Self-Care Needs and Resources of Mental Health and Psychosocial Support Workers in Syria

RAPID PARTICIPATORY ASSESSMENT

April 2016

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BelSalameh

strengthening resilience and peace in syria

تعزيـز السلام وإرادة الحيـاة في سوريـا

A project by: **abaad** أبعاد

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Contents

Figures and Tables

Figures
Percent distribution of survey respondents by:

Tables
Distribution of survey respondents in terms of:

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We hope that this report will contribute to strengthening self-care programming as part of the humanitarian response.

EXECUTIVE SUMMARY

The "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" has been undertaken within ABAAD's EU-funded "BelSalameh" project and aims to identify the needs and forms of self-care among humanitarian actors working in the field of mental health and psychosocial support with families and individuals affected by the humanitarian crisis in Syria.

Findings from this report will be utilised to inform the production of different materials, trainings (including a Training of Trainers on self-care), in addition to a standardised training curriculum produced specifically for the Syrian context.

The study was launched in October 2015. Data collection and field work began in November 2015 and ended in January 2016.

This report aims to present findings of the rapid participatory assessment whose objective is to assess the self-care needs and resources available to humanitarian actors working in the MHPSS

RESEARCH METHODOLOGY

The "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" combined qualitative and quantitative research methods to complement data collection and to enrich the study findings. The study adopted the Rapid Appraisal Procedures (RAP) approach, which included:

- Review and analysis of relevant and existing information from multiple sources.
- Survey targeting humanitarian actors: through "snowball sampling," a total number of 99 surveys were filled by humanitarian actors working in the fields of mental health and psychosocial support in Syria.
- Information related to self-care needs collected from a Discussion and Feedback session with 12 MHPSS workers from seven governorates (Aleppo, Damascus, Hasakeh, Homs, Rural Damascus, Sweida, Tartous) conducted in Beirut in August 2015.

Results of the survey on the "Self-Care Needs and Resources of MHPSS Workers in Syria" served as the primary source of data for this study. In addition to those results, the findings concerning self-care needs drawn from a parallel study conducted by ABAAD, the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment" (Section on "Self-care and Support"), were used as secondary sources of information within this study.

RESULTS OVERVIEW

The rapid participatory assessment revealed substantial and diverse self-care needs and challenges faced by humanitarian actors working in the mental health and psychosocial fields in Syria, which greatly affect their psychosocial wellbeing on one hand, and impair their ability to respond effectively to the growing mental health and psychosocial needs on the other.

Study respondents, who included national MPSS actors, have been substantially affected by the protracted crisis and the ongoing violence in Syria. In addition to the stress resulting from their work with crisis-affected populations, the majority of the respondents have experienced traumatic events and/or the loss of someone dear or people they know. Some have also experienced displacement and significant changes in their living conditions.

Results indicate that stress is common among humanitarian workers and is negatively influencing their psychosocial wellbeing. Many respondents described a reduced ability to relax and many reported disturbances in their eating habits, especially during periods of stress at work.

SELF-CARE AT THE PHYSICAL LEVEL

On the physical level, some unhealthy behaviours were revealed among survey respondents. Many respondents reported that they skip meals, rarely engage in physical activity, rarely miss work when they are sick, and sometimes neglect themselves. However, the consumption of alcohol did not prove to be common among national humanitarian actors.

SELF-CARE AT THE SPIRITUAL LEVEL

On the spiritual level, the study revealed positive indicators. The majority of respondents reported always feeling that their work has value and meaning, hoping that the situation will get better even when things go wrong (indicator of optimism and positive thinking), practicing meditation or praying, and making sure they get time to rest.

SELF-CARE AT THE PSYCHOSOCIAL AND EMOTIONAL LEVEL

On the psychosocial and emotional levels, respondents reported some positive indicators. Being frequently aware of their feelings and sensing when they are not feeling well, giving themselves time to review and reflect on what they experience, talking to someone when they are stressed, feeling adequate and appreciating themselves, encouraging themselves and engaging in a positive and supportive inner dialogue, being kind and empathic with themselves, having a supportive social network, being empathic with others, having positive and realistic expectations and motives, are all indicators of positive emotional and psychosocial wellbeing and self-care. Many study respondents explained that they believe that it is their duty to intervene and help others during these difficult times. They also explained that their work makes them feel they are actively helping their country during the crisis and contributing to its recovery.

On the other hand, respondents reported some negative indicators on psychosocial wellbeing that require prompt interventions. These indicators include feeling overwhelmed with stories of people they work with, sometimes feeling emotionally numb, frequently feeling stressed because of the workload, feeling exhausted and frustrated because of work in the humanitarian field, as well as feeling easily irritable and unable to relax.

STUDIES ON HUMANITARIAN WORKERS' SELF-CARE NEEDS AND PSYCHOSOCIAL WELLBEING

Concerning research on the needs of humanitarian workers in Syria, to date, there are no assessment studies exploring the risks to their mental health and psychosocial wellbeing or assessing their psychosocial and self-care needs and resources. The psychosocial and self-care needs of humanitarian workers are usually overlooked.

RESOURCES ON SELF-CARE

In Syria, there is lack of resources on self-care, and a scarcity of self-care and staff-care trainings and stress-management activities. Study respondents referred to a strong need for learning opportunities on recognising signs and sources of stress, understanding the consequences of cumulative stress and its impacts on wellbeing, recognising indicators of severe stress and burnout, and learning ways of dealing with stress (stress management).

The only available resource that includes information on stress management and self-care is the WHO "Psychological First Aid: Guide for Field Workers" and "Psychological First Aid: Facilitator's Manual for Orienting Field Workers."

Some humanitarian workers who participated in this study are not aware of this resource and the majority pointed out to a pressing need for Arabic, contextualised resources on self-care and stress management both to help them personally, and to assist them in facilitating self-care sessions for other staff.

As per the study results, the most stressful cases that the study respondents deal with are cases of people suffering from financial difficulties and cases of people suffering from severe mental or psychological conditions (including those struggling with loss and grief).

SELF-CARE AT THE ORGANISATIONAL AND PROFESSIONAL LEVELS

With respect to self-care at the organisational and professional levels, results indicated good self-care skills related to work, such as the humanitarian workers' ability to set appropriate boundaries when it comes to their cases, as well as their ability to set realistic goals, timelines, and work plans.

However, the study revealed significant stress factors related to work. Weak coordination among stakeholders, insufficiency of technical support and supervision, insufficiency of available and appropriate resources and information, and the poor referral system, along with the humanitarian workers' stress at the personal and professional levels, were among the main stressors identified by study respondents.

At the level of agencies, the main self-care needs identified were related to the lack of suitable and adequate interventions to mitigate stress among staff. Results of the study respondents indicated significantly poor staff-care initiatives, activities, and protocols at the organisations in which they work. There is a significant need for appropriate and regular staff-care and psychological support interventions.

OBSTACLES TO SELF-CARE

Among the obstacles identified by MHPSS practitioners as obstructers of self-care are lack of energy, too many responsibilities, time constraints, and the fear of appearing weak or vulnerable.

However, most of the study respondents felt that they need to promote their self-care practices and that they deserve to engage in self-care activities.

PERCEIVED ROLE IN PEACE-BUILDING

Regarding their perceived role in peace-building, most study respondents reported a strong belief in the value of their contributions and their role in peace-building initiatives.

RECOMMENDATIONS

The diverse needs of MHPSS practitioners currently working in Syria and the challenges they face in their work necessitate coordinated and well-planned interventions, in addition to a strategy on staff-care, to ensure that humanitarian workers can access psychosocial support services when needed.

Psychological first aid should be immediately available to workers who have experienced or witnessed extremely distressing events.

To respond to the different needs of MHPSS practitioners in Syria, there is a need for activating an MHPSS taskforce that will establish a long-term Mental Health strategy and coordinated activities that aim to address the various needs, including self-care needs of humanitarian workers.

Specific percentages of programme budgets must be dedicated to staff-care activities that aim at providing regular support to humanitarian workers.

Additional efforts should be made to improve coordination between organisations and service providers, establish a clear referral system, and ensure proper case management and follow up. Moreover, efforts need to be made to secure ongoing, sufficient, and culturally sensitive technical support and supervision of MHPSS practitioners.

To prevent and reduce the risk of burnout and compassion fatigue in staff members, organisations should focus on:
- Creating an open environment where staff members have a venue for mutual support.
- Encouraging staff members to meet with supervisors to talk about how they are affected by their work.
- Encouraging peer support within the organisation or with other humanitarian workers.
- Offering training that educates humanitarian workers about burnout and compassion fatigue and how to recognise the symptoms.
- Sharing the caseload among team members, particularly the most difficult cases.
- Making time for social interaction among teams.
- Organising appropriately planned social events and retreats away from the workplace.
- Encouraging healthy self-care habits such as good nutrition, sleep, and taking work breaks.
- Offering trainings that focus on self-care and a balanced lifestyle as a way to promote resilience despite stress.

INTRODUCTION

After five years of conflict, Syrians are now facing the largest humanitarian crisis in the world. The humanitarian situation is deteriorating further with intensified fighting, extreme levels of violence, widespread human rights transgressions, and complete disregard for the rules of international law and the obligation to protect civilians. Massive population displacements are increasing while humanitarian needs continue to rise. The protracted crisis with no end in sight, its dire consequences, and the increasing number of affected population continue to pose serious challenges and limitations to the humanitarian response.

