INTERNATIONAL MEDICAL CORPS

Psychosocial Assessment of Displaced Syrians at the Lebanese-Syrian Northern Border

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Analysis of Findings

Beirut, Lebanon

May 20th till June 17th, 2011

Report on IMC's Psychosocial Assessment of Displaced Syrians at the Lebanese-Syrian Northern Borders

This report will provide a description of the assessment conducted by IMC's Mental Health and Psychosocial team in the region of Wadi Khaled following the displacement of Syrians into the northern villages between the Lebanese-Syrian borders as a result of the internal conflicts taking place in Syria. The report will include statistical data regarding the demographics of the displaced population, the general problems stated by them, the mental health issues they are dealing with as a result of the displacement, and the coping methods they are using to ameliorate their affected tasks and problems because of the crossing. Note there was limited accurate data available on the population in the Wadi Khaled area prior to May 2011.
The data provided in this document is from May 20th - June 17th 2011.

International Medical Corps

The *International Medical Corps* (IMC) is a private, non-political, non-profit, non-sectarian, and global humanitarian organization dedicated to saving lives and relieving suffering by providing medical and mental health relief worldwide by responding rapidly to emergency situations. IMC's mission is to improve the quality of life through health interventions and related activities in order to build and strengthen local capacity.

IMC began operating in Lebanon during the war in summer 2006 and played an integral role in the provision of relief to conflict-affected populations. IMC remained in Lebanon following the August ceasefire to assist in reconstruction efforts and maintain a strong presence in the country, implementing a diverse set of development initiatives, ranging from health and mental health activities to education, livelihoods development, gender-based violence response and water/sanitation programs. Since 2008, IMC has been providing services geared towards Iraqi refugees residing in Lebanon and vulnerable individuals from the host population.

IMC has worked previously in the northern region of the country and has specific experience working in the deprived Akkar region.

Background Information

Since April 2011, political insecurity and instability in Syria forced many Syrians to flee their homes and villages. By May 2011, the situation appeared to worsen and people's security and safety deteriorated thus causing more Syrians to cross the towns close to the Akkar region in to north Lebanon.

According to a preliminary report released by UNHCR which was shared among inter-agencies (18.05.2011 – Beirut), the numbers that were reported showed a figure of 950 – 1050 families, i.e. 4000 individuals. The demographic collection relied heavily on the Mukhtars and local actors in the process of carrying out formal counts on a village-by-village basis. In the early weeks of May 2011, the majority of Syrians that crossed from Tell

Figure 1 -There is no set demarcation line between the Northern Borders of Lebanon and Syria. Most displaced Syrians cross into Lebanon from the Tal kalakh border.

Jalkh in Syria to Wadi Khaled comprised mostly of children and women as the men folk appeared to stay at home. However, by mid May, when the situation worsened, a further wave of Syrians crossed into the northern villages of Wadi Khaled and Birie. During this period it was clear that more young adult men had made the crossing.

There is no demarcation line between the borders of northern Lebanon and Syria. Inter-marriages between the people who live in between the two regions are common therefore; they have family ties in the villages and towns in the northern areas of Lebanon. As a result, most of the displaced Syrians had stayed with family and other relatives once they have crossed the border into Lebanese territory.

The region of Wadi Khaled is composed of twenty-five (25) villages and Birie is made up of fourteen (14) villages. Based on the demographic statistics provided by the Higher Relief Community (HRC) and the Mayors of both Wadi Khaled and Birie, the estimated number of displaced Syrians was 5,055 in Wadi Khaled and 1,029 in Birie.

By the end of May, based on the Working Group on Health report (23.05.2011 - Beirut), UNHCR and HRC estimated that the numbers of displaced Syrians was still ca. 4000, with males comprising of 20%.

Coordination

During the time in which the assessment was carried out, IMC Lebanon was coordinating closely with UNHCR, WHO, Higher Council for Relief, Ministry of Social Affairs (MoSA), NGOs and the Lebanese Armed Forces. In addition IMC met regularly with the international grouping of NGOs (World Vision, Mercy Corps and Save Sweden). IMC attended the series of coordination meetings held both in Beirut and in the north.

Response

In early May, Prime Minister called upon the High Relief Commission (HRC) to supervise and coordinate the response to the humanitarian needs of those displaced in the north. In addition, the Ministry of Social Affairs (MoSA) permitted the use of its Social Development Centers (SDCs) in the north to UNHCR- led teams to address the psycho-social needs of displaced persons.

