Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises in Syria

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The massive influx of Iraqi refugees into Syria in 2006 put an immense strain on the already under-resourced mental health sector. This prompted a consortium of international agencies to create an Inter-agency Working Group (IAWG) in 2008, with the goal of national capacity building. This Inter-agency Working group merged into a National Advisory Board that included the Syrian government. An integrated one-year master training programme for mental health professionals was designed. The first cohort of master trainers successfully completed the programme, and started to train frontline worker with very good results. There has been widespread advancement in awareness of integrated psychosocial and mental health approaches, multi-professional teamwork and training methodology among practitioners. This has translated into practical projects improving the quality of care for beneficiaries. In addition, comprehensive training curricula and a bilingual handbook have been drafted with the goal of integrating and streamlining psychosocial, mental health and training methodology. Initial steps have also been taken to create a unified National Mental Health and Psychosocial Council.

Keywords: capacity building, mental health, Middle East, psychosocial support, refugee, Syria

Background

The war in Iraq triggered complex emergencies in countries throughout the region as a massive influx of refugees spilled across its borders (Figure 1). Syria received the largest number of refugees, and although notable in its generous and lasting asylum policy, it is now finding its infrastructure, and in particular, the public health systems strained.

Iraqis who remain in Syria are particularly at risk; many are unable to gain resettlement to a third country[1] or to return home. Quickly diminishing resources and a lack of prospects for the future have had strongly negative effects on the refugee population, such as: deterioration of living conditions, day-to-day stress and uncertainty that compounds past distressing experiences that caused their flight from Iraq. Changes in roles and belief systems have been profound, contributing to increased domestic violence and survival sex. Many refugees had arrived expecting a temporary stay, but find themselves in *'protracted stasis'*, without the ability to make future plans. As financial difficulties have worsened, assistance has waned and treatment needs go unattended, it is expected that social, health and psychological problems will escalate (Le Roch et al., 2010).

Therefore, while the situation in Syria can no longer be considered an acute crisis, it is certainly a complex emergency[2] that has developed into a protracted refugee situation.[3] Although desperate, the conditions also provide an environment for innovative
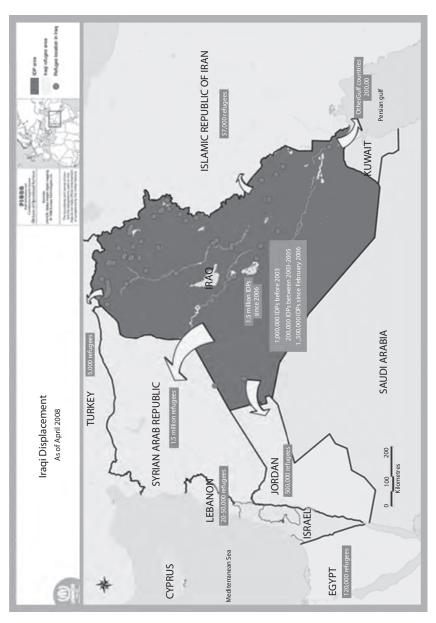
Figure 1: Map with United Nations Commissioner for Refugees estimates of Iraqi Displacement in the region. Source: Map 1: http://www.unhcr.org/487ef7144.html.

response; channelling available impetus and funding towards transition from humanitarian aid to more sustainable development programmes.

For the most part, Iraqi refugees in Syria occupy an urban refugee setting (Figure 2), which differs sharply from camp settings and presents certain unique challenges; most notably difficulty in identifying persons at risk, who are in need of support or specialised care, and providing access to adequate services. This makes community-based outreach crucial, and requires an efficient referral system.

Although regionally there are a number of humanitarian organisations operating, there are only a limited number of international and national nongovernmental organisations (NGOs) active in Syria. For this reason, the Psychosocial Support and Mental Health (PSS MH) programme for refugees is currently primarily implemented by UNHCR. However, intensive capacity building, occurring within the different levels of the public health systems and social services, will pave the way for a responsible transition to national organisations.

