interview was conducted with four mental health professionals currently working in the field within the humanitarian response for the Syrian crisis. The profile required was having at least one year of experience within the context as a national staff. See model of semi-structured interview in Annex 4.

The participants were chosen based on the personal network of the author and by suggestion of the organisations involved. They were:

Interviewee 1: Nur T., female Arab Syrian, 30-years-old, psychologist, currently working in Sexual Gender Based Violence program in RET organisation in Sanliurfa-Turkey. She has more than three years' experience working within the humanitarian response for Syrian crisis in both Syria and Turkey.

Interviewee 2: Beyaz B., female Kurdish Syrian, 27-years-old, working as a counsellor in KHA in Kobane-Syria, with two years' experience within the humanitarian response.

Interviewee 3: Rami K., male Arab Syrian, 33 years old, Mental Health supervisor, almost 3 years working in Akçakale-Turkey within the humanitarian response for Syrian crisis.

Interviewee 4: Mehmet Ali A., male Kurdish Turkish, 28-years-old, psychologist, current MHPSS team leader in Support to Life organisation. He has more than three years' experience working in Sanliurfa-Turkey within the humanitarian response to Syrian crisis.

Interviews were conducted by the author through a Skype call with each participant separately in June and July 2017. The participants signed informed consent terms (as the model in Annex 5) after receiving a basic explanation of the study, an overview of its goals and conditions of participation. Notes were taken during the interviews and were transcribed immediately following.

3. COMMUNITY-BASED SERVICE & MHPSS APPROACH

“The treatment of war-related trauma certainly has its place, but it cannot address the multiple sources of continual stress that undermine mental health in communities affected by armed conflict.” (Miller & Rasmussen, 2010)

Western clinicians and researchers developed many successful techniques and treatments to control and treat symptoms of anxiety, stress and other problems related to war exposure that are applied in safe settings, far away from the context of war where those precipitating experiences happened.

According to Kaz de Jong (2014), it is only recently that professionals started to ask themselves about the impact of war on mental health as a collective experience, subject to cultural understanding. With the humanitarian organisations operating emergency response in non-Western settings, it became clear that providing mental health care in war-affected areas and promoting recovery at destroyed environments that are often under on-going violence is a very different challenge than that in stable contexts where refugees resettle. Indeed, at this stage, research and public health have to work together.

To reach a broad range of needs of the potential patients—from those who only require a stronger community support to those who demand counselling and psychiatric care—it is necessary to consider such diversity when designing the mental health care programs in humanitarian contexts. This chapter will briefly present the community and psychosocial model of care as implemented in the Turkey/ Syria mission.

As defined by Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in emergency settings,² the composite term **mental health and psychosocial support** (MHPSS) describes “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder”. The acronym MHPSS is used within the IASC definition in this dissertation.

3.1. Teams of MHPSS

The basic team delivering MHPSS varied its composition across the sites and along the period according to operational needs and program design. A common approach between the three projects in Kobane, Akçakale and Sanliurfa is the use of lay counsellors as the main staff to provide basic psychosocial intervention. The counsellors are members of the affected community who were recruited and trained to provide such intervention. Trainings provided by

MSF and partner organisations focus on basic counselling skills, psychosocial support and mental health case identification and referral, according to the mhGAP program of the WHO.²

The rationale behind the choice of lay counsellors is that members of the same community share a common history, language, ethnicity, values and knowledge of the context that facilitates the interaction and the receptiveness to counselling by the affected population. The use of lay counsellors is especially relevant in post-disaster settings where the availability of trained experts in mental health is scarce, following the recommendation of the WHO for task shifting approach.

Other members of the team were outreach/field workers, facilitators/teachers for psychosocial activities, translator, data encoder and, when available, one psychologist in the role of team leader/supervisor of counsellors.

All teams were hired by MSF's partner organisations in each location, namely STL in Sanliurfa, IBC in Akçakale and KHA in Kobane. Supervision in the field and trainings to the staff were performed by the psychologists and experts of each organisation with the support of an expat psychologist of MSF, who was responsible for technical support of the mission across the different sites through remote or on-location support.

3.2. MHPSS activities and approach

Psychosocial activities and light mental health support is offered for children, adolescents and adults at community centre settings. The community centres are operated by NGOs in urban settings in Sanliurfa and Akçakale where Syrians attend language courses, computer classes and other social-educational activities. Mental health and psychosocial services were included in such settings to facilitate access in a non-stigmatising environment. In Kobane, activities initially started in the Outpatient Department (OPD) integrated to a primary health care provider and later expanded to a community centre with similar characteristics to the model implemented in Turkey. Main services offered across the sites were:

- Basic counselling in both individual and group modalities. Approaches used were based on brief psychotherapy, cognitive behavioural therapy and stress management techniques. Types of problems targeted were anxiety, mood problems, sleeping problems, trauma, stress, psychiatric disorders, bed-wetting and other psychosocial problems mostly caused or worsened by forced migration and war. Cases of severe mental disorder were referred to psychiatrists of NGOs (Syrian doctors) and public hospitals (Turkish doctors) in Turkey and to general doctors in Syria.
- Case management, i.e. identifying social demands of the patients and linking them to other relevant services available among NGOs and governmental services.

- Psychoeducation sessions were offered for groups of people in the waiting rooms of hospitals/outpatient facilities in Kobane and at community centres and schools in Sanliurfa and Akçakale. The sessions were short talks about mental health with the purpose of promoting positive messages on mental health and fighting stigma.
- Outreach: door-to-door visits to the houses of Syrian families living in the nearby neighbourhoods of the community centres in Sanliurfa and Akçakale with the purpose of promoting the service and raising awareness on mental health care, as well as identifying cases for counselling.

4. IMPACT OF WAR ON MENTAL HEALTH OF SYRIAN REFUGEES

“It is not easy to talk about the impact of armed conflict in the mental health without describing the horror which the people go through... seems like the only way to imagine how the war have impacted their lives, is by describing what their lives became into, i.e., by giving our testimony. Destroyed apartments, destroyed families, destroyed bodies in the streets, of course lead to destroyed thoughts, feelings and souls.” (expat psychologist, Sanliurfa)

When asked about the impact of war on mental health of Syrian refugees, one of the interviewees stated, *“The word to answer this question is ‘disaster’. Actually, you cannot explain it with words. You have to come here and see it with your eyes”* (Interviewee 4).

In this chapter, the main presenting complaints will be discussed, with contextualization of data, considering the main similarities and differences between gender and age groups.

4.1. Main presenting complaints

4.1.1. Profile of patients

As previously mentioned in the methodology, the total cohort here analysed is composed of 2650 patients that initiated counselling in one of the three border towns: Akçakale, Sanliurfa (Southeastern Turkey) and Kobane (Northern Syria). The period analysed was comprised of two years (2014 – 2016) and the total cohort is a sum of all patients that had at least one counselling session in each of the sites during that period. The opening dates of the project in each site, the period analysed and the number of patients per location is shown below in Table 1.

| Site | Period analysed | | N. of months | N. of patients |
|--------------------|---------------------------------------|--|--------------|----------------|
| | Starting date of counselling services | Last day of epidemiological calendar of 2016 | | |
| Kobane (Syria) | 29/08/2015 | 30/12/2016 | 15 | 1466 |
| Akçakale (Turkey) | 03/11/2014 | 01/01/2017 | 26 | 800 |
| Sanliurfa (Turkey) | 01/09/2014 | 01/01/2017 | 28 | 384 |
| | | | Total | 2650 |

Table 1: Period analysed and number of patients starting counselling per site.

The first site to begin offering counselling service was Sanliurfa (September 2014), followed by Akçakale (November 2014) and Kobane (August 2015), which was occupied by ISIS at the time of the inauguration of the services on the Turkish side. The counselling services in Kobane were implemented almost one year later when the town was already liberated and cleared security wise.

Regarding the distribution of age groups and gender, the majority of patients in Kobane were female adults under 44 years of age, with a predominance of female gender in all age groups (Figure 3). Male patients accounted for only 20% of the patients of Kobane. In Akçakale and Sanliurfa, gender was more equally distributed across all age groups.

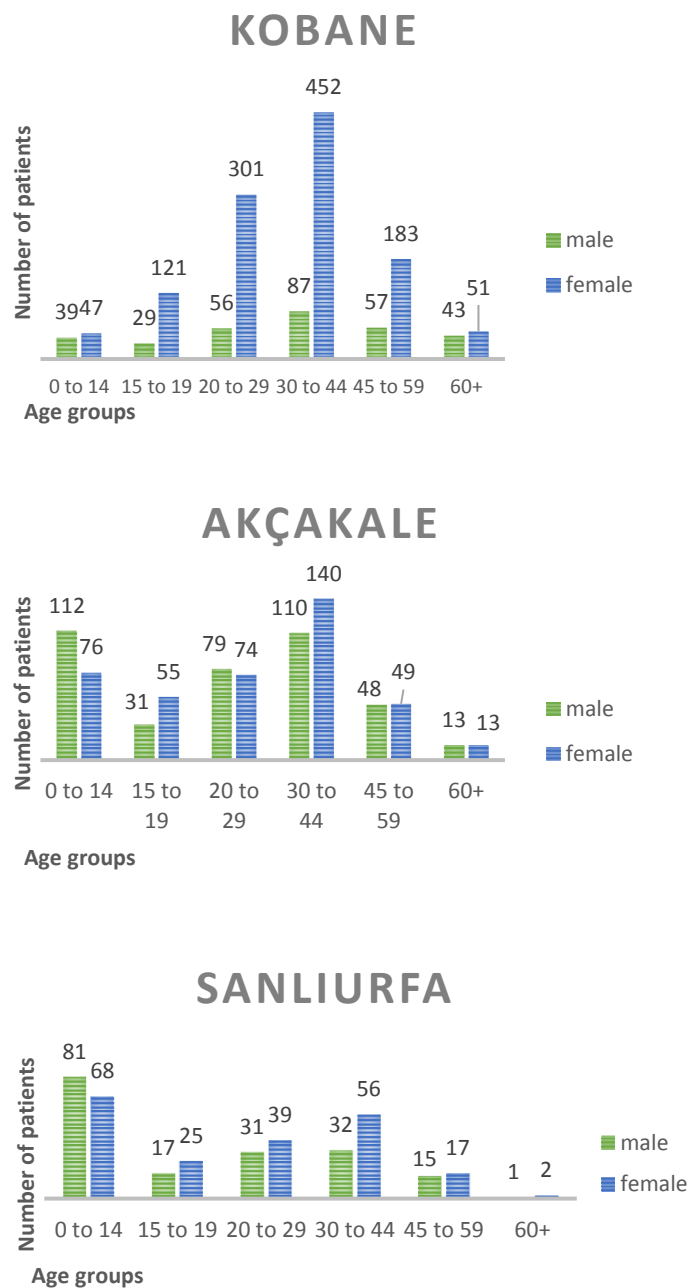


Figure 3: Gender distribution of patients per age group in the three sites.

