MHPSS Programmes for Children, Youth (0-24 years) and Parents/Caregivers in Syria and from Syria and Iraq Crises Affected Countries

Desk Review

NLG MHPSS Task Force

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Acknowledgements

Acronyms

4W	Who's doing What, Where and When
AFS	Adolescent-friendly spaces
CFS	Child-friendly spaces
CP	Child Protection
CPWG	Child Protection Working Group
ECD	Early Childhood Development
ESAY	Evidence Symposium for Adolescents and Youth
HNO	Humanitarian Needs Overview
IASC	Inter-Agency Standing Committee
IMC	International Medical Corps
INEE	Inter-agency Network for Education in Emergencies
ISIL	Islamic State in Iraq and the Levant
MENA	Middle East and North Africa
MoPH	Minister of Public Health
MoSA	Minister of Social Affairs
MHPSS	Mental Health and Psychosocial Support
NLG	No Lost Generation
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN:NGO	United Nations and Non-Governmental Organizations
PFA	Psychological First Aid
PSS	Psychosocial Support
SEL	Social and Emotional Learning
SGBV	Sexual and Gender-Based Violence
YFS	Youth-friendly spaces
WHO	World Health Organization

Introduction

Around 142 million children and youth[1] live today in high-intensity conflict zones, where exposure to extreme stressors can have major and long-term damages to their mental health and psychosocial well-being. It is now recognized documented that children and youth are particularly vulnerable, and that the detrimental effects of violence, conflict and insecurity extend well beyond their physical health and survival. Armed conflict can amplify social and psychological pre-existing problems as well as induce a range of circumstances that affect the mental health and well-being of populations. At the same time, humanitarian settings severely rupture existing social systems and networks of formal and informal care.

The devastating and protracted conflicts in Syria and Iraq have resulted in the largest refugee and displacement crises in the world. For millions of children and youth in Syria, Iraq and the neighbouring countries where populations have sought refuge – Egypt, Jordan, Lebanon, Turkey – conflict, violence, displacement and loss of family members have shaped most, if not all, their entire childhood and adolescence.

There is an emerging consensus in the humanitarian community responding to the Syria and Iraq crises that effective humanitarian responses must incorporate mental health and psychosocial support (MHPSS) approaches and services. The exposure to the traumatic events, violence and displacement that conflict generate, destroy children's supportive environment and sense of safety while heightening a sense of fear. The loss and separation from parents, caregivers, family members and community at large may lead to feelings of loneliness, grief and anxiety. Furthermore, the poor mental health of parents/ caregivers may physically and mentally affect children, further exacerbating their vulnerabilities. The protracted interruption of normalcy that children and youth endure, takes away important and healthy developmental opportunities that may have detrimental consequences throughout their life course.

At the same time, children and youth in the Syria and Iraq crises demonstrate strong resilience. In normal situations, peers, family and the community provide much of the support and care that this young people need. However, humanitarian crises diminish the ability of such networks and individuals to provide care and support. Often, parents/caregivers are in much need of support themselves. The need to provide MHPSS programmes that can contribute to the development and strengthening of supportive environments and positive coping mechanisms is evident.

1.1   Rationale for the desk review

An increasing number of humanitarian actors provide MHPSS services to populations affected by the conflict in Syria and Iraq as well as to those who have fled to neighbouring countries in the region – Egypt, Jordan, Lebanon and Turkey. In March 2019, the No Lost Generation (NLG) Mental Health and Psychosocial Support Task Force was established with the aim of improving the MHPSS response and coordination for children and youth. A clear overview of the MHPSS response for children and youth as well as lack of shared resources has been highlighted by member organizations (UN:NGO), as well as young people themselves.[2] To address this gap, the MHPSS Task Force commissioned the undertaking of a mapping of MHPSS programmes targeting children, youth and their parents/caregivers in Syria and from Syria and Iraq crises

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[1] Save the Children (2019).

[2] During the Evidence Symposium for Adolescents and Youth (ESAY) that took place in September 2018, young participants highlighted the gaps in MHPSS programming.

affected countries – Egypt, Jordan, Lebanon and Turkey. The mapping consists of a desk review and a survey disseminated at the regional level with members of the MHPSS Task Force and their country offices; with MHPSS and Child Protection Working Groups (CPWG) at the national level; with NLG partners and their country offices; and with implementing partners.

1.2   Purpose of the desk review

The purpose of this desk review was to map existing information on MHPSS programmes for children, youth (0-24 years) and parents/caregivers in Syria and from Syria and Iraq crises affected countries. This desk review informs and complements the survey that was disseminated among organizations with MHPSS programmes. This desk review is primarily for practitioners who are involved, directly or indirectly, in the implementation of MHPSS programmes, helping them to have a clear understanding of the programmes that are available as well as to identify gaps.

1.3   Methodology

The content of this desk review is based on a systematic search and review of documents relevant to MHPSS programmes for children, youth and parents/caregivers in Syria and from Syria and Iraq crises affected countries - Egypt, Jordan, Lebanon and Turkey. In the first phase, a comprehensive search of sources was conducted between June and September 2019. This was complemented with key informant interviews conducted with the MHPSS and CP Working Groups in each of the targeted countries. The outcome of this process was a preliminary desk review report and a list of 150 resources identified as relevant to the focus of this desk review. In a second phase and with the purpose of refining and finalizing the preliminary desk review, the first report was reviewed, and the list of sources refined. An extended online search was performed on technical documents, grey literature and published academic research.[3] Databases employed for this search were PubMed, Wiley Online Library and Google Scholar. In addition, web-based searches and searches on online repositories pertaining to humanitarian issues were conducted. These websites included MHPSS.net, Save the Children Resource Centre, IASC Library and OpenDocs IDS.

While a plethora of documents have been produced on the mental health of conflict-affected populations, the following categories were considered:

		Selection checklist
Document category	Document type	**Four criteria:**
Evidence	Epidemiological studies	1. Published between 2009 and 2019 AND at least one of the below:[4]
	Assessments, analysis and reports undertaken by humanitarian actors and practitioners	2. Regional relevance to the Syria and Iraq crises.
	Impact and programme evaluations	3. Technical relevance to the MHPSS needs of children and youth in conflict-affected settings or specific focus on the MHPSS needs of children
Practice	Capacity building and training materials	
	M&E materials	
	Programme documents	

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[3] See Annex 11.1.
[4] Two relevant epidemiological studies conducted in 2007 and were included in the desk review.