IMC operated a mobile medical unit and expanded its coverage to Bani Sakhr village and Rami village. The MMU operated seven days a week. IMC also provided UNHCR with a social worker to facilitate a survey of Syrians remaining in northern Lebanon. In addition to their immediate need for food, shelter and medical assistance, the servced displaced Syrians also needed psycho-social support. IMC's response continued till June 17th.

Rationale

In early May, the Ministry of Social Affairs in Lebanon asked IMC and other key organizations to form a technical committee to design and implement a preliminary psychosocial needs assessment

On May 20th, two of IMC's existing social workers were deployed to the North, to conduct a qualitative assessment of needs, mainly looking at areas of distress and types of issues that need more focused Mental Health and Psychosocial Support (MHPSS) interventions in the long term. IMC used this assessment to examine for specific needs communicated by the vulnerable population (children, women, elderly, individuals with pre-existing mental health conditions) and protection issues arising in the area of displacement, and/or protection issues faced before/during displacement. This assessment is meant to complement the quantitative assessment that was conducted by UNHCR.

IMC will share the assessment reports with donor agencies and implementing partners to leverage required support.

IMC's Psychosocial Qualitative Assessment

The main aim of IMC's presence was to investigate what kind of problems these people have and to decide how IMC can best offer support. Therefore the goal was threefold (a) to identify signs of psychological and social distress, (b) to identify signs of impaired daily functioning, and (c) to identify their coping methods.

For the assessment, IMC consulted with IMC's Global Monitoring and Evaluation Specialist and agreed with the Lebanon team on using tool 11[1] from the World Health Organization (WHO) MHPSS Assessment Toolkit.

The tool is comprised of a free listing format asking questions about the general problems faced, the types of daily functioning affected, and the coping methods being used by the displaced. The WHO tool is mostly used in major humanitarian crises and it helps provide a general overview of the psychosocial needs of the affected individuals.

The two IMC social workers conducted five days of assessments starting from May the 20th. The participants were told prior to conducting the interview that IMC cannot promise to give them support in exchange for the interview; moreover, that IMC is simply asking questions in order to learn from their experiences. In addition, the participants were informed that they are free to participate or not. The participants were also ensured that their information will remain anonymous. Each interview lasted on average from half an hour to forty-five (45) minutes.

Statistics

Demographic Data:

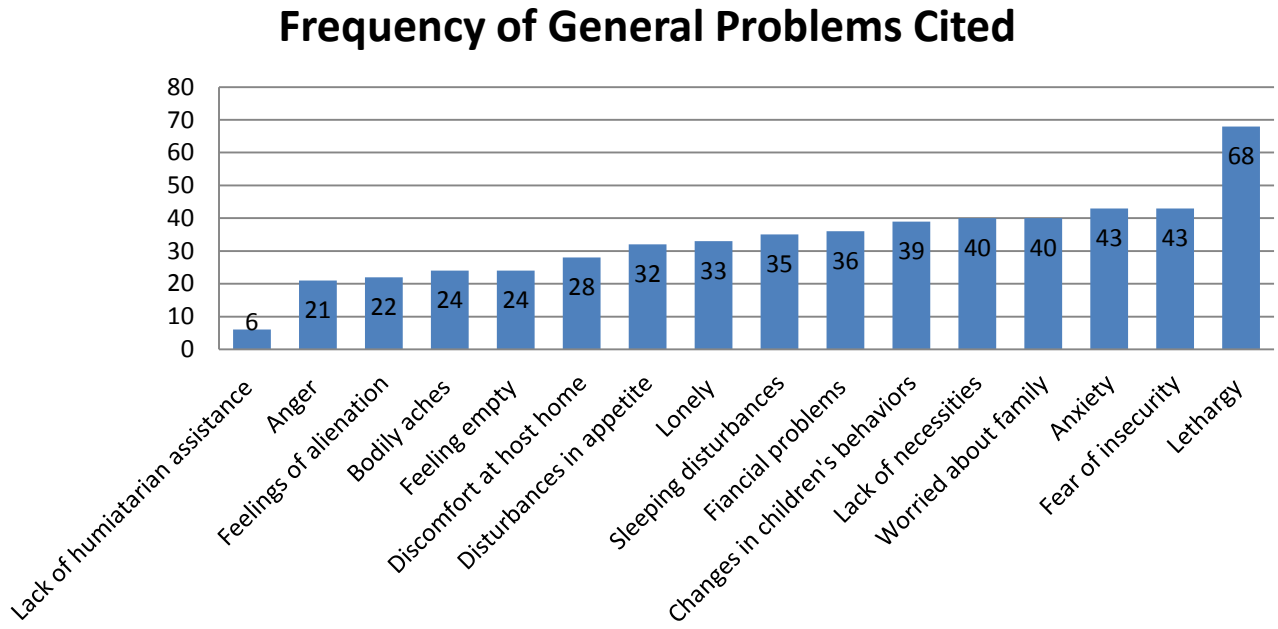
One hundred (100) individuals took part in the assessment. The sample of participants corresponds to the initial demographic report released by UHNCR where they had stated that the number of females was greater than that of males because more women and children had crossed into the northern villages bordering Lebanon and Syria.