In the Sanliurfa project, 149 patients were children from 0 to 14 years of age, out of a total of 384 patients during the period. Together with the 42 adolescents seen (15 to 19 years of age), they represent 49%, i.e., almost half of the patients attending counselling at that site. In Akçakale, 188 patients were children from 0 to 14 years of age, and 86 were adolescents from 15 to 19 years of age, out of 800 patients, representing together 34% of the patients of that location. In Kobane, the percentage of children and adolescents were only 16% of the total 1466 patients, much less when compared with Sanliurfa and Akçakale.

The settings where counselling was provided varied among the locations, which may have played a role on the number of people and subgroups that accessed the services in addition to other contextual factors. In Sanliurfa (92%) and Akçakale (80%), for example, the sessions were mostly provided in the community centre setting, whereas in Kobane, the same service was provided in two different types of setting, a primary health centre and a community centre. The majority of sessions in Kobane (63%) happened within the former setting, with 934 patients versus 529 patients who accessed counselling services within the community centre during the same period.

The bias towards targeted groups may be related to the entry door in these two types of facilities. The influx of patients in a primary health centre is usually high, reflecting in more cases being referred to mental health care by the medical team. In contrast, in the community centre, the presentation of patients is most times voluntary and highly dependent on active case finding by the outreach team in the community. This reflects on Kobane having the largest number of patients in a shorter period (1466 patients in 15 months) when compared with Akçakale (800 patients in 26 months) and Sanliurfa (384 patients in 28 months).

Thus, while in the community centre there were psychosocial activities targeting all age groups, the primary health centre may have screened mostly female adults because this was the public attending more of the medical services. While in the centres of Sanliurfa and Akçakale an expat psychologist was present during all the time since the projects were implemented, Kobane's project was mostly supported by remote management. Meaning that the presence of an expat in the Turkish side enabled more specific trainings such as working with children, whereas in the Syrian side this was not the case .

An additional factor for the disproportional sex ratio in Kobane, as mentioned by the counsellor of that location, may have been the migration of men abroad, either because they had decided not to fight or were seeking better life conditions. These men would go abroad alone to first explore living conditions and later, they would have their families join them when they had secured employment (Interviewee 2).

Last, but not least, some men of different ages who stayed in Syrian territory ended up having to fight for one side or another during the conflict. Consequently, many fought on the front lines or lost their lives in combat. All these factors contributed to the high stigma men suffer when in need of mental health support, and may have contributed to the low attendance of males in counselling, especially on the Syrian side of the border. More will be discussed concerning stigma as a barrier to access of care in Section 4.1.3.

4.1.2. Per site

“Anxiety-related complaint” was the most reported complaint at all three sites, accounting for 26% of the registered complaints of all beneficiaries attending individual counselling during the period (2014 to 2016). As exposed in Table 2, the following most reported complaints were *family related* (Kobane 17%, Akçakale 13%), *mood related* (Kobane 15%, Akçakale 14%) and *physical complaints* (Kobane and Akçakale 14%, Sanliurfa 13%), whereas behaviour-related complaints were the second most reported in Sanliurfa (16%).

| | Kobane 29/08/2015- 30/12/2016 | | Akçakale 03/11/2014 – 01/01/2017 | | Sanliurfa 01/09/2014 – 01/01/2017 | |
|--|--|-------------|--|-------------|---|-------------|
| | Patients admitted since the start of counselling service of each site until last day of epidemiological calendar of 2016 | | | | | |
| Presenting complaint (reported by patient) | Number | % | Number | % | Number | % |
| Age-related problems | 5 | 0% | 20 | 3% | 32 | 8% |
| Physical complaints | 212 | 14% | 113 | 14% | 51 | 13% |
| Social functioning | 41 | 3% | 36 | 5% | 21 | 5% |
| Family-related problem(s) | 256 | 17% | 102 | 13% | 43 | 11% |
| Economic functioning | 105 | 7% | 24 | 3% | 5 | 1% |
| Behaviour-related | 54 | 4% | 62 | 8% | 62 | 16% |
| Anxiety-related complaints | 373 | 25% | 217 | 27% | 106 | 27% |
| Mood-related problems | 218 | 15% | 108 | 14% | 30 | 8% |
| Loss/Mourning | 168 | 11% | 44 | 6% | 14 | 4% |
| Other serious mental health condition(s) | 34 | 2% | 74 | 9% | 20 | 5% |
| Total patients | 1.466 | 100% | 800 | 100% | 384 | 100% |

Table 2: Presenting complaint per location reported by patients admitted until December 2016.

The three most reported complaints, i.e., anxiety-related, family-related and physical complaints are discussed below considering its occurrence according to gender and age groups.

4.1.3. Gender perspective

Figure 4 presents the main complaints reported by female and male patients, enumerated from the most to the least reported by each. As female patients account for a larger number in the total cohort (1769 females versus 881 males), the calculation was normalized through percentage for direct comparison.

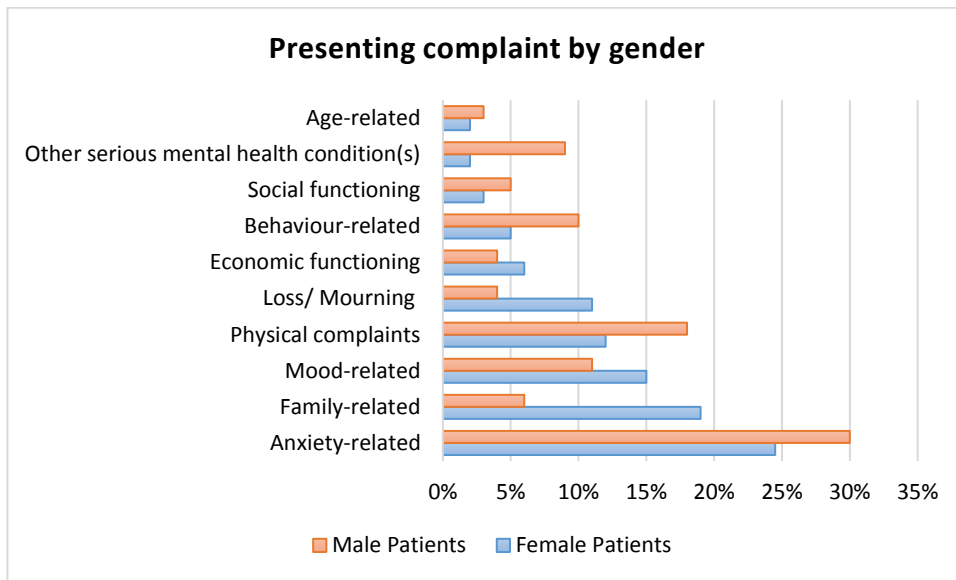


Figure 4: Presenting complaints of male and female patients (all ages) of total cohort.

As shown in Figure 4, anxiety-related is the most reported complaint for both genders: 25% of female and 30% of male respondents.

However, the second most reported complaint was different for women and men. “Family-related problems” accounted for 19% of complaints of females, whereas it accounted for 6% of the male complaints. When analysing the subcategories of family-related problems, “marriage problems”, “family discordance” and “concerns about children” were among the main worries of female patients.

In a male dominant society, boys and men tend to have more socialization opportunities in the public sphere of life than females, who are by tradition assigned to domestic responsibilities and childrearing; these being gender roles already well established in the Syrian culture pre-war. The conflict and forced migration added an extra pressure on gender inequalities. Whether at a refugee camp or in an urban context, it is known that sexual and gender-based violence impose severe restrictions on female refugees. Thus, it is not rare to see that poverty, lack of access to education and social vulnerability push young girls into early marriages in those contexts (Interviewees 1, 4).

Mehmet Ali, the interviewed psychologist from Sanliurfa, indicated, “*In our culture, men go more outside. Girls should be at home to be safe from any danger*”. The interviewed

counsellor from Kobane adds that the men are the first to leave Syria. According to her, *“The men left to Europe, some of them fight or work outside, and this helps them to cope. Women are always at home and under pressure, they become overburdened”* (Interviewee 2).

All these aspects may play an important role as to why family-related problems represent a larger burden on the mental health of females than of males, as presented above.

Furthermore, the social roles that men and women assume inside the community, and how the hosting countries deal with that, will have also an impact on their access to care. Bans imposed by male partners on women’s movement require the community services to be more proactive on outreach to make the care accessible for females (Interviewee 4).

If on one hand the situation does not seem favourable for women to access care and socialization opportunities, on the other hand, men have to face another kind of barrier, also associated with social gender roles, *“Men don’t come a lot to the mental health consultations, because in our culture they cannot be seen as weak. Women come in secret and they trust more the confidentiality of the counsellor, men cannot admit to themselves that they need support”* (Interviewed counsellor from Kobane).

The psychologist from Sanliurfa confirmed the existence of this belief among his beneficiaries that the masculinity identity of men does not give space for them to express freely their suffering, *“Fear is seen as a weakness. Although we know that all of us can be afraid, this is a normal thing, especially considering the war context, there is a harsh pressure against the male members of this community. ‘Adam gibi ol’ [Be like a man], they say in our culture”*. This association of emotional weakness to gender roles starts very early in the family education, to such an extent that many Syrian boys suffer bullying in the schools and inside their own families for showing any kind of feeling or behaviour that is not considered culturally appropriate for a male (Interviewee 4).

This aspect of the masculine social identity turns the mental problems into a stigma amongst men. Considering this factor, it is interesting to note that the second-most registered complaint of male patients were physical complaints (18%), while this is the fourth most reported by women at 12%. Epilepsy (58 cases), unclear multiple physical aches (28) and indigestion (10 cases) were among the most reported subcategories of physical complaint. Since men are usually more exposed to direct combat and fighting, it is reasonable to expect that they would present more disorders related to physical injuries and trauma than women would.

If it is socially more acceptable for a man to have a physical complaint rather than a subjective complaint related to his emotions, it remains to be seen whether the other complaints – such as family-related, mood-related and mourning – are less reported because they occur less or are actually underreported for fear of stigma. It is clear that male beneficiaries showed up with more psychosomatic complaints than women did. This may be the same reason behind the high percentage of men with anxiety complaints, which often manifests through physical symptoms related to heart beat, sweating and other signs of physiological distress. Further investigation would be necessary to verify which kind of correlation exists between physical complaints amongst men and the stigma that prevents them to talk openly about their problems and seek help.