	Case studies	and youth from the Syria and Iraq crises.
		4. Developed by members of the MHPSS TF, MHPSS WG, CPWG or implementing partners.

1.3.1 Limitations of this Desk Review

This desk review gathers and presents existing information about MHPSS programmes for children, youth, parents/caregivers in Syria and from Syria and Iraq crises affected countries. The focus of this desk review is the mapping of existing MHPSS programmes. Therefore, this desk review does not intend to provide in-depth information on the mental health and well-being of children, youth, parents/caregivers in Syria and from Syria and Iraq crises affected countries, albeit a summary of key literature and points on this topic is provided in section 3. A desk review conducted in 2015[5] provides information on the sociocultural background of the Syrian population, including children and youth, as well as cultural aspects of mental health and psychosocial well-being relevant to mental health and support.

Additionally, this desk review does not identify good practices in MHPSS programmes for children, youth, parents/caregivers in Syria and from Syria and Iraq crises affected countries; however, this desk review and the mapping[6] undertaken by the NLG MHPSS Task Force can provide the basis for this type of exercise.

2 Overview of the Situation of Children and Youth in the Context of the Syria and Iraq Crises

2.1 Syria

Nearly nine years of conflict in Syria have left 11.7 million people in need of some level of humanitarian assistance, including 5 million children. Massive and prolonged displacements have resulted in 6.2 million people internally displaced, including 2.5 million children.[7] Ongoing hostilities and the escalation of violence in various regions of the country, including the military interventions in Northeast and Northwest of Syria, are deepening the impact of the crisis in people's survival, physical and mental health as well as access to basic services and socio-economic opportunities to recover.

Children and youth continue to immensely suffer from the conflict as their physical and mental health are affected, and their daily lives permanently disrupted. For children, protection risks remain the first and foremost the concern. In 2018 alone, 1,106 children[8] were killed as a direct consequence of the conflict – airstrikes, bombs, bullets, land mines – and many more have been wounded and lost their lives from the precarious conditions imposed by the armed conflict.

Barriers to accessing education, including the large-scale devastation that has left two out of five schools in Syria damaged or destroyed, are leaving 2.2 million children out of school – over one third of Syria's child population. In addition, 1.2 million children are at risk of

[5] Hassan, G., L. Kirmayer, M. A., C. Quosh, R. el Chammay, Deville-Stoetzel, J.B., A. Youssef, H. Jefee-Bahloul, A. Barkeel-Oteo, A. Coutts, S. Song and P. Ventevogel (2015).

[6] See NLG MHPSS Mapping Report.

[7] UN OCHA (2019).

[8] UNICEF Press Release 2018, accessible here.

dropping out.[9] The harmful impact of the armed conflict on children, youth and their families extends beyond access to education. More than 80% of the Syrian population lives below the poverty line. Unable to meet their basic needs, people are increasingly resorting to negative coping mechanisms. Many children have been pushed into child labour, reported as an issue across all 14 governorates in Syria and more likely for boys than girls. Cases of sexual and gender-based violence, including early marriage, domestic and sexual violence have been on the rise for adolescent girls and boys. Early marriage was reported as an issue across 12 out of 14 governorates, affecting adolescent girls mainly. Rape and other acts of sexual violence have been committed against adolescent girls and boys in checkpoints, detention centres and as systematic attacks on civilian population. Furthermore, grave violation of child's rights remains a concern, including recruitment – particularly among adolescent boys – arbitrary detention and sexual violence. Children that have been separated from their parents/caregivers, and those who have lost their family members are at a heightened risk of exploitation, abuse and neglect.[10]

2.2   Iraq

For over 15 years, Iraq has been in a state of unpredictability and instability. From the fall of Saddam's Hussein regime and the US-led invasion in 2003, to the Islamic State of Iraq and the Levant's (ISIL) occupation (2014-2017), the people in Iraq have borne the brunt of political violence, economic and social instability. Although the number of people in need of humanitarian assistance has significantly decreased since the peak of the crisis during the ISIL occupation, there remains 4.1. million people in need of some form of humanitarian assistance, and children represent 46%.[11] The most acute needs continue to be present in the governorates of Ninewa, Al-Anbar, Kirkuk and Salah al-Din, as well as the governorates that have received the displaced populations and host Syrian refugees, namely Erbil and Dohuk. While millions of displaced Iraqis have been able to return to their homes, there remains 1.5 million internally displaced, and children represent half of that population. Both children who have returned to their homes and those that remain displaced have experienced traumatic events and have lost a sense of normalcy to their lives which in return, is having detrimental impact on their physical and mental health.

Internally displaced children in camps have disproportionate lack of access to education and are at heightened risk of negative coping mechanisms, including early marriage and child labour. Similarly, vulnerable children in host communities as well as children who have returned home are at risk of staying out of school and other basic services due to damages (i.e. lack of schools) as well as lack of documentation. Children and youth whose families or themselves are perceived as affiliated to extremist groups face discrimination, denial of basic services, exploitation and arbitrary detention.

2.3   Refugees from Syria

Around 5.7 million persons have fled Syria to the neighbouring countries of Egypt, Iraq, Jordan, Lebanon and Turkey,[12] out of which 2.5 million are children, representing 45% of the total refugee population in these countries. Most Syrian refugees live in urban, peri-urban and rural areas (95%) while 5% live in refugee camps.

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[9] UN OCHA (2019).
[10] Idem.
[11] UN OCHA (2020).
[12] UNHCR, Syrian Regional Refugee Response, 20 September 2019, https://data2.unhcr.org/en/situations/syria, accessed 29 November 2019. Figures have been rounded to the nearest decimal.

In absolute numbers, Turkey hosts the largest number of Syrian refugees (3.7 million, including 1.6 million children) while Lebanon has the highest per capita of refugees globally, hosting approximately 919,000 Syrian refugees – half of them are children. In Jordan, there are around 654,000 Syrian refugees, of whom 331,000 are children. Nearly one fifth of refugees (19%) are living in the refugee camps of Za'atari, Azraq, Mrajeeb al Fhood and King Abdullah Park, while the rest of them in host communities. In Iraq, there are 235,000 Syrian refugees out of which 44% are children, and most of them (99%) live in the Kurdistan area.[13] Egypt currently hosts around 129,000 Syrian refugees and 41% of them are children. Refugee return gained traction in 2018-2019 following the developments of situation inside Syria and in neighbouring countries. With the renewal of hostilities inside certain parts of Syria as well as uncertainties about the conditions upon return, it is projected that most of Syrian refugees will remain in the host countries.