Syrian refugees now form the biggest population of displaced persons resulting from a single conflict with over 4.6 million Syrian refugees in neighbouring countries and the wider region. Countries bordering Syria are reaching an alarming saturation point, particularly Lebanon, which hosts almost 1.1 million Syrian refugees and has, along with Jordan, the largest per capita refugee population in the world. Turkey is currently hosting more than 2.5 million Syrian refugees, the largest number of Syrian refugees in one country in the world. More than half of those displaced are children. Space for those considering leaving their country and seeking refuge abroad is gradually shrinking due to new border policies introduced by all of Syria's neighbours.

Facts and Figures (ECHO Factsheet, Syria Crisis - February 2016)

Estimated number of people in need (PiN) of humanitarian assistance inside Syria: 13.5 million

In hard to reach/besieged areas: 4.5 million

Estimated number of internally displaced: 6.5 million

Number of refugees - registered and awaiting registration: 4,598,594

Lebanon: 1,069,111   *Iraq: 245,022*

Turkey: 2,503,549   *Egypt and North Africa: 117,658*

Jordan: 636,482

Since 2011, an average of 50 Syrian families has been displaced every hour of every day[1].The humanitarian community now estimates that 13.5 million people in Syria need protection and some form of humanitarian assistance, including 6 million children. Around 8.7 million people are unable to meet their basic food needs, and 70 percent of the population lacks access to safe drinking water. Health facilities, schools, and other essential services across the country are either operating at reduced capacity or have completely closed.

Most internally displaced persons (IDPs) live in host communities rather than camps, shelters, or sites, and thousands of communities across Syria are hosting displaced persons. As a result of this prolonged displacement and the growing needs, the host communities are bearing a significant burden and are thus in need of assistance. The increasing needs among both the IDPs and the host communities has led to increased protection risks manifesting as family separation and child labour, including the worst forms of the latter; recruitment of children into armed groups, and child marriage. Currently, IDPs make up an estimated 35 percent of the urban population (4 million people). The most vulnerable urban populations are people with mobility constraints, people with no access to income or who are dependent on relief, and host communities experiencing conflicts between host populations and IDPs.

The lingering crisis, its consequences, and the increasing number of affected populations continue to challenge the humanitarian response. The growing number of refugees is placing an increased burden on existing governmental and non-governmental service providers, and is outpacing their ability to respond. Thus, the role of national and international non-governmental organisations is increasingly important in addressing the needs of the Syrian population[2] .

1 Humanitarian Response Plan 2016 https://docs.unocha.org/sites/dms/Syria/2016_hrp_syrian_arab_republic.pdf
2 "Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis," IMC
http://internationalmedicalcorps.org/document.doc?id=526.

The active conflict is also increasingly hindering the delivery of humanitarian aid, especially in Northern Syria: supply roads are often disrupted or closed, and humanitarian organisations have been forced to downscale or suspend operations in several areas due to the instability.

The current crisis in Syria has been greatly escalating needs and damaging infrastructure within the country. The entire healthcare system in Syria, including healthcare facilities, water and sanitation networks, waste management systems, and electricity supplies continue to be severely disrupted[3].

There is general evidence that exposure to continuous, distressing, and potentially traumatic events, depletion of resources, forced displacement, loss of or separation from family members and friends, deterioration in living conditions, absence of security, and lack of basic needs and services can all negatively impact mental health and psychosocial wellbeing and increase the risk of maladjustment. All the latter have both immediate and long-term consequences on the balance and fulfilment of individuals, families, and communities.

Existing studies and reports highlight the profound effects of conflict on the mental health and psychosocial wellbeing of people in Syria. Experiences of conflict-related violence and concerns about the situation in Syria are compounded by the daily stressors of displacement, including poverty, lack of basic needs and services, ongoing risks¬ of violence and exploitation, isolation and discrimination, loss of family and community support, and uncertainty about the future. The escalating crisis has brought with it significant deterioration of all aspects of life for its citizens. Prior to the crisis, Syria had a shortage in mental health professionals providing services in the country, and the underdeveloped mental health system has amplified the psychosocial consequences and evoked a greater need for response interventions.

STUDY DEFINITIONS

As specific terminology differs between and within aid organisations, disciplines, and countries, the definitions below detail the underlying conceptual principles guiding this study.

Mental Health - The WHO defines mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"[4].

Mental Health and Psychosocial Support - The IASC Guidelines define mental health and psychosocial support as two complementary approaches which include "any type of local or outside support that aims to protect or promote psychosocial wellbeing, and prevent or treat mental disorder." The term "psychosocial" is used to indicate the close connection between psychological characteristics of experiences in life (our thoughts, emotions, and behaviours), and broader social experience with the environment (our relationships, traditions, spirituality, interpersonal relationships in the family or community, culture, and life tasks such as school or work)[5]. The use of the term "psychosocial" incorporates the family and community in assessing problems and needs.

3 Regional Situation Report, January 2015 WHO response to the Syrian crisis
4 http://www.who.int/features/factfiles/mental_health/en
5 The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007

Humanitarian workers - Throughout this report, the term "humanitarian workers" includes full-time and part-time staff, paid and volunteer, national and international staff, professional and technical staff, and non-professional staff. "Humanitarian workers" is used to refer to those working on emergency response interventions within designated geographical areas facing war and emergency.

MHPSS workers - In this study, "MHPSS workers" refers to the mental health and psychosocial support (MHPSS) staff, such as: psychologists, psychosocial counsellors, social workers, psychiatrists, psychiatric nurses, animators, and others who are involved in providing mental healthcare, including individual or group counselling, psychotherapy and/or psychiatric treatment for Syrians.

Self-care - The ability of individuals, families, and communities to promote health, prevent disease, maintain health, and cope with illness and disability without the support of a healthcare provider .[6] Beyond just focusing on health and wellbeing, self-care incorporates self-management. Self-management means people drawing on their strengths and abilities to manage or minimise the way a condition may limit their life, as well as what they can do to feel happy and fulfilled. Self-care is what people do for themselves to establish and maintain health, and to prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure, and similar), environmental factors (living conditions, social habits, and similar) socio-economic factors (income level, cultural beliefs, and similar) and self-medication.

Staff care - Staff care refers to self-care and institutional responses to stress among humanitarian workers intended to mitigate distress and enhance resilience of staff in response to stressors encountered during the course of providing humanitarian assistance.

STRESS IN HUMANITARIAN WORK

The context of humanitarian work is intrinsically stressful. Humanitarian workers increasingly work in complex environments where problems related to prolonged civil conflicts, extreme poverty, and personal tragedies are constant companions. They operate in some of the toughest imaginable circumstances and often experience overwhelming workloads, long days, a lack of privacy and personal space, direct exposure to misery, ever-growing numbers of people affected by humanitarian crises, deteriorating safety and security conditions, and limited available resources. This means that humanitarian workers remain exposed to a wide variety of sources of stress. Regardless of their background, specialty, and specific role, in the field, humanitarian workers are repeatedly exposed to stories of suffering and experiences of personal tragedy. They may also witness horrific scenes themselves, have distressing experiences, or be chronically exposed to serious danger. Many often live and work in physically demanding and/or unpleasant conditions, characterised by heavy workloads, long hours, chronic fatigue, and lack of privacy and personal space. They may experience moral anguish over the choices they often have to make. Even the opportunities for learning and growth while carrying out new assignments can be stressful for staff.

6 WHO Self-care in the Context of Primary Health Care 2009

On the occasion of the World Humanitarian Day[7](August 19, 2014), Jan Eliasson, UN Deputy Secretary-General referred to dangers faced by humanitarian workers on the frontlines of disaster and war that represent a "world-wide deficit of humanity", stressing that the situation was getting worse, and that humanitarian and aid workers are increasingly coming under direct attack.

In five years, 85 humanitarian workers have been killed in Syria, 45 of them from the Syrian Arab Red Crescent. A total of 32 United Nations staff members have been detained or are missing. 50 percent of health workers have fled the country and 60 percent of public hospitals have been destroyed; they are now either closed or partially functioning[8]. Some workers continue to cross the front line to deliver life-saving assistance in some of the country's most dangerous area[9]. In Syria, health centres and health workers are often targeted by shelling and air strikes. Since the conflict broke out in March 2011, 633 medical personnel have been killed according to the NGO Physicians for Human Rights. Additionally, requests to deliver medical supplies are often refused. In April, the World Health Organisation (WHO) requested to send 2,000 renal failure treatments to Douma through an inter-agency convoy. However, the government only granted permission for 250 to be delivered. On its way into Douma, the convoy was hit by a mortar round, killing a 19-year-old Syrian Arab Red Crescent (SARC) volunteer and injuring three others.

Despite these obstacles, native Syrian medical and humanitarian workers are bearing the burden of the workload; operating under hazardous and tough conditions with scarce resources. International law safeguards medical neutrality and the principle of treating the sick and injured on all sides without discrimination. As 55 prominent medical professionals described in an open letter to The Lancet, in Syria, this principle is being threatened, criminalised, and assaulted[10].

Since the beginning of the crisis, there has not been any comprehensive assessment of the psychosocial and self-care needs of humanitarian workers in Syria. Except for a new survey[11] that examined the mental health risks of UNHCR staff, studies focusing on the psychosocial wellbeing of humanitarian workers are rare or non-existent, and the psychological difficulties experienced by humanitarian workers remain neglected.

THE STUDY OF SELF CARE NEEDS AND RESOURCES OF MHPSS WORKERS IN SYRIA

ABAAD, founded in June 2011, is a non-profit, non-politically affiliated, non-religious civil association that aims to promote sustainable social and economic development in the MENA region through equality, protection, direct service provision, and empowerment of refugee and host community groups who may be vulnerable, especially women.