Under the category of “other serious mental health conditions”, psychosis (45 cases) and substance abuse (13 cases) were also more frequent amongst men than women.

On the same line, the Syrian psychologist Rami who worked in Akçakale exemplified another aspect of Syrian society that hinders the mental health care seeking behaviour, *“The head of the clans are very important people inside the Syrian society. If this person is suffering from any kind of mental problem, he cannot show it to the others, fearing that he will lose the power and credibility of such positions. Patients sometimes even hide their faces when entering the centre, for avoiding been seen by others. They know they are facing psychological problems, they are aware of that and talk to me openly but they simply cannot let others know”* (Interviewee 3).

The strong orientation of Syrians to their family, clans and tribes that organise society is directly represented by the male chiefs of the clans. Therefore, mental problems are seen as a threat to the stability of those leaderships and the social fabric they represent, again contributing for stigmatization of mental problems.

4.1.4. Age groups

Children (0-14 years of age)

Out of the total cohort of 2650 patients starting counselling during the study period, 423 were children aged 0 to 14 years. The main presenting complaints of this subpopulation are presented in Figure 5, enumerated from least to most reported, subdivided according to gender.

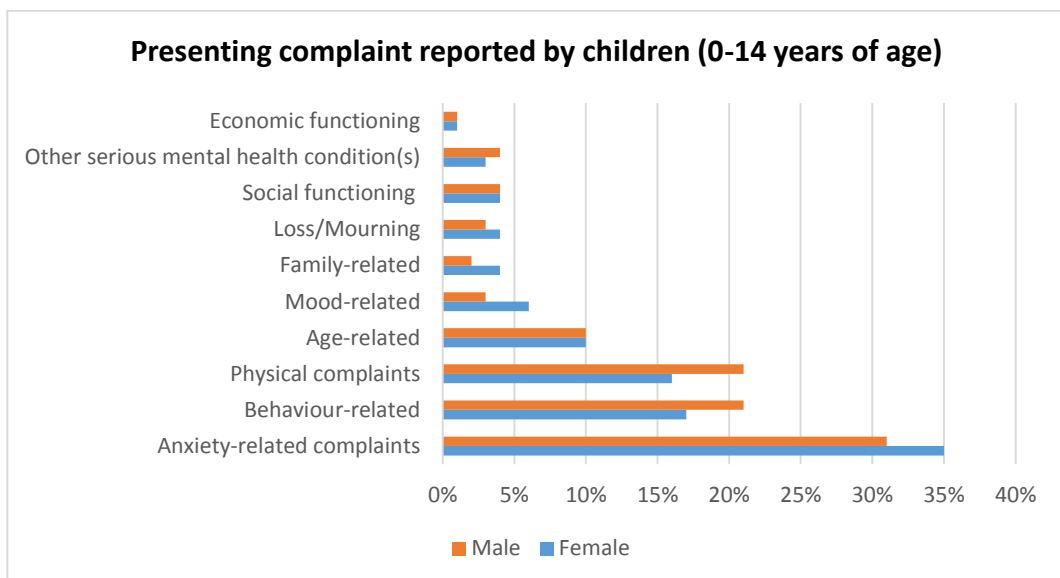


Figure 5: Main complaints by female and male children (0-14 years of age) of total cohort.

According to Figure 5, no expressive difference was noticed between genders regarding type and frequency of complaint in children. While physical complaints and behaviour-related problems are seen slightly more often among male children than in female, anxiety-related complaints were by far the most reported for both.

As subcategories of “behaviour-related” complaint, “aggression” and “shyness” were the two most common problems reported concerning children. Given that their cognitive and language skills are still under development, changes in behaviour, problems with peers and delay achieving developmental milestones were the main alerts perceived by caretakers as a sign of their children’s mental problems.

According to the experience of the counsellors, children that have witnessed scenes of violence were more prompt to use violence and aggression towards others. Scenes of war started to appear in their daily drawings and play where they can assume different roles: sometimes as a victim, and sometimes as a perpetrator of a violent act (Interviewees 2, 3, 4).

Worthy of mentioning is that bedwetting, although not explicitly included in any category of complaint, was very commonly reported by parents and caretakers of children brought for counselling. Cases of bedwetting in this context presented mostly as a secondary nocturnal enuresis in children 4 to 8 years of age who had already learned to control their bladder. Most caretakers reported that the child returned to bedwetting after a sequence of stressful events or a single precipitating event happening. Shelling sounds were very commonly reported as a precipitating event. Other events related to conflict were also referenced, such as “witnessing violent acts or combat”, “seeing someone die”, “seeing dead bodies in the streets” and “having the house destroyed”.

With the lack of a specific category in the client form for bedwetting, these cases were registered as “age-related problems” and “physical complaint” in both the Sanliurfa and Akçakale projects, but perhaps not consistently, as they were not explicitly mentioned. These two categories together were the main complaints for one-third of the children (0-14 years of age) attending counselling in Sanliurfa.

However, the lack of an accurate category for registering bedwetting cases prevented further analysis concerning the impact of such a problem among the refugee children. When coming across a problem not represented in the existing categories, the counsellor should choose “other: please define” as a subcategory to be defined and agreed locally in the project, something that did not happen in practice. For measuring the impact of bedwetting cases, a subcategory could be added under “physical complaints”.

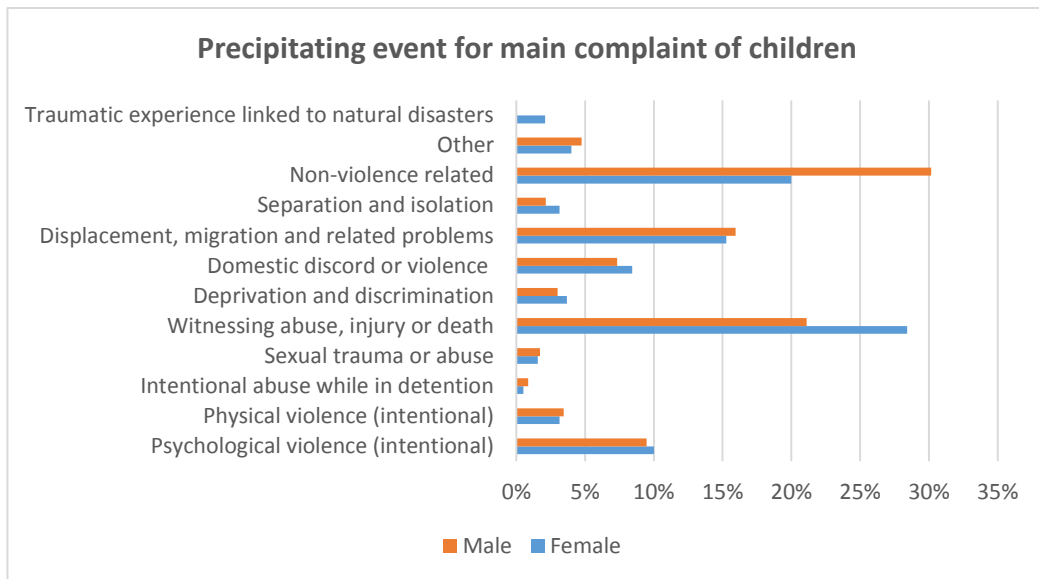


Figure 6: Precipitating events by female and male children (0-14 years of age) of total cohort.

As represented in Figure 6, the main precipitating events of main complaints of children were “witnessing abuse, injury or death” (reported by 28% of females and 21% of males), “nonviolence-related” (by 30% of males and 20% of females) and “displacement, migration and directly related problems” (by 16% of males and 15% of females). Intentional violence (psychological and physical) accounted for 13% of the precipitating events reported by females and 12% by males.

“Nonviolence-related” was usually used by the counsellors to report any precipitating event that was not directly related to the conflict, such as birth conditions, illness of a family member and other sources of adversity. However, this is one of the only categories without subcategories in the reporting tool (Annex 3). Thus, though this category was chosen by the counsellors for 20% to 30% of the children, the lack of subcategories does not allow further analysis of such data. Especially in Kobane where counsellors had almost no direct expat supervision before October 2016, the accuracy of choosing the correct codes may have been impaired at certain extent.

Adding subcategories to “nonviolence-related” precipitating event in the tool would allow a better understanding of the data collected under this label and perhaps even a change in the outcome, as the current category is too broad and the definition of what is “nonviolence-related” falls into the subjectivity of the counsellors.

Adolescents (15 – 19 years of age)

Out of the 2650 patients from all three sites, 278 were adolescents (15-19 years of age), with the majority being female (201) against 77 male. Adolescents represented approximately 10% of the total cohort.

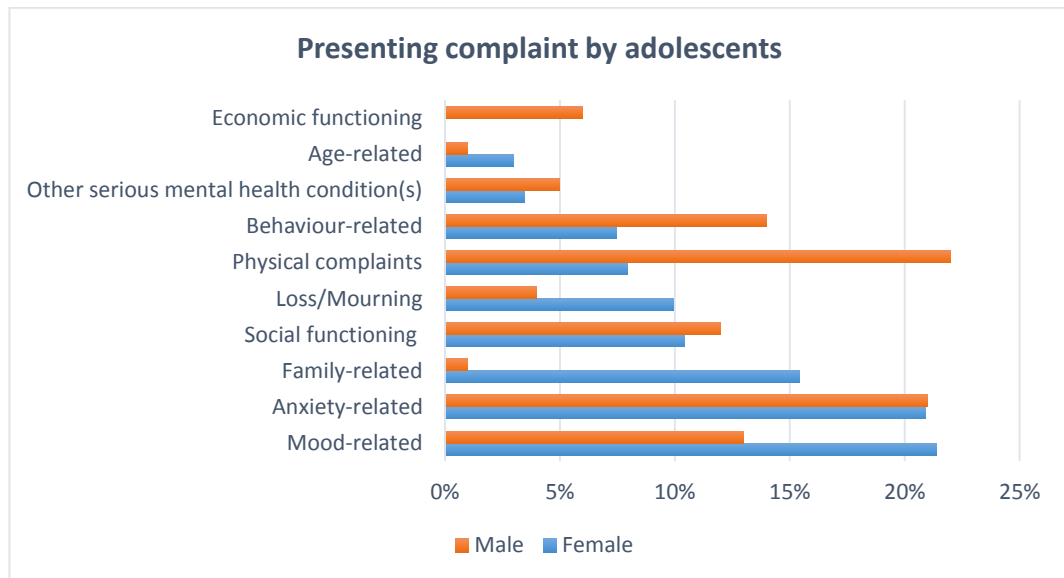


Figure 7: Presenting complaint by female and male adolescents (15-19 years of age).