Across all countries, the socio-economic situation and well-being of refugees is a grave concern. Host countries' systems and services, which were already facing challenges before the crisis, have been strained by the influx of displaced people. An overwhelming majority of Syrian refugees live in poverty, and families have been exhausting their resources. They face increasing difficulties in accessing employment, housing, health care services and education, putting them at risks of exploitation. Against such bleak situation, children and youth are particularly vulnerable to engage in child labour, early marriage and miss out on education and other basic rights. While progress has been made in access to education, 35% of the Syrian refugee school-aged children (5-17 years) across the neighbouring countries remain out of school.[14]

Against the backdrop of protracted conflict, violence and instability, precarious socio-economic situations and fracture to the social fabrics that would otherwise provide care and support, the mental health and psychosocial support needs of children and youth in Syria, Iraq and neighbouring countries is widespread.

3   An Overview of the Mental Health Needs of Children and Youth in the Context of the Syria and Iraq Crises

Evidence from the limited epidemiological studies as well as wider range of studies conducted by humanitarian actors in the context of the Syria and Iraq crises have consistently shown that the staggering levels of trauma, violence and distress that children and youth have been witnessing and exposed to, affect their physical and mental health as well as their social and emotional well-being. It has been furthermore posited that the effects of armed conflict may be long-lasting and detrimental at all levels of the social ecological model, and with implications on the overall human and economic development (education and the workforce).

While the focus and methodology between epidemiological studies and grey literature varies, several commonalities are noted.
- Evidence suggests that symptoms related to emotional disorders are the most prevalent – post-traumatic stress disorder (PTSD), anxiety and depression.
- Studies on the mental health of populations in the context of the Syria and Iraq crises are limited, and even more so those specifically addressing children and youth. Among the

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[13] UNCHR, Syrian Regional Refugee Response Portal https://data2.unhcr.org/en/situations/syria. Accessed on 11 December 2019.
[14] 3RP Strategic Overview 2019-2020.

grey literature, studies generally research the population at large; albeit the needs of children and youth are often highlighted.

- There is a larger number of studies conducted with refugee children and youth than with those inside Syria. This is in part due to the difficulties in access.
- Studies with Syrian refugee children and youth have served to shed light on the magnitude of the mental health issues for those inside Syria. At the same time, these two groups face different challenges which in turn, shape the mental health issues they may face, and the access they may have to services. [15]

3.1   Evidence from Epidemiological Studies

Global estimates indicate that far more people than previously thought affected by conflict experience some form of a mental health disorder. More than one in five people (22%) experience some form of mental disorder (depression, anxiety, post-traumatic stress disorder) and almost one in 10 experiences a moderate to severe mental disorder.[16] Assuming similar rates for children and youth, it is estimated that around one in four children is at risk of developing a mental health disorder. Inside Syria, that represents an estimate of 2 million children at risk[17], in addition to the millions of children and youth who have already been exposed to the traumatic events of the war and who have fled with or without their families to the neighbouring countries.[18]

A systematic review of studies on the mental health of children affected by conflict worldwide estimated that the prevalence of mental health disorders is much higher among these children than the general population, and that in average, 50% of them exhibited post-traumatic stress disorder (PTSD).[19] There is however a critical absence on research on the long-term effects of the these disorders, including longitudinal studies.

Epidemiological studies on the mental health in the context of the Syria crisis are limited, and even more so those that address the situation of children and youth. Available studies suggest a relatively high prevalence of symptoms associated to PTSD, depression and anxiety. In a study conducted among children in Syrian schools in the governorates of Damascus and Latakia, 50.2% of students were internally displaced and 32.1% reported a negative experience. 60.5% of those tested had at least one probable psychological disorder with PTSD the most common (35.1%), followed by depression (32.0%), and anxiety (29.5%).[20]

In another study conducted in the Syrian-Turkish border, results reported that almost half of the children (49%) showed symptoms associated with anxiety; 62% of them reported being fearful and 45% showed signs of emotional distress. More than a third of children showed symptoms of behavioural problems.[21]

In studies conducted with the Syrian population at large but including children and youth, emotional disorders have been by far, the most prevalent and clinically significant disorders. Prolonged grief disorder, PTSD, depression and anxiety have been found to be the most common symptoms. Research on severe mental disorders of people in Syria is virtually

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[15] Yaylaci (2018); Panter-Brick, Dajani et al. (2018); Sirin and Rogers-Sirin (2015; Hamdan-Mansour et al. (2017).
[16] WHO Lancet 2019. For reference, the prevalence of mental health disorder in the global population has been estimated to around 10% (Global Burden of Disease).
[17] This figure is calculated on Syria's child population (0-17) of ~7.9 million as of 2018. Source: UNICEF (2018).
[18] Polanczyk, G. V., Salum, G.A., Sugaya, L.S., Caye, A. and Rohde, L.A. (2015).
[19] V., A., M. R., J. M., S. S., B. F. Jr. and M. E. (2009).
[20] Perkins, Ajeeb et al. 2018.
[21] Cartwright, K., El-Khani, A., Subryan A., and Calam, R. (2015).

inexistent, and no significant studies have been conducted since the onset of the conflict. It is expected that the number of Syrians with psychotic symptoms would have increased given the surge in risk factors such as traumatic events from the armed conflict, massive displacement and rupture of social support networks. This could be affecting a proportion of adolescents and youth, as they may have developed severe mental disorders in the meantime.

Compared to the Syrian case, the number of epidemiological studies on the mental health of the Iraqi population is higher; [22] albeit studies on children and youth remain limited. Available studies tend to focus on the effects of trauma on refugee populations, including children.

A study[23] conducted in 2007 among children (1-15 years old) in Mosul, Iraq, found that more than one third (37.4%) of these children exhibited some form of mental health disorder. The most prevalent disorders were PTSD, enuresis and separation anxiety. Results showed that older children (10-15 years) were more affected than the younger ones. The study further demonstrated that the combination of traumatic stressors, including exposure to war, compounded with the deterioration of living conditions – poverty, unsafe living and poor nutrition – are an unhealthy mixture that prevents the normal development for these children. The study argued that at large scale, the individual impact on the mental health of children and youth may inhibit the community and society at large from being functional in the future.