In April 2015, ABAAD, with the support of the European Union, launched a project for Syria entitled "BelSalameh," (Syrian dialect, term used either to wish someone a safe return or to get well soon), which addresses the multiple psychological dimensions of the crisis and enables individuals and communities to improve their capacity to transform their negative experiences. The strength and resilience-centred approach used within this project will support the capacities of affected communities inside Syria to cope with immediate needs emanating from the crisis, recover from its impacts, and sustain this recovery over the long-term. The project aims at:

- Enhancing the capacities of professionals working in different sectors to respond to the MHPSS and GBV needs of residents of Syria, building upon learning from interventions that have taken place in Lebanon
- Enhancing coping strategies (at the individual and community levels) of the affected population through targeted psychosocial support and art techniques
- Contributing towards peace-building through community and cultural identity development as well as via social cohesion
- Bridging the gap in resources and skills related to GBV case management in emergency settings through creating a pioneer, widely-accessible online resource

The "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" is part of the "BelSalameh" project and aims at identifying needs and forms of self-care among humanitarian workers who work in the field of mental health and psychosocial support with individuals and families affected by the Syria crisis.

Data collection and field work related to the rapid participatory assessment began in November 2015 and ended in January 2016.

This report aims to present the findings of the rapid participatory assessment undertaken to assess the self-care needs and resources of humanitarian workers working in the MHPSS field in Syria.

7 The date (August 19) commemorates the 2003 attack on the United Nations compound in Baghdad when 22 of the Organisation's staff were killed
8 Human Rights Watch- Attacks on Health, Global Report, May 2015
9 Aid workers risking their lives in Syria amid heavy death toll. Feb 2016 http://www.sbs.com.au/news/article/2016/02/02/aid-workers-risking-their-lives-syria-amid-heavy-death-toll
10 Health Professionals Respond to Syria's Humanitarian Crisis. Medscape. Jan 22, 2014
11 Staff Well-Being and Mental Health in UNHCR; Geneva, 2016   http://www.unhcr.org/56e2dfa09.html

THE STUDY

STUDY OBJECTIVES

This assessment is part of the "BelSalameh" project implemented by ABAAD and supported by the European Union. The assessment was conducted to provide ABAAD, other local and international organisations, public health and humanitarian actors, in addition to relevant stakeholders with the information necessary for planning and designing protocols and policies for proper staff-care and staff wellbeing. The assessment aims at:

- Exploring the strategies of self-care among humanitarian workers who work in the field of psychosocial support and protection with individuals and families affected by the Syria crisis.
- Identifying the self-care needs and the existing gaps and obstacles as well as the existing and available resources that can be built upon.

This study is not intended to be an assessment of the psychosocial needs of humanitarian workers, or an assessment of stress and burnout among humanitarian workers. It aims at exploring humanitarian workers' coping behaviours and self-care needs.

STUDY METHODOLOGY

The "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" used different methods for data collection. It combined the qualitative and quantitative methodology to complement data collection and to enrich the study findings. Results from qualitative and quantitative components were compared and this process helped in increasing data confidence, highlighting specific findings and providing a clearer understanding of the results. Conclusions were made by analysing results from both, the quantitative and the qualitative components.

Assessment Tools

The first phase of the assessment consisted of an extensive literature review, following which an assessment tool was designed by the project consultant and reviewed by a core team of MHPSS specialists. The "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" tool (Annex I) consists of different complementary sections that aim at identifying the self-care needs and resources of MHPSS workers. A "guidance note" (see Annex II) was developed to provide practical information and necessary advice and guidance that ensure proper and effective use of the tool.

Data Collection

ABAAD circulated online surveys to a number of practitioners, humanitarian actors, and national and international organisations working in the fields of mental health and psychosocial support in Syria. Target groups responded to the survey and supported its circulation to their respective networks. Through this 'snowball sampling,' a total number of 99 surveys were filled by humanitarian workers working in Syria with the crisis-affected population.

Results of the survey on the "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" served as the primary source of data for this study. In addition to those results, the findings concerning self-care needs drawn from a parallel study by ABAAD, the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment" (section on Self-Care and Support) were used as secondary sources of information informing this study.

For the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment," ABAAD and its consultants' networks circulated the survey, and received a total of 64 responses from MH practitioners working in Syria. The surveys provided useful information on self-care needs. In addition to the surveys, 18 key informant one-on-one interviews were conducted over Skype with MH practitioners, psychologists, and counsellors to get further and more elaborate information on capacity needs and self-care needs of MH practitioners working in Syria. The interviews were conducted using the semi-structured technique, and helped to collect qualitative data. Probing was used to stimulate responses whenever deemed necessary. A total of 18 Skype interviews were conducted with MH practitioners in Syria, distributed as follows: 12 females and 6 males; 2 psychiatrists, 5 psychotherapists, 6 psychologists, and 5 counsellors.

Ethical Considerations

All participants joined this assessment voluntarily. The scope and objectives of the assessment were clearly explained to the study participants. They were told that they could withdraw from the assessment at any time, and were requested to acknowledge the informed consent process. They were reassured that the assessment is anonymous and does not require providing personal information, particularly name and phone number. Respondents were also reassured that their detailed responses would not be discussed outside of the assessment team. (See Annex III for the Informed Consent Form)

Data Processing and Analysis

Data collection and data extraction processes were done electronically using "KoBo Toolbox." Respondents accessed the survey using a web link. Data cleaning and data analysis were performed using Stata MP V13.0. Univariate statistical analysis was performed for all main Axes, such as the Axis on Self-care on the physical level, the Axis on Self-care at the psychological and emotional levels, the Axis on Self-care on the spiritual level, the Axis on Self-care at the organisational and professional levels, the Axis on the need for self-care, in addition to the Axis on the general conditions affecting psychosocial wellbeing.

Bivariate analysis was used to stratify the initial analysis by gender, profession, and geographical area. Data tabulation and graphical representation of the main indicators was done using Microsoft Excel.

STUDY LIMITATIONS

For the purpose of identifying unintended influences on information acquisition and analysis of the assessment data, the prominent limitations to this assessment are presented below:

- The use of structured and semi-structured questionnaires, such as the "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" tool, allows for less flexibility during data collection. The in-depth Skype interviews helped in reducing this specific limitation by exploring the axis of self-care further.
- A part of this assessment targeted perceptions on self-care. Subjective bias resulting from the respondents' personal or cultural views, prejudices, individual experiences, and expectations might be present. The concepts of self-care and staff-care are relatively new to humanitarian workers in Syria (and to some institutions). Some consider self-care and staff-care a luxury rather than a need.
- There is a complete lack of information about humanitarian workers located in the hard to reach areas, about their needs and the challenges they face in their work.
- The volatile situation in Syria is causing changing and increasing needs, displacement, and an ongoing brain-drain associated with the protracted trend of the population leaving the country (especially the most qualified).

- The method used to collect data from MHPSS workers through "snowball sampling" using a pool of initial key informants to nominate, through their social networks, other participants who could potentially contribute to the study has some limitations. ABAAD and the study team tried to ensure that the initial informants are as diverse as possible (professions, geographical locations, years of experience) to guarantee better representativeness.
- The study was limited by the relatively low number of male participants (23%) compared to female participants (77%). This limitation, besides the relatively small sample size, was a barrier to comparing results collected from male and female respondents.

RESULTS

QUANTITATIVE ASSESSMENT

Socio-Demographic Profile

The majority of study respondents are females (a percentage of 77% females and 23% males) and of Syrian nationality (percentage of 89% Syrian, the rest being Palestinian Syrian).
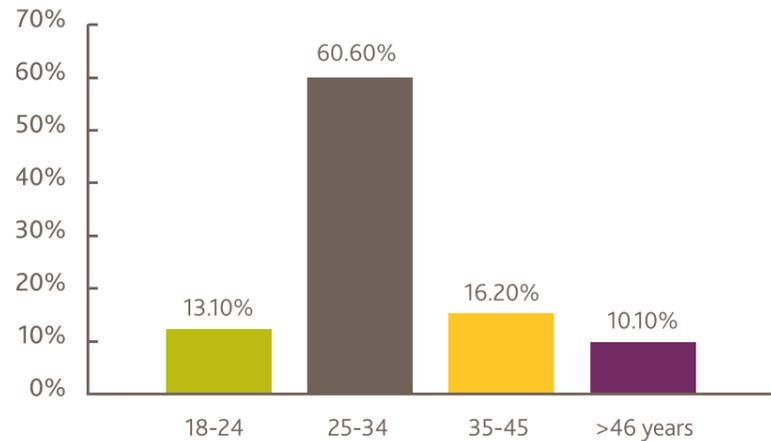

Figure 1: Percent distribution of survey respondents by age

Regarding age distribution, the majority of study respondents belong to the age group of 25-34 years (60.6%).

The majority of study respondents are currently working in Syria (95%) while a small percentage of 5% are working in Lebanon (mostly as MHPSS social workers).