Mapping the context: mental health in Syria

Understanding health and illness in the Middle East is impossible without linking it to the local context. Mental health care in Syria is still developing. Currently, for a population of 21.8 million (World Factbook, 2010), there are 89 psychiatrists. This is a ratio of approximately one psychiatrist to a quarter million people. The estimated minimum ratio by WHO is 25 times that amount, approximately one psychiatrist to 10,000 people (MHWAC, 2008). An accurate measurement of psychiatric morbidity in Syria is difficult to estimate due to the lack of data, and the wide-ranging effects of high levels of social stigma associated with mental health issues. This also prevents accurate reporting of diagnostic and other mental health statistics. Overall in Syria, support is medicalised; provided by psychiatrists with a clear dearth of community based services. Aside from resulting in an intervention-focused, overburdened and less efficient system, the lack of prevention efforts and formalised community care is problematic as modernisation has begun to erode
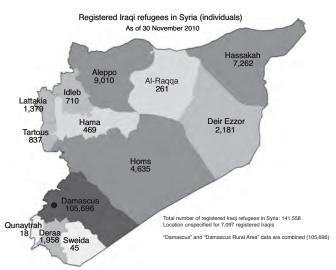

Registered Iraqi refugees in Syria (individuals)
As of 30 November 2010

Hassakah 7,262

Aleppo 9,010

Al-Raqqa 261

Idleb 710

Lattakia 1,379

Hama 469

Deir Ezzor 2,181

Tartous 837

Homs 4,635

Damascus 105,696

Qunaytrah 18

Deraa 1,958

Sweida 45

Total number of registered Iraqi refugees in Syria: 141,558
Location unspecified for 7,097 registered Iraqis

"Damascus" and "Damascus Rural Area" data are combined (105,696)

Figure 2:   Map with UNHCR estimate of registered Iraqi refugees in Syria. Source: http://ochaonline.un.org.

251

community support systems, particularly in urban areas.

In the mental health sector, the dominant area of study and practice is general adult psychiatry, taught in the medical school and designated by the Ministry of Health. There is no formal clinical psychology education or therapy training, as programmes are conducted through university faculties and concentrate on counselling, without formalised field experience. These educational differences, as well as formalisation (e.g., lifetime psychiatric licensing, vs. no legal framework for licensing psychologists) and perceived status distinctions between doctors and other mental health professionals make the professions notably hierarchical. This results in a lack of cooperation between services and support levels, and offers little integration between psychosocial support and mental health care. Furthermore, training methods and services in the sector are spread across four Ministries: Health, Education, Higher Education, and Defence. This fragmentation results in inconsistent instructions of varying quality. This is also compounded by the striking lack of updated written materials in the region. Education in the sector is largely medicalised due to the stronger presence of psychiatrists and, in part, easy access to inexpensive medications. Additionally, the strong social stigma impedes seeking help among clients, until a situation becomes acute and hospitalisation is necessary. Further adding to the problem, psychiatric hospitals are large and institutionalised, with very few integrated day programmes and no ability to follow up patients once they have been discharged. This often results in relapse.

Needs assessment
In line with the lack of mental health research in Syria, there are very few studies concerning the situation of Iraqis in the country. However, supplemented by research conducted in the region, there is a clear indication that the context within the country results in numerous psychosocial stress factors.

Studies on refugees in Syria indicate that families remain isolated, as primary social networks were lost in displacement (Le Roch, et al., 2010; Ventevogel, 2008). Family members, particularly youth and women, spend much of the day inside their homes, compounding their sense of isolation and grief, and reducing their ability to locate and develop sources of social support (Gilbert, 2009). De-professionalisation, in the sense of loss of, and lack of, opportunities for professional occupation, as well as the need to readapt to new social roles in the current environment, were cited as main stressors by 33% of one study sample (IOM, 2008). Both men and adolescents express feeling '*not useful in society*' (Jayawickrama & Gilbert, 2008). The insidious shift in family structure occurring as a result of displacement, and the inaccessibility of work for men is causing fundamental role changes, resulting in a steep rise in domestic violence among refugee households (Le Roch, et al., 2010).

