Advanced Quality Learning for Mental Health in Northern Syria

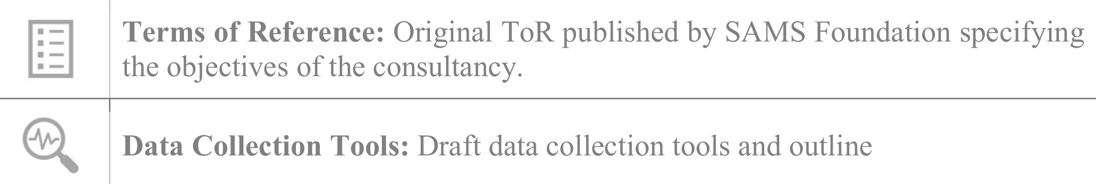
Scoping Study Report

October 2022

Programme Summary

Type of study:	Scoping Study; Research
Start & End-Dates:	May-November 2022
Country:	Syria
Region:	MENA
Specific Locations:	Northwest Syria (Aleppo, Idlib), Northeast Syria (Aleppo, Al-Hasakeh, Ar-Raqqa, Deir-ez-Zor)
Thematic areas:	MHPSS; Education; Capacity Building
Donor	European Union
Author:	Levante International Development LTD www.levante-international-development.org

Additional Documents



	Terms of Reference: Original ToR published by SAMS Foundation specifying the objectives of the consultancy.
	Data Collection Tools: Draft data collection tools and outline

Acronyms

ACU	Assistance Coordination Unit
ANET	Narrative Exposure Therapy
AOAV	Action on Armed Violence
CATTO	Accelerated Trauma Treatment for Children
CBT	Cognitive Behavioural Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
GBV	Gender Based Violence
GIZ	German Agency for International Cooperation
HCWs	Health Care Workers
HE	Higher Education
HIRS	Health Integrated Resilience System Project

HRO	Hope Revival Organization
HRW	Human Rights Watch
ICRC	International Committee of the Red Cross
IDPs	Internally Displaced Persons
iNGOs	International Non-Governmental Organisations
IRC	International Rescue Committee
ISIS	Islamic State of Iraq and Syria
KII	Key Informant Interview
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer
MdM	Médecins du Monde
MENA	Middle East/North Africa
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological and Substance Use
NES	Northeast Syria
NGOs	Non-Governmental Organisations
NWS	Northwest Syria
OCD	Obsessive Compulsive Disorder
ODA	Official Development Assistance
OHCHR	The Office of the High Commissioner for Human Rights
PFA	Psychological First Aid
PM+	Project Management Plus
POMA	Peace of Mind Afghanistan
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
PWDs	People With Disabilities
SAMH	Syrian Association for Mental Health

SAMS	Syrian American Medical Society
SBOMS	Syrian Board of Medical Specialists
SDF	Syrian Defence Forces
ToR	Terms of Reference
UNHCR	The United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UOSSM	Union of Medical Relief and Care Organizations
WHO	World Health Organization

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0. Key Terms and Definitions

Over the course of data collection across the Mental Health & Psychosocial Support (MHPSS) landscape in northern Syria, it was observed that some key terms are used and understood differently within the sector, including between practitioners themselves. For the comprehension of the Scoping Study report, definitions of key terms are set out below.

Table 1- Table showing the main MHPSS terms used in the north of Syria

Terms in English
Mental Health & Psychosocial Support (MHPSS) (الدعم النفسي الاجتماعي) A term used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental health disorder. MHPSS spans the health and protection sectors and can also include services in education, human rights, and physiological needs. *(Inter-Agency Standing Committee)*
Psychiatry (الطب نفسي) A specialty within the field of medicine that provides care by a medical doctor who specialises in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems. Because they are physicians, psychiatrists can

prescribe medication and order or perform a full range of medical laboratory and psychological tests which, combined with discussions with patients, help provide a picture of a patient's physical and mental state. *(American Psychiatric Association)*

Psychiatric Nursing (التمريض النفسي)
A specialty within the field of nursing that provides care to individuals with mental disorders or behavioural problems. Their specific responsibilities include assisting patients with activities of daily living, administering psychotropic medication and managing side effects, assisting with crisis management, observing patients to evaluate their progress, offering guidance and interpersonal support, and educating patients and their families about mental health and lifestyle choices. *(American Psychological Association)*

Clinical psychology (علم النفس السريري)
The branch of psychology that specialises in the research, assessment, diagnosis, and treatment of emotional and behavioural disorders. Clinical psychologists are doctorate-level professionals [PhD or PsyD] with training in research methods, assessment procedures such as interviewing and psychological testing, and a wide array of interventions such as psychotherapy, marital or family therapy, group therapy, cognitive rehabilitation, and social learning. *(American Psychological Association)*

Counselling psychology (الارشاد النفسي)
The branch of psychology that uses culturally sensitive practices to help people improve their well-being, resolve crises, and function better in their lives. It focuses specifically on normative life-span development, addressing both individuals and the systems or contexts in which they function. In contrast to a clinical psychologist, who usually emphasises maladaptation, a counselling psychologist emphasises adaptation, adjustment, and more efficient use of the individual's available resources. *(American Psychological Association)*

Psychosocial Support (الدعم النفسي الاجتماعي)
A term adopted by the international community and WHO to refer to culturally appropriate trainings and services to support the wellbeing of communities devastated by a disaster. It is a broad term describing a range of focused but typically non-specialised services for those in pressing need. These services can range from mental health counselling, psychoeducation, and group support to spiritual support and community or family assistance. *(American Psychological Association)*

Psychotherapy (العلاج النفسي)
Any psychological service provided by a trained professional that uses forms of communication to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behaviour patterns. Psychotherapy may be provided to individuals, couples, families, or members of a group. There are many types of psychotherapy, but generally they fall into four major categories: psychodynamic, cognitive or behaviour therapy, humanistic, and integrative. *(American Psychological Association)*

mhGAP (Mental Health Gap Action Programme) (رأب الفجوة في الصحة النفسية)
A programme developed by WHO aimed at scaling up services for mental, neurological, and substance use (MNS) disorders in low- and middle-income countries. mhGAP supports the integration of services for MNS disorders into primary healthcare settings by training general physicians, nurses, midwives, and other health practitioners in basic mental health support. *(World Health Organization)*

Psychological First Aid (الاسعافات النفسية الاولية)
An initial disaster response intervention with the goal to promote safety, stabilise survivors of disasters and connect individuals to help and resources. The purpose of PFA is to assess the

immediate concerns and needs of an individual in the aftermath of a disaster, and not to provide on-site therapy. *(American Psychological Association)*

1. Executive Summary

Syrian American Medical Society Foundation (SAMS) have commissioned a Scoping Study to gauge the feasibility of implementing advanced academic programmes for MHPSS professionals in Northern Syria. In the relative absence of available and accessible information on the MHPSS landscape in Syria, SAMS posed a wide-ranging series of Research Questions organised into two study components 1) **MHPSS Workforce Assessment** and 2) **MHPSS Education Assessment**.

A mixed-methods approach was used for the study, comprising a Desk Review of available literature, Key Informant Interviews with stakeholders involved in MHPSS provision across northern Syria, and structured surveys with the MHPSS workforce, current students and potential entrants to the workforce, and health facilities.

Workforce Assessment

Comprehensive and accurate estimates of the prevalence of mental health issues in northern Syria are challenging to determine - yet the scale of need is clear following years of conflict, displacement and lack of access to health services. Despite the high need, there are a number of interrelated factors that complicate the population's awareness of, and demand for MHPSS services - including stigma/discrimination, gender norms, lack of cultural adaptation of services and distrust/cynicism towards NGOs (See **Demand for MHPSS services** and **Political, Social & Cultural Barriers**).

MHPSS services are almost exclusively driven by the humanitarian sector with very limited private sector services available. Even within the humanitarian response, MHPSS is not a top priority, and is often not the main focus of funding (i.e it is often a component of multi-sectoral interventions principally targeting protection, education or health). NGOS are both the primary employers and one of the primary trainers/producers of new cadres, not only in the MHPSS workforce but also in the health workforce more generally. This means that NGO access and funding determine service provision and employment opportunities.

The protracted conflict has led to an exodus of healthcare workers. The crisis has exacerbated the pre-conflict geographical inequalities – where northern Syria has long had the lowest availability of health services and healthcare workers. Understanding the characteristics/distribution and estimating the size of the available workforce is complicated by overlapping/inconsistent naming of professions, loose terminology, double counting and competition between NGOs which fuels a reluctance to share information. This study surveyed a total of 275 MHPSS workers from Aleppo (Azaz and Afrin), Idlib, Ar-Raqqa, Al-Hasakeh (including Qamishli) and Deir-ez-Zor. Using this data, the Workforce Assessment breaks down and categorises the different types of workers present in Syria: Psychosocial Workers (PSWs), Trainers/Supervisors, Social/Protection Workers and Case Managers, Psychologists, mhGAP doctors, Community Health Workers, Nurses and Teachers. A high-level overview of the characteristics of these workers in terms of roles and responsibilities, workplaces, typical working hours, workloads and typical salaries can be found under **MHPSS Workforce Characteristics**.

Onset of the conflict caused many to leave their studies early, enter the workforce, or start work in different fields. This, along with the relatively unregulated nature of MHPSS services in the region, has led to varied educational backgrounds among workers. Evidence from KIIs and surveys suggest that soft skills and life experience are often valued over degrees and certification, especially for less

specialised workers like PSWs. More specialised workers are often educated outside Syria, or are still pursuing full qualifications.

Career pathways are informal, ill-defined and highly reliant on the consistency of aid funding. Training and developmental opportunities for those currently working are often pieced together by NGO employers across different projects and pots of funding - and this can lead to people working in roles and under titles for which they are not fully (or formally) qualified. For more specialised cadres (Psychologists, Psychiatrists), the most viable way to develop careers or further specialise is to pursue opportunities outside of Syria. Overall, of the MHPSS professionals surveyed, those in NES were the most ambivalent about pursuing careers within Syria in the future.

Data was generated through the survey of job satisfaction and factors which affect retention and delivery. For workers across all roles, locations, and genders, 'community recognition and respect' is a key motivation for remaining in their roles – and it appears that the majority of respondents do feel they are currently receiving this support. Incentives for professional development are also very important. Aside from the issues of improved pay and a need for increased training opportunities/ professional development, a recurring theme was a need for 'appreciation' and 'encouragement' – in particular from management, but also from society more generally.

In terms of supervision, protocols and the regulation of MHPSS service provision: Insights from KIIs suggest a general pattern of PSWs being supervised by senior PSWs and psychologists from within their organisation, and mhGAP doctors supervised by psychiatrists where these are available. Psychologists and psychiatrists are supervised remotely and cross-border, due to the lack of specialists inside Syria. Whilst there is evidence of some international protocols being implemented, as well as local approaches in early development, it is clear that there remain significant gaps when it comes to patient protocol across northern Syria. Regulation of MHPSS practice is largely outdated or unspecific to the current context, and NGOs tend to regulate themselves as opposed to deferring to local authorities.

This study further offers a mapping of the **Main Stakeholders Related to MHPSS Service Provision in Northern Syria** as well as **Professional Associations and Networks**.

Education Assessment

Levante sampled 298 students from across locations in NWS and NES – from fields of study identified by Key Informants as academic backgrounds from which the MHPSS workforce in Syria often originates. A large proportion of the sample represents students in Psychology/Psychological Counselling (36%), Education (26%), Medicine (10%) and Nursing (7%). The main institutions where students reported studying are: Free Aleppo University (NWS), University of Idlib (NWS), Gaziantep University's Afrin campus (NWS), Al-Furat University (NES), and Al-Hasakeh School of Nursing (NES).

Higher education (HE) in Syria has undergone a massive upheaval since the start of the conflict in 2011. A vastly diminished HE system in Syria, alongside an accelerating economic crisis and an ongoing conflict, has resulted in significant barriers to student enrolment and continued enrolment. 16% (47) of the students surveyed were unable to complete their courses or are ending early – with financial and transportation issues being the two biggest reasons, followed by dissatisfaction in the quality of education. Flexible scheduling emerges from the study as one of the key recommendations for how these barriers can be mitigated.

The study maps out existing degrees and available training programmes, which include the universities listed above. Due to Al-Furat University's GoS affiliation, additional universities in NES were also identified, including Al-Sharq University, Rojava University, and Kobani University. The principal deliverers of non-academic MHPSS training in northern Syria are NGOs (particularly Syrian

expatriate organisations) and international agencies, as well as the MHPSS technical working groups, which developed a training manual for PSWs. Most trainings are in WHO's mhGAP, PM+, and SH+ programmes, as well as GIZ's MHPSS supervision training, though a number of one-off, unstandardised trainings are also implemented. Of those surveyed, 165 MHPSS Worker respondents (60%) said they have received MHPSS training in their current or previous role.

The MHPSS workers and students surveyed both named PM+, technical skills for working with children, suicide prevention and CBT as some of the top key training needs for MHPSS workers in their region. They also recognised key gaps in soft skills such as communication and developing empathy for others. 42% of students surveyed reported having had some form of internship, with these respondents largely towards the final stages of their programme of study. Male students were more likely to have had internships than females. A large proportion (100) said they are currently working - again, those currently working and studying and more likely to be men than women.

55 health facilities across all governorates of NES and NWS were surveyed, including MHPSS centres and clinics, psychiatric hospitals, mobile clinics, PHCs, and NGO facilities. The survey assessed the kind of services offered by these facilities, the background and roles of their staff, capacity for serving as a practicum site, availability of supervisors, experience delivering trainings, and any support that would be needed to carry out a practicum. In brief, there are a number of sites in both regions that can adequately train PSWs. There are also 4 MHPSS centres in NWS and 1 MHPSS centre in NES that could potentially host psychiatric nursing and clinical psychology students.

The Scoping Study makes a number of **Recommendations** for the success of the academic programs SAMS intends to develop and deliver - with emphasis on Program Content and Design, Recruitment, Success and Sustainability and Strengthening the MHPSS Sector more generally. Further, the study identifies opportunities and gaps for further research to build in the findings presented.

2. Introduction

2.1 Background to Study

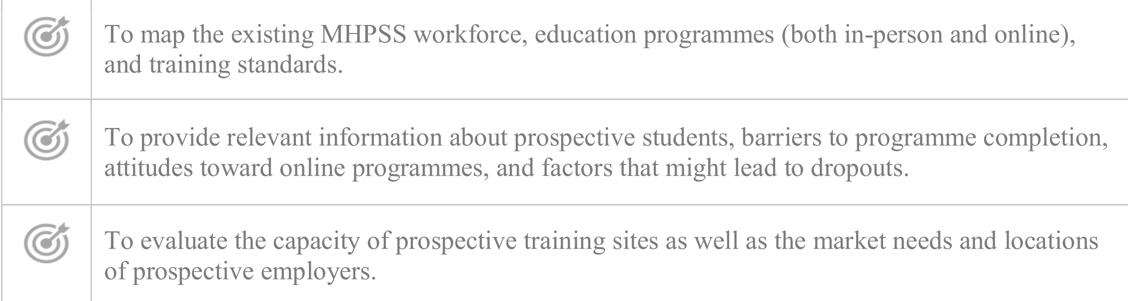
In March 2022, Levante International Development (Levante) was commissioned by the Syrian American Medical Society Foundation (SAMS) to produce a Scoping Study that would gauge the feasibility of implementing advanced academic programmes in key MHPSS fields for individuals in northern Syria. The goal of these academic programmes would be to:

- Provide eligible individuals in northern Syria with access to accredited education programmes, employment and career advancement in MHPSS fields, as these opportunities are currently unavailable

- Build capacity among the local MHPSS workforce so they can provide safe, competent, evidence-based support for individuals struggling with mental health challenges

2.2 Study Objectives

The following study objectives were agreed between the SAMS and Levante teams to ensure that the relevant information was gathered and recommendations produced that would allow for an informed approach to the proposed academic programmes.



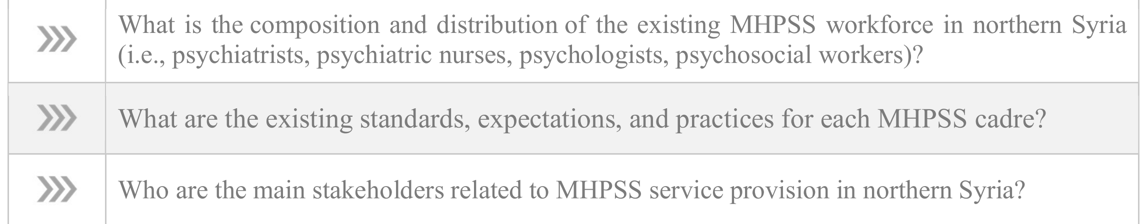
	To map the existing MHPSS workforce, education programmes (both in-person and online), and training standards.
	To provide relevant information about prospective students, barriers to programme completion, attitudes toward online programmes, and factors that might lead to dropouts.
	To evaluate the capacity of prospective training sites as well as the market needs and locations of prospective employers.

2.3 Research Questions

In the ToR, SAMS posed a total of 42 research questions for the Scoping Study (see **Annex 1: List of Research Questions**). These questions are broadly divided into two thematic areas: an **MHPSS Workforce Assessment** and an **MHPSS Education Assessment**. For the purposes of structuring the research and Scoping Study report, these questions have been further organised into categories within the thematic areas, as outlined below:

MHPSS Workforce Assessment

An assessment of the existing MHPSS workforce in northern Syria, with a focus on three overarching research questions:

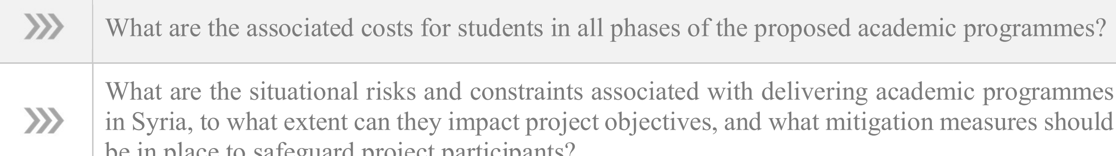


	What is the composition and distribution of the existing MHPSS workforce in northern Syria (i.e., psychiatrists, psychiatric nurses, psychologists, psychosocial workers)?
	What are the existing standards, expectations, and practices for each MHPSS cadre?
	Who are the main stakeholders related to MHPSS service provision in northern Syria?

MHPSS Education Assessment

An assessment of the existing MHPSS education programmes in northern Syria, as well as the potential for implementing new ones, with a focus on five overarching research questions:

	How many eligible candidates are available to receive education in each cadre, and how can we support them in completing these programmes?
	What are the current MHPSS programmes across Syria?
	What are the needs of training sites and their attitudes toward the programme?



⟫	What are the associated costs for students in all phases of the proposed academic programmes?
⟫	What are the situational risks and constraints associated with delivering academic programmes in Syria, to what extent can they impact project objectives, and what mitigation measures should be in place to safeguard project participants?

Given the expected challenges and limitations for the research, a need to establish the viability of answering all questions was identified at the selection and inception stages, informing the phased approach undertaken (See **A Mixed-Methods and Phased Approach**). To allow for more in-depth analysis and the development of comprehensive recommendations, it has been appropriate and logical to group research questions together in some instances. These groupings have been made clear in the findings.

2.4 Research Team

Levante partnered with POMA Global, an organisation with MHPSS expertise across the MENA region, and collaborated with the SAMS MHPSS Specialist to deliver the study:

Table 2 - Table showing the team composition and division of roles

	Organisation Overview	Study Contributions	Key Members
Levante	Levante International Development specialises in supporting humanitarian interventions and development projects globally. The team works across the MENA, sub-Saharan Africa, CIS and south-East Asia regions to support clients - even in the most challenging contexts.	Development and implementation of the research methodology. Analysis of primary and secondary data. Identification of trends and recommendations. Writing the study report	**Rio Jones,** Director and Principal Consultant **Sarulchana Viriyataveekul,** Senior Consultant **Ben Leatham,** Consultant
POMA Global	POMA is a female-led transnational network of psychologists, community leaders, researchers and development practitioners, focused on delivering MHPSS to vulnerable communities and fostering just and equitable societies across Afghanistan, the Middle East and North Africa.	Provision of MHPSS technical expertise, including reviewing relevant documentation and joining relevant stakeholder interviews. Identification of MHPSS stakeholders for interview.	**Lyla Schwartz,** MHPSS Consultant **Hannah Lane,** MHPSS Consultant
SAMS	SAMS began as a professional society for medical professionals in the Syrian diaspora and expanded to provide medical and MHPSS relief for Syrian refugees, IDPs, and host communities following the start of the war. SAMS currently provides services in NW Syria, Turkey, Jordan, Lebanon, Iraq, and Greece.	Development of the project's terms of reference and research questions. Review of data collection tools. Writing and revision of technical content in the report.	**Dana Townsend,** MHPSS Specialist

3. Context in Syria

3.1 Conflict in Syria

For nearly twelve years, since March 2011, Syria has been rocked by conflict. Over 300,000 civilians have been killed (OHCHR, 2022), with Human Rights Watch reporting reoccurring war crimes and human rights abuses across the country (HRW, 2019). Safety fears, a lack of access to basic needs, as well as the deterioration of infrastructure and services has resulted in the world's largest displacement crisis, with over 13 million people – over half the population of Syria – having either fled the country or been displaced within its borders (UNHCR, 2022). These issues remain ongoing with no clear end in sight. What started as a civil uprising has led to a proxy war between regional and global powers. The Government of Syria, supported by Russia and Iran, controls the South of the country and some areas of NWS, including the region around Aleppo. Areas of northern Syria that currently fall outside of Government control include:

- **Idlib.** As the most populated centre in the region, it is militarily controlled by the Hay'at Tahrir al-Sham (HTS) and administered by the Salvation Government (SSG). Many Turkish observation points are spread across the area, based on agreements with Russia. The southern, eastern and western outskirts of Idlib are subjected to frequent shelling and air strikes.

- **Northern Aleppo**, including the Euphrates Shield (between Azaz and Euphrates River) and Olive Branch (Afrin and Azaz districts). These areas are under direct control of Turkey and allied opposition armed groups (OAG) or the national army (NA), and administered by the interim government in coordination with the local councils. The most prominent threats to these areas are repeated shellings by the SDF/GoS and improvised explosive devices that target gatherings and sensitive places. Internal clashes between national army (NA) groups are also a threat, with major axes in Tell Reffat, Maraanaz, Minaq, Ein Daqnah and Mar'e (Euphrates Shield) and Kaimar, Abin-Afrin, Oqayba, and Basselhâya (Olive Branch). In October 2022, areas of northern Aleppo and northern Idlib witnessed clashes between HTS and other factions due to differences in ideology, which led HTS to progress to new areas such as Afrin and Kafr Jannah. This was accompanied by popular protests and ended with negotiation and HTS withdrawal from Afrin, though the situation is still subject to tension.