Regarding the distribution of study respondents by geographical location, the majority were from Damascus (53.6%)
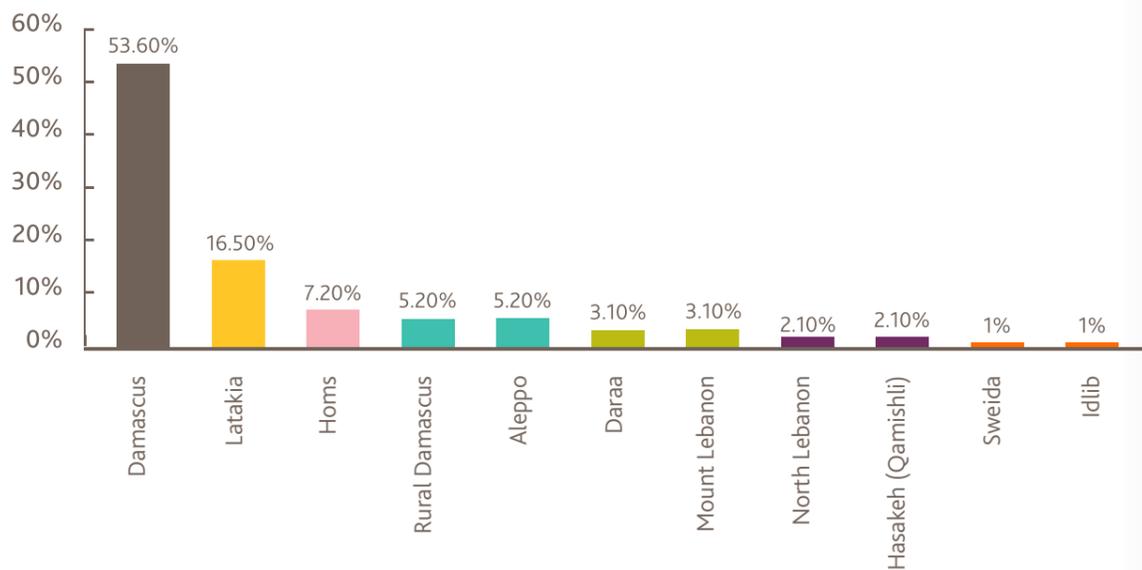
Figure 2: Percent distribution of survey respondents by geographical location

Concerning their educational level, the majority of survey respondents are university graduates (90%) while a percentage of 10% was distributed between secondary education, vocational training, and other forms of non-formal education.

Study respondents were distributed evenly among the professions of psychologist and psychotherapist, social worker, psychosocial animator, others (including psychiatrists).

The average number of working hours reported by study respondents is 8.

General Conditions Affecting Psychosocial Wellbeing

A percentage of 37% of survey respondents reported experiencing displacement. Among those who have experienced displacement, the majority (89%) reported a displacement duration of 1-3 years.

The majority of survey respondents also reported that they have been working in the humanitarian field for at least 1-3years (43.4%). Respondents reported an average of 2.8 years experience in humanitarian work.
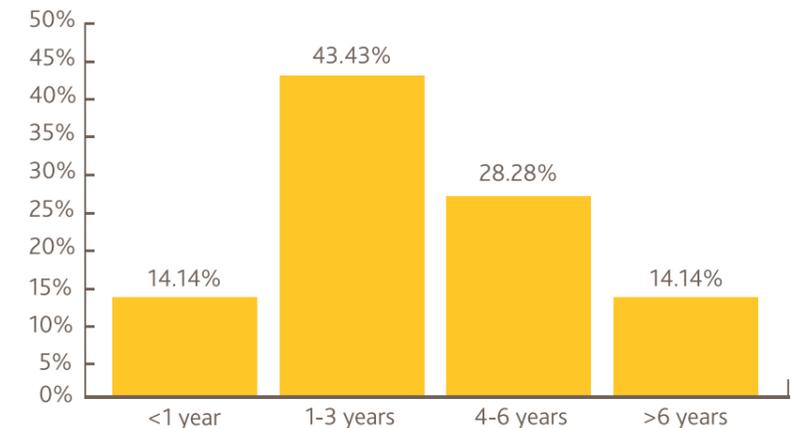
Figure 3: Percent distribution of survey respondents by duration of work in the humanitarian field

Concerning residency, the following results were collected:

Mean ± Standard Deviation	
Number of rooms in survey respondent's place of residence	3.20 ± 1.50
Number of rooms in survey respondent's place of residence	3.97 ± 1.80

Thereby indicating a Crowding Index of 1.24 (the number demonstrates not much household crowding).

SELF-CARE

Self-Care on the Physical Level

Self-Care on Physical Level	Always N (%)	Frequently N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)	Other N (%)
Eating healthy food	10 (10.10%)	25 (25.30%)	48 (48.5%)	10 (10.00%)	6 (6.10%)	-
Skipping meals	3 (3.00%)	16 (16.20%)	47 (47.50%)	28 (28.30%)	4 (4.00%)	1 (1.00%)
Engaging in physical activity	10 (10.10%)	17 (17.20%)	33 (33.30%)	29 (29.30%)	8 (0.10%)	2 (2.00%)
Getting enough sleep	13 (13.10%)	29 (29.30%)	36 (36.40%)	14 (14.10%)	5 (5.10%)	2 (2.00%)
Drinking alcohol	2 (2.00%)	6 (6.10%)	19 (19.20%)	20 (20.20%)	52 (52.50%)	-
Consuming excess coffee or other stimulants	16 (16.20%)	16 (16.20%)	22 (22.20%)	13 (13.10%)	30 (30.30%)	2 (2.00%)
Smoking	12 (12.10%)	12 (12.10%)	21 (21.30%)	10 (10.10%)	43 (43.40%)	1 (1.00%)
Not working when sick	7 (7.10%)	10 (10.10%)	38 (38.40%)	28 (28.30%)	14 (14.10%)	2 (2.00%)
Seeking medical care when sick	19 (19.20%)	11 (11.00%)	45 (45.50%)	16 (16.20%)	6 (6.10%)	2 (2.00%)
Self-Neglecting	5 (5.10%)	5 (5.00%)	29 (29.30%)	36 (36.40%)	22 (22.20%)	2 (2.00%)

Table 1 - Distribution of responses to physical self-care related indicators

Effects of stress on behaviours affecting health	Total N (%)
Eating more or less than usual when stressed at work	56 (56.60%)
Smoking or drinking alcohol more or less than usual when stressed at work	30 (30.30%)
No change	13 (13.1%)

Table 2 - Distribution of responses on the effects of stress on health behaviours

Self-Care on the Spiritual Level

Self-Care on Spiritual Level	Always N (%)	Frequently N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)	Other N (%)
I feel that my work has meaning and value	59 (59.60%)	23 (23.30%)	7 (7.10%)	4 (4.00%)	3 (3.00%)	3 (3.00%)
I practice meditation and/or pray	19 (19.20%)	26 (26.30%)	29 (29.30%)	7 (7.00%)	18 (18.20%)	-
I make sure I get time to relax/rest	12 (12.10%)	18 (18.20%)	49 (49.50%)	15 (15.10%)	5 (5.10%)	-
Even when things go wrong, I see (and hope) they will get better	25 (25.20%)	31 (31.10%)	33 (33.30%)	8 (8.20%)	1 (1.20%)	1 (1.00%)

Table 3 - Distribution of responses to spiritual self-care related indicators

Self-Care on the Psychosocial and Emotional Levels

Self-Care on the Psychosocial and Emotional Levels	Always N (%)	Frequently N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)	Other N (%)
I am aware of my feelings and I can sense when I am not feeling well	33 (33.30%)	30 (30.30%)	25 (25.30%)	4 (4.00%)	5 (5.10%)	2 (2.00%)
I give myself time to review and reflect on what I experience	23 (23.30%)	33 (33.30%)	34 (34.30%)	5 (5.10%)	3 (3.00%)	1 (1.00%)
I practice assertiveness and say no to extra responsibilities	13 (13.10%)	16 (16.20%)	37 (37.40%)	26 (26.30%)	6 (6.00%)	1 (1.00%)
I express and talk to someone when I am feeling stressed	22 (22.20%)	23 (23.30%)	34 (34.30%)	18 (18.20%)	2 (2.00%)	-
I appreciate myself and I feel I am adequate	28 (28.30%)	42 (42.40%)	21 (21.20%)	5 (5.10%)	2 (2.00%)	1 (1.00%)
I encourage myself and practice supportive inner dialogue	27 (27.30%)	34 (34.30%)	25 (25.30%)	10 (10.10%)	2 (2.00%)	1 (1.00%)
I have positive and realistic expectations and motives	29 (29.30%)	35 (35.40%)	24 (24.20%)	5 (5.10%)	4 (4.00%)	2 (2.00%)
I feel I can make a positive change through my role in life	35 (35.40%)	32 (32.30%)	25 (25.30%)	4 (4.00%)	1 (1.00%)	2 (2.00%)
I feel overwhelmed with stories of people I work with	17 (17.20%	36 (36.40%)	30 (34.40%	6 (6.00%)	3 (3.00%)	3 (3.00%)
I feel emotionally numb	8 (8.10%)	8 (8.10%)	43 (43.40%)	20 (20.20%)	17 (17.20%)	3 (3.00%)
My work and what I do make me feel satisfied	33 (33.30%)	35 (35.40%)	25 (25.30%)	4 (4.00%)	1 (1.00%)	1 (1.00%)
I get satisfaction from my ability to help others	41 (41.40%)	40 (40.40%)	13 (13.10%)	3 (3.10%)	-	2 (2.00%)
I feel stressed because of the workload	12 (12.10%)	26 (26.30%)	41 (41.40%)	16 (16.20%)	3 (3.00%)	1 (1.00%)
I feel exhausted because of my work in the humanitarian and support fields	10 (10.10%)	12 (12.10%)	40 (40.40%)	24 (24.30%)	11 (11.10%)	2 (2.00%)
I feel frustrated because of my work in the humanitarian and support fields	5 (5.10%)	1 (1.00%)	34 (34.30%)	29 (29.30%)	28 (28.30%)	2 (2.00%)
I feel that I am easily irritable	6 (6.10%)	9 (9.10%)	39 (39.40%)	30 (30.30%)	13 (13.10%)	2 (2.00%)
II feel I am kind and empathic with myself, and I forgive myself when I make simple mistakes	7 (7.20%)	25 (25.20%))	37 (37.40%)	19 (19.20%))	9 (9.00%)	2 (2.00%)
I feel unable to relax	7 (7.10%)	10 (10.10%)	50 (50.50%)	21 (21.10%)	10 (10.10%)	1 (1.10%)
I ask others for help when I am feeling stressed	11 (11.10%)	16 (16.20%)	47 (47.50%)	18 (18.20%)	5 (5.00%)	2 (2.00%)