It has been noted that the results from psychiatric epidemiological studies must be taken with caution. Standard instruments do not usually address local cultural symptoms of distress and most have not been validated for use the Syrian humanitarian context.[24]

Despite the sparse epidemiological studies on mental health disorders among children and youth affected by the conflicts in Syria and Iraq, the available evidence points towards the magnitude of the problem, encouraging for further research, particularly longitudinal studies that may reflect the long-term effects. Furthermore, the available evidence recognizes the critical needs for MHPSS programmes for these populations.

3.2   Evidence from Grey Literature

A significant large number of studies and reports have been produced by humanitarian actors on the mental health and psychosocial needs of the people affected by the conflicts in Syria and Iraq.[25]

Signs of distress
Studies that have been conducted with Syrian refugee children as well as studies with children inside Syria document a wide range of mental health and psychosocial problems, including persistent feelings of fear and anxiety; grief and sadness; difficulties with sleeping which include nightmares and bedwetting. Behavioural problems, including aggressive behaviour, screaming and shouting, as well as war-play among children have also been documented. Speech problems and mutism have also been reported. The various studies that have been conducted have documented multiple signs and sources of distress, and this can be demonstrated in different ways for younger, older children and adolescents.

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[22] Alhasnawi, S., S. Sadik, M. Rasheed, A. Baban, M. M. Al-Alak, A. Y. Othman, Y. Othman, N. Ismet, O. Shawani, S. Murthy, M. Aljadiry, S. Chatterji, N. Al-Gasseer, E. Streel, N. Naidoo, M. Mahomoud Ali, M. J. Gruber, M. Petukhova, N. A. Sampson, R. C. Kessler and G. (2009).

[23] Al-Jawadi, A. A. and S. Abdul-Rhman (2007).

[24] Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer (2016).

[25] Idem.

In children, studies have demonstrated that common signs of distress are:
- Strong emotions, such as extreme sadness, anger, anxiety.
- Aggressive behaviour demonstrated through shouting and war-play.
- Bedwetting and involuntary urination, symptoms associated with toxic stress and PTSD.
- Disruption to sleeping patterns and nightmares.

In adolescents, studies have shown that common signs of distress are:
- Strong emotions, such as depression, anxiety, anger and fear.
- Resort to risky coping mechanisms, such as substance use.
- Toxic stress, which may increase the incidence of psychiatric problems at the critical period of adolescence and later in adulthood.

A study[26] conducted by Save the Children with children inside Syria, revealed that 71% of children showed symptoms associated with toxic stress and PTSD (bedwetting and involuntary urination); and 49% of children had constant feelings of grief and sadness. Eighty-nine per cent (89%) of children were found to show persistent feelings of fear, and parents/caregivers reported that they had seen an increasing number of children showing behavioural problems, i.e. aggressive behaviour.

The studies conducted with Syrian refugee populations have shown that they face not only the trauma and distress symptoms from the conflict they and their families fled from, but experience a range of other distress factors as a result of their refugee status and the often dire economic conditions and poverty they live in.

In a study[27] conducted in 2015 by IMC among Syrian IDPs and Syrian refugee populations using mental health services in Jordan, Lebanon and Turkey, the most common mental health disorders among children were epilepsy, intellectual development disorders and emotional disorders. The high reported rates are attributed to the fact that local doctors in hospitals and primary health care (PHC) units have limited capacity to diagnose, treat and follow up these disorders. They therefore tend to refer these cases to INGOs that can provide for such services. In another study conducted in 2015 among Syrian refugee children in Turkey[28], it was found that 45% showed PTSD symptoms while 44% showed symptoms of depression.

A study[29] conducted among Syrian refugee children in Jordan highlighted the high number of physical and psychosocial concerns mong this cohort. While they had fair levels of physical health, 25% of them suffered from loneliness and 24% reported feeling depressed.

In another study[30] conducted with Syrian refugee children in Turkey, mental health problems associated with armed conflict were found to be serious, with children experiencing one or more of the following: 60% had symptoms of depression; 45% PTSD; 22% aggression and 65% psychosomatic symptoms to a significant level that reduced children's level of functioning.

[26] McDonald, A., Buswell, M., Khush, S., and Brophy, M. (2017).
[27] Hijazi, Z. and Weissbecker, I. (2015).
[28] Sirin, S.R. Rogers-Sirin, L. (2015).
[29] Hamdan-Mansour et al. (2017).
[30] Özer, S., Şirin, S., Oppedal, B. (2013).

A situation analysis of youth affected by the Syrian crisis conducted by UNHCR in Lebanon in 2014 reported that 30% of Syrian refugee youth described themselves as feeling depressed, 30% as anxious, 22% as afraid. Only 11% expressed positive feelings.[31]

Sources of distress

War-related fears
War-related fears, including fear of bombing, shelling and an overall sense of being unsafe, have been reported as a major source of distress for children and youth, particularly for those inside Syria. Inside Syria, 84% of adults reported that this was the biggest single cause of their children's high levels of stress.[32] Similarly, a study among Syrian refugee adolescents in Jordan reported that war-related fears were one of the main concerns for young people. Although these children and youth are not exposed to conflict anymore, the traumatic events that they were exposed to, compounded with their dire living conditions and feelings of hopelessness for the future, continue to affect them.
Similarly, studies conducted with adolescents inside Syria have shown that fear is an overwhelming, salient theme and is frequently associated with PTSD. Adolescents that have been exposed to prolonged violent hardship, for instance in opposition-held areas, expressed fear of warplanes and airstrikes sounds, as well as fear of "return of conflict".[33]

However, children and adolescents inside Syria are not alone in experiencing war-related fears. Those that have fled with or without their families to neighbouring countries may be experiencing similar war-related fears as a result of flashbacks and the memories of having lived in a zone of conflict. This, compounded with precarious living conditions in the countries where they have sought refuge, makes them particularly vulnerable.

Living conditions and economic pressures
The dire economic situation has pushed many families into poverty. For children and youth, depletion of resources has resulted in a degradation of living conditions, including deprivation from the most basic needs and impact on their health and nutrition. The economic pressures have created feelings of uncertainty, hopelessness and fear for the future. Many have resorted to negative coping mechanisms, which have resulted in children and youth dropping out of school, child labour and early marriage. Adolescents have expressed in various studies the weight that economic uncertainty of their families has on their well-being. Adolescents, especially boys, have expressed their desperate desire to get a job in order to be able to provide for their families as well as to gain a sense of purpose and meaning in their lives.[34]

In addition to the millions of refugees that have fled the Syria and Iraq crises, there is a growing number of Syrian children born abroad from parents that have fled the country. UNHCR estimates that 70% of these children are not registered at birth. This situation puts these children at heightened risk of statelessness and significantly narrows their future potential to acquire Syrian nationality. Furthermore, this lack of documentation presents severe social and economic barriers for these children as they may be denied basic rights, including health and education.