- **Peace Spring**. This area is isolated from the rest of the opposition-controlled NWS and includes parts of Aleppo, Ar-Raqqa, and Al-Hasakeh. Its only border is with Turkey. It is administered by opposition armed groups (OAG) or the national army (NA) in coordination with local councils and the Turkish authorities. The most prominent dangers in the region are missiles and artillery launched by the SDF in Tall Tamir, Ebo Rasen, and Ain Issa.

- **Northeast Syria.** Bordering Iraq, this area includes the vast majority of Al-Hasakeh, Ar-Raqqa, and parts of Aleppo and Deir-ez-Zor. It is governed by the quasi-autonomous self-declared Autonomous Administration of North and East Syria - a body that is closely affiliated with the Kurdish-led Syrian Democratic Forces (SDF). As of mid-November 2022, following a bomb attack in downtown Istanbul, the Government of Turkey has also renewed attacks on Kurdish positions in the vicinity of various cities such as Kobani (Ein Al Arab), Amuda, Qamishli, Derbaseyya, Derik, Tel Tamr, Qahtaneya, amongst others with both parties to the conflict threatening escalation of hostilities. The attacks typically target specific locations such as oil fields, military bases, power plants, as well as civilian targets. Although ISIS lost its last remaining territory in 2019, it has continued to stage attacks with increasing frequency near the Iraq border - an area that is also subject to periodic raids by the US. These attacks could potentially temporarily delay program activities, such as the directive by the Office of NGOs in Al-Hasakeh delaying any/all training workshops, meetings, and any other

activities other than essential services such as health, distribution of food items, NFIs, and WASH activities.

Over a decade of conflict has led to a significant humanitarian crisis. UNHCR reports that 14.6 million people in Syria are in need of humanitarian assistance (UNHCR, 2022), with civilians in the North facing particularly acute circumstances. An economic crisis, partly fuelled by the war in Ukraine, has compounded the situation, with NGOs and humanitarian organisations struggling to support the now 9 in 10 Syrians living under the poverty line (ICRC, 2022). This is especially true in NES where, despite the rising numbers of IDPs, closure of the Al-Yaroubiah border crossing between Syria and Iraqi Kurdistan in 2020 has limited their access to humanitarian aid. Much of NES now relies on the Semalka border crossing to receive aid deliveries from NGOs, but UN aid does not enter (Katoub, 2022).

3.2 Mental Health in Syria

Of the 13.1 million people across Syria estimated to have health and protection needs, over 50% reside in the northern governorates of Aleppo, Idlib, Al-Hasakeh, Deir-Ez-Zor, and Ar-Raqqa (UNOCHA, 2021). Mental health needs are especially prominent, resulting from extensive trauma and grief, poor living conditions, and inadequate opportunities for social and intellectual stimulation. As with other populations affected by collective violence and displacement, the most prevalent and clinically significant mental problems within Syria are symptoms of emotional distress related to depression, prolonged grief disorder, posttraumatic stress disorder and various forms of anxiety disorders. According to a survey of 1,951 individuals living in Syria, 44% showed signs of a severe mental disorder, 37% showed signs of full PTSD symptoms, and 27% showed signs of both. Only 11% of those surveyed showed no signs of either PTSD or mental health problems (Kakaje, et al., 2021).

Despite the immense need for mental health support, the current healthcare system in Syria is ill-equipped to provide it. Even before the conflict, mental health was a nascent sector with limited opportunities for education. MHPSS services are almost exclusively driven by the NGO sector, with very limited private services available. High levels of stigma around mental illness prevented investment into the sector as well as a demand for these services. As a result, mental health education programmes are sparse, and these specialisations have not been well integrated into the health system's organisational structure. At present there are an estimated 3 psychiatrists, 6 psychiatry residents, and 20 psychologists in NWS along with 3 psychiatrists and 3 psychologists in NES available to provide support (See **MHPSS Workforce Characteristics**). Their time has been stretched thin, and a series of other challenges restrict their work - including challenges crossing between areas and security concerns. Although the need and demand for mental health services have increased dramatically after 11 years of war and displacement, the shortage of qualified MHPSS personnel remains one of the largest barriers to increasing access.

4. Study Design and Approach

4.1 Methodological Approach and Sampling

A Mixed-Methods and Phased Approach

Levante employed a mixed-methods approach that included both quantitative and qualitative data gathered by a range of instruments (See **Data Collection Tools**). With the lack of existing literature

on MHPSS delivery and education in northern Syria, these instruments were also developed and implemented in a phased way, allowing for a more flexible and targeted approach.

In Phase 1 of the study, a Document and Data review was conducted alongside a series of Stakeholder Key Informant Interviews (KIIs), with the aim of achieving the following:

- ➔ Build an understanding of the existing mental health context in Syria, particularly in the north.
- ➔ Begin to identify trends and gaps in MHPSS service delivery and education.
- ➔ Inform tool development and implementation for Phase 2.

In Phase 2 of the study, three surveys were developed utilising the knowledge gathered through Phase 1, and implemented to target different audiences: the existing MHPSS workforce, prospective candidates for academic programmes in MHPSS, and health facilities that may serve as potential sites for a practicum, internship, or absorption of programme graduates. The aim of Phase 2 was to:

- ➔ Collect quantitative data from key target groups across the MHPSS workforce and the Syrian higher education system.
- ➔ Establish what health facilities and training sites exist in northern Syria, and which are best placed to deliver MHPSS training in partnership with SAMS.

Analysis was then conducted on all gathered data and information. See **Data Processing and Analysis** for full details.

Research Ethics and Gender

Ethical, safety and data protection issues were paramount to Levante's approach, with a particular focus on ensuring the wellbeing of our research participants. This meant that considerations of ethics, safeguarding, do-no-harm principles, and accountability were integrated into every stage of the methodology, including but not limited to: a) sensitivity training, b) informed consent and voluntary participation, c) confidentiality/anonymity, d) physical safety of respondents and interviewers, f) non-judgemental and respectful attitudes, and g) provision of information for available resources/support. Levante also firmly believes in a gender-mainstreaming approach. This means we ensured that sampling included adequate representation of female voices and that, where possible, female beneficiaries were interviewed by female data collectors for maximum safety and comfort. Data collection teams were also trained in best practices in gender sensitive approaches. Further, a 'gender-lens' was applied in data analysis to draw out gender disaggregated findings and insights on programming.

Data Collection Tools

Table 3 - Data Collection Tools

Tool Name	Data Type	Description	Rationale	Sampling Approach	Achieved Sample	Challenges & Limitations
Document & Data Review	Secondary Data	Desk review and mapping of existing academic and non-academic reports, professional associations, and the various cadres and terminologies in Syria.	To inform research and tool design, as well as build an understanding of the overall context in Syria.	Reports relevant to MHPSS in Syria were recommended by POMA and SAMS.	See Annex 1 – Bibliography.	Although there is extensive literature on the conflict in Syria, there is limited analysis on the mental health workforce and education system in northern Syria.
Stakeholder KIIs	Primary data (qualitative)	Semi-structured Key Informant Interviews with a range of high-level stakeholders knowledgeable about either the MHPSS workforce or MHPSS education in Syria.	To better understand the following in northern Syria: ➔ The current context regarding MHPSS delivery and education ➔ The gaps between current MHPSS need and provided services ➔ The profile of existing MHPSS workers and of the people seeking a career in MHPSS ➔ The credentials of existing MHPSS service providers ➔ The need for, and existing availability of, MHPSS capacity building and training Interviews also allowed for the identification of themes and knowledge gaps, as well as the creation of case studies.	A 'snowball' approach was employed, based on an initial list of stakeholders identified in collaboration with SAMS and POMA Global. The main criteria for selecting the stakeholders to be interviewed were: ➔ A specialist and/or working in MHPSS, either at the education level or implementing MHPSS activities. ➔ An in-depth knowledge on the context in Syria, especially in the north. Stakeholders were not required to be located inside Syria.	A total of 18 stakeholders were interviewed across a range of different stakeholder groups. See Annex 3 – KII Breakdown.	Some targeted stakeholders were unavailable for participation in the study.

MHPSS Workers Survey	Primary data (quantitative)	A survey of existing mental health workers in northern Syria, targeted at a range of positions and seniorities.	To build a data set on the MHPSS workforce in northern Syria: ➔ Experience, credentials, and workload ➔ Job descriptions, roles, responsibilities and salaries ➔ Mentoring & supervision ➔ Gaps in training ➔ Associations and networks ➔ Career pathways, job security and future intentions ➔ Factors affecting retention and challenges for service delivery ➔ Recommendations for training	MHPSS services were identified across all 5 northern provinces and approached to support with survey distribution. This included hospitals, clinics and community centres.	275 Workers. See **Annex 3** – for a breakdown by role type and location.	Some respondents preferred not to name their precise roles/positions or the organisations with which they work – creating some gaps in the data.
Eligible Candidates Survey	Primary data (quantitative)	A survey of prospective candidates for advanced academic programs in MHPSS, targeted at a range of education levels and fields of study.	To build a data set on prospective candidates for MHPSS training: ➔ Current employment and caring responsibilities ➔ Expectations and attitudes toward programs and preferences ➔ Potential barriers to enrolment and continued enrolment	Relevant academic departments in public and private higher education institutions were identified and approached to support with survey distribution. Students subsequently shared the survey themselves amongst peers, often through existing WhatsApp Groups. Students made themselves contactable by enumerators.	298 responses received from eligible candidates. See **Annex 3** for a breakdown by field of study, level of education and location.	
Facilities Survey	Primary data (quantitative)	A survey of senior employees at Health Facilities and Training Sites who could potentially support practicums or internships for program graduates.	To build an understanding of the existing Health Facilities and Training Sites in Syria, as well as their potential for hosting a new MHPSS academic program.	NWS: Facilities identified in the initial phases as delivering MHPSS services were targeted for data collection. NES: Agencies that manage PHCs were approached to support with survey distribution. Enumerators disseminated surveys to recommended facilities.	55 responses received (11 facilities in NWS and 44 in NES). See **Annex 3** for a list of the facilities and their locations	Many facilities were reluctant to take part without approval from Head Quarters / more senior management – and in some cases, accessing these decision-makers was challenging for the enumeration team.

4.2 Data Processing and Analysis

Approach to Data Analysis

Due to the complex political situation in Syria and the implications on stability and connectivity, it was anticipated that significant gaps in understanding around the MHPSS workforce and education system would be present in existing literature, and that data gathering would face a number of challenges. As a result, data analysis was ongoing to ensure tools could be adapted to meet need, and outreach could be targeted to fill gaps.

Data Collection Methods

With a mixed-methods approach for the study, both qualitative and quantitative data were analysed. The following table outlines the analysis approach taken to each data type:

Table 4 – Table showing the analysis approach to each data type

Primary data (qualitative)	Thematic analysis was carried out on qualitative data to identify key themes and concepts from stakeholder interviews.
Primary data (quantitative)	The data was translated, cleaned, and analysed using statistical software (SPSS, and Microsoft Excel's pivot tables). Data was disaggregated, including by region, location and a number of other relevant factors (i.e., role type, field or study, type of organisation etc.) including age and sex. Where open text responses were used in surveys, common themes were identified and data was 'coded' to allow for quantification and analysis.

4.3 Challenges and Mitigation Measures

	Challenge/Limitation	Steps to Mitigate
⚠	There are no up to date, comprehensive assessments of MHPSS needs and the prevalence of specific mental health needs/conditions in Syria, and specifically in northern Syria.	Information was collected across a range of different sources, cadres, and locations in order to build a clear picture.
⚠	Obtaining reliable and consistent estimates of numbers of specialists is complicated by different definitions (i.e., many working without qualifications, differences in what is considered a psychologist etc.).	Job titles and responsibilities of MHPSS workers were gathered through surveying to allow for comparative analysis.
⚠	Lack of data on governance models, human resources, capacity gaps, and needed structural reforms at local higher-education institutes.	Data was collected through desk review and KIIs.
⚠	Not all MHPSS practitioners contacted were prepared to participate in the surveys or interviews, either because they required permission from management, or because the organisation was reluctant to participate due to high competition for qualified staff.	Levante asked the MHPSS working groups in the north of Syria to facilitate the contacts.

5. Findings

5.1 Introduction to Findings

The study findings have been split between the MHPSS Workforce Assessment and the MHPSS Education Assessment, with each assessment being responded to in turn. The recommendations section of the report brings these two assessments together, ensuring that both are fully utilised to inform the design and implementation of the academic programmes. Due to the cultural, linguistic, theoretical, economic, and operational intricacies constituting this topic, additional research is needed to create a more comprehensive understanding of mental health in Syria; however, the findings below provide a baseline from which to build.

5.2 MHPSS Workforce Assessment

Composition and Distribution of the Existing MHPSS Workforce

Demand for MHPSS Services

The impact of the Syrian conflict and prolonged humanitarian crisis on the mental health of the Syrian population is both understudied and underestimated (Raslan, Hamlet, & Kumari, 2021). Long-term exposure to violence, displacement, fragmented/dysfunctional health systems, poverty, uncertainty, and protection concerns means that the high prevalence of mental health conditions are not in doubt. As explored under **Workload**, reports from the field and organisations delivering services to northern Syria's most vulnerable attest to an unusually high level of cases.

Nonetheless, beyond reaching a consensus on the crippling size and pressing nature of the mental health burden, few studies offer reliable estimates on the prevalence of specific disorders. WHO estimated that 1 in 10 people in Syria are living with a mild to moderate mental health condition, and 1 in 30 is suffering from a more severe condition (WHO, 2019). WHO further estimates that around 75% of vulnerable persons living with mental health conditions in Syria receive no treatment at all. These estimates are likely higher in the northwest and northeast of Syria, which continue to suffer the brunt of the crisis and hold the most vulnerable of the population.

- ➔ Recent research with adolescents and children registered into a Protection intervention in NW Syria, found that 74% (N=376) have symptoms of at least one mental health condition (Raslan, Hamlet, & Kumari, 2021).
- ➔ A March 2021 report published by Syria Relief estimates that 99% of internally displaced Syrians in Idlib suffered from symptoms of PTSD, compared to 76% of Syrian refugees in Turkey and 74% of Syrian refugees in Lebanon (Syria Relief, 2021)

The prevalence of mental health conditions is likely to worsen as the humanitarian situation further deteriorates. Some of the factors that are projected to negatively influence living conditions for Syrians include the devaluation of the Syrian Pound against the globally increasing U.S. Dollar (World Bank, 2022), food scarcity and rising costs of living (Action Against Hunger, 2022), and a recent escalation of hostilities in both Aleppo and Idlib, which has included attacks on civilians and IDP camps (AOAV, 2022; OHCHR, 2022). Further, a potential closing of the Bab al-Hawa border crossing with Syria continues to loom, which would cut off the delivery of humanitarian aid into the region (UN, 2022). The perpetual uncertainty of life in this context and difficulty in satisfying basic physiological and safety needs has exacerbated mental health problems.

While the need for MHPSS services to address these challenges is clear – an important distinction between level of ***need*** for services in the target population and the level of ***demand*** for these services must be made. Despite the high need, there are a number of interrelated factors that complicate the population's awareness of, access to, and demand for MHPSS services – as reported by stakeholders and highlighted in relevant literature:

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High levels of stigma and discrimination persist toward people with mental health conditions in Syrian society. Although emotional distress is viewed as a normal part of life, labelling it as a psychological or psychiatric condition can bring shame and embarrassment, and people with mental illness are often viewed as dangerous. <u>Recommendations</u> are to train practitioners to avoid technical jargon and psychiatric labelling, and to integrate support at non-stigmatising settings such as medical clinics and community centres. Raising awareness about common mental health challenges, their causes, and the different types of available practitioners could also reduce stigma.
The demand for MHPSS can also vary based on gender norms. Pride or honour may prevent individuals from disclosing intimate or stigmatising experiences to a practitioner of the opposite gender. <u>Recommendations</u> are to make sure that clients can choose a male or female practitioner, so they are more comfortable disclosing experiences.
Many prefer to seek out traditional healers as their first line of help for managing distress, as opposed to mental health practitioners. Traditional healers are generally perceived as more culturally acceptable and less stigmatising than mental health practitioners. <u>Recommendations</u> are to avoid minimising the value of support from religious and spiritual leaders and to find ways to include them in MHPSS programming and referral networks.
Most mental health theories and techniques were developed and tested in a western context, and their translation may lack deeper cultural adaptation. This can make it hard for local populations to connect with the material and relate it to their lives. <u>Recommendations</u> are to adopt materials that have already been utilised and validated in similar contexts. This will ensure that curricula follow established requirements without sacrificing relevance.
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<td>Distrust and cynicism towards NGOs have built up over the crisis, and since NGOs are the principal deliverers of MHPSS services in northern Syria (see Supply), individuals may be reluctant to seek out these services. These power imbalances could make clients feel subordinate or disempowered by the practitioner's expertise. <u>Recommendations</u> are to utilise a person-centred approach that emphasises empowerment, respect, and genuine partnership.</td>
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This distinction between need and demand is important for understanding the long-term opportunities of those in the MHPSS workforce and the development of the wider MHPSS landscape.

> *With everything that NES has gone through, there is a huge need in the population. According to my experience, almost everyone who has stayed here has witnessed war and not been able to access help. But there is a difference between need and demand. Most people would prefer to ask immediate family members [rather than access MHPSS service]. There are big access issues for women and girls. Poverty is also a driving factor.*

> - **MHPSS Officer, NE Syria**

These factors are further explored under **Political, Social and Cultural Barriers**. Though many individuals avoid seeking out mental health support due to these barriers, some KIIs have noted that the MHPSS services being offered by NGOs and agencies are well-utilised and sometimes have waitlists. Individuals regularly visit health facilities and clinics seeking support for various kinds of distress, and many do remain open to mental health referrals. One stakeholder observed that clients may initially approach MHPSS with hesitation, but they become more open to it as they begin to see the positive results. Their experiences are then shared with family or friends, and gradually perspectives start to shift.

Regarding private MHPSS services, discussions with Key Informants suggest that the majority of demand for this is likely to come from within the NGO sector itself – as NGO workers are most likely to be sensitised to the benefit of MHPSS support and able to afford private services.

> *I know a female psychiatrist who sometimes works in a private clinic. People who work in NGOs and their financial status is good – they can go and see a private practitioner. [Otherwise] there is no market for private practice in Syria.*
>
> - **Psychiatrist & NGO Worker, Turkey / NW Syria**

Supply of MHPPS Services and Workforce

The protracted conflict has led to the exodus of more than 70% of Syria's healthcare workforce, due to forced displacement and the deliberate targeting of health workers and facilities (Fouad & Sparrow, 2017). Even before the conflict began in 2011, mental health was not a well-funded or understood field in Syria, resulting in many services being limited in breadth and depth. According to the Syrian Arab Psychiatric Association, before 2011 there were never more than 120 psychiatrists across the whole country, with 70% of them being located in Damascus. The crisis has exacerbated the pre-conflict geographical inequalities – where northern Syria has long had the lowest availability of health services and healthcare workers.

Supply of MHPSS services in northern Syria is almost exclusively driven by the humanitarian sector. This means that the volume and type of service, as well as the availability of human resources (and in most instances, training for these human resources) are dependent on the extent and consistency of funding from international donors. Even within the humanitarian response in Syria, MHPSS is not one of the top priorities. Further, global funding for MHPSS is largely through grants that do not focus primarily on mental health but include it as a partial focus along with larger multi-sectoral or sector-specific focuses. In 2017, the MENA region received over half of Official Development Assistance (ODA) funding in MHPSS, with Syria, Iraq and Jordan being the largest recipients of aid. In recent years, this funding has dwindled due to donor fatigue over the protected Syrian crisis and the advent of crises elsewhere (The MHPSS Collaborative, 2021).

> *A lot of projects have stopped, and funding has stopped. MHPSS was not prioritised in the last UN OCHA [funding and assessments]. We have lacked advocacy. It is not a priority in terms of funding in comparison with GBV or child protection.*
>
> - **MHPSS Coordinator, NW Syria**

NGOs are both the primary employers and also one of the primary trainers/producers of new cadres not only in the MHPSS workforce, but the health workforce more generally (Bdaiwi, et al., 2020) -

see **Educational Background, Credentials & Recruitment**. As such, supply of MHPSS services and human resources is heavily linked to the presence of local and international NGOs, and their access to different areas of northern Syria. Any efforts toward training new practitioners should recognize that their absorption into the economy currently depends on the capacity of NGOs to fund their salaries, which in turn depends on the continuation of MHPSS-directed funds from external donors.

Technical Areas with the Highest Need:

There is a dearth of technical expertise across the MHPSS sector in northern Syria. With the bulk of the MHPSS workforce comprising Psychosocial Workers (PSWs), a non-specialised cadre that provides basic PFA, counselling, and psychoeducation services (See **MHPSS Workforce Characteristics**), the ability to provide advanced care is limited. Education opportunities for more technical skills are also lacking, making it difficult for workers who desire a more specialised career, or who want to expand their skill set, to do so. This lack of technical expertise does not impact the population in northern Syria evenly, with certain demographics (e.g., children, GBV survivors, LGBTQ+) and mental health conditions (e.g., addiction, suicidality, psychosis) often confronted with insurmountable challenges in finding practitioners with adequate expertise and specialisation to support them.

The prevalence of mental health conditions amongst children in northern Syria is particularly high. According to UNICEF, one in three children in Syria showed signs of psychological distress in 2021, including anxiety, sadness, fatigue, or frequent trouble sleeping (UNICEF, 2022). Save the Children reported that almost one in five of all recorded suicide attempts and deaths in North West Syria are children (Save the Children, 2021).

Children's prolonged exposure to conflict, limited opportunities for social and intellectual stimulation, and increased rates of child abuse, early marriage, malnutrition, and child labour have created an acute mental health crisis among children in northern Syria. Despite this level of need, there are stark technical gaps when it comes to children, with a number of Key Informants mentioning that child-specific expertise and interventions were lacking:

> *All the psychiatrists [working in northern Syria] are general psychiatrists so there is a need for further training to be able to address child mental health disorders.*
>
> -**Psychiatrist, NW Syria**

> *The highest needs are in IDP camps, specifically among children and adolescents. Some suffer from alcohol and substance abuse.*
>
> - **Psychosocial Support Supervisor, NW Syria**

These technical gaps exist despite concerted efforts by civil society in recent years to meet the growing mental health needs of children. For example, in 2021, UNICEF and its partners provided MHPSS services to over 220,000 children, predominantly through child-friendly spaces and mobile teams (UNICEF, Syria: children struggle with physical and psychological scars after 11 years of war, 2022). In the survey with MHPSS workers, expertise in dealing with children and child-specific conditions/behaviour was identified as one of the top needs for training.

Alongside children, notable MHPSS technical gaps also exist when it comes to GBV support. With high rates of domestic violence and associated stigma, and few earning opportunities for women without a male guardian, there are many who find themselves trapped in an abusive domestic setting. Those women who do escape, or who shun societal pressure to marry, are increasingly turning to sex

work or smuggling (World Vision, 2021). Ultimately, the combination of the ongoing conflict, the economic crisis and the prevalence of sexism and abuse within society all increase the likelihood of women developing mental health conditions.