I meet my friends when I am free	16 (16.20%)	25 (25.20%)	36 (36.40%)	16 (16.20%)	5 (5.00%)	1 (1.00%)
I have a supportive social network	22 (22.20%)	29 (29.30%)	35 (35.40%)	12 (12.10%)	-	1 (1.00%)
I talk to others about their needs and seek appropriate support/help for them	26 (26.30%)	47 (47.50%)	22 (22.20%)	1 (1.00%)	-	3 (3.00%)
I empathise with others	35 (35.40%)	42 (42.40%)	19 (19.20%)	-	-	3 (3.00%)
I can sense when the level of stress I experience is high	33 (33.30%)	31 (31.30%)	27 (27.30%)	6 (6.10%)	1 (1.00%)	1 (1.00%)

Table 4 - Distribution of responses to psychosocial and emotional self-care related indicators

Experience of Traumatic Events and/or the Loss of Loved Ones

The majority of survey respondents reported having experienced traumatic events or the loss of someone dear as a result of the crisis.

Condition		Total N (%)
Experienced traumatic events (or loss of someone dear)		75 (75.80%)
Directly experienced traumatic events	In your personal life	48 (64.00%)
	In your work	21 (28.00%)
Heard about or personally watched	In your personal life	40 (53.30%)
Any traumatic events	In your work	66 (66.70%)
Lost an acquaintance		51 (68.00%)

Table 5 - Distribution of responses to having experienced traumatic events and/or loss of someone dear

Self-care on the Organisational and Professional Levels

Self-Care on the Psychosocial and Emotional Levels	Always N (%)	Frequently N (%)	Sometimes N (%)	Rarely N (%)	Never N (%)	Other N (%)
I can set appropriate boundaries at work when it comes to my cases	18 (18.20%)	25 (25.20%)	36 (36.40%)	11 (11.10%))	7 (7.10%)	2 (2.00%)
I set realistic goals, work plans, and timelines	37 (37.40%)	37 (37.40%)	21 (21.20%)	2 (2.00%)	-	2 (2.00%)
I talk to my colleagues at appropriate times about my feelings and my reactions to professional issues	12 (12.10%)	34 (34.30%)	34 (34.30%)	17 (17.20%)	2 (2.10%)	-
I work as part of a team	49 (49.50%)	35 (35.40%)	12 (12.10%)	-	3 (3.00%)	-
I feel I am part of a team	41 (41.40%)	30 (30.30%)	23 (23.20%)	2 (2.00%)	1 (1.10%)	2 (2.00%)
I meet my colleagues and we talk about issues; share problems and solutions	25 (25.30%)	33 (33.30%)	25 (25.30%)	13 (13.10%)	1 (1.00%)	2 (2.00%)
I find it easy to refer cases with specific needs to the appropriate service providers	13 (13.10%)	26 (26.30%)	14 (14.20%)	41 (41.40%)	3 (3.00%)	2 (2.00%)
I feel that the organisation I work at appreciates my work	21 (21.20%)	32 (32.30%)	30 (30.30%)	9 (9.10%)	6 (6.10%)	1 (1.00%)
I have clear roles and responsibilities	25 (25.30%)	42 (42.40%)	24 (24.20%)	3 (3.00%)	5 (5.10%)	-

I find it easy to refer cases to specialised services	13 (13.10%)	26 (26.30%)	13 (13.10%)	43 (43.40%)	2 (2.10%)	2 (2.00%)
I feel that coordination and cooperation among organisations working in my area are not enough	15 (15.10%)	21 (21.20%)	37 (37.40%)	15 (15.20%)	8 (8.10%)	3 (3.00%)
Technical Support, Monitoring and Coaching						
I can easily access the information and resources I need in my work	15 (15.10%)	10 (10.10%)	41 (41.40%)	31 (31.30%)	2 (2.10%)	-
I can easily access technical support and supervision when I need it	14 (14.10%)	12 (12.10%)	40 (40.40%)	28 (28.30%)	5 (5.10%)	-
I receive the technical support I need either from within or outside the organisation at which I work	12 (12.10%)	11(11.10%)	40 (40.40%)	26 (26.30%)	5 (5.00%)	5 (5.10%)
I need technical support, resources, and proper tools to work more effectively	20 (20.20%)	7(7.10%)	39 (39.40%)	24 (24.2%)	2 (2.00%)	7 (7.10%)
Learning, Training, and Response						
The organisation at which I work provides all staff with learning opportunities on stress and its consequences on wellbeing	11 (11.10%)	19 (19.20%)	34 (34.30%)	21 (21.20%)	9 (9.10%)	5 (5.10%)
The organisation at which I work provides all staff with learning opportunities on indicators of severe stress and burnout	9 (9.10%)	19 (19.20%)	33 (33.30%)	21 (21.20%)	11 (11.10%)	6 (6.10%)
The organisation at which I work provides all staff with learning opportunities on how to deal and cope with stress	7 (7.10%)	18 (18.20%)	32 (32.30%)	23 (23.20%)	14 (14.10%)	5 (5.10%)
The organisation at which I work provides me with opportunities to participate in workshops and activities on stress management	8 (8.10%)	23 (23.20%)	30 (30.30%)	20 (20.20%)	11 (11.10%)	7 (7.10%)

Table 6 - Distribution of responses to professional self-care related indicators

The most significant stress is the result of cases faced at work with the following difficulties	Total N (%)
Cases suffering from severe financial difficulties	68 (68.70%)
Cases suffering from medical conditions	33 (33.30%)
Cases suffering from severe mental or psychological conditions (including loss and grief)	62 (62.60%)
Cases of people holding views, convictions, and/or affiliations different from mine	30 (30.30%)
Difficulty in referring cases with specific needs to appropriate service providers	27 (27.30%)
Other	10 (10.10%)

Table 7 - Distribution of responses about the most significant stress-causing cases

As per the study results, the most stressful cases that the study respondents deal with are cases of people suffering from financial difficulties and cases of people suffering from severe mental or psychological conditions (including those struggling with loss and grief).

With respect to their perceptions on self-care and its value, results from most of the survey respondents revealed a significant perceived sense that they need and deserve to engage in self-care activities.

Regarding their perceived role in peace-building, most study respondents reported a strong belief in the value of their contribution and their role in peace-building initiatives.

Need for Self-Care	Total N (%)
Deserve self-care	95 (96.00%)
Need self-care	92 (93.90%)
Role contributes to peace-building	79 (79.80%)

Table 8 - Distribution of responses about the need for self-care

Results Related to Self-Care Needs Drawn From the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment"

Supervision, Coaching, and Technical Support

50% of the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment" survey respondents reported a need for technical support to work more effectively. The majority of respondents (70%) reported receiving some kind of technical support. The majority of those who receive it (90%) do so from the organisations at which they work.

30% of respondents who receive technical support (mainly mental health professionals) also obtain additional and more specialised support from other sources. 10% of respondents receive remote technical support through professional networks or MH experts abroad. 58% of respondents reported that while the technical support they receive is useful, it is not sufficient; they highlighted the need for additional ongoing technical support and supervision in their work.

Referral, Follow-up, and Coordination

Survey respondents pointed out challenges related to referral and follow up of cases. They highlighted the poor coordination between organisations and the obstacles related to the lack of a clear referral system. 25% of respondents reported the absence of referral mechanisms and referral systems within their organisations, while 25% of respondents felt the existing referral system within their organisations is unclear to staff.

Self-Care and Support

MH practitioners demonstrated a need for self-care activities. 50% of survey respondents reported sometimes not being able to relax and sometimes becoming easily irritable. 45% of respondents reported sometimes having a supportive social network and asking others for help.

DISCUSSION

The rapid participatory assessment revealed substantial and diverse self-care needs and challenges faced by humanitarian workers currently working in the psychosocial and mental health fields in Syria, which impair their psychosocial wellbeing on one hand, and their ability to effectively respond to the growing mental health and psychosocial needs on the other.

The study respondents, who are national humanitarian actors working in mental health and psychosocial support, have been substantially affected by the protracted crisis and the ongoing violence in Syria. Besides the stress resulting from their work with the crisis-affected population, the majority of study respondents have experienced traumatic events and/or the loss of someone dear or people they know. Some have experienced displacement and significant changes in their living conditions.

Results indicate that stress is common among humanitarian workers and negatively influences their psychosocial wellbeing. Many respondents described their reduced ability to relax, and many reported disturbances in their eating habits, especially when stressed at work.

Self-care at the physical level revealed some unhealthy behaviours among survey respondents. Many respondents reported that they skip meals, rarely engage in physical activity, rarely miss work when they are sick, and sometimes neglect themselves.