Education

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[31] UNHCR (2014).
[32] McDonald, A., Buswell, M., Khush, S., and Brophy, M. (2017).
[33] Chen, A. and Wells, A. (2019).
[34] Yaylaci, F. T. (2018); Chen, A. and Wells, A. (2019).

Lack of schooling is a major source of distress for children and youth inside Syria as well as in the refugee host countries. Education provides learning and a prospect for a better life, and children are aware of the intrinsic connections between education and their future. Moreover, schooling should provide a sense of safety, stability and routine, as well as a space for connection and interaction with peers and friends, crucial for a healthy and normal childhood development. Beyond the immediate effects of disrupted access to education, lack of schooling has severe and long-term impact. Diminished educational quality, loss of teachers and academics and weakened educational systems ultimately hurts a country's social, economic and political development, as well as the communities and individuals.[35]

Similarly, for adolescents and youth, education is understood as vitally important, and is particularly linked with hopes for employment. At the same time, adolescents and youth that have been out of school may have a changing relationship with education. While education is considered important, those that have been out of the educational system may be reluctant to go back to it due to feelings of having missed out on too much as well as the perception that formal/traditional education is no longer relevant or does not allow them to generate the much needed income that they and their families need.[36]

For refugee children, the educational environment can become a source of distress as they face discrimination and difficulties in reintegrating into the educational system after several years of interruption. Furthermore, language barriers and differences in the curriculum may impact children's ability to pursue their education.

Lack of schooling as a result of conflict severely affects children's and youth's future social and economic prospects. At the same time, children and youth who pursue their education in times of conflict may also face difficulties in learning. A systematic review of 83 studies has shown that children with exposure to recurrent and/or severe traumatic events were at significant risk for impairments in cognitive functioning, academic difficulties, and social-emotional-behavioural problems[37]

A comprehensive review of intervention research on the treatment of those exposed to disasters and mass violence have identified five widely accepted and empirically supported principles that are used to inform intervention and prevention efforts, both in the immediate aftermath of a critical event and up to three months thereafter.[38] These five principles are: (1) to promote a sense of security, (2) to calm, (3) to foster a sense of self- and collective efficacy, (4) to promote connectedness, and (5) to instill hope. These principles are included in guidelines such as Psychological First Aid.[39] The guidelines present best practices for mental health and psychosocial support (MH/PSS) after a critical event. The five essential principles are used in school-based delivery of post-disaster psychosocial care (e.g., Psychological First Aid) and also in war and on-going conflict (e.g., The Better Learning Program, BLP: NRC, 2018).

Family stressors
Syrian children and youth have experienced violent separation and/or los of family members. The huge death toll has left an unknown number of orphaned children and nearly 10,000 Syrian refugee children are unaccompanied.[40] The separation from parents/caregivers is one of the most traumatic experiences for children, especially for the younger ones, as they

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[35] Global Coalition to Protect Education from Attack: www.protectingeducation.org
[36] Chen, A. and A. Wells (2019).
[37] Perfect, Turley, Carlson, Yohanna, & Saint Gilles (2016).
[38] Hobfoll et al. (2007).
[39] Brymer et al. (2012).
[40] UNICEF Factsheet August 2019; https://www.unicef.org/mena/reports/syria-crisis-fast-facts

provide for the critical nurture and support that is needed in their early development. However, the older children and adolescents have also immensely suffered from family separation. In various studies, adolescents have expressed feelings of sadness and anger of being separated from their loved ones or from having lost family members to the violent conflict.[41]

Violence

Boys, especially adolescents, are at increased risk of recruitment while girls, but also boys, are exposed to greater risks of sexual violence. While the issue remains largely unreported, adolescent girls living in overcrowded conditions such as informal tented camps may be at particular risk. Early marriage, particularly for adolescent girls is another issue of concern as families may resort to it as a coping mechanism to their dire economic conditions.

Various studies have also reported on increased domestic and family violence. Girls have reported pressures of confinement and restricted mobility as families may fear for their safety. However, this is depriving girls from continuing their education and connecting with friends and peers.

Coping mechanisms

A range of coping mechanisms are employed by children and youth, both positive and negative. It has been argued that negative and unhealthy coping mechanisms tend to emerge when healthy options are unavailable and when there is a disintegration of formal and informal care networks. Disconnection from family and friends, and the rupture of social support networks has been reported by the older children, in particular, as a common source of frustration. Traditionally, social support networks, for e.g. friends, along with family, particularly the parents/caregivers, represent an important support to positive coping mechanisms and can provide an important source of support and socialization. For children and youth in school, teachers, with the support of parents/caregivers, play an important role in supporting them to stabilize and recover, so that they can learn and thrive.

A report[42] conducted by IMC and UNICEF in 2013 in the refugee camp of Za'atari in Jordan noted that the top coping mechanisms for children were withdrawal (71%), crying (38%), finding things to do to keep busy (31%), and going to parents for help (31%). While children may be more prone to resort to emotional coping mechanisms, younger children and adolescents may be more at risk of adopting unhealthy choices, including substance use and self-harm. Inside Syria, a report highlighted that 48% of adults noted the use of drugs, alcohol and self-harm as an increasingly common mechanisms for young people to escape their harsh reality.[43] Furthermore, loss of livelihoods negatively affects families at large.

4   Social Norms, Attitudes and Beliefs Mental Health

There is extensive literature that sustains that health and illness, including mental health, are experienced differently across cultures. Culture therefore influences the ways in which mental health is explained and how people cope with symptoms; motivations to seek treatment; the ways in which people seek treatment (mental health specialist, primary care provider, religious figures, traditional healers); coping mechanisms and the role that families and

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[41] Yaylaci, F. T. (2018); Chen, A. and Wells, A. (2019).
[42] UNICEF, IMC (2013).
[43] McDonald, A., Buswell, M., Khush, S., and Brophy, M. (2017).

communities play.[44] A comprehensive desk review conducted in 2015[45] studied the cultural framework of mental health and psychosocial well-being of Syrians, highlighting the idioms associated with distress and the role of religion and other culture-specific practices in explaining and/or treating mental health issues. In the case of children and youth, parents and/or caregivers as well as community attitudes towards mental health have critical consequences on their access to mental health services. Socially, stigma and a culture of shame have largely prevailed around mental health. The care and support for those in need has traditionally fallen on the family and community networks. Traditional religious healers have also played a role.

