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Article

Evaluation of one mental health/psychosocial intervention for Syrian refugees in Turkey

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The town of Kilis in Kilis province, south-central Turkey is harboring about 100.000 urban Syrian refugees from the three-year-old Syrian conflict alongside its 82,000 Turkish residents. Malteser International and International Blue Crescent implemented mental health/psychosocial support intervention with the objective to improve well-being and resilience of urban Syrian refugee population. In this study, the authors presented and evaluated the effectiveness of this intervention. It was delivered to Syrian refugees in the field hospital, outpatient health centre and community skills centre in the town of Kilis. Data collection methods included HESPER survey and quantitative surveys using well-being and resilience scale. The results showed improvement of resilience and well-being of the targeted population. The intervention was effective in an urban context. Further evaluation of this intervention is needed, preferably in a form of prospective longitudinal cohort study with a control group of Syrian refugees that receives no intervention.

Key words: Turkey, community-based MHPSS intervention, urban Syrian refugees, project description, project evaluation, well-being, resilience.

INTRODUCTION

Since March 2011 until August 2014, more than 847.000 Syrian refugees have been registered in Turkey, of whom 220.000 are accommodated in camps. According to the monthly update from UNHCR for August 2014, there are 220.439 Syrian refugees registered with Turkish government who live in the official refugee camps and 619.466 registered Syrian refugees who live outside refugee camps (UNHCR, 2014). According to the Prime Ministry's Disaster and Emergency Management Presidency (AFAD), the total number of registered Syrian refugees inside camps is about 219.227, distributed in 22 camp sites in ten provinces: Hatay, Sanliurfa, Gaziantep, Kahramanmaras, Osmaniye, Mardin, Adana, Adiyaman, Malatya and Kilis (UNHCR, 2014). According to the UNFPA (2014), there are an estimated 580.230 Syrian refugees living outside camps in cities in the south-eastern region and in major cities in Turkey.

The official number of Syrian refugees in the town of

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Kilis is estimated to be about 80.000 and is almost the same as the local population. It is creating a significant impact on local resources and services (UNHCR, 2014a). The unofficial estimate is that in October 2014, there were already about 100.000 urban Syrians refugees in Kilis.

Mental health/psychosocial support needs/services for urban Syrian refugees in Kilis

The International Non-Governmental Organizations (INGOs) Malteser International (MI) and International Blue Crescent (IBC) carried out the brief assessment of mental health/psychosocial support (MHPSS) needs and services in the town of Kilis in July 2013. The assessment showed that a significant number of urban Syrian refugees previously affected by conflict in Syria suffered from stress/distress, and some of them also from more severe mental problems, mostly depression (Budosan, 2013). Multiple studies focused on depression, anxiety and PTSD among conflict-affected populations have found a strong association between exposure to trauma and mental health symptoms (Murthy and Lakshminarayana, 2006). MI and IBC also conducted the Humanitarian Emergency Settings Perceived Needs (HESPER) survey in Kilis between September and December 2013 to find out perceived needs, that is, the most serious problems or stressors of urban Syrian refugees.

"Income or livelihood" was rated by more than two thirds of surveyed refugees (74%) as one of their three most serious problems. Other areas which were named by more than 10% refugees as one of their three most serious problems included: "Clothes, shoes, bedding or blankets" (24,9%); "The way aid is provided" (24.7%); "Being displaced from home" (24.1%); "Place to live in" (21.8%); "Distress" (20.5%); "Education for children" (16.8%) and "Physical health" (10.2%) (Budosan, 2014). According to Miller et al. (2008), it is evident that stressors generated by conflict and displacement, such as inadequate housing, unemployment and changes in family structure-sometimes termed as daily stressors, are important influences on mental health status, if not more important and pressing than the impact of war-related psychological trauma. Doocy et al. (2011) demonstrated dire financial needs and limited availability of assistance for Iraqi refugees in Jordan and Syria. Wellbeing of refugees is greatly attributed to fulfilling basic needs such as sufficient income, shelter and food and these priority concerns were also reported by Medecins Sans Frontieres -MSF (2012).