The situation facing women is exacerbated by the lack of available GBV services in northern Syria, as well as the poor integration of MHPSS into other services for women. Key informants have also reported a challenge across the sector with hiring female staff, impacting the likelihood of women coming forward to seek support. In order to address this growing crisis, MHPSS workers need more comprehensive training on the interplay between GBV and mental health, and how to integrate them into general services. Further work also needs to be done to train female MHPSS workers, increasing the available pool for hire.

Whilst data on the mental health of the LGBTQ+ population in northern Syria is limited, in a survey of LGBTQ+ Syrian refugees in Lebanon in 2014, 58% of them described their mental health as poor (Heartland Alliance International, 2014). Considering that same-sex acts remain illegal in Syria, and that many within the community are forced to conceal their identities, this disproportionally high rate is unsurprising. Despite this, Coar Global, a development consultancy, reported that LGBTQ+ identity is seldom if ever used as a targeting criteria for MHPSS services, and that in order to better meet the mental health needs of LGBTQ+ Syrians, MHPSS providers should be trained to better understand LGBTQ+ issues (Coar Global, 2021).

Beyond specific demographic groups, there are also technical gaps when it comes to treating particular mental health conditions. Substance abuse and addiction are common in northern Syria, particularly amongst young people. According to a survey of over 3,000 civilians in northern Syria by the Assistance Coordination Unit (ACU), 22% of respondents knew people who consistently used narcotics and were addicted to them. Despite this high prevalence, only 2% of respondents reported that addiction treatment centres were available and effective ((ACU), 2022).

Alongside addiction, severe depression was repeatedly mentioned by interviewed stakeholders as an area lacking technical expertise:

> *When it comes to technical areas of expertise, there is a need to get more training when it comes to severe depression and suicidality.*
>
> -**Psychiatrist, NW Syria**

Whilst PSWs are trained to handle mild cases of depression, many lack an understanding of how to effectively manage cases of a higher severity, particularly when suicidal ideation is present. Without adequate training, this can impact the mental health of PSWs themselves, and lead to poor care for those most in need. With suicide rates in the northwest on the rise (Aljazeera, 2022), this technical gap is having increasingly devastating consequences.

With high rates of trauma amongst the population in northern Syria, therapeutic interventions that are effective against PTSD are expected to be beneficial. However, stakeholders have mentioned gaps in knowledge around common treatment modalities such as Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). There are no local specialists available to implement these therapies or to train other practitioners in how to use them.

According to a 2021 report published in BMJ Global Health on psychosocial interventions for refugees and asylum seekers with PTSD, it was concluded that CBT and EMDR are the most effective treatments at reducing symptoms (Turrini G, 2021). Considering the role these interventions could play in addressing the high rates of PTSD in northern Syria, it’s evident that upskilling MHPSS workers to deliver these therapies could be particularly impactful.

Geographic Areas with the Highest Need:

When engaging with stakeholders about the areas across northern Syria with the highest level of need, many found it difficult to pinpoint specific locations. This was largely due to the excessive level of need across all geographic areas:

> *When I talk about gaps, it is in the Northwest and the Northeast. Approximately all areas.*
>
> -**MHPSS Officer, NE Syria**

The conflict and economic downturn are causing a crisis across the whole region, leading to high levels of psychological distress that cannot be addressed within the current levels of MHPSS service provision. Despite this, a number of observations were made by stakeholders that indicate certain trends when it comes to geographic areas of need:

➔ **Access and stability**

NGOs are the main providers of MHPSS services across northern Syria, however, due to security issues, they are not able to be present in all areas. For example, in parts of NES where conflict is ongoing between Turkish Forces and the SDF, many NGOs have had to withdraw staff. This is having particularly devastating impacts due to the high prevalence of camps in the region, with Syrians attempting to flee to bordering countries.

Therefore, a majority of the MHPSS workforce is located in the most stable governorates across NES, particularly urban centres. Expertise is almost non-existent in rural areas and ISIS-affected areas. This imbalance is often amplified by donor requirements and the short-term nature of funding.

> *There are no MHPSS hospitals at all in NES. In Deir-Ez-Zor, there is no psychiatrist at all. There is one psychiatrist in the whole of the Ar-Raqqa area. Expertise in NES is mainly in Al-Hasakeh, Auda and Qamishli – because these areas were less affected by ISIS terrorism. As you move, geographically, towards Ar-Raqqa and Deir-Ez-Zor the quality and quantity would decrease.*
>
> -**NGO Worker, Iraq / NE Syria**

In comparison, the MHPSS workforce in NWS is distributed somewhat evenly across urban areas of Aleppo and Idlib. This is likely due to the presence of specialised MHPSS centres in both locations: 2 in Idlib (Al-Dana, Sarmada) and 2 in Aleppo (Azaz, Al Bab). Despite this, there is a high need for MHPSS services in camps and other remote areas, as specialists are not available, and residents are often unable to reach the facilities.

➔ **Areas with high levels of IDPs and refugees, including irregular camps**

In both NWS and NES, MHPSS services are concentrated in those areas where there are high numbers of displaced people. Certain parts of the Northeast have had a significant influx of IDPs and refugees since the start of the conflict. This can put pressure on existing MHPSS services due to the increase in population numbers and the high levels of trauma amongst incoming refugees. The safety issues within camps, along with difficulties accessing basic needs, can also exacerbate existing mental health conditions. The Al-Hawl refugee camp in Al-Hasakeh is an example of this:

> *In Al-Hasakeh, which receives waves of refugees, there are only an estimate of three organisations working to provide psychosocial support. There is a high need in this area due to the tension associated with the proximity to the borders and the presence of irregular camps. There is a need for more psychosocial support sessions there.*
>
> \- **International Government Health Official**

➔ **Remote areas**
Generally, there is a greater availability of MHPSS services in urban areas, particularly for in-patient care. While there are fewer restrictions (as discussed above) in NWS than in NES, there are still distribution imbalances. Although stakeholders report increasing efforts by NGOs to reach more remote areas - including through the use of mobile clinics[1] - there is still a lack of reliable services, leading those in need to travel long distances to access the care they need.

➔ **Turnover and Demand in NES**
As a result of these factors, stakeholders report that there is a substantial demand, and competition, for MHPSS staff in NES in particular. This has contributed to high staff turnover and wage inflation, especially for more specialised staff, as organisations have competed for cadres – and difficulty hiring staff full-time. Understandably, workers gravitate towards working in the most stable areas of the region – meaning difficulties in recruiting for less stable/remote areas.

MHPSS Workforce Characteristics

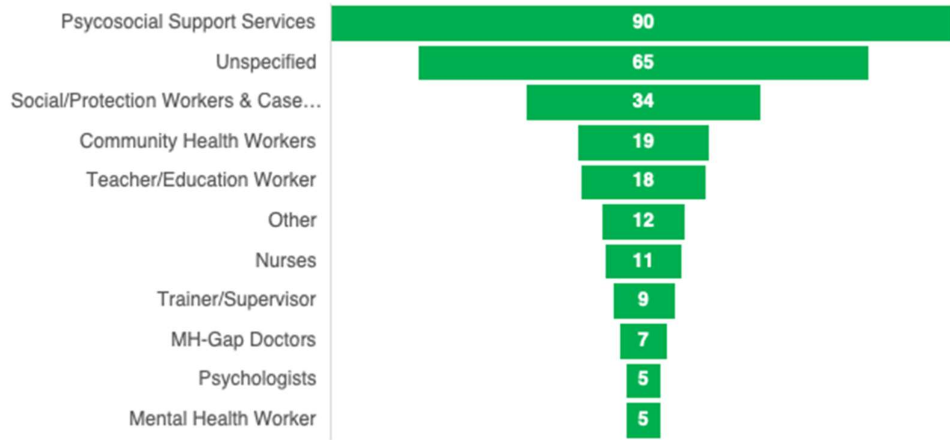
Understanding the characteristics/distribution and estimating the size of the available workforce is complicated by:

- ➔ Overlapping and inconsistent naming of professions
- ➔ Loose or incorrect use of terminology
- ➔ High likelihood of double counting due to the fact that many individuals (especially those who are more specialised) typically work for multiple organisations
- ➔ Dynamic nature of the response and Syrian population mobility
- ➔ Competition between NGOs (both for funding and for workers) and reluctance to share information

Through desk review, KIIs and a survey of those working in MHPSS, the study has sought to identify the key 'cadres' which comprise the MHPSS workforce and how they are referred to within the overall response.

[1] Though mobile medical clinics are common in northern Syria, mobile MHPSS units are less so, as most interventions require 8-10 sessions, requiring the unit to return to the same location on a weekly basis. Some mobile medical clinics include PSWs on their teams to provide psychoeducation and screenings, while others (e.g., OCHA) include individual and group counselling.

Figure 1 – MHPSS Workers Survey: Breakdown of Roles/Role Types (N=275)



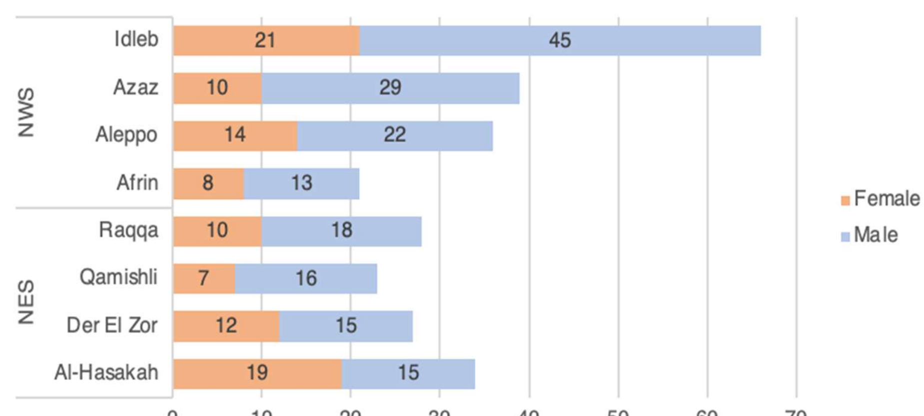
Psychosocial Workers (PSWs), alternatively called Psychosocial Support Workers, Psychological Support Workers, or Psychological Support Assistants is a paraprofessional cadre that works under the more advanced cadres. They deliver broad, non-specialised services that emphasise social and spiritual needs in addition to mental and emotional. Services can range from targeted support through screenings, psychoeducation, and counselling to universal support through community engagement and strengthening of family/social networks. Estimates on the number working in northern Syria vary – though figures provided by Key Informants suggest there are around 300 actively working in NWS and 75-90 in NES. A small minority of respondents identified themselves as **Mental Health Workers**, though it was unclear if anything distinguishes this role from that of a PSW.

Psychologists, alternatively called Counselling Psychologists or Social Psychologists, provide mental health support at a more specialised level than PSWs. Their activities can include mental health screenings, assessment, counselling, or therapy services for individuals or groups. Key Informants suggested there are as many as 20 working in NWS (5 of whom were reached by this survey), and just 2-3 in NES. It is important to note that since there are no advanced Psychology programmes in the region, most of those working as Psychologists are not qualified to implement specialised interventions that are common to practising Psychologists in other contexts (see **Educational Background** below).

Psychiatrists are the most specialised MHPSS cadre, and as such, they are especially lacking in the region. Informants reported that there are 3 fully qualified psychiatrists in NWS and 3 in NES, as well as 5-6 psychiatry residents in NWS. Some are freelance and work across multiple institutions and facilities. The study team was able to reach 2 of the psychiatrists in NWS and spoke with them in-depth through KIIs.

Social/Protection Workers & Case Managers are a category of workers who deliver social and protection services rather than mental health or counselling support specifically. This includes those working in GBV or Child Protection services. 27 such workers were surveyed in NWS and 7 in NES. **Community Health Workers (CHWs)** were also identified, which is used to categorise Outreach and Awareness workers who represent NGOs on the ground and help to deliver health campaigns and awareness raising on topics including but not limited to MHPSS. All of those sampled in this study (19) are operating in NWS. The category of **Trainer/Supervisors** work with and supervise the non-specialised cadres (PSWs, Social/Protection Workers, CHWs). 7 were surveyed in NWS and 2 in NES.

Figure 2 – MHPSS Worker Survey: Gender Breakdown of Participants



Overall, 37% (101/275) of the workers surveyed are women and 63% men. For each role covered in the survey, with the exception of teachers, men made up the majority of the sample. The average age of workers interviewed is 33.

A detailed breakdown of the surveyed MHPSS workers by type and location is provided in **Annex 2**. This information seeks to summarise key information about each cadre of the workforce delivering specifically MHPSS services.

Table 5 – High-level Overview of MHPSS Cadres Characteristics

	Psychosocial Worker	Psychiatrist	Psychologist	mhGAP Doctor	Community Health Worker
Workplace(s)	International & National NGOs	Clinics; Public Hospitals; International & National NGOs; Private Clinics *Psychiatrists typically have multiple places of work for different organisations.*	Clinics; Public Hospitals; International & National NGOs	International & National NGOs; Public Hospitals	International & National NGOs
Typical Educational Background	Bachelor's Degree *82% of PSS Workers surveyed have a bachelor's degree as highest level of education.*	Medical Degree *Trained as medical doctors, then psychiatric residency. Not all have completed residency.*	Minimum of Bachelor's Degree (General Psychology or Counselling Psychology) *Most do not have clinical psychology training.*	Minimum of Bachelor's Degree (Medicine) + mhGAP Training	Minimum of Bachelor's (usually Education); For Awareness Workers: minimum of secondary school; Most have Bachelor's
Typical Roles & Responsibilities	Individual & Group Counselling Sessions; Case Management & referral to specialised services; PFA & PM+; Awareness-raising/ psychoeducation workshops	Supervise mhGAP doctors and trainees; Receive referrals from mhGAP doctors & PSWs; Create and monitor treatment plans for severe disorders; Prescribe medications	Receive referrals from mhGAP & PSWs; Specialised interventions: CBT, Children's Accelerated Trauma Technique(CATT), NET; Group sessions; Clinical supervision of MHPSS team	Assessment of cases; develop treatment plans with mhGAP protocol; Drug treatment and follow-up using WHO's list of mhGAP medicines; Cooperation with psychologists and PSWs	PFA, Individual/group sessions, psychoeducation, case management, referrals Awareness Workers: Delivery of general health promotion and awareness sessions/campaigns
Typical Workload	Full-Time: Average of 40 working hours per week Part-Time: Average of 21 working hours per week	Intense workload and high demand for services due to severely limited numbers	Intense workload and high demand for services due to limited numbers in both NWS and NES.	Full-Time: Average of 40 working hours per week. Few work part-time.	Average of 40 working hours per week Awareness Workers: Average of 43 working hours per week
Estimated Salary Ranges[2]	NES Average: 335 USD NWS Average: 400 USD	Often have income from multiple organizations. Reported 1400-2000 USD monthly	Reported incomes of 650-1000 USD monthly	NES Average: 680 USD NWS Average: 925 USD	CHW Average: 567 USD Awareness Workers Average: 340 USD monthly

[2] Averages calculated from MHPSS Worker Survey responses

Educational Background, Credentials & Recruitment

Overall, 75% of the MHPSS workers surveyed **report having a** bachelor's degree **as their highest level of education.**

The consulted stakeholders, responsible for the recruitment of MHPSS workers into their organisation, reported **valuing 'life experience' over qualifications** in many instances – in particular an understanding of social issues and dealing directly with families and people (one of the reasons why a background in Education is attractive when recruiting PSWs). For this reason, age and experience are prioritised when hiring workers. Those who are fresh out of college without much job experience may have difficulties finding work in the field. This is an important challenge to consider in terms of the absorption of new graduates into the workforce. This emphasises the importance of the practical components of future training programmes – and ensures graduates are equipped to clearly demonstrate this experience in interviews, as well as 'soft skills' such as communication.

Licences, certificates, and diplomas have a more limited prevalence in northern Syria compared with other contexts (especially those not experiencing conflict) – not just in MHPSS but also the wider health sector. This is because many students were forced to cease training and begin delivering healthcare due to conflict – leading to a gap in in skilled medical doctors and other health cadres over the coming years (Fouad & Sparrow, 2017) and meaning that many may be taking on more responsibility than their training/skills have equipped them for (See **Technical Areas with Highest Need**).

Psychosocial Support Workers typically have bachelors level education, with a minority of those surveyed (12%) reporting that they have a master's level qualification. These degrees tend to be in humanities and social sciences - with Education the most common field of study (34%), followed by Psychology (16%). All the PSWs surveyed (53 in NWS and 37 in NES) said they received their education inside Syria. However, only half of the PSWs surveyed in NES reported that they have completed their studies in a fully accredited institution. This is likely due to the absence of such institutions in NES (Bdaiwi, et al., 2020).

> *The majority of [PSWs] I manage do not have the expertise to deal with cases [upon recruitment], apart from a minority who have a bachelor's level background in Psychology. For the rest, it takes time to train them. We focus on facilitation and communication skills first, and how to build the relationship with the client. Then we try to train them on PFA and mhGAP, so they can recognise main symptoms and ask for support from the Psychologist or Psychiatrist.*
>
> \- **MHPSS Coordinator, NW Syria**

In terms of **Psychologists**, stakeholders reported that there are no Clinical Psychology degrees available within Syria, and that the few who are qualified in this field received their education abroad (i.e., in Turkey). The only related degrees available in Syria are bachelor's degrees in General or Counselling Psychology. As such, workers identifying as Psychologists who received their education in Syria are reported to have a background in these fields rather than clinical psychology. Further, as explored under **Career Pathways**, there is evidence that many working as Psychologists are former PSWs who have been promoted to these roles through experience with cases over time and piecemeal training from their organisation – as opposed to formal qualification.

Nurses report a bachelor's level education in General Nursing. They do not have any specialised training in MHPSS, aside from the Heads of Nursing at the three psychiatric hospitals in NWS

(Sarmada, Azaz, Al Bab), who each have a master's degrees in Psychiatric Nursing that they received outside of Syria. (More information on nursing education can be found in the supplemental report on Psychiatric Nursing).

mhGAP Doctors are general medical practitioners who received their MD after completion of medical school (which, in Syria, begins after high school and lasts 6 years). Some have completed a residency, and others have not. They become mhGAP doctors after completing WHO's mhGAP training programme in which they learn the basic elements of mental health support and supervision.

Psychiatrists have also received an MD after completing 6 years of medical school. In addition, they have completed all or some of a psychiatric residency. Those who did not complete their residency had to drop out due to conflict-related disruption of studies and the increased demand for medical services. Around 5-6 psychiatrists in NWS are currently enrolled in a psychiatric residency through SBOMS (Syrian Board of Medical Specialists) – which provides support for post-graduate training, examination, and certification in a number of fields, including psychiatry (Bdaiwi, et al., 2020). At the time of this report, UOSSM International is working with SBOMs to strengthen psychiatric residencies in NWS and may provide more information about existing capacity.

Range of Salaries

Information collected on salary ranges suggests that overall, there is a high level of variance in the labour market, which has begun to fluctuate even more based on significant inflation in Syria that began in 2021. Assessing salaries for different cadres is complicated by the blurred nature of some of these cadres themselves (i.e., overlapping roles and responsibilities, varying use of role names and terminology). Broadly, it appears that salaries are dependent on factors such as location, organisation (i.e., public, international NGO, INGO), expertise, experience, and funding.

For **Psychosocial Workers (PSWs)** in northern Syria, there is a high-level of variance in terms of monthly income. Full-time workers surveyed reported wages of 200 USD per month at the lowest end of the spectrum, and 1200 USD at the highest. The lowest paid PSWs worked for local NGOs, particularly in NES – whilst those outliers at the top of the range (earning 1000 USD or more), supplement their income through work in the private sector.[3] Evidence from the survey suggests that a typical PSS worker, delivering full-time services for an NGO at around 40 hours per week, can expect to earn around 430 USD in NWS, and around 100 USD less in NES. One explanation for this could be the smaller number of international NGOs operating in NES, who typically pay higher wages than their local counterparts. Limitations to these findings include the smaller sample of NES workers in the survey and comparative reluctance of workers in NES to disclose salary-related information.

This compensation is analogous to that of **Social/Protection workers and Case Managers**, also captured in the survey. For this category of worker, the average monthly wage is 360 USD per month. However, there is a large variance – reflecting the different types of roles, responsibilities and specialties which come under the title of 'Case Manager' - or the loose manner in which this term might be employed. For example, those Case Managers (3) who reported salaries of 600 USD monthly also report performing specialised mental health services such as CBT. However, it is unclear if they are actually delivering CBT as therapy or implementing non-specialised interventions grounded in CBT principles.[4]

[3] Though their involvement in the private sector is unclear, it is more likely that these individuals supplemented their income with private sector work outside of MHPSS rather than working in the private sector as PSWs.
[4] Due to the popularity and evidence-base of CBT, many non-specialised interventions are built on CBT principles so they can be implemented by PSWs. This is not the same as psychotherapy.

Community Health Workers report an average full-time salary of 450 USD monthly. Within this category, Awareness/Outreach workers report salaries of an average of 340 USD monthly, while more specialised community workers report higher average salaries of 567 USD monthly.

mhGAP doctors surveyed (in both NWS and NES) reported an average full-time salary of 840 USD monthly. This is broadly consistent with the estimates provided by Key Informants delivering and managing MHPSS services, who also reported that mhGAP doctors can expect to earn as much as 1200 USD monthly with some organisations. Overall salaries are the same if they work exclusively with mhGAP or combine it with medical services.

The survey yielded a small sample of **Nurses** (11), most working at hospitals, INGOs, and a clinic in NWS and one nurse at a local NGO in NES (Ar-Raqqa). Those working in hospitals reported full-time salaries of between 300 and 400 USD monthly. The maximum salaries reported were 500 USD (at an INGO). Key Informants reported that nurses in MHPSS units could expect to earn at similar levels to PSWs. A recent report commissioned by SAMS on Psychiatric Nursing in northern Syria showed 60% receiving 300-400 USD, 26% receiving 401-500 USD, and the remaining 13% receiving over 500 USD (Saadoon et al., 2022).

Of the four **Psychologists** surveyed, two refused to provide information on their salary. One in NES refused to name their place of work but reported a salary of 800 USD monthly. However, Key Informants reported that psychologists can expect to earn between 600-1000 USD monthly. Among the KII respondents who provided the salary range information were an MHPSS Senior Officer in NES (Ar-Raqqa), a Supervisor of a PSS Project in NES (Ar-Raqqa), a freelance Psychiatrist in NWS, an MHPSS Officer in the Advisory Committee, and an MHPSS Coordinator, Senior PSW, and Supervisor from the same NGO in NWS.