While in children, no significant difference was observed regarding gender expression of the main complaints and their precipitating events, gender differences do start to appear in adolescents. Mood-related problems appear as the most reported by female adolescents (43 cases, 21%), and a similar percentage of male adolescents (17 cases, 22%) report physical complaints (Figure 7). Side by side, anxiety-related problems were reported by the two genders in equal percentages (16 male cases and 42 female cases, both representing 21%), to be discussed in the next section (4.2.1).

Physical complaints amongst young males break down in the following subcategories: epilepsy (9 cases), unclear physical complaints (4 cases) and others. This tendency of physical complaints to be most often reported by males than females was already discussed in Section 4.1.3. of this dissertation. These cases added to those of anxiety for a total of 33 male patients out of 77 (42%), highlighting the physicality of symptoms more prominent among male adolescents, while more subjective complaints appear among female adolescents, as discussed below.

The most common complaint of female adolescents was family-related (15%); however, the same kind of problems seem to affect only 1% of the male adolescents, the same gender tendency observed in adults and previously discussed in 4.1.3. Amongst the 31 female adolescents that reported “family-related problems”, 14 referred to problems with marriage or divorce as the detail for such a complaint. Ages of these adolescents were 19 (5 patients), 18 (5

patients), 17 (1 patient), 16 (2 patients) and one patient of 15-years-old. Nine adolescents referred to family discordance and three others indicated domestic violence, suggesting there is an early burden of marriage and relationship on the mental health of young females in this context.

In general, the presenting complaint and its precipitating event for this age group follow the same pattern found in adults. The early intake of adulthood responsibilities by the adolescents is most probably related to cultural traditions and exacerbated by the conflict context. Often, children as young as 9 years of age can be found working in bakeries and in agriculture. Many families resettled in Sanliurfa and Akçakale report that due to loss of the main income earner of the family, they see themselves obliged to put the children and adolescents to work (Interviewee 4).

Elderly (≥60 years of age)

Out of the 2650 patients from all three sites, 123 were adults over 60 years of age, accounting for 5% of the cohort, with 66 females and 57 males.

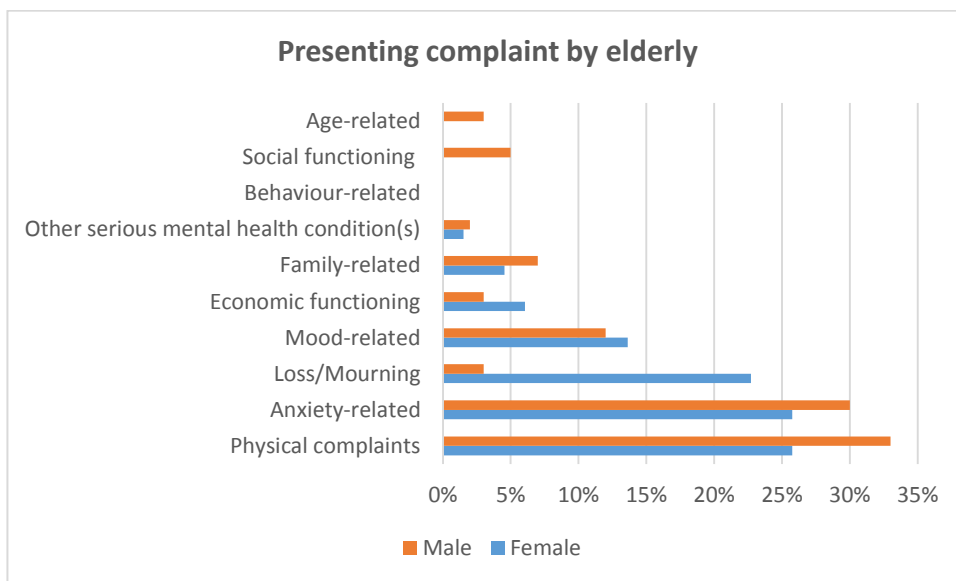


Figure 8: Presenting complaint by female and male elderly (≥60 years of age).

As represented in Figure 8, physical complaints just as frequently reported as anxiety complaints by male and female elderly. Differences between genders are not remarkable except for the “loss/mourning” complaint, which was more prevalent among females (23%) than males (3%).

According to the interviewees, this age group suffers most with the breakdown of the traditional structures, such as the organisation of the society in clans. Changes of environment and culture are not handled quickly. When the tribes get broken, some traditions tend to break as well. According to the psychologist Nur, no MHPSS service is considering the needs of this age

group, “They are a forgotten population who get affected in a very specific way by these changes” (Interviewee 1).

“In Syrian family tradition, the elderly have a special advisory place within the family. These were the people to go first for advice when there was a family or psychological issue. With the breaking of families and the spread of people over different countries, this unity function was lost, which made the older generation feel more useless and was more of a burden since they couldn’t work anymore and had to be taken care of by their children” (psychologist Antoine, personal communication).

4.2. Most reported complaint: Anxiety-related

4.2.1. Profile of patients

Anxiety was the most reported complaint among all age groups and similarly distributed by gender. Among age groups, however, there is a slight oscillation, as shown in Figure 9. There is a tendency of higher reporting of anxiety complaints among children, a drop during adolescence, with a peak in mid-age adults.

In relation to gender, higher percentages of anxiety complaints among female patients appear in children (35%) and mid-age adults (45-59 years of age), whereas in male patients, it remains consistent (28% to 32%) along all age groups, except adolescents (21%).

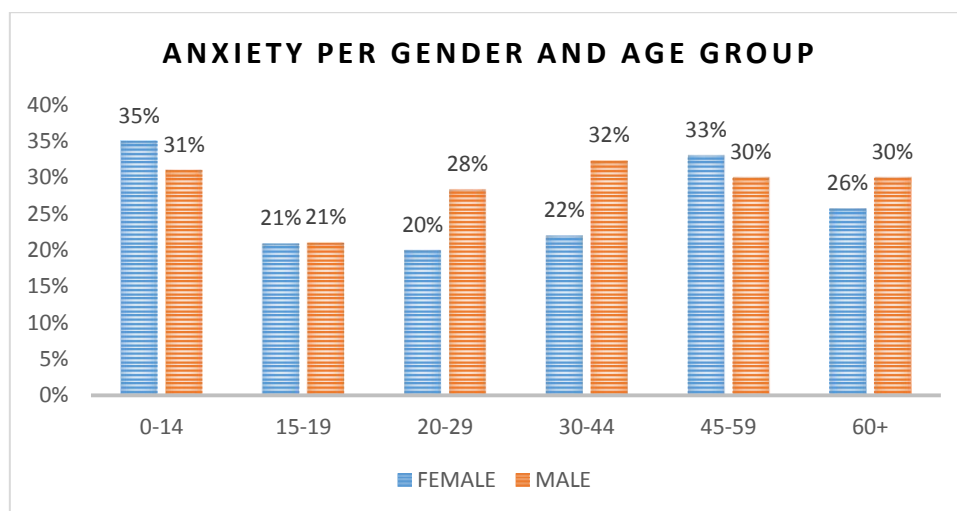


Figure 9: Percentage of patients of each age group that presents anxiety as the main complaint, divided per gender.

The percentages of patients with anxiety complaints were very similar across the three sites, in spite of the difference on the cohort size for each location: 373 out of 1466 in Kobane

(25%), 217 out of 800 in Akçakale (27%) and 106 out of 384 patients in Sanliurfa (27%). Out of the cohort of 2650 patients, 696 presented anxiety-related complaints (26%). Details of such complaints are presented below.

4.2.2. Details of anxiety-related complaints

Among the 696 registered patients, details of main complaint of 642 patients were available in the database. Figure 10 shows the most reported subcategories of anxiety.

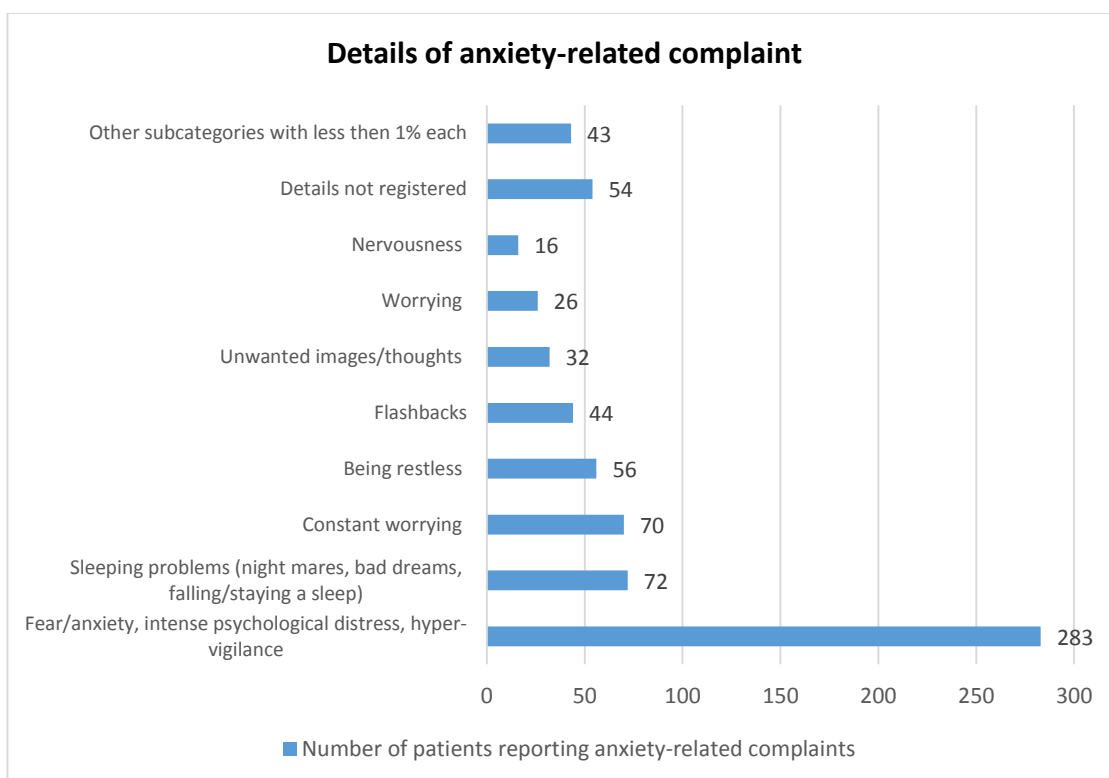


Figure 10: Number of patients (all ages, genders) that reported anxiety as the main reason for attending counselling, subdivided according to the detail of complaint.