A small number of INGOs provide interventions to address MHPSS needs of Syrian refugees in the town of Kilis. These interventions target almost exclusively urban Syrian refugee population, because INGOs do not have access to official refugee camps in Turkey. Some organizations like MSF and International Medical Corps - IMC provide services to Syrian population at all four levels of the Inter-Agency Standing Committee (IASC) pyramid (IASC, 2007). According to Meyer (2013), the interventions at different layers within IASC pyramid reinforce each other. The MI/IBC MHPSS intervention was welcomed by all MHPSS other players in Kilis, because of its objective to assist urban Syrian refugees in their coping with daily stressors and increasing their resilience.

This study provides description, evaluation and discussion of this intervention's contribution to improvement of well-being and resilience of urban Syrian refugees in the town of Kilis in the period of September 2013 to October 2014.

METHODS

Setting, provider and participants

MI/IBC started MHPSS intervention in the town of Kilis in September 2013 with, at that time, an estimated population of about 60,000 registered Syrian refugees. The town of Kilis was selected as an area of intervention because of its location close to the Syrian border and therefore a huge influx of Syrian refugees which in October 2014 reached the size of local Turkish population. Being a border town, Kilis has long had a reputation of smuggling and drug trafficking and although this has been apparently reduced, even today cigarettes, spirits and cheap electrical items can be bought at low price. With the influx of Syrian refugees as a cheap labour force, a lot of construction has been taking place in Kilis, and many Syrian refugees work for low wages in many Kilis shops and restaurants.

According to the local Turkish authorities, additional health services for urban Syrian refugees were one of the priorities for humanitarian assistance in order to reduce pressure on local healthcare system. In 2012, Kilis authorities invited INGO MI to support local health system with the opening of a field hospital. MI decided to implement its program in Kilis in a cooperation with IBC which already had their program present on the ground.

MI's headquarters selected one expatriate psychiatrist with extensive post-disaster experience as Mental Health (MH) Advisor and one MH consultant. The management staff of IM and IBC in Kilis selected local MHPSS team through an interview process in the field; two psychologists (one male and one female), one social worker and four community-level workers. The main criterion for their selection was that they were urban refugees of Syrian nationality living in Kilis. Personal characteristics and professional qualifications were considered as well. One Syrian translator has been attached to MHPSS team to help expatriates in their communication with other team members and also with the translation of training materials from English into Arabic.

MI/IBC selected direct beneficiaries based on inclusion criteria determined by MHPSS team and the major donor - Bundesministerium Für Wirtschaftliche Zusammenarbeit (BMZ). The main inclusion criterion was that a beneficiary belonged to the urban Syrian refugee population in Kilis. The host population in Kilis could be also included as beneficiaries if they had need for MHPSS intervention which could not be provided by local health and/or social services. Demographic characteristics of urban Syrian refugee population in Kilis are presented in Table 1.

Table 1. Demographic characteristics of HESPER survey participants (N=381). Figures are displayed as number of participants (% in brackets), or averages (means).

Sex			
Men			232 (60.9 %)
Women			149 (39.1 %)
Age (years): mean (SD)			34. 7 (12.1)
10-19			24 (6.3%)
20-29			132 (34.6%)
30-39			98 (25.7%)
40-49			69 (18.1%)
50-59			37 (9.7%)
60+			21 (5.5%)
Marital status	**Men**	**Women**	Total
Married	112 (29.4%)	115 (30.2%)	227 (59.6%)
Unmarried	91 (23.9%)	45 (11.8%)	136 (35.7%)
Divorced	6 (1.6%)	12 (3.1%)	18 (4.7%)
Average number of children			4
Level of education	**Men**	**Women**	Total
Illiterate (no formal education)	10 (2.6%)	9 (2.4%)	19 (5 %)
Primary school	89 (23.4%)	62 (16.3%)	151 (39.6%)
Secondary school	48 (12.6%)	51 (13.4%)	99 (26 %)
University degree	53 (13.9%)	59 (15.5%)	112 (29.4%)
Employment status	Men	Women	Total
Employed	109 (28.6%)	59 (15.5%)	168 (44.1 %)
Unemployed	100 (26.2%)	113 (29.6%)	213 (55.9%)
Religion			
Muslim			381 (100 %)
Average time displaced			15 months

Intervention

Objective

The main objective of this study was to evaluate the effectiveness of community-based MHPSS intervention for urban Syrian refugees in Kilis aiming to improve their well-being and resilience.