Anxiety and depression are the two most prevalent psychological symptom clusters experienced, with estimates ranging from 42% among samples of Iraqi refugees (Duncan, Schiesher & Khalil, 2007) to above 80% (UNHCR, CDC, 2007). Symptoms reported to psychologists include specific phobias, nervousness and anxiety in adults, and aggressiveness and withdrawal in children (Le Roch, et al., 2010), with girls tending to be more isolated and withdrawn, and boys tending towards disruptive and aggressive behaviour (Tsovili, Coutts & Quosh, 2010). Gender differences among adults are also

commonly found, with women evidencing significantly higher rates of affective disorders (WHO, 2009; Duncan et al., 2007) and middle-aged and older men trending towards higher rates of anxiety disorders and posttraumatic stress disorder (PTSD) (WHO, 2009). Age differences are also apparent in the data, showing general mental health scores deteriorating with age, and individuals over 65 consistently reporting higher rates across symptoms, including severe depression and PTSD, indicating reduced resilience (WHO, 2009). Somatisation of stress has led to increased health care needs of the refugee population which, in combination with stigma, brings beneficiaries to general medical centres more often than directly to specialised psychiatric services. Psychosocial difficulties experienced by refugees in Syria have steadily increased due to deepening socio-economic vulnerabilities and prolonged uncertainty. Psychological stress and desperation have intensified as the length of stay has increased (Duncan et al., 2007). The oppressive climate often makes it impossible for displaced Iraqis to address traumatic events that occurred prior to, or during, their flight.

Takamol: UNHCR's psychosocial support and mental health programme

Due to the combination of overwhelming need and a scarcity of qualified professionals and implementing partners, UNHCR established a pilot PSS MH Programme, under the name *takamol*, which is an Arabic word meaning '*integration*' or '*complementing*'. The programme adopts a three-fold approach:

1) A national capacity building project;
2) Case management for people most at risk; and
3) An urban outreach volunteer programme.

These three components are heavily interlinked, informing each other and functioning jointly. The psychosocial framework holds, as its primary focus, the interaction of psychological and social wellbeing, emphasising a process model and the interrelationship between factors in the social and cultural environment and psychological symptoms. The resulting methodology works towards developing and reinforcing existing resources in order to enable sustainable solutions in challenging environments.

Capacity building

During and after a complex emergency, the level of psychosocial distress is high. In the realm of PSS MH, reliance on specialist care, particularly in the developing world, is inadequate. Across the reviewed studies (Le Roch, et al., 2010; Gilbert, 2009; WHO, 2009; IOM, 2008; Ventevogel, 2008; Duncan et al., 2007), conducted in Syria and regionally, the primary recommended responses were strengthening the national healthcare system and enhancing its ability to respond to the needs of both the refugee and local populations through extensive capacity building.

With capacity building we mean more that improving resources such as knowledge, skills and competencies of individual trainees within a system or institution, but we also indicate facilitating relationships between institutions and sectors, and fostering multi-professional teamwork and advocacy. Despite the education based core of capacity building, an effective programme must also initiate a change in *attitudes* and *approaches* at all levels: policy, institution/professional, community, and individual. Ideally, this comes with networking and advocacy for legal and regulatory changes.

However, the currently existent systems are highly centralised and do not have the sufficient resources to attend to a suddenly

exploded morbidity in the population. Therefore, the most practical way to address the service gap is to train frontline workers to an international standard, and in a context sensitive way. This paves the way for the change in approach required; moving populations in need of support from professionals to frontline services, decentralising skills and improving referral mechanisms to ensure that beneficiaries are recognised and receive the level of care they need.

Project description

The project aims to not only improve service provision for the immediate emergency situation, but to go further using a multi-level, multi-professional approach to encourage cooperation and service integration, thereby standardising training in the sector. This will increase the number of qualified practitioners and ensure sustainable capacity. This will strengthen national services, including: primary health care centres and clinics (public, inpatient and outpatient); private psychosocial facilities; community centres; and school health and social counselling services. In this way, the project envisages a shift in approach from a relief-focused operation to a comprehensive development approach, benefiting both the displaced and national populations.

Project board

The project was initiated by an Interagency Working Group (IAWG), composed of international aid organizations involved in psychosocial support and mental health care[4] at the end of 2008 while preparing a mental health and psychosocial sector strategy for the Consolidated Appeal Process, which is the process and tool used by host governments, UN agencies, donors and aid organisations for coordination, strategic planning, monitoring and fundraising for humanitarian activities. The initial goal was to unify diverse, uncoordinated initiatives; however the process at that time excluded national stakeholders. Therefore, a Syrian Advisory Board was founded in 2009, involving experts and decision makers from the Ministries of Health and Education, as well as the University of Damascus and the Syrian Arab Red Crescent (SARC). Many of the advisory board members are practicing psychiatrists, psychologists and social workers. The specialised expertise of this board is a fundamental component in ensuring the comprehensiveness and context sensitivity of the project.