Workloads

Psychosocial Workers (PSWs) are expected to manage a combination of individual and group sessions daily – with stakeholders reporting around 4-7 sessions daily. In terms of volume, the loads of PSWs are considered high, but manageable. However, there were some concerns amongst those interviewed, and with PSWs themselves, that they do not have the technical skills to adequately deal with cases (see **Training Gaps** for specific tools and training topics that PSWs identified as a priority).

> *The load is okay, but there is a feeling of guilt [amongst PSWs] because they don't have adequate technical backgrounds. Those PSWs with backgrounds in psychology argue that the tools they have are not enough, especially for complicated cases. They want to gain academic qualifications and further training.*
>
> - **MHPSS Officer, NW Syria**

mhGAP doctors are reported to face very high workloads and big challenges for processing the number of MHPSS cases they deal with. The first challenge is a lack of time for mental health patients (who may need more time and space to articulate issues and express feelings), given the demands on time from medical patients. Secondly, these doctors are often faced with cases which are too complex for the skills that mhGAP has equipped them with (e.g., cases may have multiple, inter-related symptoms such as in bi-polar or OCD, making it harder for them to make diagnoses). As a result, many do not feel confident enough to prescribe psychotropic medication without consulting a psychiatrist. Stakeholders also reported that mhGAP doctors may have internal restrictions placed on them by the organisations they work for as to the number of cases they are allowed to refer to psychiatrists, in a bid to reduce the burden on them. For example, IRC reported that their mhGAP doctors are only allowed to issue referrals for up to 20% of mental health cases.

However, consultation of **Psychiatrists** is challenging, as there are so few of them, and their services are in limited supply. They are reported to have a very heavy workload and spread their time across multiple organisations or facilities, due to the fact that many cases cannot be dealt with by other cadres at earlier stages of the referral pathway. SAMS and UOSSM both manage telepsychiatry services at their specialised MHPSS centres as a way to alleviate this issue. These programmes connect local providers with a roster of bilingual psychiatrists based in other countries who advise on treatment plans.

Career Pathways in MHPSS

Evidence collated from KIIs suggests that career pathways within the MHPSS sector in northern Syria, especially for less specialised cadres (i.e., PSWs, case managers, community health workers), are often informal, ill-defined, and highly reliant on aid funding to both national and international NGOs. However, the uncertain and short-term nature of funding for the Syrian response, and limited availability of funds for MHPSS service provision, means that less specialised cadres lack job stability – blocking their ability to build skills and experience in their roles needed to develop.

> *There are no pathways because each health worker is working paycheck to paycheck, with no time or opportunities to develop. They are always anxious about whether they will have a source of livelihood next month or not. Because I am a medical doctor, I will have opportunities, but these are not available for other personnel.*
>
> - **Psychiatrist, NW Syria**

Inconsistent and short-term funding also complicates the efforts of organisations to build clear development pathways for their workers.[5] Organisations consulted reported that training and developmental opportunities, or even roles themselves, often must be pieced together across different projects and pieces of funding – with the consequence that pathways are often unclear and unpredictable.

Due to interrupted education because of conflict and a relative absence of formal training programmes/university courses, those entering the sector often come from a variety of backgrounds, with varying levels of experience and at different entry points. Stakeholders consulted suggested that typical entry points into the sector for those with minimal qualifications and experience might be as Community Awareness/Outreach workers, before becoming Case Managers or PSWs.

For **PSWs**, development pathways could be managerial/administrative or technical – depending on abilities and ambitions. For example, opportunities exist to become managers/coordinators of fellow PSWs (i.e., Senior PSWs or supervisors) or to move into programme management roles. For technical routes, one of the most viable options for development is to become trained as Psychologists. This is an approach that both international (i.e., IRC) and national (i.e., HRO) NGOs would like to provide as incentives for their existing PSWs in order to meet the needs they are encountering in the field. However, this is challenging due to the difficulties of providing access to accredited programmes. Off-the record, some respondents reported that a number of Psychologists working in northern Syria are not formally qualified; rather, they are PSWs who accumulated experience and were promoted within their organisation. Though the frequency of this is unknown, KIIs suggest that it may be a common practice. The blurring of lines between these cadres may have derived in part from WHO recommendation that all PHCs should include an mhGAP-trained doctor and *either* a psychologist or PSW.

[5] Most donors offer grants that last for 1-2 years, making it difficult for NGOs to create longer-term contracts for their staff.

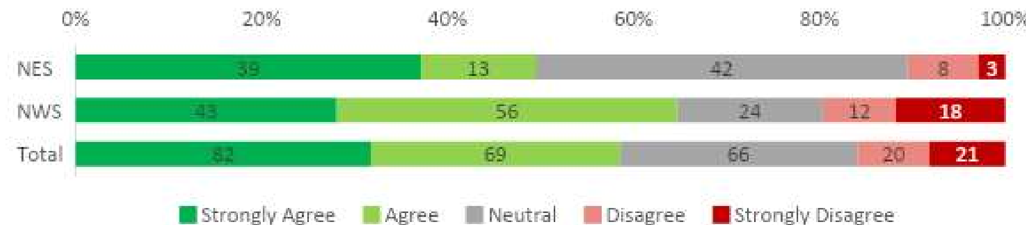
For more specialised cadres, such as **mhGAP Doctors, Psychologists and Psychiatrists**, demand for services is high and these individuals often work across multiple organisations, dividing their working week to meet demands. These more specialised cadres see emigration as the most viable way to build or develop their careers, especially if they want to focus on specific types of cases or develop their expertise in a particular area. Because there are so few specialised providers in northern Syria and such a high level of need, it means that psychiatrists and qualified psychologists must deal with all types of cases:

> *I think it's unrealistic to be sub-specialised in Syria. So, I just want to be a general Psychiatrist.*
>
> - **Psychiatrist, NW Syria**

The more specialised cadres are more confident in their long-term livelihoods and job security – but there are significant questions about if and how some cadres in the MHPSS sector could be absorbed into a Syrian labour market in a future where there are fewer donor-funded services:

> *For PSWs, if funding stops, who will pay them? Syrian society as a whole does not acknowledge this profession – there would be exactly the same problem with case managers and GBV workers… You would need to build the capacity of the government to receive these people. They all have experience, but they would not be able to work. This is a risk that must be considered.*
>
> - **Psychiatrist & NGO Worker, Turkey / NW Syria**

Figure 3 – MHPSS Workers Survey: 'I don't want to work in a field other than MHPSS'



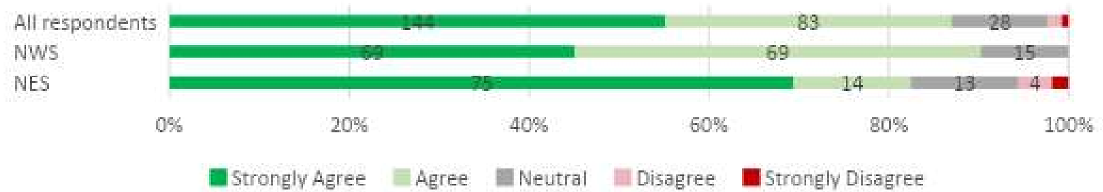
Despite this job insecurity and the lack of clarity around career advancement, a majority of respondents were positive about pursuing careers specifically within the MHPSS sector. Respondents in NES were less clear overall on this question, with 'Neutral' the most frequently selected option.

Of those who answered 'Strongly Disagree', most are in wider health and social care roles (for example doctors, protection workers, case managers, and nurses) – which explains why they may see their careers developing in fields other than MHPSS specifically. However, these respondents did include a minority of PSS and mental health workers (4) and MHPSS supervisors/trainers (3).

Job Satisfaction, Retention & Delivery

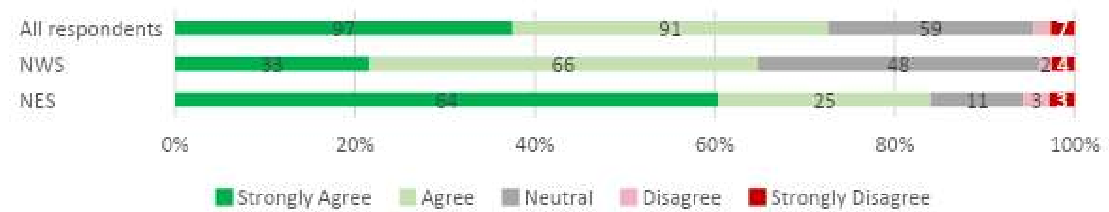
The MHPSS workers survey asked a number of questions to gauge worker satisfaction, future plans and conditions within the sector.

Figure 4 – MHPSS Worker Survey: 'I Enjoy My Job'



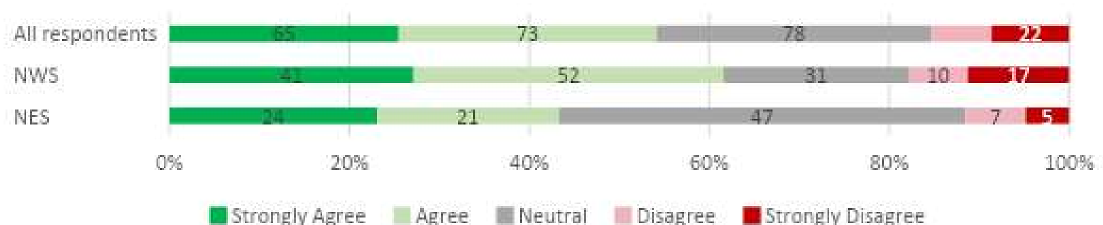
As the two figures show, the majority of respondents across regions and roles were positive about both the enjoyment of their work, and the support they receive from those around them. Those in NWS were less likely to strongly agree or gave more neutral responses about support from those around them than respondents in NES.

Figure 5 – MHPSS Worker Survey: 'When I share with my friends and community about the work, I do in the MHPSS field they respond with support'



Overall, 69% of respondents to the MHPSS worker survey said they find their profession rewarding. Those who disagreed or specified 'neutral' were spread across roles and regions.

Figure 6 – MHPSS Worker Survey: 'I am seeking a career in Syria'



Responses were more polarised when it came to intentions to seek a career within Syria. Of the seven mhGAP Doctors surveyed, for example, two strongly disagreed that they are seeking a career in Syria and a further two were neutral. As considered under **Career Pathways**, this reflects the greater opportunities in terms of salary and development available for skilled medical professionals outside of Syria. Two of the four MHPSS trainers/supervisors said they strongly disagreed that they would be seeking careers inside Syria, while a further two strongly agreed they would.

Overall, 55% (n=67) of the PSWs surveyed said they are seeking careers inside Syria. Reflecting the overall picture for all professions, those PSWs in NES were more ambivalent about pursuing a career inside Syria (81% responded neutrally).

Figure 7 – MHPSS Worker Survey: 'MHPSS Providers are compensated and valued for their work'

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
All respondents	53	94	103		5
NWS	19	73	57	12	
NES	34	21	46	4	5

Those who 'Strongly Disagreed' with the notion that MHPSS providers are well compensated for their work are all based in NES, and of the **Range of Salaries** available showed that salaries are generally lower there than in NWS.

When asked what would allow them to stay in their current position, working environment/conditions and employment arrangements were some of the most important factors for respondents in NWS, while these were less frequently selected by respondents in NES. A high proportion of mhGAP doctors (5/7) and Social/Protection Workers and Case Managers (21/30) said that an improved working environment (including workload distribution) would help them stay in their roles.

Table 6 – MHPSS Workers Survey: What factors would allow you to stay in your job?

NWS (n=162)		NES (n=112)	
Incentives related to employment arrangements	113	Community recognition and respect	54
Community recognition and respect	112	Incentives for professional development (e.g., mentoring, supervision, training)	40
Incentives to enhance the working environment (e.g., management recognition in the form of certificates, fair distribution of workload)	101	Incentives to enhance the working environment	26
Incentives for professional development (e.g., mentoring, supervision, training)	89	Incentives related to employment arrangements	21
Flexible job scheduling to maintain a balance with childcare responsibilities	26	Flexible job scheduling to maintain a balance with childcare responsibilities	21

For workers across all roles, locations, and genders, 'community recognition and respect' is a key motivation for remaining in their roles – and it appears that the majority of respondents feel they are currently receiving this support.

Incentives for professional development also featured highly as a factor identified by respondents – and was the second ranked incentive factor for workers in NES. Across both regions, 4/5 Psychologists interviewed identified this as a priority factor, as did 7/10 Nurses. However, Key Informants suggested that organisations could see investing resources in training for staff as a risk, given the high turnover and competition from other organisations. Independent entities may be better placed to offer education and professional development, rather than the NGOs that hire staff for their programs.

> *[The key incentives] are training and a good salary. But the problem is that after you have provided training, the person will leave once they get a better job offer.*

- **MHPSS Officer, NE Syria**

"

Flexibility in the role to help manage childcare responsibilities was the least selected factor in both regions. It was cited by 18% of female respondents and 17% of male respondents, suggesting this may be something to consider for workers of any gender.

Respondents to the MHPSS workers survey were asked which incentives would help them to stay in their role and to improve MHPSS service delivery. Their responses were analysed and categorised into coded themes, which are quantified below:

Table 7 – Coded Responses on Incentives to Improve Service Delivery and continue in the MHPSS workforce

Incentives	(N=276)
Better pay	57
Professional training	49
(Feeling of) Helping the community	45
Being appreciated / encouragement	36
Psychological support for employee	14
Improved management and support	12
Reduced working hours/more holiday	10
Improved facilities	8
Transportation	6
More sustainable/long term projects	5
Improved work environment	5
Improved societal attitudes to mental health	4

Survey responses suggest that MHPSS workers are acutely aware of the lack of standardisation in the sector and inconsistent approaches towards qualifications and pay:

> *Financial incentive in terms of wages [would improve delivery]. I am a psychological counsellor with five years of study, but I am equal to those who studied for just two years and have certificates.*
>
> - **Psychological Counsellor, NE Syria**

"

Aside from the issues of improved pay and a need for increased training opportunities/ professional development, a recurring theme was a need for 'appreciation' and 'encouragement' – in particular from management, but also from society more generally.

> *[There should be] responsible appreciation of the work of employees. Outstanding and successful workers should be promoted, above those who are less experienced than them.*
>
> -**Community Health Worker, NW Syria**

"

Before graduating new MHPSS workers, education programmes will need to consider how qualified (but less experienced) workers will be integrated into an experienced (but less qualified) workforce in terms of salaries, benefits, roles, and responsibilities – and the potential tensions this could cause.

Mentoring & Supervision

Supervision practices for the MHPSS workforce in northern Syria come in many different forms and follow different modalities, often varying depending on the roles and the services provided by different organisations. Insights from KIIs suggest a general pattern of PSWs being supervised by senior PSWs and psychologists from within their organisation, and mhGAP doctors supervised by psychiatrists where these are available. Psychologists and psychiatrists are supervised remotely and cross-border, due to the lack of specialists inside Syria.

Case Study: Hope Revival Organisation (HRO)

HRO is a non-profit organisation based in Turkey that implements its projects inside Turkey and Northwest Syria. HRO seeks to relieve the suffering, ensure the well-being and advance the dignity of conflict-affected populations and those who live in fragile settings. HRO has developed its own framework for providing supervision to PSWs in Syria that takes a tiered approach:

- PSWs in Syria are supervised in-person by PSS supervisors. They are experienced PSWs who have undergone training from The German Agency for International Cooperation (GIZ). They follow Holloway's systems approach to supervision.[6]
- The PSS supervisors are supervised remotely by an MHPSS Coordinator in Gaziantep, Turkey.
- Ultimately, overall management and supervision of services in Syria takes place remotely from Gaziantep, Turkey.

Respondents to the MHPSS workers survey were able provide little information on mentoring and supervision practices – primarily due to the inconsistency of such practices:

Table 8 – MHPSS Workers Survey: Mentoring & Supervision Practices for PSWs

	Less than 1 in 4 of the PSWs surveyed said they received mentoring or clinical supervision when they started their roles.
	Nearly 4 in 5 of the PSWs surveyed feel that their supervisor provides them with enough practical training and supervision to perform their job.

Respondents were also asked where they can look to gain further skills. As the table below shows, respondents in NES were much less confident about finding expertise within their own organisations.

[6] The systems approach to supervision (SAS) considers seven interconnected dimensions: the overall supervisory relationship, which affects and is affected by the supervisor, supervisee, supervisors' teaching strategies, supervisees' learning tasks, the organisational context, and the client (Holloway, 1992).

Table 9 – MHPS Workers Survey: 'Where can you gain further clinical MHPSS skills?' (Select multiple)

NWS (n=162)		NES (n=112)	
INGOs, NGOs & CSOs	76	INGOs, NGOs & CSOs	75
People in my current workplace (supervisor, psychiatrist, doctors etc.)	72	People in my current workplace (supervisor, psychiatrist, doctors etc.)	17
Institutions outside of Syria	13	Institutions outside of Syria	16
Other	1	Other	4

There are a number of challenges that make it difficult for MHPSS workers to access effective supervision in northern Syria. This includes:

- The lack of supervision training for existing MHPSS workers.
- The lack of qualified local specialists who can supervise specialised cadres
- The heavy demand on the few specialists who are qualified to provide support

These challenges, along with limited in-person access to the region, point to the necessity of **remote supervision**. This option is not always cost-efficient as it requires financial compensation for external supervisors who typically have higher salary rates, and it also relies on a stable IT infrastructure. However, it is a feasible approach that has been used successfully by many organisations. Supplemental reports by technical specialists found that in-person supervision can be arranged for a PSS education programme in both NWS and NES and for some components of a Psychiatric Nursing programme in NWS, though remote supervision will be necessary for Psychiatric Nursing in NES and a Clinical Psychology programme in either area.

Case Study: Remote Training & Supervision Delivered by IRC

"In Northwest and Northeast Syria, the IRC and WHO provided remote PSS training in Problem Management Plus (PM+) for IRC partners' frontline staff in women's protection centres and in health clinics. The training was complemented by a three month-long remote supervision. The team found that PM+ training was easy to deliver remotely because of its structure. Similarly, the supervision was also very structured and was implemented through group sessions via Skype. Each session included five people and lasted about one hour. Overall, this mechanism for training was deemed to be very feasible in complex situations like NES or NWS." (IRC, 2021)

> *I depend on mhGAP supervision tools. Every 2 months I conduct this [supervision]. The other tool is a self-evaluation/assessment tool. We use this to understand the needs of the team and how to work on them. Sometimes we have sessions where we discuss difficult cases together after the consent of the patient. We have peer support sessions; in these sessions, everyone proposes an issue or problem and how to deal with the issue.*
>
> \- **MHPSS Officer, NE Syria**

Key Informants reported that GIZ recently delivered a broad supervision training for organisations and professionals working across northern Syria.

> *We have supervision, and recently GIZ has trained us (all organisations and professionals in northern Syria) on supervision. Now supervision is more technical – but donors don't always buy into it.*

> - Psychiatrist & NGO Worker, Turkey / NW Syria

There are some local health centres supported by international NGOs, including WHO, that provide free educational courses and MHPSS supervision to support medical or mental health personnel, including the following:

Table 10 – Table of Organisations offering educational courses and supervision

UOSSM International	A coalition of humanitarian, non-governmental, and medical organisations. Member organisations pool their resources and coordinate joint projects to provide independent and impartial relief and medical care to victims of war in Syria.
Hand in Hand	An NGO working to improve the lives of the most vulnerable in NW Syria, and to strengthen the country's devastated infrastructure, particularly across healthcare, education and employment.
Medical Relief for Syria (MRFS)	An NGO focused on providing vital medical support and assistance to those in need in NE Syria. They provide mental health treatment and training in Deir-ez-Zor, Al-Hasakeh, and Ar-Raqqa.
Sarmada Mental Health Facility	Created by Syrians with the support of WHO and UOSSM, the Sarmada Mental Health Facility treats severe psychological illnesses that require hospitalisation and run daily mental clinics in several areas in NW Syria. The centre also hosts training sessions held by international Psychiatrists online.

Standards, Expectations, and Practices in MHPSS

Medications & Availability

Prior to the conflict, there was substantial ongoing development in the psychotropic medication industry in Syria, but the war brought destruction, and the medicine factories – largely based in Aleppo – were badly damaged. This led to a slowing of production which impacted the availability of supply across the country. The Ministry of Health claimed that the industry has seen a resurgence in recent years and provided the following statistic:

> 92 out of the 96 pharmaceutical factories were in service and manufacturing 9,074 types of medicine. With this vast production, only 10% of medicines were imported, with 90% made locally in Syria.
>
> **SANA News Agency, 2019**

This statistic was shared by the Syrian Observer, but they were unable to verify the content or provide details on whether pharmaceuticals from these factories are available for those outside of government-controlled areas. Regardless, informants reported that high prices of pharmaceuticals, corruption, drug smuggling, and economic sanctions against Syria continue to create accessibility issues for everyday Syrians, particularly in NES.

According to interviewed stakeholders, WHO is the primary supplier of psychotropic medication across northern Syria, though it is challenging to purchase medications in NES even if they can be made available, as a result of sanctions and donor restrictions for organisations. Although alternative suppliers are available, WHO appears to be the most reliable, and its medication of the highest quality:

> *Psychotropic drugs manufactured locally are not reliable due to the absence of quality control measures. Only WHO drugs are trusted.*
>
> **- NGO Worker, Iraq / NE Syria**

> *WHO tries every 3 months to ask organisations about their medication needs and supply them with it.*
>
> **- MHPSS Officer, NW Syria**

Whilst the exact quantity of psychotropic medication that WHO supplies to northern Syria is hard to establish, it did report in 2021 that 280,848 psychotropic medicine courses were distributed to over 50 health partners across the whole of Syria (WHO, 2022). It also reported in 2017 that psychotropic medication was distributed to 30 health partners in northern Syria specifically: 10 in Azaz-Jarabulus and 20 in Idlib and its neighbouring areas (WHO, 2017). It's clear that the WHO is working closely with health services to supply psychotropic medication to the regions that are most in need.

Despite these efforts, stakeholders report that the supply of psychotropic medication is not meeting the level of demand. In 2021, Doctors Without Borders and other aid agencies in the NES reported "imminent stock-outs of critical medicines," including psychotropics (Human Rights Watch, 2021). This is particularly damaging because psychotropic medication often needs to be taken on a long-term basis for improvements to take place, and there can be negative consequences if treatment is disrupted. For example, patients with epilepsy can experience seizures if medication is stopped abruptly. Unfortunately, epilepsy medication was a particular type of medication mentioned by stakeholders as having an unreliable supply.

These ongoing supply issues are partly due to the lack of medicine factories in the north. In NES, for example, only one factory is in operation that Turkey opened and continues to support. Most psychotropic medication used to come into Syria through 4 humanitarian aid entry points: Bab Al-Hawa, Bab Al-Sham, Al-Ramtha, and Al-Yaroubiah, as sanctioned by the UN Security Council's Cross Border Resolution (Medecins Sans Frontieres, 2022). However, after three of these crossings closed in recent years, only Bab Al-Hawa remains (with access to NWS only). Due to disagreements among the UN Security Council, there are doubts as to whether this crossing will remain open. In July 2022, it was only authorised for another 6 months as opposed to the proposed 12 months. Unless a new resolution is agreed, the crossing will cease operation in January 2023, severely impacting the supply of medication – including psychotropic medication – into NWS (Atrache & Khan, 2022).

