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

Executive Summary

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The unabated violence of the Syrian conflict has deeply affected the physical, mental health and psychosocial well-being of children, adolescents, youth and their parents/caregivers. During nearly nine years of conflict, over 5.6 million people have fled to neighbouring refugee hosting countries and beyond.[1] Many of them have witnessed or experienced the death or separation from loved ones, displacement, physical harm, and exposure to violent situations. The psychosocial impact of conflict-related violence, coupled with the stressors of displacement, including the lack of livelihood options, violence, disruption of social networks, traditional ways of coping, and most recently the COVID-19 pandemic, are having an unprecedented negative impact on the mental health and psychosocial well-being of children, adolescents, youth and their families. With the projected impact of COVID-19 on the mental health and psychosocial well-being of populations across the world, the pandemic has strengthened the case for the need of integrated MHPSS services across the Syrian humanitarian response, including for children, adolescents and youth.

The **Mental Health and Psychosocial Support (MHPSS) Task Force of the No Lost Generation (NLG)** was established in March 2019 with the aim to improve the coordination and quality of the MHPSS response for children, adolescents and youth in line with the 3RP programmes. To gain a better understanding of the response at the regional level, the MHPSS Task Force initiated in November 2019 a mapping of MHPSS programmes targeting children, adolescents, youth and their parents/caregivers in Syria and from Syria and Iraq crises affected countries – Egypt, Jordan, Lebanon and Turkey. The first phase of the mapping (November 2019-January 2020) consisted of a survey that was completed by 42 organizations (56% international non-governmental organizations (INGOs); 21% UN agencies; 18% NGOs and five per cent government agencies), and the outcomes included a desk review and a descriptive mapping of MHPSS programmes. This first phase of the mapping was conducted in collaboration with the MHPSS and Child Protection working groups at the national level, which primarily supported the dissemination of the survey. The main caveat of this phase was the limited qualitative information that was collected. The second phase of the mapping (March-May 2020) consisted of a qualitative review of identified MHPSS programmes during Phase I, employing document review and semi-structured interviews. Thirty-nine interviews were conducted with MHPSS staff from 20 organizations.

MHPSS Programming

The findings from the survey showed that the majority of MHPSS programmes concentrated on levels two (48%) and three (31%), while 17% and 5% of reported MHPSS programmes were at levels one and four respectively, of the Inter-Agency Steering Committee (IASC) intervention pyramid for mental health and psychosocial support in emergencies. The concentration of activities in levels two and three is in line with the IASC recommendations stating that most of the population in emergency situations will require non-specialized MHPSS services.

[1] UNHCR Data as of 27 February 2020.

Limited common understanding on MHPSS approach across and within organizations
A wide variety of MHPSS programmes, based on different concepts, approaches and resources, require enhancement of the evidence-based approach. While it is acknowledged that MHPSS programmes must remain contextualized, the limited use of harmonized approaches as well as indicators that can monitor and evaluate the impact of the MHPSS interventions, render it difficult to assess their relevance and quality across and within organizations.[2]

Limited number of psychosocial support interventions in formal and non-formal education
Twenty-nine per cent of organizations reported implementing psychosocial support (PSS) programmes in formal and non-formal education, making it one of the least frequent interventions at level two of the IASC intervention pyramid for mental health and psychosocial support in emergencies, as opposed to a larger number of MHPSS interventions around strengthening coping mechanisms or recreational activities for children, adolescents and youth. Organizations recognized that the integration of PSS approaches and programmes in formal education, but also in non-formal education, can be pivotal in supporting children, adolescents and youth's psychosocial well-being, which in turn, may positively contribute to the educational experience. Additionally, investment on the integration of PSS within education is highlighted as a sustainable approach that can benefit children at a larger scale.

Limited engagement with parents/caregivers
Seventy-four per cent of organizations reported implementation of parenting interventions, ranging from awareness raising sessions to more structured programmes, but with a considerable focus on one-off activities. Addressing the psychosocial needs of parents/caregivers, children, adolescents and youth in a holistic way was highlighted as a priority because it can be more effective than addressing their needs in silos.

Fragmented MHPSS response and lack of effective referral pathways
Seventy-nine per cent of respondent organizations provided case management or referral services. Organizations reported that enhanced follow-up on the case management and referral pathways is needed. Some of the key challenges with case management and referrals were the overload of cases, long waiting lists and limited availability of services in some contexts. Additionally, it was reported that overall, referral pathways are more challenging in host communities as opposed to in refugee camps, where there may be stronger coordination in the mapping and referral to adequate services.