After the first project steps were implemented, the IAWG and Syrian Advisory Board merged in 2010 to form the Project Board, reinforcing Syrian ownership as a core principle of the project. The board is co-chaired by UNHCR and the Ministry of Health. Its role is to act as the central entity to facilitate cooperation and coordination between all stakeholders involved, including the nomination of Master Trainers (see below), recruitment for, and organisation of, frontline worker trainings (FWTs), and liaising between the board and applicable national bodies.

The cascade approach

Specialists in Syria were over-burdened, but did not have the tools for burden sharing. Recognition of this need, and an opportunity to solve this, provided an incentive to participate in the training of trainers.

The constraints inherent in the local context required an application of the cascade approach (Figure 3). This methodology uses available human resources to propagate knowledge throughout the levels of service provision. Professionals are trained as trainers and, in turn, train lower levels of service providers according to assessed knowledge
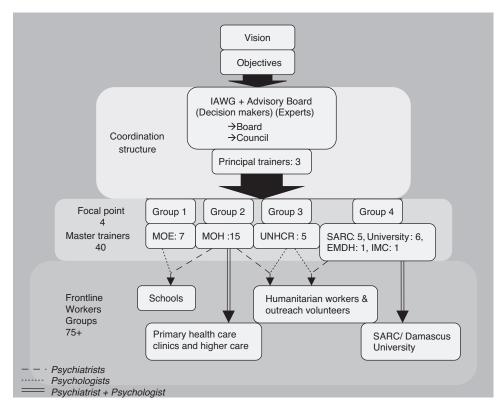
Figure 3: Cascade flow chart.

gaps. In this way knowledge is maximised with limited resources (Mpabulungi, 1999). The points of criticism regarding ToT models such as required qualities of trainees and trainers, questions of sustainability and impact if follow-ups, supervision, monitoring and evaluation were not given over a longer period of time were all considered in the project planning. (Aarts, 2010, 42) The appropriate selection, preparation and high quality implementation that used cascading with a longer term follow up eased the burden on the Syrian system.

Beneficiary groups
The project designated three levels of beneficiaries (Figure 3). The first includes: master trainers; senior psychiatrists, psychologists and social workers, who, after

the master training continue to conduct subsequent trainings. The second are four frontline workers groups operating in areas with increased refugee presence:

1) Primary health care services
2) Schools
3) Humanitarian workers and community outreach workers
4) Specialised secondary health and other services (e.g. SARC multidisciplinary units and university psychology lecturers).

These groups have received training from the master trainers, and are able to implement their skills across their service populations. The final group consists of the general population in need of psychosocial support.

Project outputs

There are three target outputs for the capacity building project:

1) Comprehensive bi-lingual training materials and a draft *PSS MH Handbook,* tailored to the Syrian context and capable of being used as a teaching guide for local professionals;

2) A cohort of 25 to 30 committed master trainers, from varying professional backgrounds, able to implement FWTs in PSS MH as multi-professional teams at the different frontline service levels;

3) A series of abbreviated, customised curricula targeted at the four primary service fields for use in FWTs.

Handbook and frontline training guides

The Middle East and North African (MENA) region in general, and the Syrian context in particular, suffer from a lack of available materials guiding best practice in PSS MH. Therefore, the project spearheaded an initiative to draft a handbook and training curricula accessible to professionals, detailing a unified, multi-professional system of care that is both compatible with current international standards (IASC, 2007; WHO, 2010), and tailored to the particulars of the Syrian context.

A participatory approach was taken in the development of the handbook, and included a comprehensive needs and capacity assessment, a first review process by 25 national experts and an international review process with 20 experts. Despite being criticised for its large volume, during the local field test in the master trainings, the second draft revision of the handbook was acknowledged (both in focus groups and by feedback questionnaire) as a useful and appropriately

comprehensive tool by the targeted professionals. The upcoming final revision will be undertaken at an international and national level, for both English and Arabic versions, along with extensive parallel contextualisation work (including local case studies, context sensitive translation adjustment, regional data).