Some NGO staff have reported buying psychotropic from surrounding countries - particularly Turkey, Jordan, and Lebanon, though the cost is prohibitively expensive. To illustrate, a month's supply of an antidepressant in the United States for one person costs about 12-15 USD per month, while in Syria this would cost 100-140 USD per month for each person (Covington, 2022). In addition, this method of purchasing medications requires them to be brought into Syria through commercial channels, and medical items such as psychotropic medications are subject to challenging custom restrictions. A WHO Representative in Syria further reported that the Syrian government has removed 70% of the medical supplies, including psychotropic medications, from aid convoys going to hard-to-reach and besieged areas (Yoldi, 2021).

In order to combat these supply issues and meet the growing need, the WHO has been recommending donations of psychotropic medications as a way for countries and international organisations to support the humanitarian effort in Syria. This demonstrates their commitment to ensuring Syrians suffering from mental health conditions have access to the medication they need (WHO, 2022).

MHPSS Practice Regulation & Protocols

Whilst regulations for MHPSS training and practice in Syria do exist, they tend to be outdated and largely unspecific to the current conflict. This results in poor protection for both medical providers and patients. For example, a freelance psychiatrist working in NWS reported that there is no real regulation of the work of psychologists, especially those who are considered 'experienced'. This raises concerns about the potential to cause harm, especially considering the discrepancies in expected experience and education. Indeed, they reported that during an assessment process they undertook of a health provider, it was discovered that one of the employed 'Psychologists' had only received basic PFA training.

In opposition-controlled areas, regulation is particularly difficult to implement due to the fragmentation of governance. One psychologist reported that efforts are underway to try and combat this, including through the development of an order in February 2022 called the Syndicate for Psychology and Psychological Counselling Graduates:

> *There is a recently developed association that encompasses psychologists, counsellors, and psychology-related qualifications. [It] is now playing a role in [regulating] job descriptions and pathways to help.*
>
> - **MHPSS Officer, NW Syria**

However, with NGOs being the main implementers of MHPSS practice across the region, there is a culture of organisations regulating themselves as opposed to deferring to local authorities. This leaves open the possibility of poor self-regulation. If improvements in MHPSS regulation are to take place, a collaborative approach between NGOs and local authorities would be needed.

One step that has been taken to create better standardisation and protocols around the delivery of healthcare - including MHPSS - has been WHO's development of an Essential Package of Health Services (EPHS) for northern Syria,[7] which outlines guidelines for clinical and public health services and the interventions determined to be a priority for the region. It states that every PHC centre - fixed or mobile - should include an mhGAP-trained doctor and either a psychologist or PSW, and they should work together to provide non-specialised diagnosis, management, treatment, referrals, and follow-up services in MHPSS. Due to the limited number of psychologists in the region, PSWs are often the ones who fill this requirement.

As the scope of PSW roles and responsibilities has often varied, WHO worked together with the MHPSS Technical Working Group in NWS to create the Standard Training Guidance Handbook for Psychosocial Workers in northern Syria (see **Current MHPSS Programmes** for details about the training). Despite the limited nature of the manual, it works to ensure standard procedures are implemented in the handling and treatment of patients. The manual can also be used for workers in NES, as long as the PSW training is delivered by a certified trainer who completed the ToT.

Whilst the manual would also be useful for workers in areas of Syria outside of NWS, it's unlikely to be recommended due to political differences between authorities.

Beyond local authorities, NGOs take their own approach to best practice. For example, in 2018, GIZ cooperated with civil society actors in Germany to develop a 'Guiding Framework for MHPSS in Development Cooperation' (GIZ, 2018). This framework sets out, amongst other things, key

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[7] The EPHS for northern Syria is referenced in the PSW manual, though the full document could not be located online - only a report on costing for the EPHS.

principles when it comes to the implementation of MHPSS in development settings, with a particular focus on Syria and Iraq. Some of the recommendations it outlines include developing joint guidelines for referrals between services, implementing ongoing monitoring to identify unintended consequences, and ensuring, where possible, that both male and female MHPSS workers are available.

In addition to local authorities and NGOs, some of the more established MHPSS interventions that are commonly used across northern Syria include their own protocols. According to interviewed stakeholders, there are specific approaches that have been outlined in WHO's mhGAP, Problem Management Plus (PM+), and Self-Help Plus (SH+) programmes. Similarly, SAMS implements an evidence-based counselling intervention called the Common Elements Treatment Approach (CETA), which outlines clear protocols for screenings and intake, delivery of sessions, and response to cases of violence, abuse, and suicidality. UNHCR also has a programme on case management and referrals that was developed specifically for IDPs in Syria (Quosh, 2016).

Whilst there is evidence of some international protocols being implemented, as well as local approaches being developed, it's clear that there remain significant gaps when it comes to patient protocol across northern Syria. This is particularly true of the referral mechanisms between services, where patients are often passed between clinics with little information or follow up, though they are also lacking within services and specialties. For example, one Key Informant noted a particular need to "work on psychological intervention protocols" in northern Syria. These protocols would support the management of mental disorders by specifying guidelines for carrying out screenings and selecting assessment tools, and a decision-making tree for procedures, interventions plans, and referrals - according to different cadres and specialties.

Political, Cultural and Social Barriers to Delivery

As discussed in the section on **Demand for MHPSS Services**, there are extensive barriers to successful delivery of MHPSS services in northern Syria. These barriers impact both the availability of services and the likelihood of those in need accessing support. Barriers include:

- **Stigma**
  Whilst the expression of intense emotion is fairly accepted in Syrian society, the labelling of distress as 'psychological' or 'mental illness' carries a high level of stigma. Those suffering are widely considered to be dangerous or crazy, and best avoided along with their families (Hassan & Kirmayer, 2015). For example, up until a few years ago, psychiatric hospitals would be nicknamed 'Asfooriah', with Asfoor meaning 'bird' in Arabic, suggesting the patient's mind has flown away like a bird. This level of stigma prevents those suffering psychological distress from seeking help (Al Laham & Ali, 2020).

> *I would say that roughly two out of every ten patients that are referred to me attend. Sometimes this is because of stigma, sometimes it's because they are not interested in psychiatric care. Patients are more likely to come if I am already at the hospital, but if they are given time to think or need to come back another day, they will not.*
>
> - **Psychiatrist & NGO Worker, Turkey / NW Syria**

A lack of understanding and education around mental health and its importance perpetuates the stigma in society. The news media, for example, rarely draws attention to the high levels of psychological distress facing citizens, and the entertainment media often uses mental illness for comedic effect (Hedar, 2017).

➔ **Gender**

Culturally, it is more acceptable for women to express emotions and appear vulnerable, meaning that the level of stigma facing men is often greater. This can prevent men from disclosing their struggles and accessing support. Without professional help, unhealthy coping mechanisms can be turned to, including social isolation and displays of anger (Hassan & Kirmayer, 2015). If this anger turns to violence, particularly in the home, the risk of other family members developing psychological distress and mental illness increases.

Both men and women are also more likely to share intimate and stigmatizing experiences, such as psychological distress or sexual violence, with a female healthcare worker. This may prevent people from accessing support if the only MHPSS workers available are men.

➔ **Religion**

It is a common belief in Syrian society that mental illness can be caused by 'Jinns' (evil spirits), particularly when hallucinations are experienced. As a result, Sheikhs are often the first line of support for people struggling with psychological distress. These Sheikhs will seek to remove the effects of the Jinn possession through conducting prayers and reading specific passages of the Quran. There is often less stigma associated with seeking help from these Sheikhs than a health facility (Al Laham & Ali, 2020).

Religious leaders also play a role in perpetuating stigma due to their lack of understanding of the medical basis for mental illness and have been known to discourage the accessing of non-traditional support for psychological distress. This can lead to extensive delays in treatment (Hedar, 2017).

➔ **Language**

There are a wide variety of Arabic dialects used across Syria, and in some regions only Kurdish is spoken. With high levels of mental health stigma already present, a patient might be tipped into not accessing support if there are difficulties communicating effectively with the health worker. This issue is exacerbated by the limited pool of available health workers in a highly fractured medical system in Syria.

Alongside this, the lack of education around mental health means that many patients do not understand the medical jargon used by health workers. As a result, the over-use of medical jargon can be alienating for some Syrians, leading to feelings of disempowerment and dependence on the healthcare worker. These feelings can prevent people from accessing, or continuing to access, care.

➔ **Transport costs, accessibility of services and displacement**

The economic crisis engulfing Syria is causing more and more people to live below the poverty line. Due to the lack of readily available MHPSS services, those seeking treatment often have to travel a long way to access it. If they do not have the money to cover transportation, or believe that the money could be better utilised elsewhere, they will simply not attend.

Due to the ongoing conflict across northern Syria, people are also regularly displaced from their homes, or opt to travel in search of more security and safety. This level of instability makes it difficult to complete full courses of treatment, with some patients leaving before all sessions have taken place.

> *There is a lot of drop-out generally. This is related to displacement and also people's financial situation. They need money for transportation.*
>
> - **Psychiatrist, NW Syria**

- **Political and legal barriers**
  The interplay of different factions and forces across northern Syria can cause difficulties for the delivery of reliable MHPSS services. For example, both Turkey and government-controlled areas of Syria limit the ability of health workers to travel between regions, and some authorities require permission to be granted before mobile clinics can enter certain areas.

  There is also a dearth of laws pertaining to mental health. This includes laws that protect the rights of those with mental illness, as well as laws that regulate medical practice. Without effective regulation, the quality of services is more likely to be variable, and the ability of services to work collaboratively is undermined. Within the laws that do exist, terms like 'crazy' and 'foolish' are used to refer to those with mental illness, further perpetuating stigma (Hedar, 2017).

MHPSS Stakeholders in Northern Syria:

The most active stakeholders delivering MHPSS services in northern Syria are NGOs, both local and international. They are the organisations working to fill the provision gaps and meet the growing need across the region. According to our survey of MHPSS workers and KIIs, some of the most active NGOs delivering MHPSS in northern Syria are:

International NGOs

- **International Rescue Committee (IRC)**
  Across Aleppo, Idlib, Al-Hasakeh, Ar-Raqqa, and Deir-ez-Zor, IRC integrates mental health services into their primary care work; runs community-based classes, counselling, and protection services for children; and manages safe spaces for women and girls that offer GBV support, counselling, and skills training.

- **German Agency for International Cooperation (GIZ)**
  GIZ is one of the key agencies supporting the MHPSS sector in northern Syria. Their activities include a training program for MHPSS supervisors, development of a 1-year training curriculum in 'lay counselling', financial support for PSS and Protection services, CETA training, and resilience-building programmes.

- **Humanity & Inclusion (previously Handicap International)**
  HI emphasises awareness raising on issues related to disability and works to enhance access to services and rehabilitation for Syrians with reduced mobility and intellectual disabilities. Their services include management of a health centre in Idlib that provides mental health support.

- **Relief International (RI)**
  RI's network of community health workers work in Aleppo, Idlib, Al-Hasakeh, and Deir-ez-Zor to raise awareness about available services and to promote mental health and GBV prevention. RI protection teams manage safe spaces for women and girls, offering case management, and individual and group counselling for GBV survivors.

➔ **Médecins Sans Frontières (MSF)**
In Aleppo and Idlib, MSF supports 8 hospitals that include MHPSS services. MSF has also provided mental health support at Al Hol camp in Al-Hasakeh.

➔ **Médecins du Monde (MdM)**
In Idlib and Al-Hasakeh governorates, MdM provides PSS services by adapting their intervention models to meet the distinct needs of men, women, boys and girls. They manage a number of PHCs that offer PSS and counselling services.

➔ **Un Ponte Per (UPP)**
UPP works in the NES areas of Ar-Raqqa and Al-Hasakeh. Their engagement began through humanitarian aid convoys of medical supplies and developed into the provision of integrated health services. MHPSS activities include SGBV awareness raising, protection services, and community-based PSS.

With the political situation becoming increasingly turbulent in northern Syria, many iNGOs have had to withdraw staff members from some regions, particularly in NES, out of safety concerns. For example, in 2017, Turkey began a clamp down on iNGOs operating on its southern border, and the relationship remains tenuous to this day. As a result, locally run NGOs have had to try and expand their reach in recent years to meet the growing need.

Syria-focused NGOs

➔ **Syrian American Medical Society (SAMS) Foundation**
Headquartered in the US, SAMS supports Syrian refugees throughout the region as well as IDPs in northern Syria by providing a range of MHPSS and medical services in Idlib and Aleppo. This includes a specialised, outpatient mental health clinic in Al-Dana that includes a telepsychiatry programme with 10 international psychiatrists, management of psychotropic medication, psychotherapy, and psychoeducation services. SAMS also integrates mhGAP trainings, PFA, and mental health screenings at general health facilities and manages over a dozen safe spaces for vulnerable individuals that offer PSS and counselling. SAMS also offers child and adolescent counselling using the CETA training and intervention programme.

➔ **Union of Medical Relief and Care Organisations (UOSSM International)**
UOSSM is "a coalition of humanitarian, non-governmental, and medical organisations from the United States, Canada, United Kingdom, France, Switzerland, and Turkey" (UOSSM, n.d.) that provides training and direct services in MHPSS and general health for those in Idlib and Aleppo. This includes three in-patient MHPSS hospitals located in Sarmada, Al-Bab, and Azaz, which provide psychotherapy, psychiatric care, and supervision for MHPSS workers, as well as several daily clinics that offer PSS and training sessions. UOSSM also offers a telepsychiatry programme with 7 psychiatrists and 1 psychologist through the Health Integrated Resilience System (HIRS) Project.

➔ **SAWSAN**
SAWSAN is the branch of UOSSM France that operates in NES. They manage around 11 Primary Health Centres (PHC)s and clinics covering Deir-ez-Zor, Ar-Raqqa, and parts of Aleppo. Some of these facilities include basic MHPSS services, such as group sessions, individual counselling, post-surgical counselling, and community-based support. Staff includes PSWs, case managers, and community health workers.

- **Syria Bright Future (SBF)**
  SBF was founded with the goal of improving mental health among Syrian communities in Jordan and NW Syria and raising awareness about psychosocial well-being. This includes a range of PSS services across Aleppo and Idlib focused on women and youth empowerment, child-friendly spaces, and psychoeducation in GBV and violence prevention.

- **Hope Revival Organization (HRO)**
  HRO works to improve access and availability of evidence-based, high quality and culturally sensitive MHPSS for populations in NW Syria, as well as refugee communities in Turkey. HRO integrates mental health into primary care through clinical supervision and interventions by mhGAP-trained doctors as well as capacity building in the prevention of sexual exploitation and abuse, services in GBV and child protection, community empowerment, and PSS for all age groups based in Idlib.

- **Hand in Hand for Aid and Development (HIHFAD)**
  Headquartered in the UK, HIHFAD works to build a healthy and secure Syrian society through the provision of emergency aid, healthcare, shelter, education, protection, livelihood, WASH and nutrition-based programmes. They deliver MHPSS in NW Syria through a series of medical teams and mobile clinics, utilising the expertise of employed psychologists. They also provide PSS and peer support for vulnerable individuals with a particular focus on persons with disabilities.

- **Syria Relief and Development (SRD)**
  SRD is an aid agency that provides support to displaced Syrians in Southern Turkey and NWS. This includes various mental health and PSS services in Aleppo through Al Fardos Maternity Hospital (Darat Azza), Kafra Qasrah PHC (Afrin), and Akhtarin Hospital (Azaz).

- **Action for Humanity (AFH, previously Syria Relief)**
  AFH provides aid and support to refugees in Jordan, Iraq, and Turkey, as well as IDPs across northern Syria. This includes researching the extent of poor mental health amongst IDPs, as well as delivering direct MHPSS support in Idlib through individual counselling, child-focused PSS and education, and group therapy.

- **Medical Relief for Syria (MRFS)**
  An NGO focused on providing health support and assistance to those in need in NE Syria. This includes mhGAP-based services, case management, psychoeducation, and community awareness in trauma, stigma, and stress mitigation. These services are available at PHCs in Deir-ez-Zor (Al-Kasrah), Al-Hasakeh (Al-Qahtaniyah, Abo-Qobaya), and Ar-Raqqa (Baydar).

- **Ihsan Relief and Development**
  Ihsan was founded with the mission of providing relief, recovery and development for Syrians living in NWS as well as refugees. Their programming includes activities in education, livelihoods, WASH, shelter, and food security. Ihsan also provides a range of protection services, including child-friendly spaces with case management, PSS, youth vocational training, and social activities; and safe spaces for women and girls with GBV case management, PSS, and vocational training.

- **Islamic Charities**
  There are a number of faith-based and civil society nonprofits that provide PSS, case management, and legal services related to child protection and GBV for individuals across northern Syria (particularly Aleppo and Idlib). This includes Mercy Without Limits, Shafak, Bonyan, Violet, Onder, and Ghiras Alnahda, among others.

Alongside NGOs, **local authorities** have a management and coordination role to play when it comes to MHPSS delivery. Health directorates, committees, and the Ministry of Health for the Syrian

Interim Government work to oversee the provision of MHPSS services, including trying to ensure that workers have legitimate qualifications. They also play an oversight role with regards to securing medication and mapping services across the region. Local authorities in both NWS and NES were interviewed as part of the supplemental Psychiatric Nursing report to gauge perspectives on integrating a psychiatric specialisation. For Psychology and PSW, some local associations are in the early stages of developing advocacy plans to create more standardisation in the cadres (see below).

Within every Governorate in NES is a health committee that NGOs are required to work with. These committees include a mix of health professionals and lay people - many of whom are businessmen. As a result, they do not always pursue interests related to health and may not necessarily understand or have sufficient oversight of health-related matters.

Alongside local authorities, WHO plays a pivotal coordination role across northern Syria. In addition to the monitoring of their flagship MHPSS interventions (e.g., mhGAP, PM+, SH+), WHO also plays a role in supplying psychotropic medication to the region (see **Availability of Psychotropic Medication** above), and management of the MHPSS technical working groups in NWS. There is also a MHPSS technical working group operating in NES, which is managed by Medical Relief For Syria (MRFS).

> *[I attend the] mental health technical working group. We meet on Skype and it is chaired by MRFS. We have monthly meetings to provide updates about what we do.*
>
> -**MHPSS Officer, NE Syria**

The purpose of these working groups is to bring together key MHPSS stakeholders to plan activities, share updates and gather information. For example, recent agenda items for the NES working group include reviewing work and projects from the previous quarters, providing an updated MHPSS service map, and discussing mental health care of patients with Monkey pox.

Professional Associations and Networks

In many contexts, professional associations and networks play an important role in establishing guidelines and standards for cadres, creating opportunities for professional development, and fostering collaboration between key stakeholders. The following diaspora associations include varying levels of emphasis on the MHPSS sector. Due to the political context and the presence of many in Turkey, their activities are mostly restricted to NWS.

In addition to its charitable arm, **Syrian American Medical Society (SAMS)** is also an association for medical professionals in the Syrian diaspora, most of whom are based in the United States. SAMS' membership includes a number of psychiatrists who have maintained a close involvement with the Foundation's MHPSS programming through the activities of its Mental Health Committee, providing oversight and technical trainings. Members have volunteered by assessing qualifications of local MHPSS teams, providing requested trainings, serving on the telepsychiatry programme's roster of specialists, and fundraising.

Syrian Expatriate Medical Association (SEMA) was established in Gaziantep, Turkey and obtained registration in several EU countries, including France, Italy, and the UK. SEMA is a group of doctors and health professionals providing relief in Syria and surrounding countries. They are considered one of the first to promote GBV mainstreaming at health facilities and ensure the presence of GBV case managers who provide PFA, PSS, and referrals for mental healthcare.

In the survey of MHPSS workers, respondents in NWS frequently mentioned the **Union of Medical Relief and Care Organisations (UOSSM)** as an association that they are aware of. In addition to the

direct services described above, UOSSM International also provides training for MHPSS workers, offering 27 different courses. Some of these courses are delivered by other organisations, with UOSSM providing the hosting infrastructure.

Syrian Association for Mental Health (SAMH) was developed in 2012 to address the psychological impacts of the conflict by creating a space for psychiatrists, psychologists, and clinical social workers to communicate and coordinate response. Their primary focus is on providing supervision and consultation services, as well as leading research to better understand mental health needs in Syria and the most effective interventions. SAMH also holds annual conferences in Turkey to discuss the status of Syrian mental health.

American Arab, Middle Eastern, and North African Psychological Association (AMENA-Psy) is an association of Arab/MENA psychologists and mental health professionals. They do not focus on Syria specifically, but their membership is inclusive of those in the Syrian diaspora, and their activities are broadly relevant to the MENA region. Objectives include activities to destigmatize mental illness among Arab/MENA communities; development and dissemination of research and ethical guidelines for providing MHPSS services to Arab/MENA populations; engagement in Arab/MENA policy development and social justice, and other activities related to professional development, psychology education, and public awareness of mental health issues.

There are also a number of relevant associations operating within Syria that have been identified by Key Informants, including:

The Syrian Board of Medical Specialties (SBOMS) comprises 23 scientific committees and is an affiliate of the Ministry of Health of Syrian Interim Government. SBOMS coordinates activity with health directorates in Idlib, Aleppo and Hama, primarily through supporting postgraduate certification, examination and training across a range of healthcare fields, including psychiatry. Their aim is to build standardisation, ensuring that training is accredited and recognised. They are currently working on a review of 'on the job' training, which is common amongst healthcare workers in northern Syria. There is a fear that workers' skills may not be recognised by employers once the conflict is over, so SBOMS is developing an accreditation programme that certifies their abilities (Bdaiwi, et al., 2020).

Syndicate of Psychology and Psychological Counselling (SPPC) was formed in early 2022 as a response to fractured governance. A group of psychology and counselling graduates organised a conference to discuss formation of an association where they can work together to define and regulate job descriptions and career pathways in MHPSS. They have since received licensing by the Interim government. SPPC is still in the establishment stage and developing their strategic goals, so no documents have been issued yet.

Association of Persons with Mental Health Experiences is an independent, voluntary association established in 2022 in NWS consisting of mental patients and relatives who provide care. The association works to reduce the social stigma surrounding individuals with mental illness and advocate on their behalf. It also seeks to adapt an organisational framework for all mental patients and their families that satisfies their core needs.

Syrian Association for Psychosocial Supporters (SAPS) was founded in 2021 by PSWs based in NWS (the majority in Idlib). They currently have around 130 members who have more than 4 years of practical experience in the field and are qualified to provide focused, non-specialised support (level 3 of the IASC pyramid). According to the SAPS chairman, "The aim of the association is to create an entity that represents PSWs, because they often face marginalisation from other organisations in the sector that prioritise counselling and psychology graduates over those with practical experience." Their goal is to advocate on behalf of PSWs so that NGOs consider the value and impact that they bring to their work and support them to further develop their skills.