5   National MHPSS Systems and Services

Prior to the conflicts in Iraq and Syria, mental health systems and services in these countries were already relatively weak and insufficient, and particularly in the realm of children's and adolescents' mental health. At the policy and legislative levels, national budgets devote very little or nothing at all to mental health care. Among the NLG countries, four out of the six countries have a child and adolescent mental health plan. However, national implementation of those plans remains ineffective. The national health systems and infrastructures are ill-equipped to deal with the needs. Inside Syria, in addition to the already weak infrastructures before the conflict, the damages to the already existing facilities and a severe shortage of trained mental health care professionals, particularly psychiatrists and psychologists, has left a void to address mental health disorders.

While the countries are unprepared to meet the mental health care of children and youth, the unmet pre-conflict and the conflict-inducted mental health needs have multiplied. In light of this, humanitarian actors have been at the forefront of building capacity and providing services.

In neighbouring countries where people have fled to - Egypt, Jordan, Lebanon and to a lesser extent Turkey – the situation is similar. The relatively weak national mental health systems have quickly become overburdened by the needs of displaced populations. Refugees in these countries face additional challenges in accessing available national services due to lack of knowledge; lack of resources; lack of documentation which may leave them out of the national health care systems and services. Finally, they may also experience fear and discrimination when accessing services.

The table below summarizes national mental health systems and services in the countries. Among them, Iraq has by far the lowest number of mental health care professionals.

Table 1: WHO Mental Health Atlas 2017

		Egypt	**Iraq**	**Jordan**	**Lebanon**	**Syria**	**Turkey**
Policy and Legislation	Stand-alone policy or plan for mental health	Yes (since 2015)	Yes (since 2014)	Yes (since 2011)	Yes (since 2015)	Yes (since 2013)	Yes (since 2011)
	Plan or strategy for child and/or adolescent mental health		No		No	Yes (since 2017)	

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[44] Gopalkrishnan, N. (2018).

[45] Hassan, G., L. Kirmayer, M. A., C. Quosh, R. el Chammay, Deville-Stoetzel, J.B., A. Youssef, H. Jefee-Bahloul, A. Barkeel-Oteo, A. Coutts, S. Song and P. Ventevogel (2015).

		Egypt	Iraq	Jordan	Lebanon	Syria	Turkey
Human Resources	Number of mental health professionals[46] per 100,000	8.4	1.77	5.91	23	10.3	205.42
	Psychiatrists % of the total mental health workforce	1.6 19%	0.34 19%	1.12 19%	1.21 5%	0.37 4%	1.64 0.8%
	Number of child psychiatrists % of the total mental health workforce	200 2.5%	3 0.6%	no information	5 0.4%	no information	240 0.1%
	Psychologists % of the total mental health workforce	0.26 3%	0.11 6%	1.27 21%	3.3 14%	1.02 10%	2.54 1%
	Mental health nurses % of the total mental health workforce	4.8 57%	1.22 69%	3.3 56%	3.14 14%	1.02 10%	150.25 73%
	Social workers % of the total mental health workforce	0.45 5%	0.09 5%	0.22 4%	1.33 6%	0.8 8%	1.64 0.8%
Facilities	Number of psychiatric hospitals	18	2	5	5	3	9
	Community-based/non-hospital mental health outpatient facility	1	575	22	20	400	149
	Outpatient facilities specific for children and adolescents	10	7	no info	10	15	no info
	Other outpatient services for children and adolescents (e.g. daycare)	6	no info		4	no info	

6 Provision of MHPSS Services by Humanitarian Actors

A growing number of international agencies (UN, INGOs) and national NGOs are providing MHPSS services to children and youth. However, the overall response continues to be under funded and insufficient to meet the demands. Another key challenge, identified by both practitioners and adolescents themselves, has been the lack of information and clear overview of MHPSS programmes.[47]

6.1 IASC Guidelines for MHPSS in Emergency Settings

The IASC 2007 Guidelines for MHPSS in Emergency Settings, which have become the reference guidelines for the provision of MHPSS in emergency settings, categorize services according to four distinct layers and stresses the multi-layered approach and delivery of MHPSS services. With such vision, there is an emerging consensus that MHPSS services are to be conceptualized as an integrated approach to the humanitarian response and that the services are to be implemented through integrated approaches within existing sectors. For children and youth, as well as their parents/caregivers, such sectors are health, protection and education.

According to the IASC pyramid, there are four levels of services:

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[46] Mental health professionals include the following: psychiatrists; child psychiatrists; other specialist doctors; mental health nurses; psychologists; social workers; occupational therapists; speech therapists and other paid mental health workers.

[47] No Lost Generation (NLG) regional forums at the Evidence Symposium for Adolescents and Youth (ESAY) in September 2018 and was further highlighted at the Child Protection Workshop in December 2018

Level 1 – Basic services and security

In emergency settings, the well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). MHPSS responses at this level may include advocating that basic needs and services are put in place; documentation of MHPSS and influencing humanitarian actors to deliver services that promote well-being and psychosocial well-being.
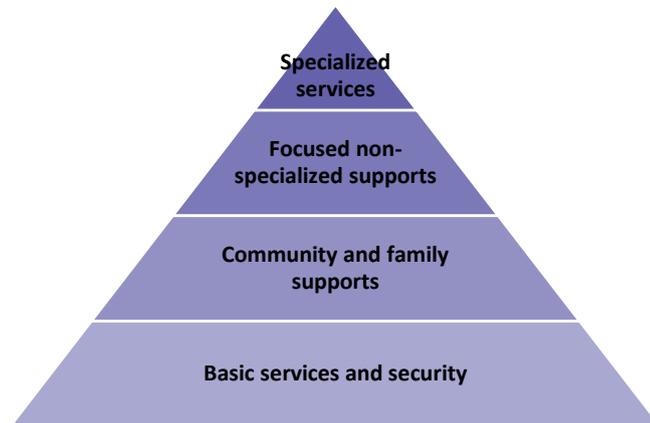

Figure 1: IASC pyramid

Level 2 – Community and family supports

In this level, responses are for a smaller number of people who are able to maintain their mental health and well-being if they receive help in accessing key community and family support. MHPSS responses for children and youth at this level include formal and non-formal educational activities, supportive parenting programmes, livelihood activities and the activation of social networks such as women's groups and youth clubs**.**

Level 3 – Focused, non-specialized supports

In this level, responses are for a smaller number of people who require more focused individual, family or group interventions by trained and supervised workers, although not necessarily with years of training in specialized care. MHPSS services include psychological first aid (PFA) and basic mental health care by primary health care workers. These services include all MHPSS services that are provided by non-specialized professionals.

with the fourth and final level of the pyramid focused on services that are delivered by specialized professionals.