The handbook draft materials are the basis for the master trainings. The main authors of the handbook, a German–Jordanian clinical psychologist and a Jordanian psychiatrist, work multi-professionally themselves, and were the principal trainers for the master trainings. This ensured consistency between the material and the trainings, and allowed for feedback and revision during the process.

Training of trainers

The training of the master trainers was based on a qualitative (focus groups, individual interviews and field visits) and quantitative (baseline survey) training needs assessment done throughout the public health and social services sectors. The resulting curriculum integrates complementary theoretical and practical components, designed to update practitioners' knowledge, promote an integrated PSS MH approach, and enhance training skills with a heavy focus on strengthening cooperation and multi-professional teamwork in the field.

Training structure

The master training consisted of an introduction day, six modules, an exam period and a certification day (Figure 4). It is a one year programme, with one module of 3–4 training days each month, totalling over 170 training hours. The first training cycle ran from December 2009 to November 2010. The full content of the handbook, including theoretical perspective and

	Module 1	Module 2	Module 3	Module 4	Module 5	Module 6
MH care	Depression	Anxiety disorders	Specific disorders (e.g., PTSD, OCD, bipolar disorder)	Psychoses	Mental disorders in children	Specific disorders (e.g. substance abuse, the elderly)
PSS	Introduction; Psychological first aid; Community-based PSS; Stress and trauma in children	Models of psychological health and suffering in children and adults; Stress and trauma; Refugees	Basics of counselling ; Special issues: torture, rape, domestic violence	Helping the helpers ; Credibility assessments	Understanding children with special needs ; Counselling and PSS through schools	Integration of PSS and MH interventions
Skills training	Basic communication skills ; teamwork ; basic training strategies	Interviewing – comprehensive assessment of bio-psycho-social situation; Basic training strategies	Bio-psycho-social case management; Assessment of training needs of frontline workers	Managing professional stress and burnout; Peer support; Planning a training session	Training evaluation, planning and observation; Team teaching	Planning a series of 3 training sessions for service providers; Team teaching

Figure 4: Training module content overview.

methods, was divided into six modules; each one with a mental health component, a psychosocial component and a training skills component. The final module tied themes together; reinforcing good practice in applied training designs, and an integrative approach.

Importantly, the training modules utilised professional adult education techniques, including experiential learning (learning through doing) and peer learning (professionals teaching their specialties to their peers for mutual mastery).[5] All of the master trainers trained together, cross-professionally.

For the practical aspect of the training, the master trainers were divided into 20 teams of two, for support and to practice multi-professional teamwork. Each of these teams provided trainings to selected cohorts of frontline service providers in the four, previously mentioned, fields. Trainings were based on training needs assessments done with each professional group, and served to develop the standardised curricula.

Each team conducted a supervised three-hour FWT session between modules 5 and 6. In addition, each team was responsible for a four hour FWT session (two hours per trainer), evaluated for certification. Within one year of graduating, every master trainer is required to provide five additional supervised FWTs. The supervised implementation of these trainings, including continued evaluation has begun, and will be implemented throughout 2011.

Trainer profile
The Project Board developed a set of criteria guiding the selection of master trainers. These included a minimum of five years' work experience in mental health and psychosocial support with refugees as well as training experience. A total of

44 master trainers were nominated from the Ministry of Health, the Ministry of Education, the University of Damascus, the Syrian Arab Red Crescent, UNHCR, IMC and EMDR (19 male, 21 female; 12 psychiatrists, 28 psychologists and social workers). The majority of the nominees worked in the urban centre of Damascus, however, there were also several from governorates across Syria.

Evaluation

Training evaluation

Master trainers were evaluated along three criteria:

1) Development of their knowledge base, evaluated through periodic multiple choice testing after each module. The final exam was in short answer and case study format.
2) Practical skill development, evaluated through their performance in certification trainings.
3) Training programme adherence, evaluated through attendance and motivation.

Knowledge tests

The total results of the knowledge tests show that all of the master trainers passed the 70% cut-off point, meeting the programme outcome goal. The lowest average score on the knowledge tests overall is 37%, and the highest is 91%. Notably, over the course of the modules, average knowledge test scores increased across master trainers, by an average of more than 10%.