Among the 642 patients, the subcategory labelled “fear/anxiety, intense psychological distress, hyper-vigilance” was reported most frequently (283 patients, 41%), followed by sleeping problems (72 patients, 10%) and constant worrying (70 patients, 10%). To be noted that “worrying” and “constant worrying” are two different categories whose proximity might justify them being analysed together. In that case, “worrying & constant worrying” would respond for 15% of the complaints (96 patients).

A lesser number of patients reported flashbacks (44 patients, 6%) and unwanted images (32 patients, 5%). Subcategories with less than 1% each were grouped as “other subcategories”. For complete list of subcategories, see Annex 2.

The instruction for the counsellors to mark only one main complaint, and consequently only one of its subcategories in the patient file, may have caused the sub-representation of other complaints that the patient may have had. The counsellors often reported that patients usually expressed more than one complaint and, therefore, they were asked to choose the most disabling to be considered as the “main complaint”. For example, if a patient reported “fear”, “constant worrying” and “being restless”, the counsellor had to choose one as the main complaint according to the fields available in the patient file (Annex 1).

Even assuming that such decision should be taken always in discussion with the patient, this limitation may have two main consequences: 1) that the data does not show the full extent of patients distress; 2) that the data can be biased because of the way counsellors and patients do choose one complaint over the other to be considered as the “main complaint”. As this information is collected in the first session, is also possible that the patient is not yet comfortable enough to open up his/her main complaint, as well as the process of counseling itself might give the patient an insight that makes him/her change the complaint later on.

As the data collected has no diagnosis validity, it is not possible to infer how many of those patients would meet criteria for other disorders, presumably post-traumatic stress or other anxiety disorders. However, anxiety-related complaints being by far the most reported, regardless age groups and gender, shows the importance of addressing anxiety as a common mental disorder among refugees.

Worry was a word commonly used to describe people’s psychological status in Kobane. The counsellor Beyaz explained that the worries started in Kobane much before the clashes arrived to the town. This is because the war in other parts of Syria was already a general concern for Kobane’s community. After ISIS attacked, the worry about the conflict coming to the town came true, causing *“All the psychological pressure that was under control to explode like a burst”*.

4.2.3. Precipitating events for anxiety-related complaints

Although anxiety seems to affect Syrians inside and outside Syria equally, the differences start to appear when analysing the source of anxiety in the two contexts. In Kobane, 24.5% (89 out of 363 patients) mentioned that the precipitating event for their anxiety complaint was psychological violence, such as having their home destroyed and witnessing death or disappearance of a family member. Another 77 patients reported witnessing, hearing about abuse, injury or death as a precipitating event for their anxiety.

As an example, the counsellor of Kobane described how the two attacks to Kobane have had an impact on the community. To her perception, the second attack of ISIS [June 2015], though it lasted only few days, caused much more acute stress and anxiety than the first attack that lasted several months [September 2014 – January 2015], *“It took us by surprise, in a normal day, at 5 am. The community didn’t have time to flee, as has happened before. When our security forces were aware of the clashes approaching the town, they evacuated the villages so we didn’t*

watch anything, most of us fled to Turkey. This time, nobody was prepared, and a massacre happened just in front of our eyes”.

Additionally, in a post-conflict context, there is lack of basic infrastructure, such as safe water, affordable food options and fuel. While inhabiting this scenario, the population is not only psychologically haunted by the violence witnessed but also struggles with surviving in the present conditions, which is another source of anxiety and stress. In Kobane, 43 people mentioned living in poor conditions due to war and the deprivation of basics, such as food and water, as the precipitating event for their anxiety-related complaint.

In the same site, another 57 patients declared domestic discord and violence as a precipitator for anxiety; however, it is interesting to note that the majority did not attribute it to the war, and they were assumed problems raised previously and regardless war.

When compared with the precipitating events mentioned by the refugees in Akçakale and Sanliurfa, similar events were revealed, with the following remarkable difference: deprivation of basics is no longer mentioned, and the consequences of displacement became more relevant for those who travelled cross borders. Having to flee from home because of danger and separation from family members during fleeing or migration appear as the two most mentioned precipitating events for anxiety complaints in both Turkish sites, Akçakale and Sanliurfa. Psychological violence and witnessing abuse, injury or death remain the most common precipitating events for anxiety across all the three sites.

Having fled to another country, a refugee will always worry about the family members and friends that stayed back in Syria. Here, there is an important psychological factor related to social values that adds to the stress burden at the individual level. As the community and family cohesion are important values in the Syrian culture, those who fled for survival might sometimes feel like they have abandoned their own country and community. It comes up as a feeling of guilt, which can reach a severe level of psychological suffering, *“Being finally in a safe place, some feel they don’t even have the right to eat, while there are people inside Syria who cannot eat. There is a huge psychological suffering in that”* (Interviewee 1).

Bringing all this emotional baggage with them to a new country, refugees now have to worry about how to earn for the family’s needs, how the children will grow up and study and how life will stabilize again in a sense of routine and community. The pursuit of returning to a sense of normality seems to be the major challenge for the refugee community, this is because of the acute stress they have passed by or the current challenge of adapting to a different culture in a new country that hardly provides adequate support.

The psychologist Nur, who worked as a counsellor in different areas in Syria during the conflict and now works in Turkey, highlighted how the sources of stress affected her work on the two sides of the border. In Syria, she was working under acute stress, *“We were in danger and always fearing our clinic to be bombed, or invaded. We were not comfortable. We couldn’t talk to our patients freely, because this could put all of us in danger of life or death”*. For both, patients and workers, crossing the border relieved a significant part of this acute stress.

“After working in Syria”, she continued, “working in Turkey is very easy, because we are not under that stress anymore. In Syria we hear from the families that our former patient was killed, this kind of pressure that is very hard to cope with, when you have it in a daily basis”. Once in Turkey, other challenges, including financial problems, appeared. For example, “People are worried about how to continue their education, how to find a job, how to survive” (Interviewee 1).

Summarizing, the sources of anxiety could be categorized into three areas. Firstly, the problems existing previously to the war and most of times exacerbated by the conflict and forced migration. Previous mental health conditions, domestic violence and social inequalities are in this category. Secondly, life threatening experiences in the war scene, such as exposure to violence and lack of basic supplies. In the third place, the challenges of socialization and adaptation imposed by the arrival to the hosting country. This last point is explored below.

4.3. The challenge of social integration

One of the challenges mentioned by the interviewees is the social integration of Syrians in Turkey. At a glance, Syrian and Turkish communities might look similar in many aspects, being geographically neighbours and having shared a mutual past of hundreds of years under the rule of the Ottoman Empire. Common aspects are found at the social and cultural levels, in its traditional hospitality to guests, the importance of community life over individual will, the patriarchal structure, as well as in the strong influence of Islam in both societies.

However, difficulties in the integration of Syrians in the Turkish society show that differences are much more remarkable than ever thought. Mehmet Ali, psychologist from Sanliurfa, elaborated his perception as a local, *“We always thought that local culture of Sanliurfa and the one of our neighbours [the Syrians] were similar to each other. If someone asked me before the war, I would say yes, they are. But now I understand we are really different, as we try to put host community and Syrian community together and we see that they don’t really integrate easily”*.

As typical, the spoken languages are more hybrid in the border cities, allowing, for example, a Syrian from Kobane to communicate easily in Sanliurfa if he speaks Arabic or Kurdish even if he does not know the Turkish language, though accents might slightly differ from one location to another. On a more private level, however, as Mehmet Ali indicated, some families with different ethnical backgrounds, such as Kurdish and Arabic, though pacifically sharing the same public sphere, do not allow their members to get married to people from the other ethnicity.

Thus, it is important to understand that the culture guides the choices of migration of many people. Economical constraints, no doubt a relevant factor, is not the only reason why many Syrians do not go further from the border cities between Turkey and Syria. Many of them do choose to stay in the border because the culture and social norms are thought to be closer (Interviewee 4). This could explain the overcrowding of refugees settling across the border cities

of Turkey instead of migrating to the west of the country, also to stay closer to the home-country in order to migrate back in case of conflict ending.

On one hand, if the Syrian communities are not being well integrated to the host communities, this might be also a mechanism of preserving its unit. Social rituals, such as massive presence of community in weddings, for example, remain as a cultural practice and a very powerful coping mechanism to the members of that community, even if now they live abroad and do not have the same economic conditions as before (Interviewee 4).

This group solidarity is also described by interviewee 1, *“Family support is something positive. If you belong to a family and a tribe, when you have financial problems, you will receive support from them. People can do sacrifices for the others because they belong to the same family and tribe. They cut from their own comfort to give the other members who are in need. They share houses. This keeps the family and community united, in spite of all constraints”*.

4.4. Other barriers to care

In the previous sections of this chapter, some of the barriers refugees face to access care were discussed, such as those linked to gender roles (4.1.3.). Although differences were found regarding the practical implications of stigma for both males and females, this barrier ultimately affects everyone and the society as a whole.

The counsellors and psychologists at the three sites reported that when they started to run the programs of mental health and psychosocial support, people were very reluctant to attend the sessions.

One of the reasons for such stigma is the strong belief in traditional healing practices and religious explanations for mental health. The health seeking behaviour among Syrians firstly embraces the traditional practices and only in case of failure appeals to medicine, as testified by the interviewees:

People often first go to the religious leaders, the Sheikhs, believing that their problems are spiritual. (Interviewee 2)

In Syria, people think that only crazy people go to the doctor. Second, they believe in jinn. In their minds, the jinn and the person will be in the same body. The jinn is responsible for the symptoms, not the person. Maybe this person did some mistake according to Koran. So he/she will look for a Sheikh in order to get rid of the jinn. There are also some people believed to have the power of performing witchcraft. It is a kind of bad Sheikh, called Saher. They can write something bad that will disturb someone. So people go to consult the religious men believing they are been victims of witchcraft. When we interview the client, we ask if they have visited any other service before us. It is often that people have tried solving the psychological

problems by visiting these religious men first and only come to us when their first choice have failed. (Interviewees 3 and 4)

Traditional beliefs often associate mental health issues with spiritual causes, attributing the power of treatment and cure to religious leaders, herbalists and other traditional healers, making the medicine and the counselling the last choices of the person.

When accessing the health care system in Syria, known as very strong and developed before the war, persons that need mental health care do not find community-based services, *“No, before the war we didn’t have this kind of service available for the Syrians”* (Interviewee 3). Meaning, a hospital-centred model of care also contributed to the stigmatization of mental problems in Syria.

Interviewee 1 testified about this fact, *“Before the war, there was a very restricted web of mental health care in Syria, both private and public wise. People only know the outpatient clinics and the mental hospitals for very severe cases. There was a mental hospital in Damascus. There was no community centre or a psychiatric ward integrated to general hospitals. Families with a member with psychosis or other severe problems lock them down in rooms. Again, this means a shame for the family. If the situation is out of control, they take them to mental hospitals. However, we don’t know what happens there inside”*.