Level 4 – Specialized services

In this level, responses are for a small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. These services are delivered by specialized professionals and the MHPSS responses include psychological or psychiatric support with severe mental disorders where the needs exceed the capacities of existing primary/general health services.

6.2   Previous MHPSS Mappings

A review of previous MHPSS mappings, namely the 4Ws that have been conducted in the NLG countries, was conducted to inform the current mapping. As not all countries have undergone this process or the last MHPSS 4W was conducted several years ago, the mapping was complemented with information gathered through the desk review. It is important to note that these mappings are not focused on children and youth, but they concern all the targeted population. One of the identified challenges in the delivery of MHPSS interventions has been the lack of systematic gender and age disaggregated data, making it difficult to fully comprehend the breadth and scale of programmes for this population.

A few highlights from previous mappings are presented here below. However, this must be read with caution as the information is limited and stems from mappings conducted in various years.

- Concentration of activities in levels 2 and 3, and to a lesser extent level 1. Level 4 presents the lowest number of activities.
- Jordan reported the largest number of activities (4Ws from 2017) with 1,235 MHPSS activities.
- The largest number of organizations was present in Lebanon (60 as of 2019). The smallest number of organizations was present in Syria (25, mapping from 2014) and no information was available for Egypt and Turkey.
- In Jordan, the MHPSS workforce was mainly non-specialized staff (84.16%) whereas specialized staff constituted 15.84%. No similar information was collected for the other countries.
- Most of the MHPSS programmes in Jordan, Lebanon and Syria were funded and implemented at the time of reporting. No information was collected for Egypt and Turkey.
- Case management/referral mechanisms were available in Jordan, Lebanon and Syria. No information was available for Egypt and Turkey.

Table 2: Overview of MHPSS mappings in the NLG countries[48]

	4Ws	No. of org.	No. of activities	Levels of implementation	Areas of implementation	MHPSS Workforce	Age target	Funding	Case management /referral
Egypt	X[49]	X	X	Focus on level 1 (raising awareness) and level 2 (mainstreaming of community-based psychosocial support; life skills activities.	Mainly Greater Cairo	X	X	X	No (as of 2014)
Iraq	2019 (ongoing)	65	X	All levels	Focus on Al-Anbar and Ninewa with implementation also in Dahuk, Erbil and Kirkuk		~92% of interventions target children below 18 years old	Various funding sources, mainly governmental institutions	No info
Jordan	2019 (ongoing) [50] 2017	34	1235 (2017)	Level 1: 7.74% Level 2: 43.87% Level 3: 57.42% Level 4: 26.45%	All governorates, but majority of operations focused in Amman, Irbid, Zarqa and Mafraq.	84.16% Non-specialized staff 15.84% specialized staff (psychologists and psychiatrist)	50.9% 0-18 years (2017) 86% of reported activities addressing the needs of children and youth	77.4% funded/implemented 10.7% funded/not implemented 1.3% not funded/implemented 10.5% not reported	Yes (national case management and SOPs)
Lebanon	2015	60 (2019)	1121	Level 1: X Level 2: 34.2% Level 3: 55.6% Level 4: 10.3%	30.4% Bekaa 29.9% Beirut & Mt. Lebanon 18.6% North 21.1% South	X	X	Community-focused activities: ~50% funded/not implemented 30-35% funded/impl. Case focused and general MHPSS: ~20-30% funded/not implemented ~15-30% funded/implemented	Yes (case management SOPs)

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[48] Information on this table is from the most recent source, unless specified.

[49] X = no information

[50] 4Ws MHPSS Jordan Mapping is being updated on MHPSS.net https://app.mhpss.net/mapping-analysis/jordan-mapping

	4Ws	No. of org.	No. of activities	Levels of implementation	Areas of implementation	MHPSS Workforce	Age target	Funding	Case management /referral
Syria	2014	25	406	All levels with focus on levels 1 (information dissemination) and level 2 (psychosocial support in education, supporting inclusion of social/psychosocial). Protection (CP), GBV mainstreamed.	Over 50% in Damascus. Other main areas are rural Damascus and Aleppo.	Employees and volunteers	X	403 out of the 406 activities funded	11 out of 25 org. with referral mechanisms
Turkey	X	X	X	X	X	X	X	X	No

7 Challenges with the Provision of MHPSS Programmes

Challenges in the provision of MHPSS services have been documented by humanitarian actors and include:
- Geographical reach of services, especially in the hard-to-reach areas inside Syria.
- Limited accessibility to mental health services.
- Limited capacities to address the specific mental health and psychosocial problems experienced by children and youth.
- Funding: overall funding for the Syria response has been relatively limited based on the identified needs. As reference, the 3RP programme in 2018 was funded to 62% of the pledge.

Additionally, challenges in the provision of MHPSS programmes for children and youth at the global level, but with significance to the Syria and Iraq crises have been highlighted in a global report by Save the Children as:[51]
- **Multi-sectoral programming and coordination.** Typically, MHPSS has fallen under Child Protection and integrated into other sectors, namely Education and Health. A challenge has been in the identification and attribution of who takes the lead. This situation has led to competition for funding as well as duplication of MHPSS activities, making MHPSS integration into programming challenging. Coordination has also proven to be challenging under these circumstances, although in the context of the Syria and Iraq Crises, national MHPSS WG and a regional NLG MHPSS Task Force has been established. Finally, there appears to be a wide range of definitions of MHPSS for children and youth, which in turn, has led to varied forms of capacity building, training and reporting of the activities.
- **Engagement of young people.** There are gaps in the specific MHPSS needs of children and youth, and on the variety of their needs according to age, gender and context. Moreover, there are gaps in engaging and attracting the most excluded, and in understanding the drivers for that exclusion. MHPSS programming is largely, not "speaking" young people's language.
- **Engagement of caregivers.** Addressing the MHPSS needs of children and youth goes hand in hand with addressing those of parents or caregivers. In many cases, interventions have focused on raising awareness and building their knowledge, without addressing their own needs which in turn, impact on the mental health and well-being of children and youth.
- **Capacity building.** Despite growing interest on MHPSS for children and youth, there are clear gaps in the capacity to deliver those services with well-trained, supervised and specialized staff.