The pattern of improvement across psychosocial and mental health modules is similar, although mental health had a higher baseline and generally higher averages throughout. Master trainers reported that the mental health concepts were easy to understand, reflecting the medicalised education

and service systems. It is interesting to note, however, that while the multiple-choice module tests often demonstrated a stark difference in total scores between psychosocial and mental health tests, the case study based final exam only varied by approximately 3%. This suggests minimal disparity in applied knowledge, arguing for further investment in psychosocial education.

Certification training

A standardised training evaluation form, with quantitative and qualitative items, including dimensions such as quality of training, knowledge of trainer and use of adult learning techniques, was used for each training session by the primary supervising trainer, a Syrian clinical psychologist, a second professional supervisor from the respective organisations, the peer co-trainer, and the participants. Feedback sessions were conducted after each FWT.

The training supervisors reported high knowledge absorption and ability to run trainings, as well as good consistency between self assessment (post training) and supervisor assessment. They cited clear methodological improvement, with practical knowledge rated at an average of 9/10 for the final trainings. The supervisors also reported significant improvement in psychosocial skills, but cited a continuing need for training to build greater practical aptitude. High absorption of psychiatric health curriculum by non-psychiatrists was also observed.

Attendance

Attendance rates for the first modules was 100%, and for the last ones 87.5%. Only four trainers out of 44 dropped out of the course; far fewer than expected. All dropouts occurred after Module 1, rather than slowly and throughout, indicating

strong programme adherence and commit-
ment.

Master trainers' perceptions
Each module was rated by the master train-
ers on certain indicators, using a scale of
1—4; with 1 being *'Disagree'*, 2 being *'Tend
to disagree'*, 3 *'Tend to agree'* and 4 being
'Agree'. Quantitative and qualitative items
captured the dimensions of training process,
quality and satisfaction. Average ratings
per indicator ranged from 2.84 to 3.65. Mean
ranged from 3.1 for module 4, to 3.26 for
Module 5.

The master trainers used an anonymous
standardised training evaluation form
after Module 6, with quantitative and
qualitative items, similar to the form used
for the certification trainings, and gave an
overall average rating for principle trainers
of 8.5/10.

The results of an overall quantitative and
qualitative self-evaluation of knowledge
and competencies at the end of Module
6 were measured with a scale from
1—10 (with 1 being *'very little'* and 10 being
'very much'). Notable is that the highest self-
perceived knowledge is in mental health
and training methodology, the lowest it is
in school counselling, indicating future
training needs.

During a guided focus group discussion
it was stated that the most important
training experiences for the trainees
were the handbook (a knowledge based
resource), teamwork (multi-professional
interaction) and generally how to run
trainings and present information. This
superbly followed the project's goals for
their experience.

All of the master trainers graduated with
success. The trainers, the Ministry of Health
and the UN Resident Coordinator, certified
the training.

Monitoring and external evaluation
Although the general frame was prepared
through the needs and capacity assessments,
consultations between trainers and the board
chair, after every module, allowed fine-tuning
of training content and methodology.

Additionally, in concordance with the larger
PSS MH Programme administered by
UNHCR, the Capacity Building Project
underwent a midterm, mixed method,
internal/external process of outcome/impact
evaluation by a multi-professional team from
the University of Uppsala, Sweden. The
evaluation included four expert field visits
in March, May, July and November 2010, a
case study assessment and interviews with
participants and trainers. The resulting
recommendations have, for the most part,
been fulfilled. A separate article is planned
on the evaluation approach, process and
results, but some notable points are worth
mentioning here.

Structurally, the interagency nature of the
Capacity Building Project, in conjunction
with the initiation of the National Advisory
Board, meant that there were numerous
individuals active in the project, and that it
was at times difficult to communicate clearly
with all parties involved. The merger of
the Interagency Working Group with the
National Advisory Board, streamlining
meeting attendants, resulted in more direct
and effective communication.

Although it has been contested in the litera-
ture, the external evaluators found that this
programme demonstrates the effectiveness of
a cascade approach (Figure 3). The key to
the success of this method is that modelling
occurred on all levels of project implemen-
tation; most importantly the multi-professio-
nal approach, which was modelled at the
Project Board level, just as much as in the
trainings by the main trainers and master
trainers.

