

Mental health literacy of internally displaced Syrian young people and their parents in Syria: paving the way for mental health education and promotion in vulnerable communities.

Survey Based Study Protocol

Version 1.1 8th December 2017

Eleanor Hitchman, Mental Health Adviser, MSF-OCA

Dr Shameran Slewa-Younan. Senior Lecturer in Mental Health, School of Medicine, Western Sydney University, Australia

Kate White, Health Adviser, MSF-OCA

Isidro Carrion-Martin, Epidemiologist, MSF-OCA

Professor Anthony F Jorm, Professorial Fellow and NHMRC Senior Principal Research Fellow, Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia.

**Proposal Information**

First version 29 September 2017

1. Revision 8 December 2017 Version 1.1

XX 2017 Version 1.2

Study design Simple random sampling

Study type Cross-sectional observational study

Study subjects Population living in the survey area

Study period March – May 2018

Study site Manbij IDP camps, Aleppo Governorate, Syria

Kobane town, Aleppo Governorate, Syria

Ain Issa IDP camp, Ar-Raqqah Governorate, Syria

Tal Abyad town & surrounding villages, Ar-Raqqah Governorate,

Tal Abyad town & surrounding villages, Ar-Raqqah Governorate

Principal investigator Eleanor Hitchman for MSF-OCA Email: eleanor.hitchman@amsterdam.msf.org

Co-investigators Dr Shameran Slewa-Younan, Western Sydney University, Australia

Vanessa Cramond, Medical Coordinator, MSF-OCA

Kate White, Health Advisor, MSF-OCA

Isidro Carrion-Martin, Epidemiology Advisor, MSF-UK

General Health Director, Aleppo Governorate

General Health Director, Ar-Raqqah Governorate

Representative of Ministry for Displacement & Migration, Aleppo Governorate

Representative of Ministry for Displacement & Migration, Ar-Raqqah Governorate

Professor Anthony F Jorm, Professorial Fellow and NHMRC Senior Principal Research Fellow, Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia.

Collaborating institutions School of Medicine, Western Sydney University, Australia

Directorate of Health, Aleppo Governorate

Directorate of Health, Ar-Raqqah Governorate

Ministry for Displacement & Migration, Aleppo Governorate

Ministry for Displacement & Migration, Ar-Raqqah Governorate

**Table of Contents**

1. **List of abbreviations 4**

**2. Background 5**

2.1 Context 5

2.2 Mental health in Syria 7

2.3 Mental health Literacy 8

2.4 Consequences of war and conflict on children 9

2.5 Current mental health services offered by MSF 10

3. **Justification 11**

**4. Objectives 12**

4.1. Primary Objective 12

4.2. Specific objectives 12

5. **Methodology 13**

5.1. Study design and area 13

5.2. Study Population 13

5.3. Eligibility criteria 13

5.4. Definitions 14

5.5. Sample size 14

5.6. Sampling and recruitment strategy 15

6. **Survey Instruments 16**

6.1.1 Mental Health Literacy Survey 16

6.1.2: SRQ-20 17

6.1.3a: CRIES-13 17

6.1.3b: MFQ 17

6.2 Administration 17

6.3 Interview Language 18

6.4 Implementation 18

7. **Data Management 19**

7.1 Data Collection 19

7.2 Data entry 19

7.3 Data analysis 19

7.4 Data protection and management 20

7.5 Quality assurance 20

8. **Ethical considerations 20**

8.1 Informed consent 21

8.2 Risks and benefits related to survey participation 21

8.3 Outcome 22

9. **Collaboration 23**

9.1 Dissemination of findings 23

10. **Recruitment, Training & Implementation 23**

10.1 Selection and tasks of study teams 23

10.2 Supervision 24

10.3: Suggested MSF support in the field 24

10.4 Training of study teams 24

10.5 Timeframe in the field 24

11. **Logistics 25**

11.1 Supplies required 25

11.2 Transport 26

11.3 Budget 26

11.4 Study schedule 26

**12. Bibliography 27**

**13. Annexes 30**

1. **List of abbreviations**

|  |  |
| --- | --- |
| CI | Confidence Interval |
| DoH | Directorate of Health |
| EUR | Euro |
| FGD | Focus Group Discussion |
| FSA | Free Syrian Army |
| GIS | Geographic Information System |
| OS | Government of Syria |
| GPS | Global positioning system |
| IBM SPSS | Statistical Package for the Social Sciences |
| IDP | Internally displaced population |
| IED | Improvised explosive device |
| IOM | International organization for migration |
| IQD | Iraqi Dinar |
| ISIL | Islamic state of Iraq and the Levant |
| ISIS | Islamic State of Iraq and Syria |
| IT | Information Technology |
| KPG | Kurdish Paramilitary Group |
| MdM | Médecins du Monde |
| MedCo | Medical coordinator |
| MHAM | Mental Health Activity Manager |
| MHL | Mental Health Literacy |
| MSF | Médecins Sans Frontières |
| MTL | Medical team leader |
| OCA | Operational centre Amsterdam |
| PHC | Primary Healthcare Clinics |
| PI | Principle Investigator |
| PKK | Kurdistan Workers' Party |
| PTSD | Posttraumatic Stress Disorder |
| PYD | Syrian Kurds and the Democratic Union Party |
| SDF | Syrian Democratic Forces |
| TAF | Turkish Armed Forces |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |

1. **Background**
   1. Context

The ‘Arab Spring’, a period of civil unrest, revolts and uprisings, affected millions of people across