Gender	36% Male	64% Female	
Average age	32 years		
Marital Status	72% Married	28% Single	
Religion	100% Sunni Muslims		
Average Household	8		
Area of Origin	61% Talkalah	21% Alarida	
Date of Arrival	78% May 2011		
Level of Education	56% Elementary	23% High School	18% Illiterate
Skills	42% Housewife	14% Construction	11% Unemployed
Disabilities	8% of families with a member with a disability		

[1] World Health Organization. Free listing on local indicators of problems, daily functioning, and coping methods. In: *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises*. Geneva: WHO, 2011.

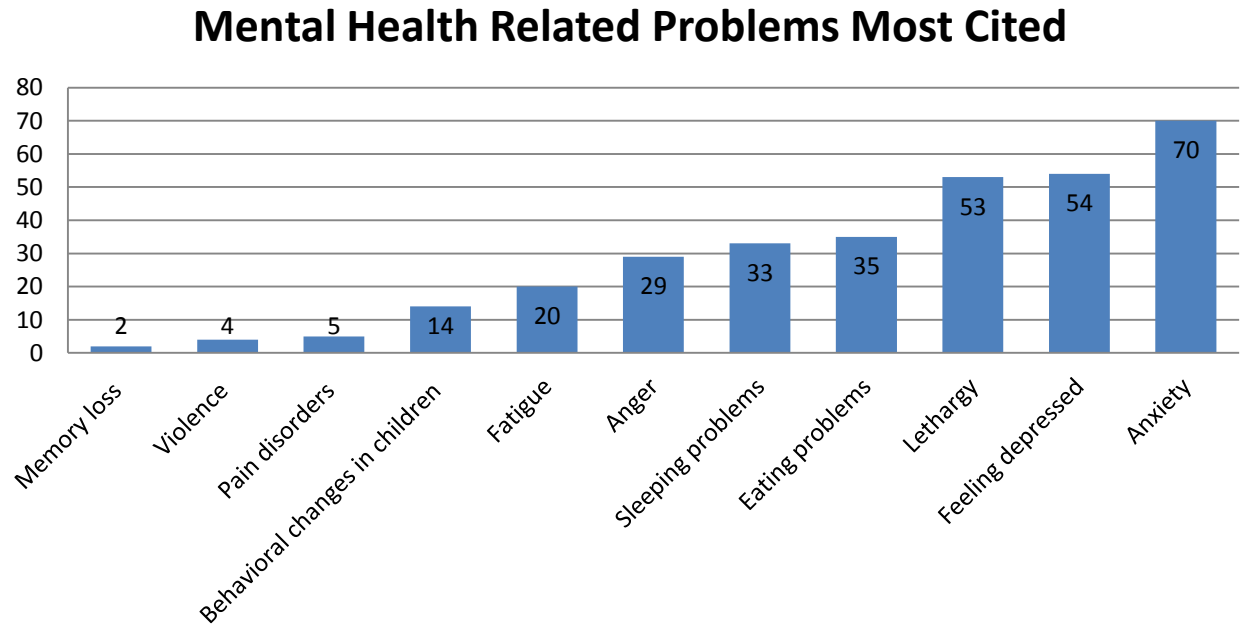
General Problems

The assessment required that the participants provide a free listing of the ten general problems they are currently facing and experiencing. In order to analyze the results of this assessment, the free listing responses were categorized by similarity and context and then placed under a general umbrella category that encompasses the various yet similar responses; a frequency counting was then conducted on the broader categories.



Mental Health

The mental health section of the WHO assessment required the interviewer to ask for just problems and then make decisions which cited problems are mental health related and ask participants which of those are most important. Again, the free listing answers were categorized and grouped together to fall under one umbrella, and a frequency listing was conducted on the answers.