Design

The intervention started in September 2013 and it is still ongoing. The three main intervention stages included: 1) MHPSS training of MHPSS team and non-specialized healthcare providers; 2) psychological/ MH intervention and 3) Social intervention (Table 2). After the initial MHPSS training in August 2013, MHPSS team started to provide psychological assistance in the field hospital which opened in September 2013. With the opening of an outpatient health centre at the transitional refugee camp in October 2013, two psychologists divided their work between the field hospital and outpatient healthcare centre. This centre closed in November 2013 because the Turkish government relocated Syrian refugees to another location. When community skills centre opened in November 2013, one psychologist, social worker and all community workers relocated to the centre. Syrian volunteers who offered their assistance to help with the activities of community skills centre started to organize different social activities according to their expertise.

Evaluation

Only the initial training of MHPSS team was evaluated with pre-post-test. The test was composed of 10-item 5-point Likert scale to evaluate perceived competencies and 10-item multiple choice knowledge test. It was designed by MH Advisor and translated by a Syrian translator into Arabic. Tested categories were related to the content of MHPSS training (Table 2). The face validity of the test, that is, whether the test seemed to be good enough to test MHPSS knowledge, was determined by MHPSS team who read all the test questions. The content validity of test, that is, checking the content of the test against content of relevant tests previously used and described in the literature in similar settings was determined by MH Advisor, and it was satisfactory. The actual on-the-job

Table 2. Titles, objectives and content of activities of MHPSS intervention.

S/N	Title of the activity	Objective of the activity	Content of the activity
1.	MHPSS training of MHPSS team and non-specialized healthcare providers	To become familiar with MHPSS, most common MH conditions and MHPSS interventions in communities and non-specialized healthcare setting	Mental Health / Psychosocial Support in Disaster Settings, Definition of Mental Health / Psychological First Aid, Coping and resilience, General principles of care, Communication skills, Psychosocial interventions, Five areas of disability, Family and Peer-support, Problem-solving therapy, Working with children, Common and severe mental health conditions, Psychiatric medications
2.	Psychological/MH intervention	To provide emphatic and non-intrusive practical care and support by assessing needs and concerns and helping people to connect to information, services and social supports thereby protecting people from further harm; to identify, treat and refer beneficiaries with severe MH conditions to specialists	Psychological first aid for patients in the field hospital and outpatient healthcare centre and their families, Psychological first aid to beneficiaries of community skills centre and their families Identification, treatment and referral of patients with severe MH conditions to specialists
3.	Social intervention	To mobilize community members and empower them to restore social cohesion/trust and build their capacity to take charge of their own health and well-being.	Educational activities (English, Turkish language, computer classes, Health education, First Aid, Vocational activities (cooking, electric repairs, journal & media design, graphic design, beauty course), Recreational activities (children activities, cinema, music, trauma relieving exercises-TRE).etc.

implementation of MHPSS knowledge/skills was observed and evaluated through occasional supportive supervisions in the field conducted by MH Advisor and MH Consultant.

A 17-item, 5-point Likert well-being scale was based on the Camberwell Assessment of Needs Short Appraisal Schedule (King's College London, 2014). It provided valuable information with regards to the satisfaction of beneficiaries with different aspects of their well-being (Table 3).

A 7-item, 7-point resilience scale was a modified 14-item resilience scale (Gail et al., 1987). MH Advisor finalized both scales and the Syrian translator translated them from English into Arabic. No back translation was done because of time pressure to start with evaluation of the intervention.

The local MHPSS team as a representative sample of urban Syrian refugee population in Kilis determined the face validity of scales. All members of MHPSS team read all questions on both scales and agreed that they might be good enough for the evaluation of well-being and resilience of direct beneficiaries. The international staff determined the content validity of scales by checking their content against content of other relevant scales measuring well-being, and resilience, and it was satisfactory.

RESULTS

MHPSS training intervention

The initial MHPSS training resulted in an average improvement of perceived competencies by 12 and 61.6% correct answers on knowledge post-test. The calculated averages were based on individual scores per participant. The results were considered as satisfactory to start MHPSS intervention. The observation of actual on-the-job performance suggested overall good level of cooperation between MHPSS team and non-specialized healthcare providers. Still, there was a gap between results obtained in the training and the practices observed in patient encounters.