Syndicate of Nursing Technicians and Midwives is an association of working nurses and midwives throughout NWS. Though they are currently active, more information is needed on their strategic goals, membership numbers, and scope of activities.

Additional interviews and meetings with leaders from these associations are needed in order to collaborate around development of MHPSS education programmes and standards for each cadre.

5.3 MHPSS Education Assessment

Prospective Candidates

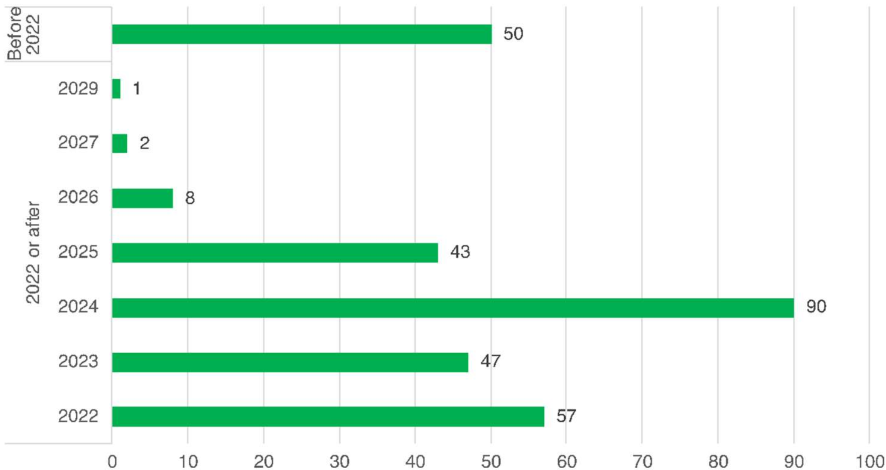
The Scoping Study conducted a survey with current students who are considered potential candidates to enrol in specialised MHPSS training. Having identified through the first phase of data collection the fields of study from which the MHPSS workforce is typically recruited, as well as prominent institutions offering these courses, the evaluation team worked to reach students from across NES and NWS.

Education and Previous Experience

Reflecting the targeting of the survey, 75% of those sampled (n=298) reported a bachelor's degree as their current, or highest, level of education. A further 11% said they have some college coursework completed but have not finalised studies. The remainder have, or are studying for, master's degrees or doctorates (6%), have high school diplomas, or are studying technical/vocational training.

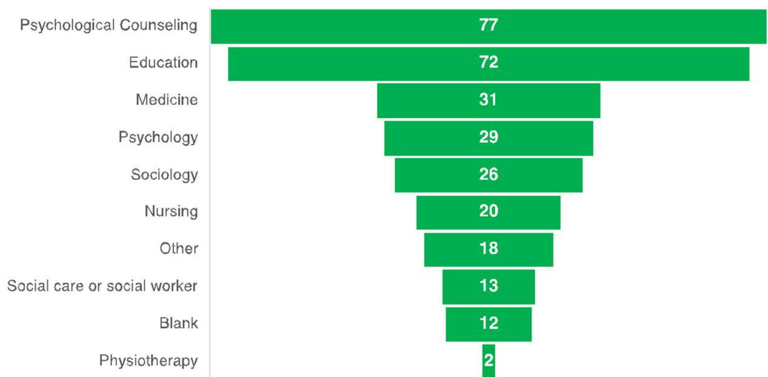
Of the 298 students surveyed, 50 reported having already completed some form of study (26 of whom completed their study within the last two years, 2020-22). 248 from the sample are graduating either in 2022 or after.

Figure 8 – Prospective Candidates Survey: Graduation Years



From the fields of study identified by Key Informants as academic backgrounds from which the MHPSS workforce in Syria often originates, a large proportion of the sample represents students in Psychology/Psychological Counselling (36%), Education (26%), Medicine (10%) and Nursing (7%):

Figure 9 – Prospective Candidates Survey: 'What is your Field of Study?'



Psychology students reported receiving specific training in PFA (specifically those based in Idlib), case management, child protection, and GBV. Psychological counselling students reported receiving PM+, PFA, and suicide prevention training. Art therapy was also mentioned by one respondent. Students of other disciplines were unlikely to report having received any MHPSS specific training, with the exception of a few Education students.

Locations

Most of the Psychological Counselling students sampled were based in NWS (96%)[8] and studying at universities in Idlib and Aleppo, with the remaining 3 respondents based in NES (Ar-Raqqa) and studying at GoS-controlled universities. General Psychology students were more evenly distributed across NWS (41%) and NES (59%). All the Medicine students sampled were in NWS, while all of the Nurses sampled were in NES studying at Al-Hasakeh School of Nursing. Sociology and Social Care students were mainly reached in NES. Education students were sampled from across all governorates. The main institutions where students reported studying are:

- **Free Aleppo University (NWS) -** Founded in 2015 by the Syrian Interim Government's Ministry of Education as an alternative to GoS-based universities, it has since been contested in northeast Idlib by the rival opposition government, the Syrian Salvation Government. Free Aleppo's Faculty of Education includes a department for Psychological Counselling. However, there is no formal recognition or accreditation of Free Aleppo's programmes outside of opposition-controlled areas. Surveyed students were largely based in Azaz where the university is located; several students were also from Ar-Raqqa, though it is unclear if they are from Turkish-controlled areas or from SDF-controlled areas (NES) and participating in cross-line study.

- **University of Idlib (NWS) -** The university was formed in 2017 and is associated with the Syrian Salvation Government (SSG). It uses infrastructure that previously belonged to the Idlib City campus of the University of Aleppo. The Faculty of Education includes a Department of Psychological Counselling.
- **University of Gaziantep (NWS).** Based in Gaziantep, Turkey, the university has a few branch campuses in NWS, including Azaz, Afrin, Al-Bab, and Jarabulus. The Faculty of Education is located in Afrin, which is where all the surveyed students are based.

- **Al-Furat University (NES)** – Al-Furat is a GoS-controlled university based in Deir-Ez-Zor. It includes Faculties of Medicine and Education. Sampled students attended from across NES, including Ar-Raqqa and Al-Hasakeh.

[8] This imbalance was not due to an uneven sampling distribution but because Psychological Counselling degrees are more widely available in NWS.

➔ **Al-Hasakeh School of Nursing (NES) -** The nursing school does not currently offer a psychiatric nursing specialty, though general nursing programmes include some coursework on mental health. More information is available in the supplemental Psychiatric Nursing report commissioned by SAMS (Saadoon et al, 2022).

Students based in Ar-Raqqa also reported studying Psychology, Psychological Counselling, Education and Social Work at other universities in Syria, including the University of Damascus (4) and Tishreen University in Lattakia (3).[9] There are a few additional universities in NES worth noting, though they do not offer MHPSS specialties, and none of their students were sampled for this study:

➔ **Al Sharq University (NES) -** Al Sharq is an SDF-controlled university in Ar-Raqqa that was newly established in late 2021. The university includes a Faculty of Arts with Arabic Language and Literature, Faculty of Education with emphasis on teaching natural sciences and English, Institute of Technical Education, and Institute of Languages.

➔ **University of Rojava (NES) -** Based in Qamishli (Al-Hasakeh governorate), this is an SDF-controlled university established in 2016. The university has five faculties and two institutes, including a Faculty of Medicine and a Faculty of Education.

➔ **Kobani University (NES) -** Based in Kobani (Aleppo governorate), the university was founded in 2017 with Colleges of Sciences and Humanities. Since then it has expanded to include an Institute of Education and a Department of Computer Science.

Age and Gender

The average age of prospective candidates surveyed is 24, with the youngest students surveyed being 18 and the oldest 45.

Figure 10 – Prospective Candidates Survey: Age Distribution

46 respondents described themselves as Heads of Household, with an average household size of 5-6 people.

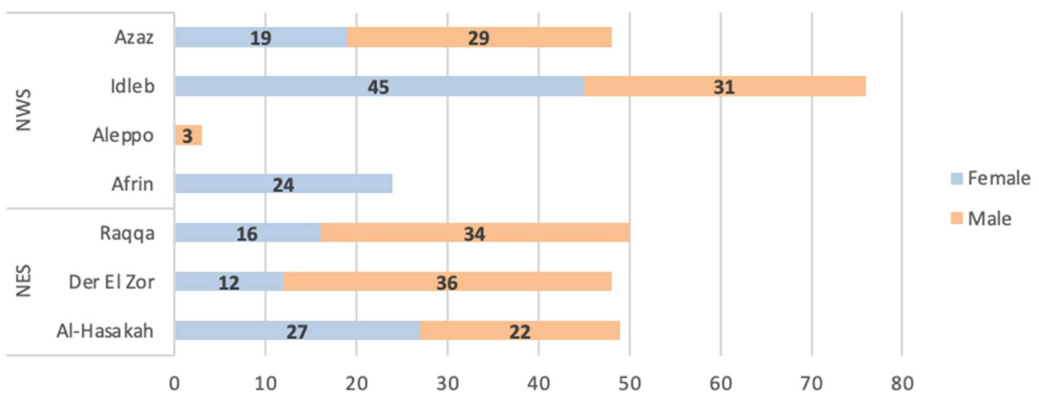
[9] Most are current students, and two graduated recently. They did not specify if they studied remotely or travelled to GoS areas.

Figure 11 – Prospective Candidates Survey: Gender Breakdown of Key Fields of Study Sampled

Field of study	Male	Female
Social care or social worker	8	5
Nursing	9	11
Sociology	17	9
Psychology	22	7
Medicine	26	5
Education	39	33
Psychological Counseling	18	59

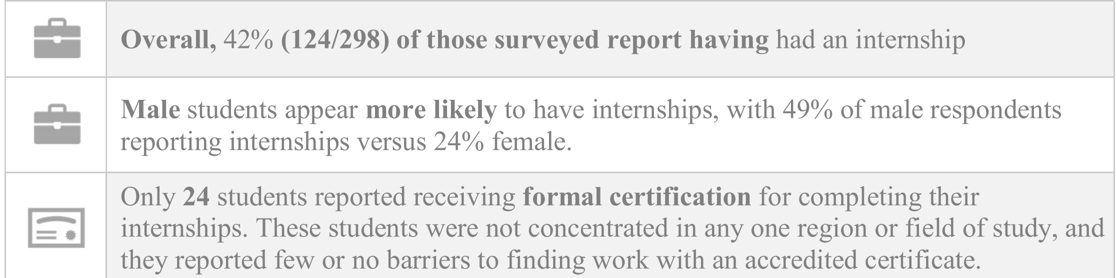
Study of Psychology, Medicine, and Sociology appears to be dominated by males, whereas respondents from Social care, Nursing, and Education are more gender balanced. This is with the exception of 'Psychological Counselling' where the overwhelming majority of respondents are female.

Figure 12 - Prospective Candidates Survey: Gender Breakdown by Locations Surveyed



Internships

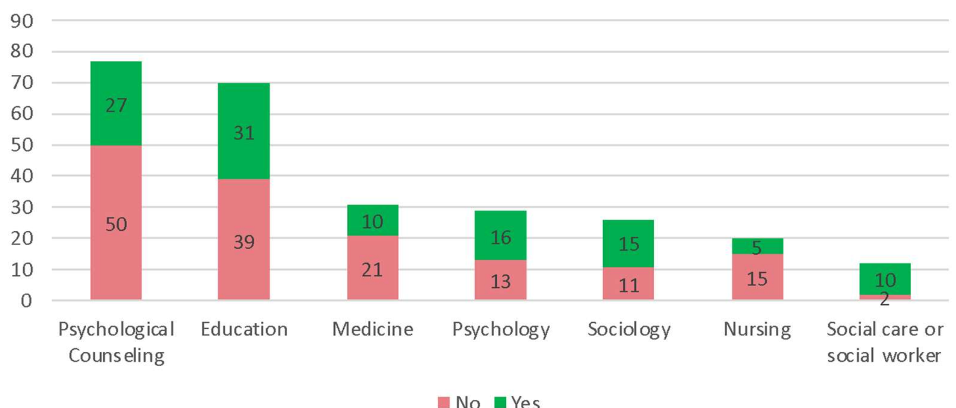
Table 11 – Prospective Candidates Survey: Key Information on Internships



	Overall, 42% **(124/298) of those surveyed report having** had an internship
	Male students appear **more likely** to have internships, with 49% of male respondents reporting internships versus 24% female.
	Only **24** students reported receiving **formal certification** for completing their internships. These students were not concentrated in any one region or field of study, and they reported few or no barriers to finding work with an accredited certificate.

Of those who will graduate in 2022 or after, 40% have already had an internship. Those about to graduate this year or next, are most likely to have already had an internship – suggesting that work experience usually comes towards the end of courses. The respondents did not specify the site or duration of these internships.

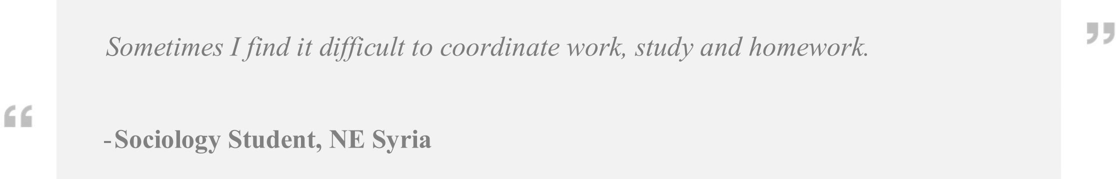
Figure 13 – Prospective Candidates Survey: 'Have you ever had an internship?'



As the figure shows, those completing study in Social Care/Work have almost all had an internship – likely due to the vocational nature of that course. Psychological Counselling students in NES appear to have opportunities for internships, as 6/7 of these students reported having this experience (including students who studied at Damascus, Hama and Tishreen Universities). Approximately half of Education and Psychology students respectively have undertaken internships. Only 32 respondents answered questions on pay received for internships. They reported that they do receive a stipend for internships but did not specify the amounts received.

Employment Status:

100 of the students surveyed report that they are currently working in MHPSS and providing services alongside their studies, though it is unclear how many of them equated work with internships. Only 26 of the respondents provided full job titles, and the results confirm the relatively loose nature of the relationship between fields of study and roles in the workforce. For example, some nursing students are currently working as PSWs; some psychological counselling students are working as teachers and social workers; and one student studying Education is working as an MHPSS Officer. The survey also captured a further 43 students who are not employed in MHPSS services but characterised themselves as 'seeking job opportunities' in the sector. These students (including 19 Psychological Counselling and Psychology students) specified the demands of studying and a lack of job opportunities as the key barriers to employment. Only 2 respondents reported **childcare responsibilities** or pregnancy as a barrier to work.



> *Sometimes I find it difficult to coordinate work, study and homework.*
>
> -**Sociology Student, NE Syria**

Only 24% of female respondents to the Potential Candidates Survey said they are currently working, in comparison to 43% of males.

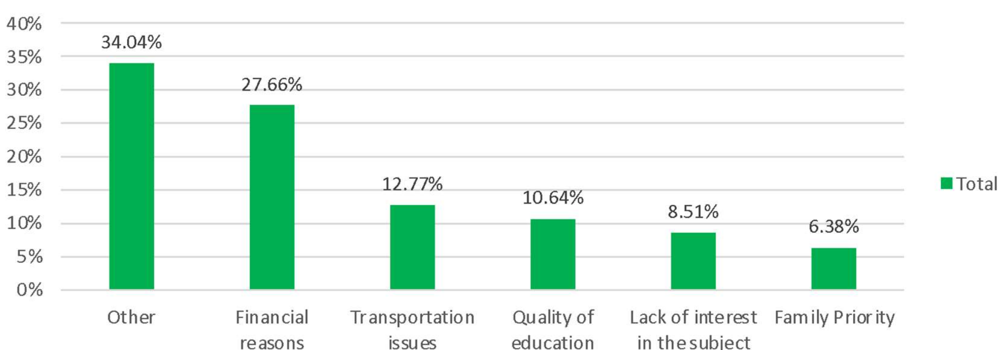
Barriers to Enrolment & Continued Education

Higher education (HE) in Syria has undergone a massive upheaval since the start of the conflict in 2011. What was once one of the most well-established HE systems across the Middle East has

become fractured and politicised, with reports of human rights abuses taking place across campuses, academics fleeing the country and infrastructure being destroyed (Dillabough, et al., 2019). A vastly diminished HE system in Syria, alongside an accelerating economic crisis and an ongoing conflict, has resulted in significant barriers to student enrolment and continued enrolment.

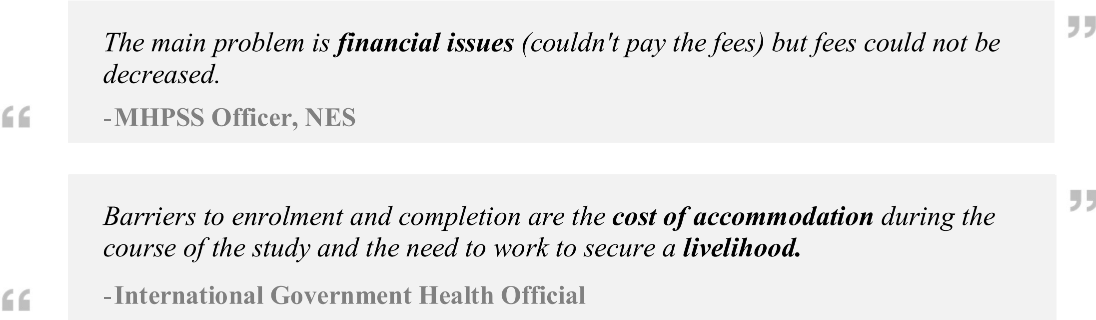
In our survey of 298 undergraduates across northern Syria, nearly 16% (47 respondents) were not able to continue their course or had ended their education early. Amongst these students, the following were noted as the biggest reasons for non-completion (those who specified other did not provide an explanation):

Figure 14 – Prospective Candidates Survey: 'For which reason could you not complete your study?'



➔ **Financial**

After 'Other', financial reasons were by far the most common barrier given for non-completion of education. With an economic crisis gripping the country, the ability of students to both pay their fees and cover the cost of living is becoming increasingly difficult. This issue extends to both public and private universities, despite the difference in fees being considerable. For example, at Free Aleppo University in 2019, fees ranged between $50 and $250 USD per year (Enab Baladi, Free Aleppo University: Displacement Leaves Marks but Educational Process Resists, 2019), whilst at private universities, annual fees often reach many thousands of dollars (al-Watan, 2021). This theme of financial issues being a major barrier was reiterated by a number of Key Informants:



> *The main problem is **financial issues** (couldn't pay the fees) but fees could not be decreased.*
>
> **-MHPSS Officer, NES**

> *Barriers to enrolment and completion are the **cost of accommodation** during the course of the study and the need to work to secure a **livelihood.***
>
> **-International Government Health Official**

Of those 13 respondents who cited 'Financial Reasons', 10 are female – suggesting that this is an issue affecting women in particular. 76% (226/298) of Prospective Candidates surveyed said that parents or family members have paid or are paying for the cost of their studying. Only 20 respondents said scholarships covered the main cost of their study. Of these, the majority are Psychological Counselling students based in Azaz and Afrin, NWS (though not attending any one particular institution).

➔ **Quality of education**
The ability of HE institutions in northern Syria to deliver high quality education has been severely impacted by the conflict. Beyond the damage to buildings and infrastructure, many experienced staff members have fled or been displaced, leading to under-qualified graduates being appointed or staff members having to teach subjects they are unfamiliar with. Alongside this, there are limited textbooks and resources available, and curricula are often outdated and increasingly reliant on rote learning (Dillabough, et al., 2019). The integrity of HE itself has also been threatened with increasing reports of cheating and bribery taking place (Kirdar, 2017). All of these factors are resulting in students experiencing a lower quality of education and ultimately leading some to drop-out. A technical review of each program's undergraduate curricula and faculty credentials would be valuable, though this analysis would first require an MOU or other formalised partnership with the university.

➔ **Access and transportation**
Issues with transportation was the third most common reason given for non-completion of education. The limited number of HE institutions in northern Syria coupled with the unreliable transportation system makes getting to and from university buildings difficult for many. To combat this, institutions have been increasingly attempting to deliver education remotely. Foreign HE institutions have also been developing online learning for IDPs and Syrian refugees, ensuring that the right to education is upheld (Rubin & S. Bose, 2022). For example, universities in Jordan have provided remote professional diplomas for Syrians in the past. Though they expressed a willingness to design similar programs in MHPSS cadres, they also noted that the ability of students to effectively engage with online learning is limited:

> *One barrier is how they will take the course, because internet connection is needed. The feasibility of taking a course is a big issue, especially **if they are from a remote area**. Good internet and electricity are a big challenge.*
>
> **-Professor of Psychiatric Nursing, Jordan**

Whilst the above barriers are increasing the rates of students in northern Syria dropping out of their courses early, they will also be preventing some students from enrolling in the first place. Prospective candidates who know they cannot afford the fees, who live too far away, or who have heard that the quality of education is poor are unlikely to apply in the first place. There are, however, some additional factors that may be acting as barriers to enrolment:

➔ **Stigma**
It is well-established that mental health stigma is pervasive in Syrian society. Whilst this stigma primarily impacts patients, there is evidence to suggest that it also impacts the attractiveness of training and working in the field. Of the 222 students surveyed, only 65% agreed or strongly agreed with the following statement: *"When I share with my friends and community about the work I do in the MHPSS field, they respond with support."* This sentiment that working in mental health is not the most attractive proposition was reiterated by Key Informants:

> ***Nurses don't prefer to work in psychiatric fields**. For example in Jordan, nurses here have extra salary just to encourage people to go into this area, because there's an extra risk from stigma and the patients. Especially for girls, they want to avoid mental health stigma, because people may look at them differently and it might make it harder to get married. If the students already work in a psychiatric area, they may agree to take the course.*
>
> **-Professor of Psychiatric Nursing, Jordan**

If incentives are required to encourage nurses to work in psychiatric settings, in part due to stigma, it is likely that many prospective students would prefer to study a non-mental health related subject for similar reasons.

➔ **Academic requirements**

Following the outbreak of the conflict in 2011, many institutions – both public and private – reduced their entry requirements to prevent falling student application numbers. This meant that virtually anyone who had passed their Secondary School General Examination in Syria suddenly met the threshold for HE. Despite these efforts, the number of applications continued to drop, and the number of drop-outs from existing students soared.