8 Coordination of MHPSS Services

8.1 Regional Level: The NLG MHPSS Task Force

The NLG initiative is a concerted effort of multiple stakeholders – UN agencies, NGO organizations, with support from the international donor community and individual champions, that aims to ensure that children and youth affected by the crises in Syria and Iraq have access to education, protection and opportunities for positive engagement with their communities and society at large. Initiated in 2013 to support the humanitarian response to the Syria and Iraq crises, the initiative comprises joint, evidence-based advocacy to push for investment, policy change and programmatic improvements in the areas of education, child protection, and adolescents and youth. Within this initiative, the regional MHPSS Task Force

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[51] Save the Children (2019).

was established in March 2019 with the overall purpose of contributing to an improved MHPSS response for children and youth (0-24 years). This task force consists of specialists in the areas of MHPSS, Child Protection and Education, who are involved in the delivery of MHPSS services. The task force is co-led by the Norwegian Refugee Council and War Child Holland, and to date includes 22 UN agencies and NGO organizations.

The objectives of the task force are[52]:
1. Coordinate advocacy efforts to present joint advocacy with collective asks to decision-makers and influencers.
2. Create a repository of shared resources (evidence-based documents, learning and capacity building tools).
3. Identify and promote good practices in MHPSS interventions and programming.
4. Facilitate learning and exchanges between country offices and global practitioners.

8.2   National Level: MHPSS and Child Protection Working Groups

The IASC MHPSS Guidelines recommend the establishment of coordination mechanisms for the MHPSS response in the country. MHPSS-dedicated working groups have been established in all the NLG countries to coordinate their MHPSS efforts. In addition, MHPSS activities are also coordinated through the Child Protection working groups. During the interviews conducted with these working groups, it was noted that national-level groups are relatively well established and operational.

	Lead(s) of MHPSS WG	Lead(s) of the CPWG
Egypt	UNICEF and UNHCR	UNICEF and UNHCR
Iraq	IMC and WHO	UNICEF and UNHCR
Jordan	IMC and WHO	UNICEF and UNHCR
Lebanon	MoPH and co-chaired by UNICEF and WHO[53]	MoSA; UNICEF and UNHCR
WoS	IMC and WHO	UNICEF
Turkey	IOM	UNICEF and UNHCR

9   MHPSS Resources

As part of this desk review, a compendium of MHPSS resources for children and youth was created with the purpose of identifying and collecting relevant resources for practitioners. Online searches were conducted and as part of the survey, respondents were asked to share their resources. A compendium of resources was created on Excel and shared with members of the regional MHPSS Task Force to promote the circulation of tools, manuals and guidelines between organizations as well as to avoid duplication of efforts and materials.

During the creation of the compendium, the following issues were noted:
- Lack of accessible resources for training (for. e.g. tools, manuals) in MHPSS services in the MENA region, and particularly regarding MHPSS services for children and youth in the MENA region.
- Lack of materials in Arabic that could be employed by local NGOs and their staff.

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[52] NLG MHPSS Task Force ToR.
[53] Website: https://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program.

- Jordan, Lebanon and Syria had a larger number of documents while Egypt, Iraq and Turkey recorded a lower number.

A total of 176 resources were identified and compiled for the compendium. Out of these, 99 resources focused on the MENA region countries while 77 were resources of a global nature. Reports and assessments were the two most common categories of resources for the MENA region whereas at the global level, manuals, guides and guidelines represented the largest number of compiled publications.

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11 Annexes

11.1 Document search

Keywords	Date	Engine	Number of results	Title screening
(((((child* or youth* or adolescent* or parent* or caregiver*)) AND ("mental health" or mental or well-being* or "psychosocial support" or psychosocial or trauma or "post-traumatic stress" or depression or anxiety or grief or panic or separation or "psychiatric disorder")) AND (conflict or "armed conflict" or war or "civil war" or crisis or displacement or refugee or violence)) AND (Egypt* or Iraq* or Lebanon* or Jordan* or Turkey* or Syria*))	04.12.2019	Wiley Online	83,196	N/A
Title: child* or youth* or adolescent* or parent* or caregiver*)) AND ("mental health" or mental or well-being* or "psychosocial support" or psychosocial or trauma or "post-traumatic stress" or depression or anxiety or grief or panic or separation or "psychiatric disorder")) AND (conflict or "armed conflict" or war or "civil war" or crisis or displacement or refugee or violence)) AND Anywhere: (Egypt* or Iraq* or Lebanon* or Jordan* or Turkey* or Syria*))			42	7
(((((child* or youth* or adolescent* or parent* or caregiver*)) AND ("mental health" or mental or well-being* or "psychosocial support" or psychosocial or trauma or "post-traumatic stress" or depression or anxiety or grief or panic or separation or "psychiatric disorder")) AND (conflict or "armed conflict" or war or "civil war" or crisis or displacement or refugee or violence)) AND (Egypt* or Iraq* or Lebanon* or Jordan* or Turkey* or Syria*))	06.12.2019	PubMed	1877	N/A
Title: child* or youth* or adolescent* or parent* or caregiver*)) AND ("mental health" or mental or well-being* or "psychosocial support" or psychosocial or trauma or "post-traumatic stress" or depression or anxiety or grief or panic or separation or "psychiatric disorder")) AND (conflict or "armed conflict" or war or "civil war" or crisis or displacement or refugee or violence)) AND Anywhere: (Egypt* or Iraq* or Lebanon* or Jordan* or Turkey* or Syria*))	06.12.2019		65	29
Keywords: MHPSS		Save the Children Resource Centre	49	
Keywords: MHPSS + Country names			6	
(child* or adolescent* or youth or parent or caregiver) AND ("mental health" or "psychosocial support") AND (Egypt* or Iraq* or Lebanon* or Jordan* or Turkey* or Syria*)		Google Scholar	133	16

11.2   NLG MHPSS Mapping Report

The NLG MHPSS Mapping report is accessible on this [link.](#)

11.3   MHPSS Compendium of Resources

The compendium of MHPSS resources is accessible on this [link.](#)