Alcohol consumption, as revealed by the study, is not common among national humanitarian actors. Most respondents reported they never drink alcohol; this might be due to religious beliefs and social norms, especially that consumption of alcohol in Syria has been traditionally low[1].

Results on self-care at the spiritual level revealed positive indicators. The majority of respondents reported always feeling that their work has value and meaning, hoping that things will get better even when they go wrong (indicator of optimism and positive thinking), practicing meditation or praying, and making sure they get time to rest. The results are consistent with findings from the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment," which demonstrated that faith is a significant protective factor; spiritual and religious practices are common coping behaviours among the crisis-affected population. A great amount of evidence exists on the effectiveness of positive religious and/or spiritual coping for many people, both those affected by an illness, a disability, or a crisis, and their caregivers. Religion and spirituality have consistently been identified as factors that promote coping and healing, in addition to facilitating recovery[2].

On the psychosocial and emotional levels, respondents reported some positive indicators of emotional and psychosocial wellbeing and self-care: being frequently aware of their feelings and sensing when they are not feeling well, giving themselves time to review and reflect on what they experience, talking to someone when they are stressed, feeling adequate and appreciating themselves, encouraging themselves and engaging in a positive and supportive inner dialogue, being kind and empathic with themselves, having a supportive social network, being empathic with others, as well as having positive and realistic expectations and motives.

1 World Health Organisation. Syrian Arab Republic. Global status report on alcohol and health – 2014 edition. Geneva: WHO; 2014.
2 International Journal of Emergency Mental Health and Human Resilience. Role of Religion and Spirituality on Mental Health and Resilience: There is enough evidence. 2015.

These results can be linked to the respondents' skills, experience, and work in mental health and psychosocial support, their role as "carers," and the satisfaction they get from that role. Caregivers can derive considerable amounts of satisfaction from knowing that they are helping others through difficult phases in their lives. This is especially the case during an emergency when "caregivers" are from the same country or community and are also affected by the crisis. Many study respondents explained that they believe it is their duty to intervene and help others during these difficult times. They also explained that their work makes them feel they are actively helping their country during the crisis, and contributing to its recovery.

On the other hand, respondents reported some negative indicators on psychosocial wellbeing that require prompt interventions. These indicators include: feeling overwhelmed with stories of people they work with, sometimes feeling emotionally numb, frequently feeling stressed because of the workload, feeling exhausted and frustrated because of work in the humanitarian field, and feeling easily irritable and unable to relax. Those indicators demonstrate the impacts of cumulative stress and compassion fatigue on the psychosocial and emotional wellbeing of humanitarian workers. The stressors humanitarian workers face put them at risk of experiencing traumatic and cumulative psychosocial effects. Although a significant level of stress is likely inescapable, in the short term, these stressors can leave them feeling overwhelmed, insecure, fearful, or chronically fatigued. In the longer-term, these stressors can have more serious effects of burnout, chronic anxiety and depression, apathy, and post-traumatic stress disorder.

Humanitarian workers' strong desire to help others often masks their own needs. Despite their professional skills, they are unaware of stress as a phenomenon that can influence their work ability and performance. Accumulated stress affects not only their motivation, personal morale, and individual performance, but also the quality of care they provide. When humanitarian workers experience burnout or compassion fatigue, their beneficiaries suffer as well; if humanitarian workers neglect their emotional wellbeing and do not care for themselves, their ability to care for others will be diminished or even depleted. Both anecdotal reports and empirical studies have abundantly documented, on various groups of humanitarian workers, the negative emotional consequences of exposure to these stressors.

Burnout, which refers to work-related feelings of hopelessness, emotional exhaustion, and being overwhelmed, may result from work environments that involve excessive workloads and little support. Compassion fatigue, which refers to evidence of secondary traumatisation, is a term also used to refer to changes in feelings toward beneficiaries, loss of interest, compassion, or work satisfaction – in addition to increasing self-doubt about one's abilities or choice of profession[3]. Compassion fatigue is caused by empathy. It is the natural consequence of stress resulting from caring for and helping traumatised or suffering people. It involves a preoccupation with an individual or his/her trauma, and it does not require being present at the stressful event. It is extremely important to encourage humanitarian workers to recognise and accept symptoms and to commit to addressing personal issues.

Concerning research on the needs of humanitarian workers in Syria, apart from this assessment, to date, there are no studies exploring risks to their mental health and psychosocial wellbeing or assessing their psychosocial and self-care needs and resources. The psychosocial and self-care needs of those workers are usually overlooked.

With respect to self-care at the organisational and professional levels, results indicated good self-care skills related to work, such as the humanitarian workers' ability to set appropriate boundaries with the cases and their ability to set realistic goals, timelines, and work plans.

However, the study revealed significant stressors related to work. Weak coordination among stakeholders, insufficiency in technical support and supervision, insufficiency of available and appropriate resources and information, and the poor referral system, along with the humanitarian workers' stress at the personal and professional levels, were among the main stress factors identified by study respondents.

Throughout this study and the parallel study by ABAAD on the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment," MHPSS workers pointed out to additional stress at work resulting from the need for technical support, supervision, and coaching. Some reported receiving some form of technical support (mostly social workers, psychologists, and counsellors who reported receiving technical support from within the organisation at which they work). However, the majority of respondents reported that the technical support they receive is not sufficient. Moreover, many MHPSS practitioners highlighted the challenges related to receiving technical support from international mental health experts. The most prominent obstacles are the language barrier, in addition to the need for more regular and culturally-specific technical support.

Coordination among organisations working in the MHPSS field, and between the latter and other existing service providers in Syria is generally weak, as reported by most study respondents (results consistent with those from the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment"). There is no established system of referral, and usually, referral is done by MHPSS practitioners through their own personal networks. Consequently, case follow-up is usually inexistent.

At the level of agencies, the main self-care needs identified were related to the lack of proper and adequate interventions to mitigate stress among staff. Survey results indicated significantly poor staff-care initiatives, activities, and protocols within the organisations at which they work. There is a significant need for appropriate and regular staff-care and psychological support interventions. Staff-care activities are crucial to help workers deal with their own stress and avoid, or at least manage, some of the severe stresses and traumas that potentially arise from doing their work. The purpose of staff care is to create a healthy and productive workforce; to strengthen wellbeing among staff and improve the quality of their work by promoting emotional, cognitive, spiritual, and physical health. Strengthening staff well-being includes self-care and institutional responses to stress in order to support those working in difficult conditions, dealing with vulnerable cases, and being regularly exposed to human suffering and tragic stories. Very few study respondents reported some staff-care activities conducted by their respective organisations. However, even on the rare occasions that activities aimed at alleviating the staff's stress are conducted, survey respondents described them as "stressful" because they are not planned appropriately and are conducted during weekends or holidays.

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3 Antares Foundation. Managing stress in humanitarian workers Guidelines for good practice, July 2006

In Syria, there is lack of resources on self-care, and a scarcity of self-care and staff-care trainings and stress-management activities. With respect to training, a few mental health professionals who participated in this study mentioned workshops on stress-management conducted for UNRWA staff. However, study respondents referred to a strong need for learning opportunities on recognising signs and sources of stress, understanding the consequences of cumulative stress and its impacts on wellbeing, recognising indicators of severe stress and burnout, and learning ways of dealing with stress (stress management).

The only available resource that includes information on stress management and self-care is the WHO Psychological First Aid Guide[4] for Field Workers and the Facilitator's Manual for Orienting Field Workers, a resource for first line Field and Aid Workers as well as MH practitioners engaged in emergency responses (critical incidents). PFA is not a clinical or specialised intervention but an approach to better function as a helper in a disaster situation and to "do no harm," but rather foster a safe, positive, and supportive environment for people who are affected. PFA is a non-intrusive way of providing psychosocial support and linking people to basic services. PFA training includes information on stressors such as loss and grief, reactions to stressful events, information on how to listen in a supportive and empathic way, information on how parents can help children cope, means of linking people to needed services, and how to know when and how to refer someone who is experiencing more severe distress (e.g. significant impairment in daily functioning, danger to self or others). PFA training also includes a module of self-care for helpers. There is a need for PFA in conflict and crisis situations as people are often poorly prepared, and are thus unsure of how to respond to those in distress.

Some of the humanitarian workers who participated in this study are not aware of this resource, and the majority pointed out the pressing need for contextualised resources in Arabic on self-care and stress management to help them personally, and to assist them in facilitating self-care sessions for other staff.

Among the obstacles MHPSS workers identify as standing in the way of self-care are lack of energy, too many responsibilities, time constraints, and the fear of appearing weak or vulnerable. However, most of the study respondents reported that they need to promote their self-care practices and that they deserve to engage in self-care activities.

Regarding their perceived role in peace-building, most study respondents reported a strong belief in the value of their contributions towards and roles in peace-building initiatives. These results are consistent with results on self-care at the spiritual, psychosocial, and emotional levels, where respondents reported both, a strong belief in the value of their work, as well as getting satisfaction from their work.

According to the study results, the most stressful cases that study respondents deal with are cases of people suffering from financial difficulties and cases of people suffering from severe mental or psychological conditions (including those struggling with loss and grief).

The humanitarian crisis in Syria has resulted in a massive depletion of resources, forced displacement, loss of or separation from family members and friends, deterioration in living conditions, lack of security, and lack of basic needs and services, among other needs. The study respondents, who are national MHPSS workers, who have been affected by the ongoing crisis in their country, many of whom have limited (1-3 years) work experience in the humanitarian field, and who have diverse capacity needs (demonstrated by the "Capacity Needs and Resources of MH Practitioners Rapid Participatory Assessment") can be greatly influenced by the cases they work with, identify with the crisis-affected people, and may feel helpless when faced with the great levels of need.