Discussion

Successes

The collaboration among institutions and the multi-professional approach, characterised by the Capacity Building Project, defines a unique methodology for the PSS MH sector in Syria. Mental health care had been strongly medicalised prior to the implementation of this project, and now there is a greater understanding and integration of psychosocial concepts and practices, as reported through feedback from both master trainers and stakeholders. In response to the project, the first multi-professional PSS MH training and care unit has been planned within a government hospital. According to a follow-up assessment, both the MoH and MoE have integrated PSS MH capacity building in their annual work plans. Ninety percent of all master trainers confirmed that they had planned FWT sessions for 2011.

The handbook, the training package and the frontline worker field curricula, have laid the groundwork for incorporation of the developed curricula into regional institutions. Eventually, they will serve as a basis for further training and capacity building, with an opportunity for additional application in a variety of contexts across the mental health spectrum, regionally, and beyond. A national university expressed interest in incorporating the training into their postgraduate curricula, using the pool of master trainers as lecturers for planned cross-sectional PSS MH courses at the medical school and psychology department. The strong partnership between project board members allows for a clear coordination of leadership roles; bringing together high level stakeholders (such as the Ministries of Health and Education as well as Universities and the Syrian Arab Red Crescent) to provide an inclusive forum for technical assistance, advocacy for international standards in PSS MH, and an opening for future policy dialogue. A High Level Round Table (comprised of the aforementioned stakeholders in addition to the Syrian Women Union and the Ministry of Higher Education), hosted by the Project Board, under the leadership of the Syrian Ministry of Health and UNHCR in November 2010, set the foundation for a formalised National MH PSS Council. This Council is modelled after the multi-professional Project Board, and integrates resources from the Ministries involved, in order to maximise expertise and access. The institution of this national body also has laid the groundwork for informed future policy decisions in the mental health sector.

Five of the master trainers are Iraqi, two of whom are Iraqi psychosocial outreach volunteers with the UNHCR Outreach Programme. Inclusion of outreach volunteers, and their invaluable perspective, in capacity building trainings is imperative. This inclusion empowers these vital actors, and facilitates positive identity reconstruction, not only for the trainers themselves, but also for the refugee and host communities. Importantly, it also allows national bodies to view refugee community involvement as an asset; by giving community members enhanced skills and agency.

Challenges and dilemmas

The agencies involved have different planning periods, and financial and budgetary regulations, requiring flexibility and creativity. Most funding is annual, and the lack of pooled funding hampered planning and a greater consistency of services. Therefore, a structure that would allow interagency projects to apply for communal grants, or allocate portions of funding to a collective pool, would be useful. Frequent

staff turnover, dependency on personal leadership, differing incentive policies across agencies and the bilingual nature of the project also created their own challenges. Consequently, a structure that facilitates the designation of staff to interagency projects, formalises information sharing and institutionalises commitments, as well as rotating leadership, would help to ensure continuity and equal participation of all agencies. Additionally, a structure that facilitates the deployment of staff to national stakeholders, in order to build internal capacity and national ownership, as well as leadership, is essential. Interagency politics and competition slowed the pace of progress, and impacted negatively on the team's enthusiasm. However, commitment to the project's potential overcame these challenges successfully.

Lessons learnt
Prior to the initiation of the PSS MH Programme and the Capacity Building Project, a thorough situation analysis was important in order to ensure an understanding of the system, and the local context (cultural, political and institutional). This allowed programme implementers to capitalise on the strengths of the system, supported by the development of strategic relationships.

The master trainers indicated clearly that continued supervision, assessment and follow-up workshops are crucial to monitor quality, support and to adjust the process accordingly. This corresponds to the main criticisms of the cascade approach, i.e., quality decreasing with moving down the cascade, and isolated trainings with limited supervision. Although aware of these challenges, the context necessitated this approach. The project design, however, addressed the challenges successfully by:

- Nominating master trainers through involved agencies, according to set criteria
- Mobilising and acknowledging existing resources across specialities
- Development, adjustment and provision of unified training material (this was found to be crucial to ensure a systemic approach to the training process, particularly as it cascades down)
- Using the first master training series as an opportunity to adjust the handbook material
- Extending the master training over a year with a maximum of one intensive module per month, allowing for knowledge absorption, reflection and practical application
- Utilising adult learning and participatory training methodology, as well as a practical focus in accordance with the *IASC guidelines*
- Responsible focal points per organisation (Figure 3)
- Piloting FWTs with training supervision and continued monitoring during the training cycle
- Continued trainee evaluation and intensive feedback provided, following FWTs
- Strengthening of independent coordination and peer exchange among participants beyond the training
- Organising follow-up workshops

One positive outcome of the cascade approach is that the FWTs are conducted by specialists, allowing for an exchange of perspectives and efficient referral system determination, thereby bridging hierarchies and easing burden sharing.