Problems and Reasons

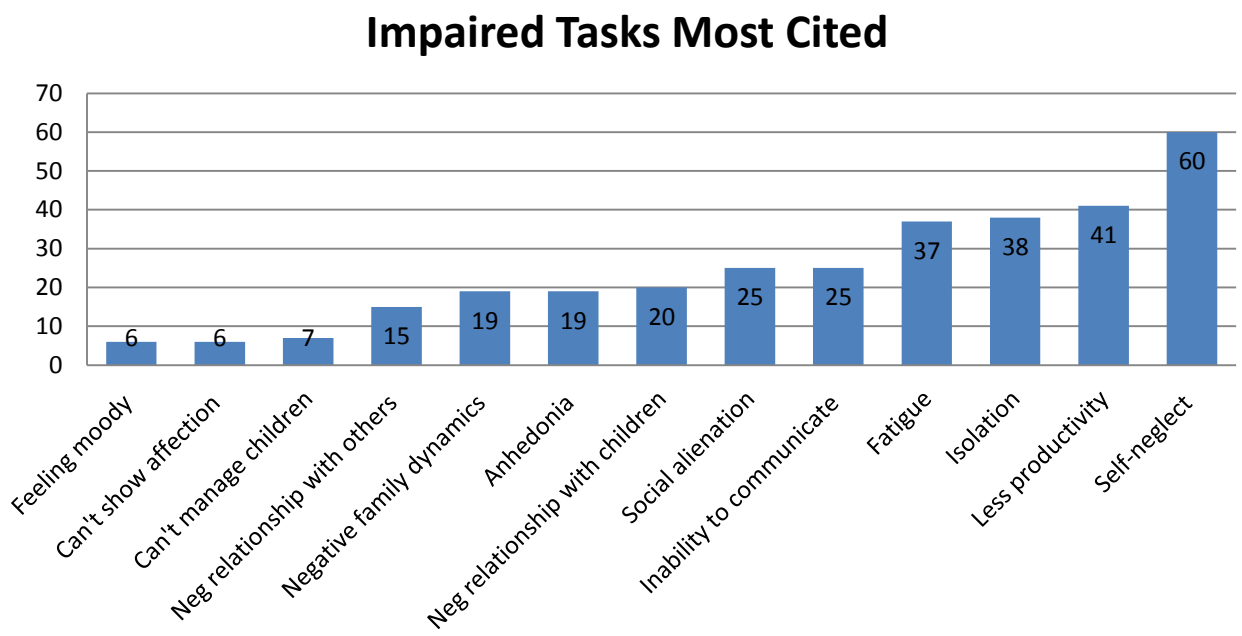
The section following the listing of the mental health-related problems is concerned with having the participants mention what are the three most important problems they are facing and what their reasoning are. The table below shows the most problems and reasons cited:

Problems Cited:	**Reasons cited:**
1. Anger	1. Affects children
2. Fear	2. Affects relationships with others
3. Stress	3. Affects daily functioning
4. Lethargy	4. Feeling hopeless
5. Feeling Depressed	5. Affects family dynamics
6. Anxiety	6. Feeling hostile
7. Hopelessness	7. Feelings of guilt (Survivor's Guilt)
8. Hate	8. Affects health
9. Fatigue	
10. Sleep Disturbances	
11. Bodily Aches	

Although the interview asks the reasons for the problems listed above, the responses provided are more "as a result of the problem" and not the reason for the problem per say. This can be accounted for by there being a misunderstanding of the question by either the interviewer or the interviewee. However, the answers that can be considered or seen as "reasons" are:
(a) Feeling hostile,
(b) Feeling hopeless,
(c) Feelings of guilt/shame.
The feelings of hostility can be seen as closely relating to the problem of anger; feelings of hopelessness can be linked to the problem of hopelessness; and feelings of guilt/shame can be the root to the problems of lethargy and feeling depressed.
However it was noted that the problems of anger, fear, stress, feeling depressed, anxiety, fatigue, and sleep disturbances affects children, family dynamics, relationships with others, daily functioning, and health. Therefore, the debilitating problems are directly causing effects on the displaced Syrians' health, wellbeing, social interactions, and relationships with their children – making them feel incapacitated.