4 15WHO, Psychological First aid: Facilitators' manual for orienting field workers. 2013; http://apps.who.int/iris/bitstre am/10665/102380/1/9789241548618_eng.pdf; for a (non-official) Arabic version see: MHPPS.net Website, Arabic translation of PFA Facilitator's Manual (2013) slides, for use when training on the PFA Guide for Fieldworkers (2011), http://mhpss.net/?get=242/13926 30443-20131020DRAFTLSPFAFGuideSlides17Oct2013Arabic.ppt

CONCLUSION AND RECOMMENDATIONS

The diverse needs of MHPSS practitioners currently working in Syria and the challenges they face in their work necessitate coordinated and well-planned interventions, in addition to a strategy on staff-care to ensure that humanitarian workers can access psychosocial support services when needed.

Although stress is intrinsic to humanitarian work, some of the stress experienced by humanitarian workers can be prevented or reduced. Similarly, the effects of stress on individual staff members can be mitigated or responded to by actions undertaken by humanitarian agencies. Stress management is a necessity rather than a luxury, and should be given more attention both by individual workers and by humanitarian agencies. Both humanitarian workers as individuals and humanitarian agencies share the responsibility of addressing stress, for health and for good practice reasons. Ultimately, beneficiaries who are affected by humanitarian crises will also benefit.

Promoting staff wellbeing includes self-care and institutional responses to stress, tailored for humanitarian workers in particularly difficult and stressful environments. The purpose of promoting staff well-being is to create a healthy and productive workforce. Resilience must not be assumed as a given quality that all aid workers possess in any situation. There is room for improvement in enhancing resilience factors and containing causes of vulnerability. Finally, it must be recognised that responsibility for aid workers' wellbeing is shared between the individual and the organisation[1].

Psychological first aid should also be immediately available to workers who have experienced or witnessed extremely distressing events.

Agencies need to share their knowledge and promote cross-cultural learning to create "best practices," especially for smaller relief organisations that have fewer resources[2].

Humanitarian aid organisations bear a dual responsibility. They must effectively carry out their primary mission and, at the same time, they must protect the wellbeing of their staff. The agency has a responsibility, consistent with its humanitarian objectives, to foster resiliency and strengthen human capacity. The organisation and its policies play a key role by creating conditions that not only reduce the risk of burnout and compassion fatigue, but also promote healthy, more effective workers.

To respond to the different needs of MHPSS practitioners in Syria, including the self-care needs, it is important to activate an MHPSS taskforce to establish a long-term MH strategy and coordinated activities that aim at responding to the various needs, including self-care needs of humanitarian workers.

Specific percentages of programme budgets must be dedicated to staff-care activities that aim at providing regular support to humanitarian workers.

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1 http://www.dochas.ie/Shared/Files/4/resilience-of-aid-workers.pdf
2 The Applied Anthropologist, No. 2, Vol. 31, 2011, pp. 49 – 53

Additional efforts should be made to improve coordination between organisations and service providers, establish a clear referral system and ensure proper case management and follow up. Moreover, efforts need to be made to secure ongoing, sufficient, and culturally sensitive technical support and supervision of MHPSS practitioners.

To prevent and reduce the risk of burnout and compassion fatigue in staff members, organisations should focus on:

- Creating an open environment where staff members have a venue for mutual support. Encouraging staff members to meet with supervisors to talk about how they are affected by their work.
- Encouraging peer support within the organisation or with other humanitarian workers.
- Offering training that educates humanitarian workers about burnout and compassion fatigue and how to recognise the symptoms.
- Sharing the caseload among team members, particularly the most difficult cases.
- Making time for social interaction among teams.
- Organising appropriately planned social events and retreats away from the workplace.
- Encouraging healthy self-care habits such as good nutrition, sleep, and taking work breaks.
- Offering training that focuses on self-care and a balanced lifestyle as a way to promote resilience to stress.

ANNEXES

ANNEX I - TOOL ON RAPID ASSESSMENT OF SELF CARE NEEDS AND RESOURCES

"This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union.

The assessment aims at:
  • **Studying the strategies and forms of self-care among humanitarian workers who work in the field of psychosocial support with individuals and families affected by the Syria crisis.**
  • **Studying the needs in the field of self-care and identifying the existing gaps and obstacles as well as the existing and available resources that can be built upon.**

This assessment tool is anonymous and does not require specifying the name of the person filling it or any information pertaining to his/her identity. The project team respects the privacy and confidentiality of all study participants. The project team is only seeking information that can be useful to understand the self-care needs and resources."

Thanks for your cooperation,

The project team

General Information

1- Nationality   ◯ Syrian   ◯ Palestinian-Syrian

◯ others (please specify, if possible) _____

2- Age ◯ less than 18years ◯ 18-24years ◯ 25-34years ◯ 35-45years ◯ above 45years

3- Sex   ◯ Male   ◯Female

4- Region   ◯ Syria please specify governorate

◯ Lebanon please specify governorate

5- Educational level ◯ elementary   ◯ intermediate   ◯ secondary   ◯ university

◯ vocational training   ◯ others, please specify_____

6- Type and nature of work ◯ psychiatrist   ◯ psychologist/psychotherapist

◯ psychosocial animator   ◯ social worker   ◯ other, please specify

7- Number of working hours (approximately) _____

General Conditions Affecting Psychosocial Wellbeing

1- Did you experience displacement and change of residence?

◯ yes   ◯ no

• If the answer is yes, please specify the type of displacement

◯ internal   ◯ external

• If the answer is yes, please specify duration of displacement

◯ less than a year   ◯ 1-3years   ◯ more then 3years   ◯ others, please specify _____

2- Residence:

Do you live … ◯ alone   ◯ with your family   ◯ with others, please specify _____

• How many rooms is your place of residence consisted of? _____

• How many individuals live in your place of residence? _____

3- Duration of work in the humanitarian field in Syria (and other emergency settings)

◯ less than a year   ◯ 1-3years   ◯ 4-6years

◯ more then 6years   ◯ other, please specify _____

4- Do you have previous experience in humanitarian voluntary work before your current work?

◯ yes   ◯ no

If your answer is yes, please specify years of previous experience _____

The Concept of Self-Care

In your opinion, what is self-care (what it means, is it necessary, what is its importance…)?

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Self-Care on the Physical Level

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and Explanation
1. I make sure I eat healthy food						
2. I forget to eat my food (I skip meals)						
3. I engage in physical activity (sports, walking…)						
4. I get enough sleep						
5. I drink alcohol						
6. I have coffee (or other stimulants) excessively						
7. I smoke						
8. I make sure I do not go to work when I am sick						
9. I get medical care when I am sick						

10. I neglect myself						

11. Do you tend to eat more or less than usual when you are stressed at work?	⚪ yes ⚪ no	Please explain
12. Do you tend to smoke (more or less than usual) or drink alcohol (more or less than usual) when you are stressed at work?	⚪ yes ⚪ no	Please explain

Self-Care on the Spiritual Level

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and Explanation
1. I feel that my work has meaning and value						
2. I practice meditation or/and pray						
3. I make sure I get time to relax/rest						
4. Even when things go wrong, I see (and hope) it will get better						
5. How do you describe the value of your work (your thoughts and feelings regarding the value of your work)	Please explain briefly using some key words					

Self-Care on the Psychological and Emotional Levels

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and Explanation
1. I am aware of my feelings and I can sense when I am not feeling well						
2. I give myself time to review and reflect on what I experience						
3. I practice assertiveness and thereby say no to extra responsibilities when I am not able to carry more						
4. I express and talk to someone when I am feeling stressed						
5. I appreciate myself and feel I am adequate						
6. I encourage myself and practice supportive inner dialogue or self-talk (words of encouragement, remind myself of my strengths…)						
7. I have positive and realistic expectations and motives						
8. I feel that I can make a positive change through my role in life						

9. I feel overwhelmed with stories of people I work with					
10. I feel emotionally numb as if I have no feelings					
11. My work and what I do make me feel satisfied					
12. I get satisfaction from my ability to help others					
13. I feel stressed because of the workload					
14. I feel exhausted because of my work in the humanitarian and support fields					
15. I feel frustrated because of my work in the humanitarian and support fields					
16. I feel that I am easily irritable					
17. I feel I am kind and empathetic with myself and forgive myself when I make simple mistakes					
18. I feel unable to relax					
19. I ask others for help (friends, family members, others) when I am feeling stressed					

20. I meet my friends when I am free					
21. I have a supportive social network					
22. I talk to others about their needs and seek appropriate support/help for them					
23. I empathize with others					
24. I can sense when the level of stress I experience is high					

25. How does stress influence you? What are its most common manifestations?	Please explain...
26. What do you usually do to handle stress? What activities and behaviours you implement to let stress out?	Please explain...
27. Have you experienced traumatic events (or loss of someone dear)?	◯ yes ◯ no If your answer is yes, please answer the following (and you can tick more than one option) ◯ **You have directly experienced/lived traumatic events** ◯ In your personal life ◯ In your work ◯ **You have witnessed violent events** ◯ In your personal life ◯ In your work ◯ **You have lost someone you know (specify)**