Interagency cooperation and the modelling of multi-professional teamwork were very valuable in creating attitude change over the course of this project. In addition, an interagency working group needs

committed leadership by one organisation, as well as a clear structure and identified roles and responsibilities for all actors involved, aligned with their respective mandates. Constructing commitments and institutionalising them was also helpful. At the same time, participatory engagement with all stakeholders from the beginning, and involvement of decision makers, as well as with experts from the different institutions, was crucial.

The development of a firm and early strategic plan that is logically linked to existing services is vital to keep stakeholders involved.

In order to ensure sustainability, project transition to complete national ownership is necessary. Therefore, allocating the time to carefully prepare this transition, and to develop an appropriate and well-articulated exit strategy that ensures continuity (including long-term vision and acceptance), is essential. Government participation from the onset laid a solid foundation. For this purpose, documentation throughout the life of the project is also very important; initiating the creation of institutional memory that outlasts staff turn over.

A design for programme evaluation should be integrated from the outset of the project, and continuous evaluation, throughout each stage of operation, as well as of the outcome/impact, is vital to maintain quality. For these reasons, a combination of external/internal evaluators was found to be highly effective.

Conclusion

As a result of the Interagency Capacity Building Project and national level, multi-professional coordination, the formal support systems have already demonstrated improvement of the skills and knowledge levels of the master trainers and frontline workers. The development of unified materials that can be utilised beyond Syria, improvement of the system level, and the national coordination mechanism, also indicate project efficacy. Improved access and service delivery across Syria will eventually lead to the enhanced psychosocial wellbeing of the targeted population(s). The coordination network ensures improved response, monitoring of progress and integration of psychosocial support and mental health into existing systems of care.

The external evaluators selected the Syrian National Capacity Building Project as a best practice example for the mental health and psychosocial support sector. It is notable that many best practice examples are developed in emergency contexts, as these situations often facilitate the recognition of service gaps, and provide the opportunity to invest financial and human resources in a concerted manner. However, what is as essential, as it is challenging, is not to simply stop once the emergency has eased and access to funding becomes more difficult. Most often, in these cases, the services provided simply disappear, without the effective development of national programmes. The goal of this project and of all the team members was to invest instead in the integration of services into the Syrian system, enhancing national ownership and ensuring sustainability and a smooth transition.

Acknowledgements

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[1] For a definition of resettlement please see the UNHCR Resettlement Handbook at: http://www.unhcr.org/pages/4a2ccba76.html.

[2] For a definition of a complex emergency please see the Complex Emergency Database at: http://www.cedat.be/glossary.

[3] For a definition of a protracted refugee situation please see: UNHCR. *Protracted refugee situations* (EC/54/SC/CRP.14), June 2004.

[4] UNHCR, UNICEF, the United Nation's Population Fund (UNFPA), the World Health Organization (WHO), the International Medical Corps (IMC), the German *Gesellschaft für Technische Zusammenarbeit* (GTZ) with support of the European Commission.

[5] A separate article is planned on the master training methodology.

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Announcement

Join the Mental Health and Psychosocial Support Network
Approaches to providing mental health and psychosocial support (MHPSS) are evolving rapidly, and examples of good practice are fast emerging from the field. However, those working in MHPSS are dispersed across the world, separated by language, culture, professional roles – with varying access to information and communication technologies. The MHPSS Network is set up to close the gap in the sharing of information, resources and expertise.

What does mhpss.net have?
MHPSS Network is built around an interactive website: a place to meet colleagues, create discussion groups to seek advice or exchange views, share documents through a digital library and post events, training courses and vacancies.

Who can join mhpss.net?
Anyone around the world with an interest in mental health and psychosocial support can join the network. This includes people from affected communities, as well as those working in all levels of humanitarian or development aid, government, policy, training, academia and media.
Access the MHPSS Network at www.mhpss.net