Whilst entry requirements were largely removed as an enrolment barrier for domestic students, this is not the case for Syrian refugees in neighbouring countries. For example, at Hasan Kalyoncu University in Turkey, barriers still exist:

> *Our [international] students are mostly from Syria and Iraq. Barriers for international students are diploma (very important requirement). If they are from other countries,* ***our higher education council does not accept every diploma****.*
>
> **-University Coordinator, Turkey**

Addressing and Mitigating Barriers

With financial reasons being the most cited barrier to continued enrolment, it's clear that all associated course costs must be as low as possible for a higher percentage of students to graduate. This includes the standard tuition fees alongside common hidden costs like examination, registration and resit fees. However, even with education-related costs being minimised, the economic crisis facing Syria will prevent many prospective and current students from managing their living costs. There is a distinct lack of HE grant and scholarship opportunities in northern Syria, particularly outside of Aleppo, meaning that those who are struggling financially are simply excluded from higher education (Enab Baladi, 2021). To combat this, further financial support programmes should be considered.

Beyond financial assistance, in our survey of prospective candidates, many of whom are already supporting the delivery of MHPSS services, respondents were asked '*What are the factors that would allow you to stay in your education/ job?'*. The most common response was the availability of flexible scheduling (75.6%), followed by incentives related to employment arrangements (62.6%), incentives to enhance the working environment (56.7%), incentives for professional development (56.3%) and community recognition (48.6%).

Considering the impact the conflict is having on the stability of many people's lives in northern Syria, it's no surprise that **flexible scheduling** was the most common response. From safety fears to travel issues, there are a multitude of reasons why a student might not be able to attend classes or work at any given time, or why they might have a strong preference for certain times or days over others. A course that allows students, where possible, to make their preference for scheduling known, or to choose from multiple time options, or to follow up with learning material online if needed, would increase the likelihood of students reaching graduation.

Interestingly, the availability of flexible scheduling was especially important for those whose background is in medicine (93.8%) or psychology (87%) and less important for those whose background is in social work (61.5%). This could be due to medicine and psychology courses being more demanding, or requiring a higher number of contact hours, although we do not know for certain.

Incentives were also popular amongst respondents. Opting into and staying in higher education is particularly difficult in northern Syria at present. The threat of violence is high and many students are struggling to survive due to the economic crisis, making the prospect of fleeing or finding full time employment increasingly attractive. Knowing that a job was guaranteed at the end of the course, or that ongoing opportunities for professional development were available would help students stay in education. This theme of incentives was reiterated in Key Informant Interviews:

> *If we start with 20 students, I cannot guarantee how many will complete by the end of the programme. Students need incentives to complete, such as salary, promotion or certificate.*
>
> -**Professor of Psychiatric Nursing, Jordan**

Whilst community recognition was the least popular option overall, it was the most popular response for those with a background in social work (76.9%). It's possible that social workers more acutely feel the impact from a lack of community recognition due to their integration into the communities they are supporting.

Current MHPSS Programmes in Syria:

Existing Degree/Training Programmes & Methods

Psychology/Psychological Counselling. At the Undergraduate level, Free Aleppo University and the University of Idlib (both in NWS) are the two major institutions offering degree programmes in Psychological Counselling, both sampled for this survey.[10] Other respondents studied Psychology and Psychological Counselling at Gaziantep University's branch in Afrin. These degrees are 5-year programmes, but there is some scepticism about the standards and instructors' expertise. Further, degrees from Free Aleppo and University of Idlib are not recognized or accredited outside of northern Syria (Bdaiwi, et al., 2020).

Clinical Psychology. Key Informants pointed out that there are no programmes in Clinical Psychology at either the undergraduate or the postgraduate levels in northern Syria. Outside of the north, University of Damascus has recently started a 5-year bachelor's programme in Clinical Psychology with support from AMAL and GOPA. This programme structure is uncommon, as Clinical Psychology is most often taught at the masters or doctoral level of study instead of the bachelors level. University of Damascus is also preparing a master's programme in Psychotherapy, through which Clinical Psychology graduates can learn specialised interventions such as CBT, EMDR, NET, and others.

Psychiatry. The only postgraduate MHPSS offering currently available in the north is Psychiatry, which is supported by the Syrian Board of Medical Specialties (SBOMs). UOSSM and SBOMS are currently working together to update the Psychiatry curriculum for NW Syria and support new medical school graduates to complete Psychiatric residency.

Private Universities. There are a number of private universities offering education and training in different parts of Syria at the undergraduate and postgraduate levels, including Al-Shamal Private University in Idlib (Sarmada); Mari University in rural Idlib (Saraqib); Osmania University in Idlib; Academy of Health Sciences in Idlib (Atmeh), which offers nursing and physiotherapy; Al-Hayat

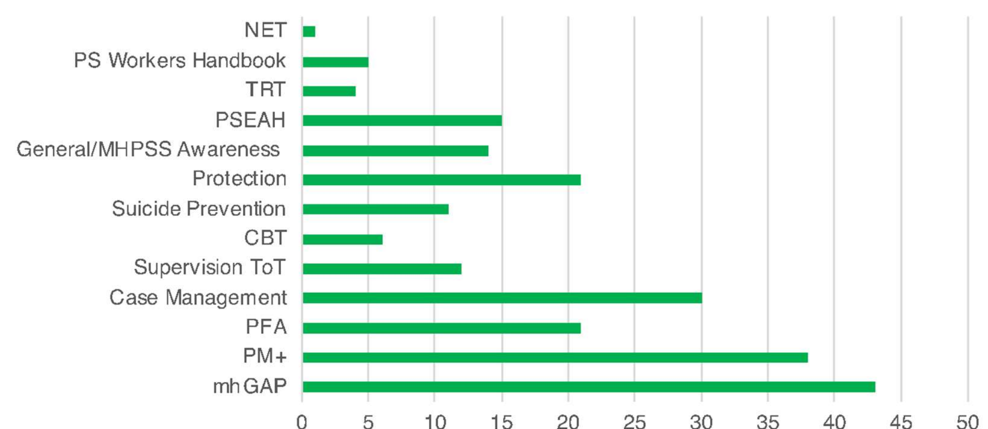
[10] The supplemental report on Clinical Psychology and PSS commissioned by SAMS also identified North Private University (Idlib), Al-Nahda University (Azaz), Ma'ali University (Al Bab), and Al-Zaytoonah University (Azaz) as offering degrees in Psychology and/or Counselling.

University of Medical Sciences in Idlib (Maarat al-Numan), which offers nursing; and Al-Zahra University in Aleppo (Jarabulus), which offers education studies (Nour & Shahadeh, 2019).[11]

Despite their offerings, private universities are often poorly regulated with little standardisation or governance and have been challenging for the local health directorates to regulate. Some have faced internal administrative, financial, and governance challenges which affected their credibility and caused some to close. The Syrian Salvation Government has also tried to enforce registration, permits and affiliation with it, thus driving some private universities to close their doors. Though some private universities provide options for distance learning in addition to on-campus training, they are also far more expensive. At a tuition rate of around $1,000 USD per year, they are less accessible for many students.

Non-academic Training. The principal deliverers of non-academic MHPSS training in northern Syria are NGOs (particularly Syrian expatriate organisations) and international agencies. This includes training in WHO's mhGAP and PM+ programmes, which are very prominent in the region,as well as GIZ's MHPSS supervision training. As discussed in **MHPSS Practice Regulation & Protocols**, the MHPSS TWG in NWS offers a training program for PSWs who have at least two years of experience in MHPSS. The full training can last up to a year, including 9 months of supervised practice. Modules include principles of care, PFA, mhGAP, case management, self-care, psychoeducation, supervision, children, positive parenting, survivors of GBV, survivors of chemical attacks, inclusive care, and PM+. Of the MHPSS workers surveyed, 165 respondents said they have received MHPSS training in their current or previous role. A breakdown of types of training, techniques and interventions received is provided below:

Table 12 – MHPSS Workers Survey: 'Did you Receive MHPSS Training in your current or previous role? If so, what?' (N=165)



mhGAP training was the most frequently cited training offered, as this is WHO's flagship MHPSS programme. This training is most often received by medical doctors (and other medical specialists included in the sample) and PSWs across both NWS and NES. Through SAMS, mhGAP training has also been offered to nurses and midwives. The only location where no respondents reported receiving mhGAP training is Qamishli, NES.

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[11] Al-Shamal was set up as a merger of Oxford University of Syria (a branch of the Yemeni Oxford University) and the University of Rumah. Mari University is based in Mersin, Turkey, and the Idlib branch was established in 2017.Osmania University was established in Istanbul in 2016 as a branch of the University of Malaysia. Before the war, it had faculties in Talbiseh, ar-Rastan, and Houla, which moved to Idlib. Academy of Health Sciences was established by the Syrian Expatriate Medical Association (SEMA)

Only 20% (17/89) of surveyed PSWs reported having received Problem Management Plus (PM+) training (i.e., an intervention for supporting distressed adults). Of these, the majority work in NWS. Others who reported receiving PM+ training are Psychologists (2), Mental Health Workers (3) and Community Health Workers (4). Psychological First Aid (PFA) training (i.e., a basic intervention to support immediate needs during a disaster) has been received by a minority of respondents in the study (21), primary Social/Protection Workers, PSWs, and Community Health Workers, almost all of which are located in NWS.

While Suicide Prevention training is a frequently cited need (See **Training Gaps** below), only 11 respondents overall reported receiving this training, most likely because this is a subject area rather than a developed curriculum like the others. Trainings in this subject are likely to vary in terms of length, content, and quality. Respondents who have received suicide prevention training are concentrated in Idlib and Aleppo, working for a range of different organisations (including national and international NGOs). The majority (6/11) are PSWs, though this training would be valuable for all MHPSS cadres.

The trainings focused on specialised interventions, such as Cognitive Behavioural Therapy (CBT), Teaching Recovery Techniques (TRT) and Narrative Exposure Therapy (NET), were cited largely by Psychologists. Though not included in the questionnaire, SAMS has also implemented training in the Common Elements Treatment Approach (CETA), which trains PSWs to provide counselling support for children and adolescents.

Training Gaps

Respondents to the workers survey were asked to name topics/areas for training they consider a priority for the MHPSS Workforce in their region:

Table 13 – MHPSS Workers Survey: 'What do you consider to be the priority training topics for MHPSS workers in your region?' (Ability to name multiple)

Priority training topics (MHPSS workforce)	Respondents
Problem Management Plus (PM+)	58
Working with children / child-specific behaviour and disorders	37
Suicide prevention	33
Cognitive Behaviour Therapy (CBT)	26
Developing communication skills and empathy with others	23
(Advanced) Case Management	22
Child Protection	22
Fundamentals in MHPSS (i.e. basic concepts and awareness training)	21
Mental Health Gap Action Programme (mhGAP)	20
Gender Based Violence / Sexual Abuse	20
Teaching Recovery Techniques (TRT)	16
Working with stress-related disorders, including PTSD	16
Addiction	12
Psychological First Aid (PFA)	9
Working with people with disabilities (including mental) and the elderly	7
Eye Movement Desensitization and Reprocessing (EMDR)	4
Session facilitation skills	3
NET	3
Self-care	2
English	1

A recent report on PSS needs in NWS commissioned by SAMS similarly identified the following training needs for PSWs: (1) Stress Management (77%), including dealing with difficult clients, coping strategies, and self care; (2) Ethical standards (76%); (3) Crisis response (73%), including trauma treatment; (4) Assessment and diagnosis (71%), including intake and examination, DSM5, personality and intelligence tests, and writing reports; (5) Community mental health (70%), including PSS for families, children, and GBV survivors; and (6) Psychotherapy (70%), including communication skills, theory, CBT, psychodynamic approaches, and to a less degree, DBT, Client-centred therapy, and EMDR (Alsheikh, 2021).

As highlighted under **Technical Areas with Highest Need (Workforce Assessment**, the ability to 'deal with' children and their specific behaviour and needs, is a clear area where the Syrian MHPSS workforce feel they need additional expertise and support. This was reported by workers from across roles and locations. As mentioned above, the Child CETA intervention is a non-academic training programme that may help bridge this gap for MHPSS practitioners. Respondents also report the need for specific skills to help them deal appropriately with people with disabilities.

PM+ was the most frequently mentioned training priority, highlighted by PSWs, Case Managers, and a minority of the mhGAP doctors surveyed. This is an intervention developed by WHO that trains practitioners to support adults struggling with common but often severe conditions like depression, anxiety, and PTSD.

MHPSS workers in Syria are frequently dealing with traumatised individuals and groups, which was reflected in the requests for training in TRT, EMDR and other methods for dealing with those suffering from PTSD and other stress-related conditions. Suicide also features very highly as a concern for workers survey, who frequently cited Suicide Prevention as an area where training is required.

Communication skills were highlighted by PSWs, Social/Protection Workers and Case Managers and Teachers. When respondents were asked what skills they need to improve themselves, in order to increase their effectiveness in delivering services, 'communication skills' was overwhelmingly the most frequent response. Notably, Key Informants also mentioned communication and other soft skills as an area that they especially prioritise when hiring MHPSS staff.

Health Facilities to Support Practicums and Internships

Northwest Syria

9 of the 11 facilities surveyed in NWS reported a willingness to serve as a practicum site for MHPSS trainees during their practicum. However, two of the sites reported that they could not host any trainees at this time - Humanity and Inclusion's Psychological and Physiotherapy Center in Atmeh (Idlib) and Protection Centre in Azaz (Aleppo). Another reported that they could only host one trainee but lack supervision capacity to support them - Medical Care Hospital in Idlib. The 2 facilities that reported an inability to serve as a training site are UOSSM's Mental Health Center in Sarmada (Idlib)[12] and Atmeh Charity Hospital in Atmeh (Idlib). The remaining 6 sites willing to take in trainees include:

SAMS MHPSS Center Al-Dana: As one of the few specialised MHPSS centres in NWS, SAMS facility in Al-Dana is well-positioned to serve as a training site. The staff includes 2 psychiatry residents, 4 psychologists, and a psychiatric nurse, along with participation from SAMS Mental Health Committee and a telepsychiatry program. Staff has received additional training in PM+, suicide prevention, person-centred support, and NET for Children. Services include provision and

[12] Another recent report commissioned by SAMS included interviews with UOSSM's Center in Sarmada, and they expressed a willingness to host trainees in psychiatric nursing.

management of medication, psychotherapy, individual and group counselling, and psychoeducation workshops. Though senior practitioners have limited time, they are able to dedicate some toward supervision, and can host up to 12 trainees depending on the practicum guidelines.[13]

UOSSM's Physicians across Continents in Azaz: Managed by UOSSM, the Azaz centre is an inpatient MHPSS hospital for severe, chronic disorders. They provide psychological assessment and diagnosis, psychotropic medications, and referrals for psychiatric treatment. Staff are required to have a bachelor's degree, but many do not have a formal MHPSS background. They have received non-academic trainings in areas such as child mental health, addiction, suicide prevention, and PSS. The centre expressed a willingness to host 15 trainees and have prior experience training students in MHPSS, but they cannot commit senior practitioners to provide supervision to the same extent as other centres.

Aman Women Empowerment Centers in Jindires and Afrin: These centres focus primarily on non-specialised mental health support and protection. In Afrin, services include support from an mhGAP-trained doctor, child protection, and community awareness raising. PSWs have Bachelor's degrees in Psychological Counselling, Sociology, and Education, and have received non-academic training in suicide prevention and case management. In Jindires, services include PSS, psychoeducation, and awareness, and staff have been trained in GBV, safe referral pathways, and facilitation/coaching. These centres can potentially host 10 (Afrin) to 15 (Jindires) trainees and have the capacity and time to dedicate to supervision.

Hand in Hand Hospital in Atmeh: This hospital includes general health services as well as mhGAP and PSS. There is some formal background in MHPSS, supplemented by non-academic trainings in specialised services such as CBT, TRT, and psychodrama, as well as non-specialised support like PFA and PM+. The hospital expressed a willingness to take in 20 trainees, and noted that senior practitioners have the time to dedicate toward supervision.

Syria Relief, CFS Center in Jindires: Services at this centre are primarily protection-focused, with providers offering child protection with various child-focused psychoeducation curricula, parenting sessions, case management, and training/supervision in protection for other providers. Some have an undergraduate background in psychology, and providers have received training in PFA, minimum standards of protection, and child development. The centre expressed a willingness to host 20 trainees. Senior practitioners are able to dedicate time to supervision, though they reported that they do not have a specialised trainer; rather, "there are project coordinators who do these tasks."

Northeast Syria

Due to the relative lack of specialised MHPSS support in NES, the surveyed facilities include primary health centres (PHCs) and general health clinics rather than centres focusing specifically on MHPSS services. Most of the facilities in NES are managed by a few key NGOs. The study team reached out to these NGOs, who suggested specific facilities that may be well suited as MHPSS practicum sites.

SAWSAN: The survey covered 11 PHCs and clinics across Deir-ez-zor, Ar-Raqqa, and Aleppo that offer a range of health services. 4/11 sites said that they have experience offering training for MHPSS students or interns; these sites reported that SAWSAN has a dedicated training centre in Ar-Raqqa where trainings for new employees takes place. SAWSAN also manages Abu Hamam Healthcare Centre in Deir-ez-Zor, which offers individual and group counselling sessions in a dedicated Psychosocial Support Office.

[13] SAMS can receive four trainees per day. If the practicum requires them to be on-site twice per week, then SAMS can receive 12 trainees over 6 days. The numbers from other sites may also fluctuate based on the requirements.

5 /11 facilities said they could be used as potential sites for training/practicums: the Abu Hamam Center in Deir-ez-Zor, 2 PHCs in Hajin and 2 PHCs in Ar-Raqqa (Ar-Raqqa city and Al-Karama). Reasons given for the suitability of these sites were availability of space, equipment and the presence of senior practitioners who would be able to provide some field supervision and share experiences. The respondents did not know what kind of compensation would be required for these supervisors, and each said they could take an average of 10 participants per facility. Support needed by the facilities include the provision of trainers and expertise for any sessions, as well as screens/electronic devices for training.

Médecins du Monde (MdM): The survey covered 13 MdM-managed facilities in Al-Hasakeh, Ar-Raqqa, and Aleppo. These facilities include clinics (4), PHCs (5) and mobile clinics (4). 11/13 facilities report providing MHPSS services, and the survey respondents largely comprised psychologists and PSS workers nominated by MdM. All 4 of the MdM mobile clinics reported having Psychological Support Centres, as well as Khanik Health Centre in Aleppo. A psychological counselling room is also available at Tell Al-Barak clinic in Qamishli. These facilities receive mental health cases from their community health workers, as well as referrals from doctors, nurses and those reached through GBV services.

10/13 facilities report that they have experience of hosting training and internships. However, most of the responses focussed on internal training delivered to MdM staff, or some sessions delivered in the community (i.e. awareness sessions). Khanik Health Centre in Aleppo reported providing PFA training for those from the local community.

Only 5/13 facilities said they could be used as a practicum site, including Tell Al-Barak Clinic in Qamishli, Al Ghurra Polyclinic in Al-Hasakeh, and Sareen Health Center, Mishta Al Noor Dispensary, and Khanik Health Centre in Aleppo (districts unknown). They focused on the experience of their staff as key factors which would facilitate this, though most of these facilities said they would need screens/display devices and laptop equipment as well as budgets and compensation for supporting the students. Lack of time for supervision was highlighted as a challenge, and they would require supervision training.

International Rescue Committee (IRC): 13 IRC facilities were surveyed, all of which provide MHPSS services across NES. Staff at these facilities include psychiatrists (IRC is the only organisation to say they have psychiatrists available - likely working across facilities), psychologists, PSS workers and mhGAP doctors. Only 3/13 facilities suggested they would be open to hosting a practicum, including Ar-Raqqa MHPSS Centre (which has a psychiatrist on staff and could host 20 students), Hazimeh dispensary in Ar-Raqqa (which could host 5 students), and Al-Hasakeh PHC Centre. Limited space and pressures from a large number of cases were raised as the biggest reasons for other sites' reluctance to support. The Ar-Raqqa Centre specified that it would need compensation for field supervisors (amounts not specified) as well as technical specialists who can provide remote supervision and follow-up.

Relief International (RI): 7 facilities across Deir-ez-Zor and Al-Hasakeh were surveyed, with those responding largely general physicians. Respondents from Relief International reported few MHPSS staff beyond a small number of PSWs and CHWs. Only 2/7 sites reported a willingness to host students, and only one with experience providing PSS: Sabha mobile clinic in Deir-ez-Zor.

Summary

The health facility questionnaire was designed to gauge the facilities' overall interest in participating in a practicum and to establish a baseline of standards needed for the facilities to host trainees (e.g., general MHPSS capacity, experience, and supervision). Prior to confirming facilities as training sites, a technical evaluation will need to be conducted to provide a more detailed assessment of the facilities' qualifications and track record. Additional communication will also be needed closer to

programme implementation to determine whether their situation or willingness to accept trainees has changed. Further, additional communication is needed to determine financial compensation for the facility supervisors, as most of them declined to answer. Those who responded to this question specified $300 USD per month or $10-15 USD per hour (in NWS).

In NWS, most of the surveyed sites offer basic PSS services and would be best suited for hosting PSS trainees and interns. Trainees in Psychiatric Nursing and/or Clinical Psychology should be hosted by one of the specialised MHPSS centres. SAMS MHPSS centre reported a willingness to accept trainees in either cadre. According to the supplemental report on Psychiatric Nursing, the 3 psychiatric hospitals managed by UOSSM reported a willingness to host trainees in psychiatric nursing. These hospitals include the centre in Sarmada, Physicians across Continents in Azaz, and a hospital for acute psychiatric cases in Al Bab (which could not be reached for this study).

In NES, even though there are substantially fewer specialised MHPSS workers, the facilities survey returned a number of sites that could potentially host students. The most notable among these are SAWSAN's Abu Hamam Center in Deir-ez-Zor (with a PSS Office), IRC's MHPSS Centre in Ar-Raqqa (with a psychiatrist, psychologist, and PSWs on staff), and MdM's Tell Al-Barak Clinic in Qamishli (equipped with a psychological counselling room).

6. Conclusion and Recommendations

Advanced education opportunities in MHPSS cadres such as Clinical Psychology, Psychiatric Nursing, and Psychosocial Support are crucial. Across the entirety of northern Syria - particularly NES and the more remote areas of NWS - the existing MHPSS workforce is significantly overstretched and unable to meet the growing need. Although there are some existing MHPSS-related training courses and undergraduate academic programmes delivered by (i)NGOs, associations, and universities in northern Syria, they lack rigour in terms of duration, breadth and depth of content, and technical oversight/supervision. MHPSS workers are left without sufficient skills to meet the scope and severity of mental health issues that they are faced with. Without increasing the size and capacity of the MHPSS workforce, the severity of the mental health crisis in the region will continue to worsen, which will have reverberating impacts over the next generations.

Potential Risks

The following risks need to be considered carefully when designing education programmes in MHPSS cadres. Mitigation measures for each of these are included in the list of recommendations below.

Attrition/Dropout. Student dropout could occur due to the cost of tuition, an excessive amount of travel needed to reach the education centres or practicum sites, interference of childcare or other household responsibilities, placing a higher priority on full-time salaried work, or other causes that have not been identified. This would reduce the project team's impact on capacity building within Syria and support for those with mental health. The programmes need to be designed around identified barriers and/or the trainees need to undergo an extensive interview process to ensure that those who are selected will commit to completion of the programme.