Self-Care at the Organisational and Professional Levels

Statement	Never	Rarely	Sometimes	Frequently	Always	Other Comments and Explanation
1. I can set appropriate boundaries at work with the cases I work with (ex: no phone calls after work hours…)						
2. I set realistic goals, work plans and timelines						
3. I talk to my colleagues at appropriate times about my feelings and my reactions to professional issues						
4. I work as part of a team (in cooperation with a team)						
5. I feel I am part of a team						
6. I meet my colleagues and we talk about issues, share problems and solutions						
7. I find it easy to refer cases with specific needs whom I work with to appropriate service providers						
8. I feel that the organisation I work at appreciates my work						
9. I have clear roles and responsibilities						
10. I find it easy to refer cases to specialised services						
11. I feel that coordination and cooperation among organisations working in my area are not enough (please explain)						
Technical support, monitoring and supervision						
1. I can easily access information and resources I need in my work						
2. I can easily access technical support and supervision when I need it						
3. I receive technical support I need from within or outside the organisation I work in (please specify)						
4. I need technical support and resources and proper tools to work more effectively (please specify)						
Learning, training and response						
1. The organisation I work at provides all staff learning opportunities on stress and its consequences n wellbeing						

2. The organisation I work at provides all staff learning opportunities on indicators of severe stress and burnout					
3. The organisation I work at provides all staff learning opportunities on how to deal with stress and cope with it					
4. The organisation I work at provides me with opportunities to participate in workshops and activities on stress management					

I find that the most significant stress I experience comes as a result of my work with cases facing the following difficulties:	You can tick more than one option : ◯ cases suffering from severe financial difficulties ◯ cases suffering from medical conditions your personal life ◯ cases suffering from severe mental or psychological conditions (including loss and grief) ◯ cases of people holding views, convictions and affiliations different from mine ◯ difficulty in referring cases with needs to appropriate service providers ◯ other, please explain ...

The Need for Self-Care

A) After all you have thought about and answered, do you feel that:

1- You deserve self-care?   ◯ yes   ◯ no

2- You need self-care?   ◯ yes   ◯ no

Why? Please explain ...

B) What are the most important protective and supportive factors that help you deal with stress and overcome difficulties? (personal factors, social factors, others)

C) How do you define resilience? What contributes to it?

D) With respect to peace-building:

1- How do you define peace-building initiatives?

2- Do you think you have a role in peace-building? Yes - no

3- If yes, please describe how?

ANNEX II - GUIDANCE NOTE ON THE USE OF THE ASSESSMENT TOOL

Objectives and Structure of the Guidance Note

This document aims at providing practical information, necessary advice, and guidance to ensure the proper and effective use of the "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment" tool. It sheds light on the basic principles that govern the assessment process. It also provides information related to each section of the assessment tool, describing its objectives and relevance. The guidance note serves to explain the objectives and value of the assessment exercise and guarantee informed consent from those participating in the assessment.

Objectives of the "Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment"

This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union.

The assessment aims at:
- Studying the strategies and forms of self-care among humanitarian workers who work in the field of psychosocial support with individuals and families affected by the Syria crisis.
- Studying the needs in the field of self-care and identifying the existing gaps and obstacles as well as the existing and available resources that can be built upon.

"BelSalameh" aims at supporting individuals (women and men) by enabling them to play an effective and active role in promoting resilience and healthy coping on the individual and societal levels, and to contribute effectively in promoting opportunities for peace building in their communities.

This assessment is based upon the profound belief, acknowledgement, and appreciation of the fundamental role played by humanitarian workers. It is also based upon the realisation of the enormous strains on those working in the psychosocial and mental health fields and providing support and care to people in need.

The assessment shall inform different consequent activities such as resource development and trainings, to help support humanitarian workers and improve their work.

Professional and Ethical Considerations Governing the Assessment Process

The assessment of needs and resources is considered a fundamental activity for the proper planning, implementation, monitoring, and evaluation of interventions. It is necessary for identifying existing gaps and needs that require response as well as existing resources and opportunities that can be used and built upon. In emergencies, findings from needs assessments make good decision-making possible. They help put information together to build a full picture of the needs of the disaster-affected community.

There is a set of ethical principles that the assessment team should abide by to ensure a proper assessment process that respects and protects the research team as well as the research participants, causing No Harm[1]. Consideration should be given to the ethical issues regarding ownership and use of information, confidentiality, raised expectations versus unmet needs, and the dangers of stigmatising groups and communities. We present here some main principles:

Objectivity

Including reliability of information and avoidance of bias or modifying information as per the researcher's subjective interpretation of results. Including reliability of information and avoidance of bias or modifying information as per the researcher's subjective interpretation of results.

Confidentiality and Privacy

Including the protection of all information provided by the study participants, dealing with the information in a professional manner and limiting the use of the collected information to the study. It also includes avoiding sharing of information with others outside the assessment study context and thereby respecting the privacy of participants.

Informed Consent

The participation in the study should be voluntary. It is necessary to properly explain the purpose of the study, the topic it tackles, its importance and the different steps it includes and getting the participant's consent at the beginning of the assessment.

Trust

An essential element of any assessment process. It is necessary to build trust with the assessment study participants and ensure its respect in all the assessment phases.

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1 ACAPS (2014) Humanitarian Needs Assessment: The Good Enough Guide, The Assessment Capacities Project (ACAPS), Emergency Capacity Building Project (ECB) and Practical Action Publishing, Rugby, UK.

Truthfulness and Accuracy

Trustworthiness of information, trust that the results reported by others are valid and that no bias influences the results.

Safety

Includes protecting the study participants from any potential physical, psychological, emotional, social or economic harm, or even causing any suffering as a result of the assessment.

Notes on the Different Sections of the Assessment Tool

The assessment tool is composed of different complementary and related sections.

Section One: General Information

This section includes a variety of questions about the study participants regarding age, sex, nationality, geographical location, educational level, and the nature and type of work. It also includes questions about the different activities implemented by the psychosocial and mental health workers and questions assessing the participants' workload.

Section Two: General Conditions Affecting Health and Psychosocial Wellbeing

This section includes questions about the main factors that might influence the humanitarian workers' health and psychosocial wellbeing. This includes factors such as living conditions, residency and crowding, displacement, and experience in the field of humanitarian work.

Section Three: Concept of Self-care

This section aims at exploring the respondents' awareness on self-care and its value. It aims at exploring respondents' knowledge and perceptions on self-care.

Section Four: Self-Care on the Physical Level

This section includes different questions that aim at identifying respondents' self-care practices concerning their physical health. Maintaining a balanced diet, engaging in physical activities, keeping a proper sleeping pattern, and getting some rest are all indicators of self-care on physical level.

Section Five: Self-Care on the Spiritual Level

This section includes questions that aim at exploring indicators of self-care on the spiritual level that usually help an individual cope with stress using healthy strategies.

Section Six: Self-Care on the Emotional and Psychological Levels and the Coping Strategies

This section tackles different aspects of emotional wellbeing and ways of coping with stress. The questions in this section aim at exploring the stress factors as well as the protective and supportive factors present in the respondent's life. The questions also tackle coping behaviours usually adopted by the respondent.

Section Seven: Self-Care on the Organisational and Professional Levels

This section includes different questions on stress and protective factors present in the respondents' life at the professional level. It aims at exploring the respondents' needs affecting psychosocial wellbeing at the level of work as well as the organisation's staff-care strategies.

Section Eight: The Need for Self-Care

The survey presents diverse questions on self-care that would encourage the respondents to think of their self-care needs and practices. This section aims at encouraging the respondents to assess their need for self-care and to reflect on their perceptions regarding self-care.

This section also aims at exploring the respondents' awareness of their roles in contributing to peace-building and promoting resilience within their community. These questions aim at exploring the respondents' outlook on the future and on their role in promoting community resilience and building on the existing assets and resources for a better future.

ANNEX III - INFORMED CONSENT FORM

Self-Care Needs and Resources of MHPSS Workers in Syria
Rapid Participatory Assessment

This rapid participatory assessment is part of the "BelSalameh" project being implemented by ABAAD and supported by the European Union.

The assessment aims at:

- Studying the strategies and forms of self-care among humanitarian workers who work in the field of psychosocial support with individuals and families affected by the Syria crisis.

- Studying the needs in the field of self-care and identifying the existing gaps and obstacles as well as the existing and available resources that can be built upon.

The assessment shall inform different consequent activities such as resource development and trainings, to help support humanitarian workers and improve their work.

This assessment tool is anonymous and does not require specifying the name of the person filling it or any information pertaining to his/her identity. The project team respects the privacy and confidentiality of all study participants. The project team is only seeking information that can be useful to understand the self-care needs and resources.

I have the right to stop filling the survey when I feel the need to. I also have the right to review the results of the study when it is ready.

I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.

Date _____

Participant's Signature _____

Thank you for your cooperation,

The assessment team

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LIST OF ACRONYMS

ABAAD	"Dimensions"
CBO	Community-based organisation
HIS	Health Information System
IASC	Inter-Agency Standing Committee
IDP	Internally displaced persons
INGO	International non-governmental organisation
IOM	International Organisation for Migration
MH	Mental health
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
mhGAP	Mental Health Gap Action Programme
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide for management of mental, neurological and substance use disorders in non-specialised health settings
NGO	Non-governmental organisation
PHC	Primary healthcare
PFA	Psychological First Aid
PiN	People in need
PTSD	Post-Traumatic Stress Disorder
SHARP	Syrian humanitarian assistance response plan
SARC	Syrian Arab Red Crescent
SGBV	Sexual and gender based violence
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WG	Working Group
WHO	World Health Organisation

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