Impairment of daily activities

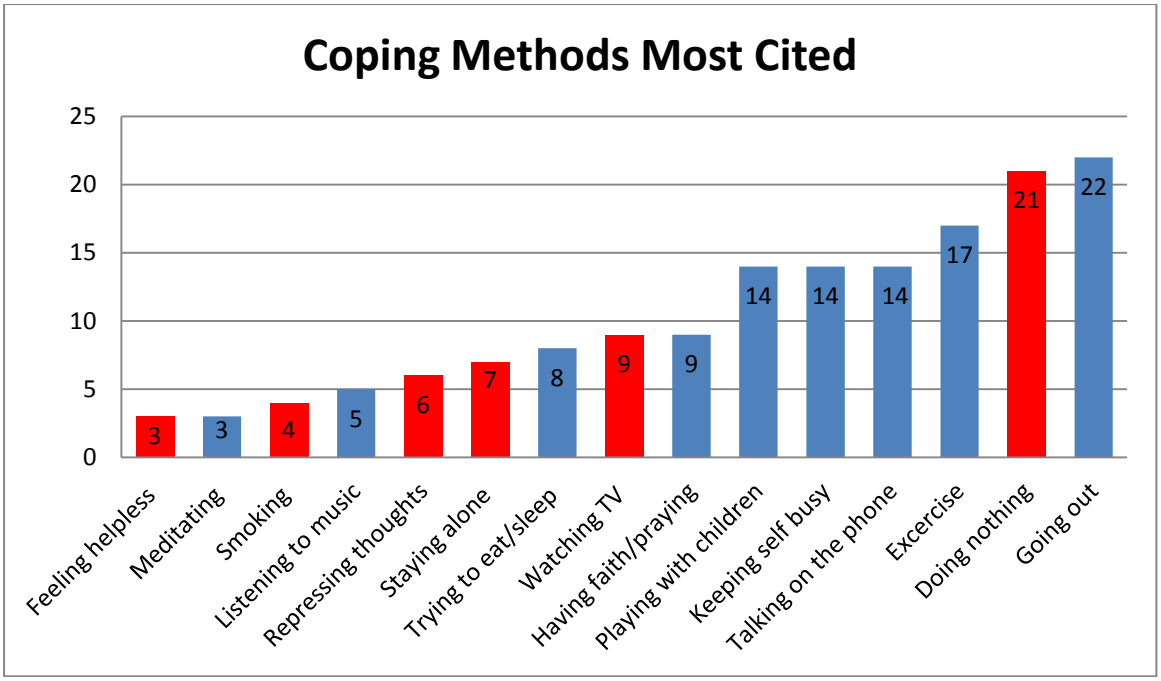
This section of the assessment investigated the tasks impaired by the problems that were stated previously. The question asked them to list the kinds of tasks that will be difficult for them to complete or partake in as a result of the specified problems. However, it is important to note that the impairments in tasks should have only been asked of those participants with actual mental health problems and not part of the general focus group discussion; nevertheless that was not the case with the displaced Syrians in this report.



Self-neglect was the task that was shown to be the most impaired. Self-neglect included grooming and taking care of oneself physically; and that included eating and sleeping sufficiently. With less productivity participants said that they felt tired and incapable of taking part in daily activities. Feelings of isolation were mentioned; where the participants described themselves as feeling alone and no one understanding their predicament in regards to the dangers they faced when crossing the border into Akkar. The family unit was shown to be affected greatly by the problems that were discussed; with mothers claiming that because they have witnessed changes in the behaviors of their children, this caused them to react negatively with them thus creating an atmosphere of negativity with the children and within the family itself. Mothers expressed an inability to show affection towards their children and this feeds into their feelings of isolation, alienation, and negative relationships. Managing the children's behaviors was also shown to be a task that was impaired. Feeling moody and frustrated were described as them being angry and feeling 'hatred' by the interviewees and this can correlate with the levels of negative relationships they expressed with others. Therefore, the social aspect of everyday interactions and tasks were shown to be the most affected by the problems exhibited by the displaced Syrians.

Coping Methods

Various coping methods were provided as means to help the displaced Syrians deal with their problems. The graph below shows the mechanisms that were mostly cited; the ones in red are negative coping mechanisms, whereas the blue are positive coping mechanisms.
Positive coping mechanisms are viewed as activities that reduce the level of stress or discomfort being felt by the interviewees; these included: (a) exercising, (b) going out, and (c) playing with one's children.
Negative coping mechanisms are stress-inducing or exacerbating; these were: (a) smoking, (b) watching TV [specifically the news and worrying about the ones still in Syria], (c) doing nothing [which caused 'negative ruminating thoughts' to occur], and (d) staying alone [increasing one's feelings of social alienation].