MHPSS intervention in the field hospital and outpatient health centre

From November 2013 to October 2014, MHPSS team provided psychological intervention to 1163 beneficiaries in the field hospital and 151 in the outpatient health centre. The MHPSS team performed the evaluation of MHPSS intervention from September 2013 to March 2014 on a randomly selected representative sample of 61 direct beneficiaries. The evaluation of MHPSS intervention implemented from April 2014 to October 2014 was performed by MHPSS team on all beneficiaries who received the intervention. The results were presented

Table 3. Questions on 5-point well-being scale and 7-point resilience scale.

Question No.	5-point well-being scale	7-point resilience scale
1.	How satisfied are you with your life in general?	I agree / disagree with following statement: I usually manage one way or another
2.	How satisfied in general are you with yourself?	I feel that I can handle many things in time
3.	How satisfied are you with your: Physical health?	I can get through difficult times because I have experienced difficulties before
4.	Relationship with friends?	I have self-discipline
5.	Marital relationship?	I keep interested in things
6.	Other close family relationships?	I can usually find something to laugh about
7.	Ability to perform activities of daily living?	My life has meaning
8.	Income / financial situation?	
9.	Legal situation?	
10.	Spirituality/Religion and Culture?	
11.	Housing/living arrangement?	
12.	Educational achievements (formal and informal)?	
13.	Vocational training?	
14.	Engagement in recreational and leisure activities?	
15.	Mental health?	
16.	Use of drugs / alcohol?	
17.	Any other area of your life?	

as averages of evaluated beneficiaries (Table 4).

MHPSS intervention in the community skills centre

From November 2013 to October 2014, MHPSS team provided psychological and social intervention to 1196 beneficiaries in the community skills centre. 42 randomly selected beneficiaries who received this intervention from November 2013 until March 2014 and all beneficiaries who received this intervention from April to October 2014 were evaluated. The results were presented as averages of evaluated beneficiaries (Table 4).

DISCUSSION

As a result of the presented outcome indicators, this study is a valuable contribution to the evidence base on effectiveness of community-based MHPSS intervention for an urban Syrian refugee population. In the Evidence Review Report (Blanchet and Roberts, 2013), it was emphasized that one of key gaps in the area of MHPSS includes evidence on effectiveness of interventions aimed at strengthening participation of affected communities in humanitarian settings and strengthening social support and coping mechanisms at family and community levels. These interventions were also described in Action sheets 5.1 and 5.2 (IASC, 2007). According to Meyer (2013), there is a lack of guidance on how to support MHPSS programs in urban settings and the limitation of many MHPSS interventions worldwide is a lack of outcome indicators in terms of the impact on the real life of people (Perez-Salez et al., 2011). According to Quosh et al. (2013), there is lack of published studies on mental health of Syrian IDPs and refugees.

The study findings showed that objectives of community-based MHPSS intervention were achieved. The average improvement of resilience by 17.1% in all locations from September 2013 to October 2014 was higher than the average improvement of wellbeing of 15.3%. Attributing these results solely to this intervention is however not completely justified as other factors may have contributed as well; other interventions by NGOs, time and gradual adjustment of urban Syrian refugees to life in Kilis.

The initial training of local MHPSS team was only partially successful if compared with other similar trainings described in the literature (Budosan and Jones, 2009; Hijazi et al., 2011). One of the possible explanations could be that training participants were new refugees themselves facing difficult living circumstances and unable to fully focus on acquiring new knowledge/skills.

The supervisions in the field confirmed that MHPSS team provided only PFA (World Health Organization, 2011) and various social interventions (Table 2). Social interventions were important because there is enough evidence that a fertile social context and strengthening community decreases the association between the individual emotional response to adversity and distress

Table 4. Results on well-being and resilience scale before and after the intervention (number of points on a scale) and improvement post- intervention (%)

Location	5-point well-being scale			7-point resilience scale		
	Before (No. of points)	After (No. of points)	Improvement (%)	Before (No. of points)	After (No. of points)	Improvement (%)
Field hospital	2	2.8	16	3	4.2	17.1
Outpatient health centre	2	2.8	16	2.5	3.9	19.9
Community skills centre	2.9	3.6	14	3.7	4.7	14.3
Average **TOTAL**	2.3	3.1	15.3	3.1	4.3	17.1

(The Global Fund, 2014). Although, MHPSS team was able to identify some beneficiaries with severe MH conditions, non-specialized healthcare providers in the field hospital were not confident enough to treat them. In June 2014, the collaboration with IMC resulted in beginning of referrals of such beneficiaries from the field hospital to IMC psychiatrist. By October 2014, ten beneficiaries were given psychiatric medications as a part of their treatment.