Shortage of structures and limited capacity on MHPSS
Respondents noted that the mental health systems inside Syria but also in the refugee host countries are fragile and present significant barriers of access for Syrian refugees. With national mental health systems overstretched and with organizations noting a considerable demand for focused services, there is increasing pressure on the higher levels of the IASC intervention pyramid for mental health and psychosocial support in emergencies. At the same time, organizations noted the limited number of MHPSS trainings that build the capacity of non-specialized staff to provide focused, non-specialized mental health and psychosocial services. The investment on focused, non-specialized services (level three in the IASC multi-layered intervention model for MHPSS) can reinforce the sustainability of interventions by building the capacity of local, non-specialized staff as well as mitigate the pressure on the highest level of the IASC intervention pyramid for mental health and psychosocial support in emergencies. Additionally,

respondents noted that it is crucial that the specialized mental health staff providing services to Syrian refugees are aligned with the MHPSS approach and integrated into the overall humanitarian response.

Limited knowledge on the specific needs of adolescents, including on negative coping mechanisms
Organizations reported that adolescents are systematically targeted across the different MHPSS programmes. While adolescents are integrated into the MHPSS response, there is a significant need to enhance the understanding of adolescents from a gender and life course perspectives, acknowledging the different MHPSS needs between younger (10-14 years) and older adolescents (14 years and above), and designing tailored MHPSS programmes that holistically address these needs. Linked to this issue was the dearth of data and interventions addressing negative coping mechanisms such as risk behaviours, self-harm and suicide, increasingly reported among adolescents.

Research, Monitoring and Evaluation

While the majority of MHPSS interventions concentrated at levels two and three of IASC intervention pyramid for mental health and psychosocial support in emergencies, the implementation of evidence-based psychosocial interventions such as Problem Management +, Inter-Personal Therapy, Self-Help Plus is still limited. Greater investment on assessing the quality of community-based psychosocial interventions is critical to ensure the do-no-harm principle, flag harmful practices and identify potentially scalable interventions. Organizations recognized that research, monitoring and evaluation is an area that has seen progress over the years, but that requires further investment, for instance through contextually appropriate and validated indicators as well as research that is rigorous yet adaptable to the needs of complex humanitarian emergencies.

Wide variation of goals, outcomes and indicators
The variation of goals, outcomes and indicators has led to difficulties in demonstrating MHPSS programmes' value or impact. Several organizations highlighted the limitations that pose the sole use of quantitative indicators to measure the effectiveness of MHPSS interventions, which are insufficient to reflect the multi-dimensional effects of the interventions.

Improvement needed on community-based approaches to MHPSS programmes
Community-based approaches were recognized as critical and as an area of improvement, as organizations increasingly invest on this approach. Organizations noted that trust building is essential in community-based approaches and that the participation and engagement of local actors, partners, community leaders, parents, children, adolescents and youth at all stages of the MHPSS interventions facilitate the creation of solid community networks that can support and sustain the effectiveness and sustainability of MHPSS interventions in the long term. While many organizations do employ participatory needs assessments, regularly conduct consultations and garner feedback from individuals, there remains a need for placing greater emphasis on community-led actions and particularly, on the systematic engagement of children, adolescents and youth. This has been an area which has been systematically been identified as key, but also broadly overlooked. Moreover, mixed method approaches that integrate community-based monitoring and evaluation mechanisms as well as observations and assessments with MHPSS users while a programme is implemented, can provide more reliable evidence on the quality and effectiveness of the MHPSS interventions.

Funding

Short-term duration of funding

Based on the available information on funding shared by organizations, 76% of MHPSS programmes were funded or had secured funding at the time of the survey, while six per cent of MHPSS interventions were not funded. Organizations recognized that the MHPSS response remains strongly dependent on funding, rendering the delivery of MHPSS services subject to the availability of funds. The short-term duration of funding, the increased competition for depleting resources and donor fatigue represent a constant threat to the sustainability of MHPSS interventions. The nature of funding has created a paradox wherein donors are increasingly demanding sustainable approaches; yet the short-term nature of funding limits the ability to invest on systems strengthening and emphasize maximization of local resources that are key to sustainable approaches.