Moreover, there was a change in mental health services that can be directly attributed to the start of the conflict. As an example, in pre-conflict Kobane, one psychiatrist used to work at a private clinic as well as at the hospitals in the town. Following the conflict, mental health services were not available at all (MSF, assessment report²⁵).

Contextualising the pre-war country profile of mental health services is important to understand one of the challenges faced by mental health care providers for the refugees displaced by the conflict. As often reported by Syrians, there is a high stigma associated with seeking mental health support, reinforced by the psychiatric care in long-stay mental hospitals as the only model of care available in pre-war Syria.

MHPSS services inaugurated in the camps and cities of the neighbouring countries include varied—and very often occidental—programs of individual counselling, group counselling, psychosocial activities, psychological care and referrals to different levels of mental health care. It should not be surprising if the refugees do not immediately recognise those services as positive and reliable given the stigma they have witnessed. Thus, such programs must find creative ways to attract more people to the services by presenting the new modalities of treatment in a positive and culturally appropriated way to reduce stigma and improve access.

The political affiliation of the beneficiaries might be a barrier for them to access the community centre as well. Even if the humanitarian organisations are told to be neutral and independent, there is a strong ideology associating any western intervention to an “American school” that is not welcomed in the Middle East (Interviewee 4).

5. CONCLUSIONS

It is necessary to understand the impact of war on mental health as a collective experience, which is subject to cultural understanding, as outlined by De Jong.⁴

The findings show that anxiety-related are the most reported complaints among the Syrian refugees of all ages and both genders who were seeking support of counselling at the three sites (26% of the total cohort) during the period analysed (2014 – 2016). Indeed, the post-conflict town of Kobane in war-torn Syria and the hosting towns of Sanliurfa and Akçakale in Turkey (not affected by war) present similar prevalence of anxiety-related complaints. This data suggests that the level of anxiety does not diminish for a refugee after having fled a country at war and being able to cross borders to a stable country. However, sources of anxiety showed to be different on the two sides of the border.

In the post-conflict zone of Kobane, the acute stress seems to be precipitated by two main factors: the immediate lack of basic resources and services and witnessing of mass violence. In contrast, in the safe zone of the neighbouring country where basic infrastructure of services is guaranteed and violence is not massively present, refugees have to deal with adaptation to a new context and more medium- and long-term struggles, such as settling with family in a safe place, continuing education, rebuilding a professional pathway and remaking social bonds.

The sources of anxiety among Syrian refugees appear to be related to social and family factors present before and exacerbated by the war. Experience of conflict and violence, as well as forced displacement and the challenges of rebuilding life in a new environment, are precipitating factors of anxiety and other common mental disorders.

This scenario shows the importance of a comprehensive approach to address anxiety and other mental problems among refugees, both staying in the post-conflict setting and those migrating to other countries. In the short-term, addressing basic needs and acute psychological reactions, while considering adaptation issues in the medium- and long-term, must be under consideration when designing a MHPSS program for refugees.

Secondly, service providers must consider gendered perspectives, as types of complaints and its related sources (precipitating events) tend to differ for male and female refugees. Differences regarding types of complaints seem to be more prominent after adolescence, whereas irrelevant during childhood. Thus, social roles that are culturally established among Syrians seem to play a role in the perception of mental health issues, ultimately affecting access to care for both women and men. In spite of women tending to be more isolated from social life in this context of conflict, they are still accessing more counselling services when compared with men, especially inside Syria. Early intake of family responsibilities are burdening more female adolescents and adults than men at same age.

Stigma suffered by men should not be underestimated, as mental health issues are highly associated with weakness and lack of masculinity. A society in which men take on

important leadership roles through the organisation of patriarchal clans can become a barrier for men to recognize their mental suffering and seek help.

Stigma against mental problems may be contributing to underreporting of cases among men. Seeking help for psychosomatic complaints seem to be socially more acceptable in these contexts, which can be demonstrated by men reporting more physical complaints than women. Not surprisingly, men are the most difficult group to reach by the counselling providers, which is confirmed by the disproportionate ratio found between males and females in the total cohort (67% of the patients were female).

Bedwetting was found to be a very common problem reported by care takers of children, however not quantified due to the lack of a correspondent category in the registration tool. Adding “bedwetting” as a subcategory to the main complaint labelled “physical complaints” could help to better estimate the prevalence of this problem^a. On top of that, other suggestions are made for improvement of the monitoring tool used by MSF:

- Create subcategories for the precipitating event labelled “non-violence related”, according to the main types of problems the counsellors report to be registering in this category;
- Piloting the tool in each project location could help to look for the relevance of each category and adapt it according to most reported complaints and precipitating events in the area.

As demonstrated by many studies,²² the armed conflict in Syria has been changing the health determinants of the country and the needs of its population, thus demanding a quick adaptation of the care provided by the humanitarian aid organisations and governments. After almost seven years of ongoing war in Syria, part of the displaced population living on the Turkish side of the border is migrating back to recently stabilized areas in North Syria. Others, however, no longer hope to return to Syria nor migrate somewhere else with the borders of Europe being closed, as raised by some interviewees. Therefore, mental health and psychosocial support programs must adapt their models of care to the needs of the Syrians in a sensitive way to different ethnic and cultural groups.

For refugees to rebuild their lives, community integration is a key factor that remains a challenge even in neighbouring countries, such as Turkey. The pursuit of returning to a sense of normality seems to be the major challenge for the refugee community, because of either the acute stress they have suffered or the current challenge of adapting to a different culture in a new country. By studying in deep these social determinants when designing a mental health service for this population, we will be contributing much more effectively to the prevention and care of individuals with mental health issues in the context of migration and refuge.

^a At the time of publication of this dissertation, MSF was carrying on a revision in order to improve the tool, with proposed changes that are congruent to some of the suggestions mentioned here.

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7. ANNEXES

ANNEX 1 - Patient/ client file

Client N° (رقم المراجع):

Project (مشروع): DB N° (رقم قاعدة البيانات):

ملف المراجع

| | |
|--|---|
| Client N° (رقم المراجع) : (مطلوب/Required) | Date of first visit (تاريخ الزيارة الأولى): (اليوم-الشهر-السنة dd-mm-yyyy) |
|--|---|

| | | |
|---|--|---|
| Project location/code موقع / رمز المشروع | Clinic location/code موقع / رمز العيادة | Counselor name/code اسم / رمز المستشار |
|---|--|---|

معلومات عن المراجع

| | |
|--|---|
| 1.1 Name (only when appropriate) الاسم (فقط عندما يكون ذلك ملائماً) | 1.3 Permission to contact – يسمح بالاتصال به – <input type="radio"/> No / لا <input type="radio"/> Yes – how / نعم- كيف / |
| 1.2 Address / phone – العنوان / الهاتف – | Informed consent الموافقة المستنيرة <input type="radio"/> Confidentiality explained – شرح السرية – <input type="radio"/> Role of counselor – دور المستشار – <input type="radio"/> Overview of psychosocial program لمحة عامة عن البرنامج النفسي الاجتماعي |

| | | | |
|---|---|---|--|
| Age (العمر) | (سنة تماماً – full years) | 1.4 School/education المدرسة/التعليم | Village code – رمز القرية – |
| Sex (الجنس) | <input type="radio"/> Male (M) – ذكر <input type="radio"/> Female (F) – أنثى | 1.5 Marital status الوضع العائلي <input type="radio"/> Single – عزيب / عازبة <input type="radio"/> Married متزوج <input type="radio"/> Divorced – مطلق <input type="radio"/> Widowed – أرمل <input type="radio"/> Partner missing / left فقدان/ ترك الشريك | 1.6 Family tree of client شجرة العائلة للمراجع |
| 1.7 Social situation (housing, employment, finances) – الوضع الاجتماعي (المسكن، العمل، التواحي المالية) – | | | |

Coping mechanisms**آليات التكيف**

4.1. Coping strategies used for most important complaint (including seeing other professionals/traditional healers/religious leaders consulted or use of distraction, medication, alcohol/ drugs)

استراتيجيات التعامل أو التكيف المتبعة بالنسبة للمشكلة الأهم (بما في ذلك مراجعة الاختصاصيين الآخرين / المعالجين التقليديين / الوعاظ الذين تمت استشارتهم أو استعمال تثقيت الإتياب والأدوية والكحول / المخدرات)

4.2. Possible solutions for complaint – الطول المعقفة للشغرى –

4.3. Social support network (family, friends, neighbours etc.) – شبةة الدعم الإجماعى (العقلة، الأصقاء، الجيران، ... إلخ) –

General check-up**فحص عام**

| | |
|---|---|
| 5.1. Suicide risk? – مخاطر الانتحر – <input type="radio"/> No – لا <input type="radio"/> Yes – نعم | 5.2. Risk of violence? (including domestic violence) مخاطر العنف: (بما في ذلك العنف المنزلى) |
| 5.3. Observed problems with thinking (orientation, memory, concentration, psychotic symptoms): ملاحظة وجود مشاكل في التفكير (إدراك ما يدور حول الشخص، الذافرة، التركيز، أعراض الاضطراب النفسى) | |
| 5.4. Psychiatric Diagnosis? (only diagnosis of psychiatrist or medical doctor) تشخيص الطب النفسى: (تشخيص الطب النفسى أو الطبيب العام فقط) | 5.5. Other Serious Medical Diagnosis, if any تشخيص الحالات الطبية الخطيرة الأخرى، إن وجدت |
| 5.6. Medication / Self-Medication (name, dosage, duration) – الأوية العلاجية / الأوية العلاجية الذاتية (الاسم، الجرعة، المدة) – | 5.7. Substance Abuse / إساءة استعمال المواد: <input type="radio"/> No – لا <input type="radio"/> Yes (type and duration) – نعم (النوع والمدة) |

Observations (appearance, hygiene, mood, affect, anxiety, vigilance, behavior, speech, contact, eye contact, others) – ملاحظات (المظهر، النظافة، المزاج، التأثر، القلق، التيبه، السلوك، الكلام، الاتصال، الاتصال البصرى، وغيره) –

Client N°:

Mutual agreement on future interventions الاتفاق المتبادل على التدخلات المستقبلية

Agreement for treatment focus/objective discussed? – الموافقة على تركيز العلاج / مناقشة الهدف من ذلك؟ –

Goals of the Client / أهداف المراجع

- -1
..... -2
..... -3

Counsellor Treatment Plan خطة علاج المستشار

Summary of Counsellors (additional) – ملخص المستشارين (الإضافي) –

Counsellor's hypothesis of most important complaint – فرضية المستشار المتعلقة بالمشكلة الأهم –