Absorption of Graduates. In order for the programme to be successful, the students must be hired by health facilities and MHPSS centres after graduating from the programmes. If they are not hired, then the programme will not see the desired impact toward strengthening the MHPSS workforce and reducing the mental health burden.

Leaving Syria. Graduates could leave northern Syria so they can utilise their skills and training in another location that provides better compensation and carries less safety risks. This would inhibit the objective of increasing capacity within Syria and endeavouring to support those with mental health needs locally.

Programme Sustainability. Implementation of these programmes is currently funded by the EU and managed by SAMS. A detailed sustainability plan is needed to ensure that these programmes can continue to be offered by local universities and education centres beyond the current grant period.

Instruction. To maximise the impact of these education programmes, it is crucial that the instructors are qualified educators with adequate technical knowledge of the courses they are set to teach. Without this, the students could receive inaccurate or outdated information that they then bring to their service delivery.

Supervision. If qualified or experienced practitioners are unavailable to provide supervision for the new trainees – or the trainees and supervisors do not adhere to the agreed-upon structure of the practicum – then patients could experience low-quality service delivery and potential harm.

Curricula Development. In order for these programmes to be both rigorous and sustainable, the curriculum guides need to be designed in accordance with standards and benchmarks[14] that have been established for each cadre, with materials and content that have been created with the local context in mind.

Recommendations

Programme Content and Design

MHPSS workers in northern Syria operate in a unique and challenging environment. Whilst increasing the numbers of qualified professionals would reduce the existing burden on services and allow for more comprehensive MHPSS delivery, addressing the mental health crisis in the long term requires the workforce to be equipped with a higher level of knowledge and skills than what they are currently receiving. As a result, the following learning topics are recommended for inclusion in the academic programmes:

- **Managing workloads and self-care**
  Graduates of the academic programmes will be entering an MHPSS workforce that is under-resourced and understaffed. There is a high likelihood of burnout, as well as inefficient and ineffective service delivery, unless graduates can effectively manage their workloads and their own mental health.

- **A person-centred approach**
  Taking a person-centred approach to mental health care is particularly important in a context like northern Syria where stigma is rife. Graduates should be taught to emphasise empowerment, respect and genuine partnership, and avoid using technical jargon or psychiatric labelling that patients may not understand. Avoiding unbalanced power dynamics should be a priority in all cases.

- **Soft skills needed for hire**
  With life experiences and age frequently favoured over academic qualifications during the recruitment process for MHPSS roles, teaching students the practical skills needed to get

[14] Standards in Clinical Psychology have been set by APA and EFPA. Standards in Psychiatric Nursing have been set by ICN and ANA. There are no agreed-upon standards or benchmarks in PSS.

hired will be crucial. Without the appropriate skills to effectively demonstrate their competence and knowledge, it's unlikely that graduates will get hired over more experienced candidates. This is particularly true of communication skills, which was the most cited skill type that MHPSS workers said they wanted to improve.

➔ **Integrating MHPSS into different settings**
Considering the level of stigma around mental health, the integration of MHPSS into a variety of settings and services not traditionally associated with mental health would be beneficial. Graduates must be prepared to deliver MHPSS in community settings like schools and workplaces, as well as less stigmatised health facilities like general hospitals and patient clinics. In any case, awareness raising and stigma reduction activities remain crucial.

➔ **Culture and mental health**
Culture intersects with mental health in a multitude of ways in northern Syria. From gender, to religion, to language, to stigma, it's important that graduates understand the role that culture plays within MHPSS delivery, as well as how best to navigate areas of friction or potential misunderstanding. Ultimately, MHPSS workers need to be able to explain mental health concepts to patients and clients in ways that make sense in the Syrian context and dialect, whilst also ensuring that their approach doesn't dissuade further help-seeking behaviour. For example, religious leaders are often the preferred source of mental health treatment in northern Syria, and many interpret distress through a spiritual lens instead of a physiological one. MHPSS workers need to find ways to meaningfully acknowledge spiritual beliefs and practices so they can better connect with patients.

Alongside including particular learning topics within academic programmes, there are a number of principles that should be adhered to when developing programme content:

➔ **Adopt or adapt existing materials that have been validated in similar contexts**
Alongside teaching students about the interplay between culture and mental health as a topic, the course materials themselves should be culturally appropriate for students in northern Syria while also adhering to established disciplinary standards. To achieve this and ensure that the curricula are developed efficiently, existing Arabic-language materials with a track record of success in the region should be utilised, as opposed to new materials being developed with limited validation. If materials need to be adapted, new versions should be tested with both prospective candidates and existing MHPSS workers to ensure they are appropriate.

➔ **Integrate practical experience where possible**
As health facilities have repeatedly noted their preference for age and experience when hiring MHPSS workers, it is crucial to integrate practical experience into the academic programmes as much as possible to allow students to apply their learnings in supported, real-life scenarios before entering the job market. Ideally this would take the form of both a practicum for course credit and a postgraduate internship. To avoid harm, students should receive on-site training in the facility's protection protocols (eg. GBV, PSEA) and referral mechanisms during the practicum, and also receive ongoing supervision from someone qualified in their cadre.

➔ **Provide supervisor training for existing MHPSS providers**
Practicum trainees and interns should receive ongoing supervision at their facilities. If there are no providers available who are qualified in their field, then the supervision model should use a coordinated hybrid approach that combines remote technical supervision from an external practitioner with in-person management and oversight. In either case, on-site supervisors should receive training in the criteria that the trainee is expected to complete for the practicum (e.g., the division of direct and indirect client contact hours) as well as best practices for supervision.

➔ **Consider the pathways to specialised training**
Whilst it is clear that specialised skills are lacking in northern Syria - particularly with regards to certain demographics (children, PWDs), mental health conditions (addiction, suicidality) and treatments (CBT, EMDR) - the current scope of need and lack of basic providers would make highly specialised training largely redundant at present. Across all academic programmes, priority should be placed on developing the core skills of each cadre so they can provide a baseline of competent care for a wide variety of populations and conditions. That said, coursework should provide students with a foundation in these areas, with supplementation from non-academic trainings for programme graduates. Specialisation pathways should be considered for the future to better serve those with more specific needs.

Programme Recruitment

The success of the academic programmes is reliant on the effective recruitment of high-calibre candidates. The following is recommended to ensure this is achieved:

➔ **Give reassurances about cost and quality of education**
With financial issues and concerns over the quality of education being the biggest barriers to enrolment and continued enrolment, potential candidates for the academic programmes should be assured of the steps being taken to provide financial support to students and maintain a high quality of education (see **Ensuring Programme Success** below). Administrative staff should discuss these concerns prior to the programme and schedule regular check-ins with students so that any challenges or concerns around programme costs and quality can be addressed. Additionally, information about the employment prospects of graduates should be shared, using case studies of students who have gone on to achieve success.

➔ **Combat stigma among potential candidates**
Stigma is likely to prevent some eligible candidates from applying to the academic programmes. Reducing this stigma is important not only to increase applications, but also because graduates will play an important role in broader community-based stigma reduction, via conversations with patients' families and home visits. Recruitment materials and communications should include important facts about mental health, common sentiments that applicants might relate to, and impactful stories of successful MHPSS treatment. During the program, students should learn from current PSWs about the realities of their work, the impact they made, and best practices for engaging with individuals and communities that are not educated on mental health.

➔ **Target women for recruitment**
Project staff should make extra efforts to recruit women into the education programmes. Data show that there are currently more men working in the MHPSS sector than women, and Key Informants noted that there are fewer female workers available for hire. Yet, best practices demonstrate that clients should have the option to choose between a male and female provider. Research in Syria further indicates that clients are more likely to disclose sensitive information to women, and that female providers are culturally preferred for child-focused support.

➔ **Identify a base-level of soft skills during interview**
Whilst elements of soft skills can be taught (e.g., leadership, communication, relationship building, adaptability, and strategic thinking), for the greatest chance of programme success, a clear demonstration of soft skills or indication of the capacity to learn soft skills should be an element of the recruitment process. These skills could be identified using cooperative tasks during the interview process to test out applicants' communication, time management, empathy, patience, flexibility, and critical thinking skills.

Ensuring Programme Success

Beyond effective recruitment, there are several steps that should be implemented to ensure a higher likelihood of success with the academic programmes:

➔ **Implement financial assistance for students**
With an economic crisis severely impacting the financial security of the population in northern Syria, the likelihood of attracting enough quality candidates that can fully pay tuition fees and cover their cost of living is low. As a result, tuition fees should be as low as possible, and stipends should be made available to students most in need. At a minimum, projects staff should try to cover hidden expenses involved with the programmes, such as transportation costs and registration, examination, and resit fees. Another way to offset costs for young people is to invite members of the existing MHPSS workforce to attend courses, as they may have access to INGO training budgets that could be used to cover programme costs.

➔ **Explore securing funding to guarantee employment for graduates**
Efforts should be made to guarantee employment for programme graduates, as the assurance of a job following graduation is likely to reduce dropout rates and mitigate students' financial concerns. Many health facilities have specified that they are willing to take on practicum trainees and interns, but there is no assurance that they will be in a position to employ them after graduation. Since employment opportunities rely heavily on donor funding, programme staff should be able to clearly demonstrate the quality of graduates. They should also communicate closely with NGOs in the region about new graduates entering the job market so they can be included in grant proposals and hiring strategies.

➔ **Provide an official transcript of learning subjects completed**
Although the certification requirements vary across northern Syria when applying for a job, it would be helpful to provide graduates with an official record of the learning subjects completed and their performance in these subjects. This would ensure that graduates who apply for a position will be able to demonstrate their knowledge and skill set to the employer.

➔ **Ensure dropouts can demonstrate and implement learning**
The current context in Syria means that a certain level of dropout is inevitable within all academic programmes. To ensure that the learning they completed prior to dropout does not go to waste, subjects should be taught in succession rather than simultaneously, and modules should be self-contained where possible. For training of cadres that are non-specialised (e.g. PSWs) or where the student is already qualified to practise in their field (e.g. Nursing), this will allow them to utilise knowledge from the subjects or modules they completed, and to include these courses in their resumes. However, this approach is not encouraged for specialised cadres like Clinical Psychology, as learning does not become integrated until students go through the practicum. Including coursework on their resume could put them in positions that they are not qualified for and potentially lead to harm.

➔ **Prioritise flexible scheduling and remote access**
There is a high likelihood of students having to miss in-person learning with some regularity due to the unstable political and economic context, and the unreliability of public transportation. As a result, efforts should be made to make the academic programmes as flexible as possible. This could include asking students for preferences on course schedules or running repeat sessions as needed. All materials should be available to download or access online, although learning should never take place solely online due to internet connectivity issues.

Strengthening the MHPSS Sector

When graduates of the academic programmes enter the MHPSS workforce, they will face significant challenges that will impact their ability to deliver effective services. Beyond the delivery of academic programmes, the following actions should also be considered to strengthen the MHPSS sector across northern Syria:

- ➔ **Work to standardise wages and progression in the sector**
  The disparities in wages across the MHPSS sector, and the health sector more generally, are leading to resentment within the workforce as well as inflated competition for certain positions. These disparities are fuelled by a lack of standardisation in the qualifications and experience required for different roles, as well as stark differences in salary between public, private, and INGO-run facilities. Collaboration with networks and technical working groups is needed to close this gap between wages so workers receive equal pay for the same roles across different facility types. It is also important to ensure that wage decisions consider the worker's level of experience. In cases where workers lack formal qualifications, they should be the first to receive offers for education or training.

  The lack of career progression within the sector is also leaving skilled workers frustrated and looking for better prospects. Although career progression within organisations can be difficult due to lack of funding, organisations and facilities should explore possible pathways for promotion alongside working to standardise wages. This will ensure that there are clear routes for junior staff to advance, gain more responsibility and earn higher wages.

- ➔ **Encourage the use of incentives to deter high turnover of staff**
  The high turnover of MHPSS staff within organisations causes inefficiencies and instability in the sector. Whilst the likelihood of employers being able to increase direct financial incentives is low, programme staff should communicate with their networks to encourage employers to implement other incentives, including greater opportunities for professional development. Although employers might be resistant to introducing new incentives due to a belief that employees will make use of them and quickly leave, up-front investment will ultimately lead to higher rates of retention, resulting in financial efficiencies in the long term.

Building on the Scoping Study

The Scoping Study that Levante has conducted has tackled a range of questions relating to the MHPSS workforce and education system in northern Syria. Due to the scale of the topic, there remain extensive areas for further exploration that would require additional funding. Examples include:

- ➔ **Detailed mapping of MHPSS services**
  Whilst this Scoping Study has provided an overview of MHPSS services across northern Syria, there remain gaps in understanding, and provision is constantly changing. A detailed mapping of which organisations are operating where, what services they are providing, where their funding comes from, and what their plans are for the future would significantly aid MHPSS efforts.

- ➔ **Detailed mapping of MHPSS workforce numbers and information**
  Similarly, the study has only provided estimates about the numbers of MHPSS workers from different cadres who are operating in northern Syria, as well as their job descriptions. To effectively improve the effectiveness and efficiency of the MHPSS operation in the region, a more concrete understanding would be useful.

The existing MHPSS working groups, networks and associations that are present in northern Syria are well placed to conduct these further studies.

In the process of researching and writing, Levante has also determined a key question for SAMS to further explore prior to implementation of the academic programmes:

➔ **How will qualified but less experienced workers be integrated into an experienced but less qualified workforce?**
Graduates from the proposed academic programmes are likely to be younger and less experienced than many existing providers in the MHPSS workforce, but they are also likely to be more qualified and have a wider breadth of technical knowledge and skills. This may lead to potential workplace tensions, especially around how salaries, benefits and responsibilities are decided. Programme leaders need to consider how they will manage these discrepancies prior to their graduates entering the job market.

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8. Annex 1 – Research Questions List

MHPSS Workforce Assessment:

What is the composition and distribution of the existing MHPSS workforce in northern Syria (i.e., psychiatrists, psychiatric nurses, psychologists, psychosocial workers)?

RQ 1. What is the supply and demand for human resources related to service provision?
RQ 2. What are the distribution imbalances?
RQ 3. Which of the technical and geographical areas have the highest need?
RQ 4. What is the educational background, credentials, experience, and workload of those who are currently practising in public and private settings?
RQ 5. What is the disaggregation by governorate, gender, and type of worker?

What are the existing standards, expectations, and practices for each MHPSS cadre?

RQ 6. What is the range of salaries offered through different types of employers?
RQ 7. What are the job descriptions, roles, and responsibilities of each cadre?
RQ 8. What knowledge, skills, and qualifications are required?
RQ 9. What mentoring and supervision practices are currently in place?
RQ 10. What is the availability of psychotropic medications, and who manages it?
RQ 11. What are the career pathways for each cadre (if any)?
RQ 12. How is practice regulated and by whom?
RQ 13. Are there existing protocols for dealing with mental health patients?
RQ 14. What is their workload? What task shifting practices are utilised?
RQ 15. What legal, cultural, and social barriers to successful delivery currently exist?

Who are the main stakeholders related to MHPSS service provision in northern Syria?

RQ 16. What are their roles and responsibilities with regard to supervision, licensing, workforce management, and deployment?
RQ 17. What available options are there for hiring (private sector, NGOs, etc)?
RQ 18. Which health facilities need graduates and are able to receive them? What is their level of commitment to hiring programme graduates?
RQ 19. What is the prevalence of use, satisfaction, and willingness to pay for MHPSS services?
RQ 20. What incentives could help them improve deployment, retention, and service delivery?
RQ 21. How are 'public' and 'private' sectors defined in each location, and what collaborations between private and public sectors could foster sustainability, scalability, and community acceptance?
RQ 22. What associations and networks are currently in place for MHPSS professions, and what (if any) role do they play in standardisation of the field(s)?

MHPSS Education Assessment:

How many eligible candidates are available to receive education in each cadre, and how can we support them in completing these programmes?

RQ 23. What is their formal education background and previous experience?
RQ 24. What is the gender breakdown and any difficulties/needs related to gender?
RQ 25. Where are they from, and where do they currently reside?
RQ 26. Are they currently employed or have childcare responsibilities?
RQ 27. What are their attitudes and expectations for these programmes (e.g., prior experience with remote learning, extent to which they are willing and able to travel for education, language skills, career aspirations post-graduation)?
RQ 28. What are the barriers to enrollment and continued enrollment?
RQ 29. How can we mitigate this risk and increase their likelihood of graduation?

What are the current MHPSS programmes across Syria?

RQ 30. What degree or training programmes already exist, and what is their quality (including undergraduate programmes in nursing and psychology and postgraduate programmes)?
RQ 31. What contents, entry requirements, and training methods do they use?
RQ 32. How much do these programmes cost for the students/trainees?
RQ 33. What are the training gaps?
RQ 34. How well do the current offerings meet the needs of trainees and practitioners?
RQ 35. What are the governance models, human resources, capacity gaps, and needed structural reforms at local higher-education institutes?
RQ 36. How widely accepted are credentials/certificates/diplomas from training programmes?

What are the needs of training sites and their attitudes toward the programme?

RQ 37. Which health facilities can support the practicums and internships?
RQ 38. To what extent can they commit senior practitioners for field supervision?
RQ 39. What is the expected workload and financial compensation for supervisors?
RQ 40. Are there any licences needed by the graduates before employment? If yes, who provides these licences?

What are the associated costs for students in all phases of the proposed academic programmes?

RQ 41. What costs need to be included in the budget (e.g., internet, travel, tuition, etc.)?
RQ 42. How could these costs be reduced?
RQ 43. How could students be supported to meet costs?
RQ 44. What is the availability and pattern of part-time work during the study period?
RQ 45. Where post-graduate internships exist, what is a reasonable salary for interns?
RQ 46. What costs do the participating facilities require (e.g., practicum/internship supervisors)?

What are the situational risks and constraints associated with delivering academic programmes in Syria, to what extent can they impact project objectives, and what mitigation measures should be in place to safeguard project participants?

9. Annex 2 – Key Informant Breakdown

Removed for confidentiality

10. Annex 3 – Breakdown of Survey Samples

Prospective Candidates Survey

Total sample size: 298 Responses

		NW Syria				NE Syria			Total
		Aleppo	Idlib	Afrin	Azaz	Raqqa	Al Hasakah	Deir El Zor	
Level of Education	**High School**						8	5	**13**
	Technical/Occupational		1				2		**3**
	Some College		13	13	1	2		5	**34**
	Bachelor Degree	3	62	11	47	41	37	24	**225**
	Masters or Doctorate					7	2	10	**19**
	Professional Training							4	**4**
	Total	**76**	**3**	**24**	**48**	**50**	**49**	**48**	**298**
Field of Study	**Psychological Counselling**		36	11	23	3		4	**77**
	Psychology		8		5	9	2	5	**29**
	Nursing					6	14		**20**
	Social Work					5		8	**13**
	Sociology			2		10	3	11	**26**
	Education		13	10	2	16	16	15	**72**
	Medicine	3	16	1	11				**31**
	Other		2		6	1	14	5	**28**
	Blank								**2**
	Total	**76**	**3**	**24**	**48**	**50**	**49**	**48**	**298**

MHPSS Workers Survey

Total sample size: 275 Responses

		Aleppo	Idlib	Azaz	Afrin	Raqqa	Al Hasakah	Der El Zor	Qamishli	
Role	**Psychosocial Workers**	6	23	17	7	4	9	1	23	**90**
	Trainers/Supervisors		4	2	1	2				**9**
	Social/Protection Workers & Case Managers	6	7	10	4	1	5	1		**34**
	Psychologists		4		1					**5**
	mhGAP Doctors		2	2	1	2				**7**
	Community Health Workers	9	6	2	2					**19**
	Mental Health Workers		3	1	1					**5**
	Nurses	1	8	1		1				**11**
	Teacher/Education Workers		1				5	12		**18**
	Unspecified	9	4	3	3	18	11	9		**58**
	Other	2	7		1	1	2	1		**19**
	Total	**36**	**65**	**39**	**21**	**29**	**34**	**27**	**23**	**275**
		162				**113**				

Facilities Survey

Total sample size: 55 responses (11 in NWS, 44 in NES)[15]

Sample breakdown:

Facility Name (NWS)	Location	Facility Type	Role of Respondent(s)
Protection Center	Aleppo (Azaz)	MHPSS Centre	Child Protection Officer
Physicians Across Continents	Aleppo (Azaz)	MHPSS Clinic	Resident Doctor
Aman Women Empowerment Center (2)	Aleppo (Afrin, Jindires)	MHPSS Center	Office Manager (2)
Syria Relief, CFS Center	Aleppo (Jindires)	MHPSS Center	Center Supervisor
UOSSM Center	Idlib (Sarmada)	MHPSS Centre	Health Centre Manager
Atmeh Charity Hospital	Idlib (Atmeh)	Hospital	PSS Supervisor
Humanity and Inclusion	Idlib (Atmeh)	MHPSS Centre	Head of HI Officer
Hand in Hand Hospital	Idlib (Atmeh)	Hospital	Administrative Manager
SAMS Center	Idlib (Al-Dana)	MHPSS Center	MHPSS Officer
Medical Care Hospital	Idlib	Private Hospital	Hospital Manager

[15] The table includes all the NWS facilities and only the NES facilities that could potentially serve as practicum sites.

Facility Name (NES)	Location	Facility Type	Managing NGO
Abu Hamam Centre for Healthcare	Deir-ez-Zor (Abu Hamam)	NGO facility	SAWSAN
SAWSAN Hajin PHC	Deir-ez-Zor (Hajin)	PHC	SAWSAN
SAWSAN Ar-Raqqa PHC	Ar-Raqqa (Ar-Raqqa)	PHC	SAWSAN
SAWSAN Al-Karama PHC	Ar-Raqqa (Al-Karama)	PHC	SAWSAN
Ar-Raqqa MHPSS Centre	Ar-Raqqa (Ar-Raqqa)	MHPSS Centre	IRC
Hazimeh Mobile Clinic	Ar-Raqqa (Ar-Raqqa)	Mobile Clinic	IRC
IRC Al-Hasakeh Office	Al-Hasakeh (Al-Hasakeh)	MHPSS Clinic	IRC
Tell Al-Barak Clinic	Al-Hasakeh (Qamishli)	MHPSS Centre	MdM
Al Ghurra Polyclinic	Al-Hasakeh (Al-Hasakeh)	PHC	MdM
Sareen Health Center	Aleppo	MHPSS Clinic	MdM
Mishta Al-Nour Mobile Clinic	Aleppo	Mobile Clinic	MdM
Khanik Health Centre	Aleppo	PHC	MdM
Al Hajnah Clinic	Deir-ez-Zor (Basira)	PHC	RI
Sabha Mobile Clinic	Deir-ez-Zor (Basira)	Mobile Clinic	RI