Capacity Development and Staff Care

Lack of follow-up and supervision for staff trained on MHPSS

Theory-based trainings have been noted as insufficient to build the capacity of staff on MHPSS, and several interviewees noted the need for training programmes that incorporate learning by doing, i.e. practice. Curricula on evidence-based interventions such as Psychological First Aid (PFA), Problem Management Plus, but also MHGAP Humanitarian Intervention Guide, require field practice, as well as regular supervision via on-site visits. Among the key common challenges regarding staffing was the relative high staff turnover, which is intrinsically linked to the short nature of funding and inability to secure positions in the long term. Additionally, the recruitment of Syrian staff posed severe limitations in some contexts as work permit processes are lengthy and often difficult to obtain, limiting the opportunities to involve them in the response.

Limited opportunities for staff care. While 57% of organizations reported the existence of staff care policies, greater emphasis and investment on staff care was highlighted together with the need to institutionalize a culture that is supportive of staff care and that allows MHPSS staff to maximize the services and resources available. Additionally, it was recognized that frontline staff, especially refugee outreach volunteers or workers, are particularly at risk of compassion fatigue and vicarious trauma when confronted with challenging environments – which they may themselves be facing in their personal lives – and high-risk cases, requiring additional support to mitigate the effects of stress and burnout. Several respondents noted that the creation of peer-to-peer support groups present the opportunity to provide guidance and support and can contribute to a culture of self-care.

Recommendations

Based on the findings of this mapping, 15 recommendations were developed. Consensus around their **prioritization and feasibility** was obtained through consultation and validation with the NLG MHPSS Task Force members. Against the backdrop of the COVID-19 pandemic, which has rendered the MHPSS response ever more relevant, below are the **top priority recommendations.**

MHPSS Programming	**Advocate for holistic and comprehensive MHPSS interventions that address children, adolescents and youth's broader social environments,** including socio- economic and educational barriers, as well as parents/caregivers' psychosocial well-being.

	Invest in the integration of psychosocial support in formal and non-formal education settings by building the capacity of teachers, counsellors, and other care-workers with periodic, relevant and structured trainings, to deliver PSS as an integral component of the curriculum and other activities, in addition to specific PSS activities.
	Ensure that the voices and perspectives of children, adolescents and youth - boys, girls and the most marginalized - but also of parents/caregivers and community members are systematically taken into consideration. Mechanisms must be developed and implemented so that they have an opportunity to take a more active and leading role at all stages of the MHPSS programming, including in the monitoring and evaluation mechanisms.
	Promote multi-layered, MHPSS approaches focusing on adolescents, including on parent-adolescent relationship. The impact of the Syria crisis, now amplified by the socio-economic impact of COVID-19, has deeply affected young people's psychosocial well-being and hope for the future.
Research, Monitoring and Evaluation	**Gain a better understanding of the MHPSS needs of specific groups, namely adolescents and youth engaging in negative coping mechanisms like suicide and self-harm.** While anecdotal evidence accounts for a surge on this issue among adolescents and youth, a better understanding of suicide-related behaviours, at-risk-groups and cultural approaches to suicide and self-harm must be gathered to enable the design of interventions that can address these specific needs. It is therefore crucial to generate more age and gender disaggregated data that can help better understand the specific needs of adolescents and youth, providing age and gender-sensitive interventions to their mental health and psychosocial well-being. Similarly, other groups for which there is considerable dearth in data are children with disabilities, street children and unaccompanied children.
Sustainability	**Advocate for longer-term funding that can support the undertaking of more research on evidence-based programmes as well as longer-term capacity development plans.** These two areas can contribute to improving the quality of service delivery and at the same time, contribute to developing more sustainable interventions.
Capacity Development and Staff Care	**Invest in longer-term capacity development tailored to the specific contextual needs and learning needs of MHPSS staff, as well as strengthen the mainstreaming of MHPSS approaches with staff across the humanitarian response.** Trainings on MHPSS interventions must include regular and systematic supervision, on-site coaching and field practice. It is recommended that organizations conduct assessments on their capacity development gaps and needs and build their capacity development plans accordingly, combining practical and theoretical approaches and exercises that enhance the learning. For frontline staff, systematic supervision and coaching must be strengthened.
	Increase investment on staff care, including self-care. Organizations should commit to the institutionalization of staff care by mitigating internal stressors, establishing transparent, equitable and supportive management systems, fostering a culture supportive of staff care, including for instance, the establishment of peer-to-peer support groups, and providing opportunities for staff to make use of the services when needed. This must be expanded for frontline workers during COVID-19.