Focus of intervention of counselor

- تركيز تدخل المستشار
○ 1. Inner problems / المشاكل الداخلية
○ 2. Lack of skills / الإفتقار إلى المهارات
○ 3. Overwhelming feelings / المشاعر الغامرة
○ 4. Practical problems / المشاكل العملية
○ 5. Trauma-related symptoms
الأعراض ذات العلاقة بالصدمة
○ 6. Psychiatric support / treatment
الدعم / العلاج النفسي

Objective of therapeutic intervention (what do you want to achieve?) – أهداف التدخل العلاجي (ما الذي تريد تحقيقه؟) –

Therapeutic interventions – التدخلات العلاجية –

Client File – file closure**ملف المراجع- إغلاق الملف**

Client N° (رقم المراجع) : (مطلوب/Required)

Total number of sessions (العدد الإجمالي للجلسات):

Date file closed (تاريخ إغلاق الملف): (dd-mm-yyyy/اليوم-الشهر-السنة)

| | |
|---|---|
| Main presenting complaint – status at last visit الشكوى الرئيسية المقدمة- الحالة في الزيارة الأخيرة <input type="radio"/> 1. Completely resolved – تم حل المشكلة بالكامل <input type="radio"/> 2. Decreased – انخفضت حدة المشكلة <input type="radio"/> 3. At same level – بنفس المستوى <input type="radio"/> 4. Increased in severity – زادت حنتها | Complaint rating at last visit تصنيف الشكوى عند الزيارة الأخيرة 1 2 3 4 5 6 7 8 9 10 ⊕ ⊖ ⊕ |
| Type of exit – نوع المغادرة <input type="radio"/> 1. Discharged – إخراج <input type="radio"/> 2. Drop out: Unable to trace/no reason is given انسحاب: عدم القدرة على تتبع مكانه / لم يعط أي سبب <input type="radio"/> 3. Drop out: Different expectation/only information needed انسحاب: اختلاف التوقعات / الحاجة إلى المعلومات فقط <input type="radio"/> 4. Drop out: Dissatisfied with the service انسحاب: عدم الرضى عن الخدمة <input type="radio"/> 5. Drop out: Client reports he/she is feeling better انسحاب: يفيد المراجع بأنه / بأنها تشعر بالتحسن <input type="radio"/> 6. Relocated/lives too far away تغيير الموقع / يقطن بعيداً جداً <input type="radio"/> 7. OTHER – أخرى | Functional rating at last visit تصنيف الأداء عند الزيارة الأخيرة 1 2 3 4 5 6 7 8 9 10 ⊕ ⊖ ⊕ يحول إلى / Referred to <input type="radio"/> 1. Psychiatric care (primary/specialised) رعاية نفسية (تولوية أو متخصصة) <input type="radio"/> 2. Primary health care – رعاية صحية أولية <input type="radio"/> 3. Hospital care – رعاية صحية في المستشفى <input type="radio"/> 4. Non-medical organizations منظمات غير طبية <input type="radio"/> 5. Social welfare – الرعاية الاجتماعية <input type="radio"/> 6. OTHER – أخرى <input type="radio"/> 7. Group counselling – individual (MSF). مجموعة الإرشاد – الفردية (التي تقيّمها أطباء بلا حدود) |

Notes : – ملاحظات

ANNEX 2 - List of Presenting Complaints and Details

MSF MH Monitoring Guideline, January 2014

1. Age related problems

- 1.1. School related (learning difficulties etc.)
- 1.2. Old age related
- 1.3. OTHER: please define

2. Physical complaints²

- 2.1. Unclear single physical complaint/aches
- 2.2. Unclear multiple physical complaints/ aches
- 2.3. Palpitations (heart pounding)
- 2.4. Indigestion (such heartburn, stomach burn, upset stomach) without physical cause
- 2.5. Intense physiological distress
- 2.6. Hunger/malnutrition
- 2.7. Body weakness
- 2.8. Heat/heaviness in any body part
- 2.9. Epilepsy
- 2.10. T.B.
- 2.11. HIV/AIDS
- 2.12. Other chronic illness
- 2.13. OTHER: please define

3. Social functioning

- 3.1. Isolation/no friends
- 3.2. Displaced
- 3.3. Too much duties (household, work related)
- 3.4. Idleness/boredom (no work/duties, no social activities)
- 3.5. Difficulty saying 'No'
- 3.6. OTHER: please define

4. Family related problem(s)

- 4.1. Marriage/relationship problem
- 4.2. Family discordance/tension
- 4.3. Domestic violence (of client or other family member)
- 4.4. Divorce/ Husband run off
- 4.5. Separation from family or family members (due to conflict) other than lost or abducted
- 4.6. Inability/difficulty getting children
- 4.7. Concerns about children
- 4.8. Child raising problems (other than school related problems)
- 4.9. OTHER: please define

5. Economic Functioning

- 5.1. Unable/difficulty paying school fees/ uniforms/ schoolbooks
- 5.2. Female headed household
- 5.3. (Single) Children headed household
- 5.4. Poverty/ substantial lack of resources/ no finances
- 5.5. OTHER: please define

² This category can only be used in combination with consultation of medical staff (nurse, clinical officer, medical doctor)

6. Behaviour related

- 6.1. Aggression/ anger
- 6.2. Frequent conflicts
- 6.3. Shyness
- 6.4. Loss of morality (such as juvenile delinquency, no obedience etc.)
- 6.5. Eating problem (not or eating too much)
- 6.6. Loss of control over emotions
- 6.7. OTHER: please define

7. Anxiety related complaints

- 7.1. Flashbacks (feeling the event happens again)
- 7.2. Unwanted images/thoughts
- 7.3. Sleeping problems (night mares, bad dreams, falling/staying a sleep)
- 7.4. Fear/anxiety, intense psychological distress, hyper-vigilance
- 7.5. Constant worrying
- 7.6. Avoidance of people, places, conversations etc.
- 7.7. Amnesia (memory problems)
- 7.8. Not feeling anything (Feeling detached, small range of emotions)
- 7.9. Being restless
- 7.10. Concentration problems
- 7.11. Worrying
- 7.12. Nervousness
- 7.13. Startled responses
- 7.14. Becoming mute/ stop talking
- 7.15. Witch craft/ Jin related problems
- 7.16. Spiritual crisis
- 7.17. OTHER: please define

8. Mood related problems

- 8.1. Sadness for long time during the day for several weeks
- 8.2. Crying a lot, not being able to stop
- 8.3. No pleasure or loss of interest in normal daily activities (adjusted for the situation such as camp condition)
- 8.4. Disinterest in caring for themselves (food, clothing, hygiene)
- 8.5. Low energy/ tiredness of big part of the day
- 8.6. Feeling worthless
- 8.7. Feeling ashamed
- 8.8. Lack of future perspective
- 8.9. Suicidal thoughts
- 8.10. Suicidal attempt(s)
- 8.11. Withdrawn (prefer being alone, no social life)
- 8.12. Apathy/ indecisiveness
- 8.13. Not being able to finish things
- 8.14. Guilt (not survivor guilt, see 9.7.)
- 8.15. OTHER: please define

9. Loss/Mourning

- 9.1. Partner
- 9.2. Parents(s)
- 9.3. Child (this includes death of born, unborn child)
- 9.4. Siblings
- 9.5. Other relatives
- 9.6. Friend
- 9.7. Missing/ abducted family member (nuclear or other)
- 9.8. Survivor guilt
- 9.9. OTHER: please define

10. Other Serious Mental Health Condition(s)

10.1. Substance abuse

10.2. Schizophrenia/ psychosis (including delusions)

10.3. Delirium

10.4. Organic brain damage

10.5. Dementia

10.6. OTHER: please define

ANNEX 3 - List of Precipitating Events and Details

MH Monitoring Guideline, January 2014 23

Below is a list of events that people have reported. If you want to add events please define them as accurately as possible, but first try to use existing event options. Always consult MH advisor and Health advisor before starting to monitor the new events categories specifically.

1. Psychological Violence

These include:

- 1.1. Having your home (or important place like school or workplace) severely damaged or destroyed
- 1.2. Fleeing or hiding from soldiers or enemies
- 1.3. Having to lie to protect yourself or others (includes signing official statement to protect yourself or others)
- 1.4. Living in the middle of conflict, and being forced into dual loyalties to survive
- 1.5. Being threatened with harm or feeling like you are in serious danger
- 1.6. Being in an area of active conflict combat, but you were not actively participating and were not injured
- 1.7. Actively participating in combat either as a soldier or civilian fighter
- 1.8. Forced to join military
- 1.9. You refused or escaped from imposed military duty
- 1.10. Being near death because of illness or injury
- 1.11. Your pregnancy (for men: your wife's) was threatened, or a young baby died because of conflict conditions
- 1.12. Death of a family member besides a young baby due to war/conflict/criminal
- 1.13. Disappearance of family member
- 1.14. Death of friends due to conflict
- 1.15. Having to abandon injured, dead, or dying people
- 1.16. Death of your child related to conflict
- 1.17. Death of spouse related to conflict
- 1.18. Being lied to or being made to feel uncertain about family member's whereabouts
- 1.19. Being abandoned by your family while you were in prison
- 1.20. Feeling like you were abandoned by allies during the conflict
- 1.21. Feeling like you were deceived by your own leaders or high-ranking officials
- 1.22. Being forced to abandon your child(ren)
- 1.23. OTHER: definition is needed in project
 - o 1.23.1 project defined other item #1
 - o 1.23.2 project defined other item #2
 - o 1.23.3 project defined other item #3

2. Physical violence (Intentional)

These include:

- 2.1. Directly exposed to chemical weapons
- 2.2. Being injured in active combat
- 2.3. Being shot or shelled with explosives
- 2.4. Physical violence from non-family member
- 2.5 OTHER

MH Monitoring Guideline, January 2014 22

3. Intentional abuse during detention

These include:

- 3.1. Forced to stand, kneel, or walk for a long time
- 3.2. Being forced to attend party activities or having ideas or beliefs forced on you ("brainwashing")
- 3.3. Being intimidated or "blackmailed"
- 3.4. Being humiliated in front of others (stripped naked, insulted, screamed at, beaten)
- 3.5. Being beaten in front of family or friends
- 3.6. Being handcuffed, tied up, or shackled
- 3.7. Being blindfolded
- 3.8. Being intentionally NOT told what was going to happen to you next or where you were going to be taken
- 3.9. Being taken and left in an unknown place
- 3.10. Being hit, slapped, beat, or kicked by a person or with an object
- 3.11. Having your ears, eyes, nose, or mouth injured with objects
- 3.12. Having any part of your body subjected to burning, freezing, or electrical shocks
- 3.13. Having your body injured by hanging, needles, or having hair or nails pulled
- 3.14. Being immersed in water or sprayed with high-powered water
- 3.15. Being cut or stabbed
- 3.16. Being nearly killed by hanging or suffocation, near-drowning, or other intentional injury (like being dragged)
- 3.17. Being abused with urine or faeces
- 3.18. Being abused with bright lights, loud noises, or bad smells
- 3.19. Being placed in solitary (isolated) confinement or being deprived of sensations
- 3.20. Being deprived of adequate food or water
- 3.21. Being awakened repeatedly and being deprived of sleep
- 3.22. Having medical care withheld when you were very sick
- 3.23. Living in very poor conditions in prison (crowding, problems with sanitation or temperature)
- 3.24. Being forced to work hard or for a long time or under very bad conditions
- 3.25. Being interrogated, physically searched, stopped for identification and questioned
- 3.26. Being falsely accused of things you did not do or being arrested
- 3.27. Forced to make a confession about yourself or others
- 3.28. Being threatened with severe injury or execution
- 3.29. Being made to watch while others were tortured or executed, or hearing others being injured or tortured
- 3.30. Being confined in a village, town, or house by soldiers or police
- 3.31. Being jailed for less than three months
- 3.32. Being in jail, prison, or a re-education camp for more than three months
- 3.33. OTHER: definition is needed in project

4. Sexual trauma or abuse

These include:

- 4.1. Any unwanted sexual experience
- 4.2. Having your private parts touched when you do not want that
- 4.3. Being threatened to be sexually molested or raped (but it didn't actually happen)
- 4.4. Having your private parts harmed (cut, burned, cold or heat, electricity, etc...)
- 4.5. Having your private parts penetrated by objects or hands
- 4.6. Being "raped" (forced to have sexual intercourse *vaginal, anal, oral+ against your will
- 4.7. OTHER: definition is needed in project

NOTE: perpetrator is not registered here because it is not part of the formal medical/psychosocial intake. Furthermore, if we use this category it has to be asked to every client reporting sexual violence that we do not want.

5. Witnessing, hearing about abuse, injury or death

These include:

- 5.1. Seeing your family or friends get seriously injured or ill because of conflict
- 5.2. Seeing other people get seriously injured or ill because of conflict
- 5.3. Seeing a family member or a friend being raped
- 5.4. Seeing another person being raped
- 5.5. Seeing your family or friends being killed
- 5.6. Seeing others being killed
- 5.7. Seeing someone being mutilated or blown-up
- 5.8. Watching other people die
- 5.9. Helping ill or wounded people (includes refugees)
- 5.10. Seeing dead bodies or parts of human remains
- 5.11. Digging up, burying, or handling dead bodies or parts of human remains
- 5.12. Seeing organized violence, mass demonstrations, or horrible events on television
- 5.13. Seeing injury or death of many people at once, or witnessing mass graves
- 5.14. Seeing injured or dead animals
- 5.15. Heard about people being abused by harsh methods
- 5.16. Heard that children or other innocent people were injured or killed
- 5.17. Heard about mass killings and people being put in mass graves
- 5.18. OTHER: definition is needed in project

6. Deprivation and discrimination

These include:

- 6.1. Having very little food, water, or clothing because of discrimination
- 6.2. Having to live in poor conditions because of the violence (fleeing, in mountains, poor shelter and hygiene)
- 6.3. Having your home, business or important personal property confiscated
- 6.4. Being forced to stop work or schooling
- 6.5. Being monitored (repeatedly investigated, or watched and followed, or having to report to officials)
- 6.6. Being oppressed (can't gather publicly, meet friends, speak your opinion)
- 6.7. Spiritual or religious oppression, not being allowed to execute your spiritual rituals, to gather, being forced to accept (other) religion etc.
- 6.8. Being forced to work without remuneration (in kind or money)
- 6.9. OTHER: definition is needed in project

7. Domestic discord or violence

These include:

- 7.1. Experiencing severe family conflict because of the conflict
- 7.2. Experiencing severe family conflict NOT because of the conflict
- 7.3. Experiencing violence from a family member because of the conflict
- 7.4. Experiencing violence from a family member NOT because of the conflict
- 7.5. Experiencing marital problems NOT because of conflict
- 7.6. Experiencing marital problems because of conflict
- 7.7. Abuse from husband
- 7.8. OTHER: definition is needed in project

8. Displacement, migration and related problems

These include:

- 8.1. Being moved to a government area or “new economic area”
- 8.2. Having to flee from your home or community because of danger
- 8.3. Having to flee from your home or community because there is no work or because of other discriminations
- 8.4. Being beaten up or poorly treated in a IDP/refugee camp
- 8.5. Thinking you would not ever be able to leave a IDP/refugee camp
- 8.6. You or family members were denied refugee or asylum status
- 8.7. Feeling afraid that you will be sent back to your country from a IDP/refugee camp
- 8.8. There was separation from family members during fleeing or migration
- 8.9. OTHER: definition is needed in project

9. Separation and isolation

These include:

- 9.1. Raising your children alone
- 9.2. Your children were often alone because of conflict circumstances
- 9.3. Being taken away by enemies (armed actor, bandits, criminals), and separated from your family
- 9.4. Having a spouse or a child be put in jail, prison, or camp
- 9.5. Being separated from your family because of conflict circumstances
- 9.6. NOT being able to take care of family members because of separation
- 9.7. NOT being able to see a family member who is dying, or can't witness burial
- 9.8. OTHER: definition is needed in project

10. Non violence related

11. Others

12. Traumatic experience linked to natural disasters

These include:

- 12.1 Having your house / business or personal belongings severely damaged or destroyed
- 12.2 The death of a family member
- 12.3 The disappearance of a family member
- 12.4 Having been unable to help injured people
- 12.5 Not knowing the whereabouts of the body of a family member or not being able to access it.
- 12. 6 Being injured
- 12.7 Not being able to continue to work or go to school

ANNEX 4 - Model of Semi-Structured Interview

Semi-structured interview with staff working in the context

*Blank spaces will be filled with the name of the location where the person works (ex: Sanliurfa-Turkey, Akçakale-Turkey, Kobane-Syria)

*Interviews will be conducted by skype

*No information will be requested about specific cases. If any information regarding a case is mentioned during the interviews even without being requested, such information will not be used in any way in the study.

1 – Introduce yourself/ name/ age/ organization/ position/ experience working in the context/ how long.

2 – How do you think war affects the mental health of Syrian refugees living in _____?

3 – What are the most affected groups according to gender/ age, and why?

4 – How does culture impact negatively on MHPSS needs of refugees?

5 – How does culture impact positively on coping/ resilience of refugees?

6 – Do new comers from Syria/ the conflict zones face different MHPSS problems compared to those refugees who are settled in the region already?

7 – Do you see any change in the kind of MHPSS problems faced by refugees who came in the beginning of the conflict (2012-2014) and those who came more recently (2015 onwards)? Any significant change in the last two years?

8 – What are the main challenges on providing MHPSS care to Syrian refugees in _____?

9 – What are the main benefits on providing MHPSS care to Syrian refugees in _____?

10 – What could improve on MHPSS care to Syrian refugees in _____?

11 – What kind of MHPSS care is available in _____?

12 – Do you think that MHPSS care available to Syrians now in _____ were available in Syria before the war? If yes, which of them?

13 – Do you want your name to be disclosed in the publications related to the thesis or would you prefer to be anonymous?

14 – Do you give me permission to contact you later for any clarification?

ANNEX 5 - Model of Informed Consent Form

Informed Consent to Participate in a Research Study

Topic of the study: Impact of war on the mental health of Syrian refugees in Southeastern Turkey and North Syria.

Study's responsible: Nádia Duarte Marini, psychologist, Médecins Sans Frontières (MSF), Student of Master in Mental Health Policy and Services of the NOVA University of Lisbon, Portugal, Faculty of Medical Sciences.

Contacts: namarini@yahoo.com.br; Skype: ndmarini; Phone number (landline): +55 11 25389951/ WhatsApp only: +90 538 045 3443.

Objectives of the study: 1) Describe the impact of the Syrian civil war in the mental health of Syrian refugees who attend mental health community-based services in Southeastern Turkey and North Syria; 2) Promote good practices in that field of study; 3) Strengthen the relation between practice and research.

Ultimately, this study will be published in a Master's thesis format, and its related publications, such as articles in scientific journals and presentations at scientific events.

Study methods: If you agree on participating in this study, you will be interviewed by the study's responsible via Skype or telephone call in a date and time previously arranged by e-mail. This arrangement is necessary because the study's responsible is located in another country different than yours.

In the interview, you will be asked questions about your perception of the topic of the study according to your experience. The call duration is estimated to last from 40 to 60 minutes, and your voice or image will not be recorded. The interviewer may take written notes during the call in order to register a summary of the ideas discussed. If you agree so, after the interview you may be contacted by the study's responsible in order to clarify any point or be asked a new question related to the study.

No information will be requested about specific cases/patients to you. If you mention any confidential information regarding a case during the interviews, even without being requested to do so, such information will not be used in any way in the study.

The information provided by you will be analyzed along with quantitative data collected by MSF in your project, literature of the field and the experience of the study's responsible, guaranteeing it will not be taken out of context.

Risks of being in this study

There are no expected risks of being in this study. No information provided by you will be used against the overall purpose of the study, which is abovementioned, or against you and the organizations involved.

Annexes - Consent form

Benefits of participating in the study

You will be contributing to give more visibility to mental health and psychosocial needs of Syrian refugees outside your region.

Confidentiality

Fragments of the interview and indirect quotes may compose part of the analysis that will be published in the format of a Master's thesis and related publications, such as presentations in scientific events and articles in scientific journals.

In such material, your identity will be disclosed, unless you do not want to. In this case, you can be referred by a fictitious name. You will be asked about your option in the end of the interview. You may also change your option at any moment after it, as long as you express it to the study's responsible before the publication of the thesis, expected to happen after September, 2017.

Right to refuse participation or withdraw at any moment

Your participation in this study is entirely voluntary and you can give up at any time without affecting your relationship with the study's responsible or with the organizations involved. You have the right to not answer any of the questions, as well as withdraw completely from the interview at any moment in the process. You have the right to request that the study's responsible do not use specific content or the entire interview in the study.

Right to have clarifications

You can ask questions about the study and have them answered at any moment before, during or after your participation by talking to the study's responsible via the provided contacts. Feel free to discuss it internally in your organization and express concerns about your participation.

Consent

By signing the line below, you testify that you have read and understood all the information as provided above, as well as you agree to voluntarily participate in this study.

Participant's name

Participant's signature

Date

Study's responsible signature

Date

Annexes - Consent form