The intervention in Kilis followed a needs-based approach (European Commission, 2007). Needs-based approach is important because people with real needs are often overlooked and even ignored in humanitarian settings as they don't have any political voice. The intervention was well integrated within the IASC pyramid (Figure 1) and it followed the approach of integrated programming for well-being (Williamson and Robinson, 2006). A psychosocial approach (Meyer, 2013) was taken during other humanitarian interventions implemented at the first layer of IASC pyramid (Figure 1).

Limitations

MHPSS intervention improved well-being and resilience of targeted population. However, it is impossible to single out which activity contributed most to these outcomes. The mental health component of the intervention was weaker than the psychosocial one because it did not manage to change the actual clinical practices of non-specialized healthcare providers in the field hospital. A lack of technical support of a MH program coordinator on the ground was a limiting factor. MH coordinators on the ground are crucial in steering MHPSS programs around many challenges of MHPSS program implementation (World Health Organization, 2008). A shortage of in-service training and supervision of non-specialized healthcare providers was also an external limiting factor. MH trainings in other countries showed the importance of in-service training (Budosan and Jones, 2009; Hijazi et al., 2011), which can lead to increased demand for and access to MH services (Ventevogel et al., 2012). Shared care model (World Health Organization, 2008) was implemented to a certain extent only later during the intervention by establishing collaboration with IMC psychiatrist.

It was not feasible to implement longer and/or more structured psychological techniques because of limited duration of stay of beneficiaries in the field hospital (on average two weeks) and a lack of privacy in all project locations. PFA was a main psychological technique used by MHPSS team in spite of an ongoing search for evidence on its effectiveness (Schultz and Forbes, 2013). On average, two sessions of PFA were delivered per beneficiary. Culturally appropriate guidelines to diagnose and treat stress related disorders and depression were introduced in June 2014. Use of culturally appropriate instruments in Syria was previously described in the paper of Quosh (2013).

Strengths

The intervention filled existing gaps in the provision of MHPSS services to urban Syrian refugee population in Kilis and it was well-integrated within the local health/social welfare system and Syrian refugee community. Although, it did not target some needs/daily stressors of refugees which ranked high according to HESPER survey (income & livelihood, place to live in), it increased resilience of beneficiaries and helped them to better cope with existing stressors. Resilience has been described in a literature as a protective factor against the development of psychopathology among refugees (Arnetz et al., 2013). Quosh et al. (2013) reported less attention to resources, resilience and coping perspectives of Syrian refugees and displaced people in the available literature.

The intervention strengthened the social network of urban Syrian refugees in Kilis and they were mobilized and empowered, rather than only assisted. Syrian volunteers joined the centre to help and conduct various social activities. Good coordination with the UN organizations, (I) NGOs and local Turkish government was achieved. The good coordination among humanitarian actors on the ground is of utmost importance in order to