Summary of Major Findings

One hundred (100) participants had been interviewed by two IMC social workers regarding their general problems, mental-health related problems, the tasks that are impaired as a result of these problems, and which coping mechanisms they use to deal with the hardships. 64% of the participants were females and 36% were males; this is in accord with the initial data released by UNHCR stating that more women than men had crossed the border into the northern Lebanese villages of Akkar and Wadi Khaled. 72% were married and 28% were single. 61% of the participants were from the Syrian region of Talkalah and 62% of them had crossed into Lebanon in the beginning month of May 2011. In regards to their educational level, 56% claimed to have completed elementary level of schooling. 42% of the displaced Syrians identified their skills as that of house-wife.

The general problems that were the most cited were lethargy and anxiety/fear of insecurity and instability. Lethargy was described as feeling bored, restless, and uncertain about the future. With the mental health related problems, anxiety symptoms and feeling depressed were said to be the most evident problems. Fear of instability and of deportation back to Syria, and worried thoughts about loved ones still in Syria constituted the category of anxiety. Again, anxiety and feeling depressed were selected to have the highest ranking of stated problems that seem to interfere with their daily functioning and affects the relationship they have with their children with mothers stating that they are unsure of how to deal with their children and how to manage them. The most impaired tasks were that of self-neglect and feeling less productive. The interviewees described themselves too lethargic to groom themselves; they added that they felt constantly fatigued and tired because they had difficulty either achieving or maintaining sleep during the night as a result of having nightmares and remembering the traumas or because of feeling discomfort and ill at ease at the host's home with issues of privacy and not enough sleeping spaces to be key points of focus. Means of coping revealed that going out was the most popular means to be implemented, by walking around the host's house and acquainting themselves with other displaced Syrians in the neighboring house; whereas doing nothing came in second as the most coping technique to be used. Doing nothing entailed the participants describing their behaviors as though in a state of limbo; sitting in front of the window and watching their children play outside, or sitting and trying to repress their thoughts and worries about the loved ones that are still in Syria.

Assessment Limitations

There were errors in the form of implementing and making use of the WHO assessment tool. This was evidenced in the manner in which questions pertaining to mental health problems, as well as gathering information on the reasons and causes of the mental health cited problems. Moreover, questions pertaining to impairment should have only been asked of those with actual mental health problems and used as part of the interview process. These errors could have been resulted from either a misunderstanding from the interviewee or the interviewer's inability to ask the questions properly. A recommendation would be to provide future interviewers a training course, with role-playing, to prepare them on how to conduct the WHO assessment.

Conclusions

Among displaced Syrians in the North of Lebanon, prevalence of symptoms of mental health conditions was substantial and significantly associated with displacement status and underlying exposure to distressing events prior, during and after displacement into Lebanon.

IMC has identified the need for a widely-targeted, social support intervention that will protect and support the mental health and psychosocial wellbeing of a conflict-affected and temporarily displaced population. While social and outreach workers have been deployed in the North by other agencies, there is a need for capacity building of non-specialized staff, including community workers, volunteers, and NGO staff to provide basic emotional and practical support to individuals and families crossing the border. Non-specialized staff and local and international NGO staff interacting with the displaced population most frequently, must be equipped with the skills and tools needed to support and manage the needs of a population exposed to a distressing event.

In addition, in line with its global approach to Mental Health, IMC will be expanding its community based mental health program to target the North region. IMC will build the capacity of clinic staff (doctors and nurses) to identify, manage (mild to moderate cases) and refer (severe cases) the most common mental health disorders seen at the PHC level. Working out of three PHC clinics in the North, IMC will engage PHC/outreach social workers, and specialized staff to work with clinic staff (doctors and mid level staff) on managing patients in need of psychiatric, psychological and social support.

And finally, together with the Ministry of Social Affairs (MOSA), IMC has identified the need for listening and counseling training for social workers to enhance services provided to victims of Domestic Violence and Gender Based Violence at the Social Development Center level. The training would be in line with current efforts with MOSA to standardize GBV Documentation for use by social workers, screening tools for use by PHC and case management staff and a Code of Conduct for use by PHC staff. IMC has conducted a mapping of SDCs in the North and Bekaa areas, and will identify, together with the MOSA, centers that would undergo listening and counseling training.

Prepared by IMC team in Lebanon

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