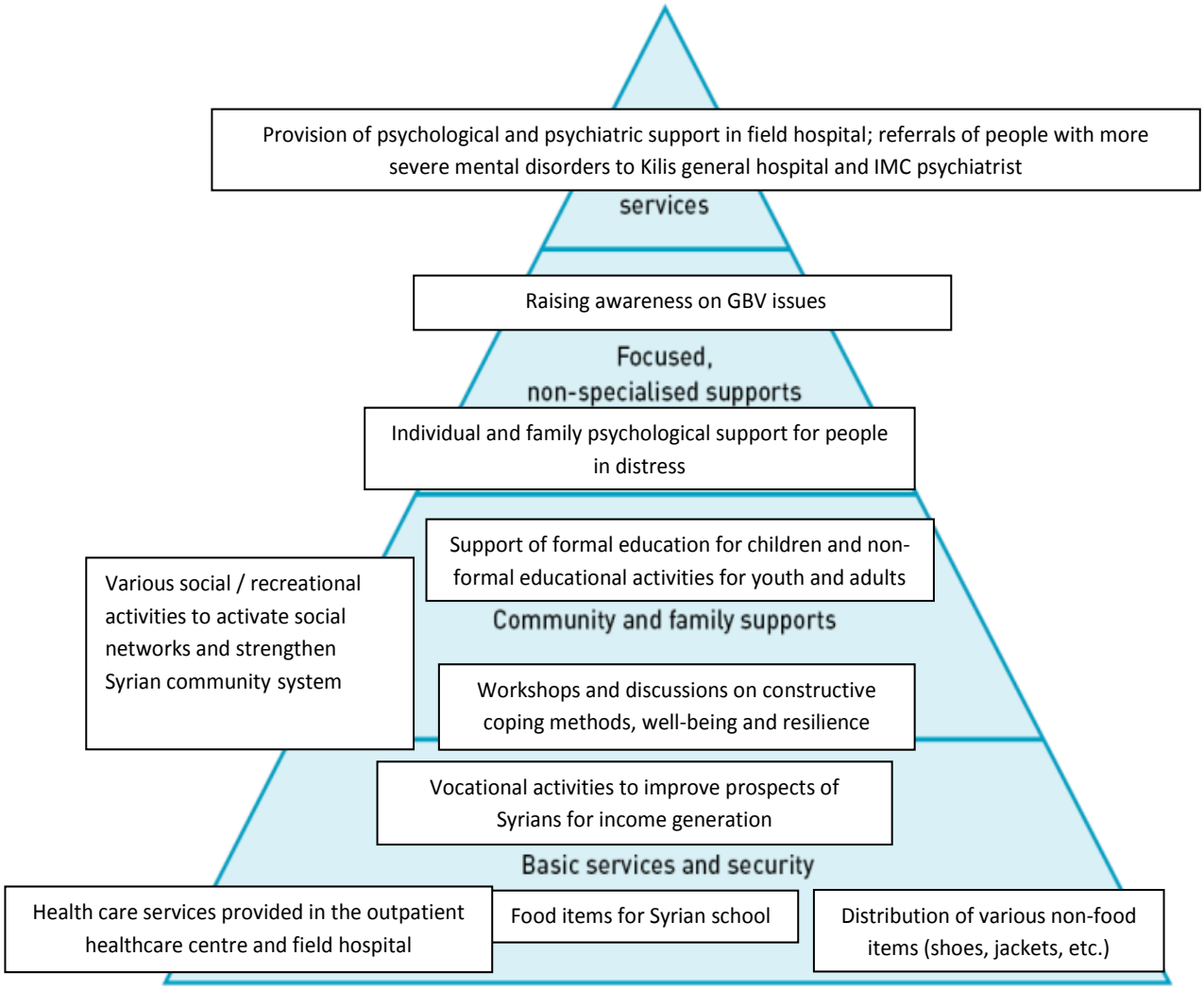

Figure 1. Four layers of IASC pyramid and MHPSS intervention implemented by MI/IBC in Kilis.

avoid duplication of program activities and waste of valuable resources (IASC, 2007).

The intervention's approach was in tune with relevant international recommendations on how to provide MHPSS in emergency settings (The Sphere Project, 2011; Ommeren et al., 2005; IASC, 2007). The whole intervention was culturally competent and acceptable to community actors as indicated by the high level of engagement of beneficiaries and volunteers throughout the program. Only in the first year of intervention, 2322 urban Syrian refugees benefited from some 30 social activities of community skills centre and more than 30 Syrian volunteers were engaged at different stages of the program. For comparison purposes, UNHCR's community skills centre in Damascus reached more than 1,600 beneficiaries after four years (Quosh, 2013). Community actors can play a critical role in achieving better outcomes in the field of MH care and psychosocial well-being (Ventevogel et al., 2012).

Recommendations and future perspectives

Further evidence-based studies of various community-based MHPSS interventions to refugees in urban settings are recommended. Each urban setting has its specific economic, political and cultural context, and each refugee and host population have specific collective memory and mentality which can affect program implementation. There is an increased demand for context sensitive, integrated, multi-level and multi-disciplinary community-based MHPSS interventions which can address basic needs and daily stressors, as well as past (potentially traumatic) experiences (Quosh et al., 2013).

Conclusions

This prospective, semi-quantitative study has demonstrated feasibility and effectiveness of one community-based MHPSS intervention for urban refugees. Further evaluation of this intervention is needed, preferably in a form of a prospective longitudinal cohort study comparing group of Syrian refugees who receive MHPSS intervention with the control group.

Conflict of Interests

The authors have not declared any conflicts of interest.

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