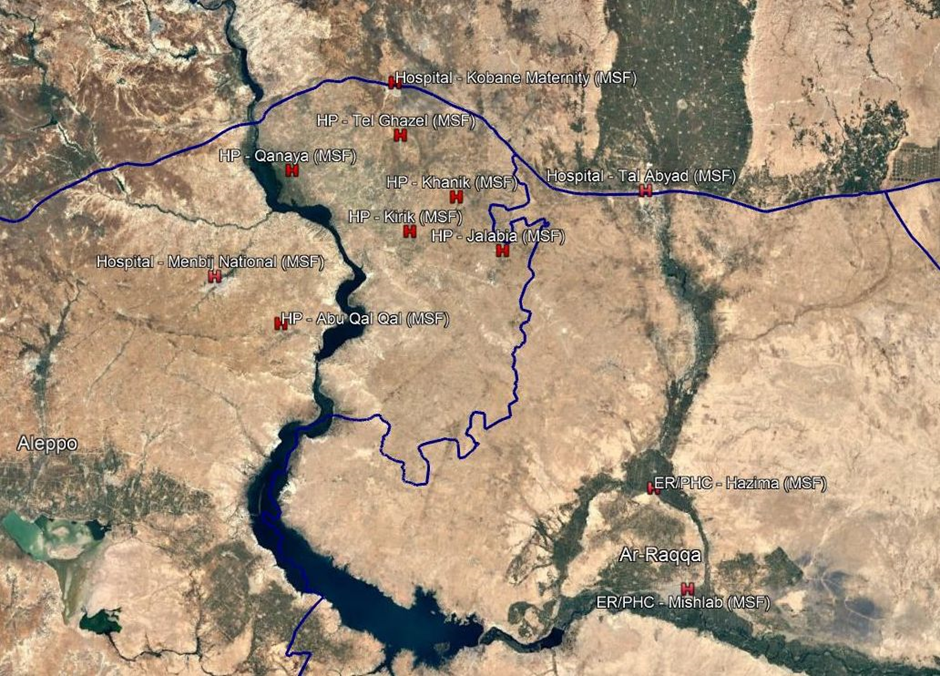
the Arab world. It began with a Tunisian uprising in December 2010, followed by similar revolts

in Egypt, Libya, Yemen, Syria, Bahrain, and other Arab nations. These events led to the collapse

of several regimes, and called for the establishment of democratic governments. In Syria, peaceful demonstrations abruptly changed into conflict and unrest in Damascus and Aleppo on March 15th 2011, and by June 2011, armed clashes erupted in many locations. By September 3rd 2013, over 100,000 people had been killed, over two million individuals had fled their homes seeking refuge in neighboring countries, and another four million people were forced to leave their homes within Syria.

The healthcare system in Northern Syria has effectively collapsed as a result of the conflict. There are severe shortages of medical supply; insufficient medical professionals, a nascent government with little experience in public policy, no free access to primary or secondary healthcare (outside MSF supported facilities) and no vaccination or broader preventive healthcare programmes which leave the population vulnerable to outbreaks. It is largely cut off from international organisations and supplies. The border crossing between Kobane/Suruç was closed by Turkish authorities in February 2016. The border crossing was the only one open between Turkey and Syria with access to the North-East and it is not expected to re-open any time soon. There is a clear lack of humanitarian actors. Since the Government of Northern Syria is not recognized as an official government, international support is minimal. UN operations are constrained by GoS and many NGOs based in the north east of Syria are unequipped to respond to the needs.

Map: MSF Project Locations in Northern Syria



Ar-Raqqah Governorate

Current displacement in Ar-Raqqah governorate exceeds 30,000 people per month. Local military and civil authorities do not trust the displaced because they lived under ISIS for several years and therefore screening processes are intense and movement restrictions can be severe. Approximately 10,000-15,000 people displaced into Jab Shaer in April 2017. Movement of displaced from Jab Shaer to a new camp in Ain Issa (Shahid Aziz) was followed by mass movements to Manbij a few days later There were reports of massive displacement in Karama, east of Raqqa, of approximately 50,000-70,000 people (March-April 2017).

Tal Abyad

Tal Abyad is based in the North of Syria at the Turkish Border. At the census of 2004 the population was around 130.000 people in Tal Abyad district, no current accurate estimates are available and difficult to know with multiple displacement. Until the start of the civil war, Tal Abyad was under control of the Government of Syria. In September 2012 different groups took control over Tal Abyad under the flag of the Free Syrian Army. In June 2013 Al-Nusra Front and later ISIS took control. Although fighting in Tal Abyad has abated since October 2015, the city remains fragile to Turkish interference and internal disputes. Nevertheless, the mixed nature of the population (75% Arab, 15% Turkmen, and 10% Kurdish) makes it an important refuge for many in the conflict. War-wounded patients are arriving in Tal-Abyad as the Raqqa offensive intensifies and needs of urgent medical and psychological support have increased.

Ar-Raqqah City

Ar-Raqqah has been under ISIS control since early 2014, with an estimated population of around 250,000 people. Up to 200,000 people are expected to be displaced from the conflict. Given the symbolic status of Ar-Raqqah as the ISIS capital, the battle is expected to be fierce. Indiscriminate bombing and shelling has been a hallmark of coalition military tactics in the Syrian conflict. On the other hand, vehicle based suicide attacks (VBIEDs), victim operated improvised explosive devices (IEDs/booby-traps) and improvised mines are common tactics of ISIS. All of these tactics disproportionately affect civilians, and a high number of civilian (and military) war wounded are expected from the Ar-Raqqah offensive. According to the UN, 181,400 people have fled Raqqa city (UN Habitat September 2016) which indicates that nearly 79% of the original population fled the city since ISIL captured Raqqa in 2014. Main triggers for displacement were fear of rape, recruitment of children and forced conscription of adult males. Later, collapsing public services (health, education, and employment) made people decide to flee.

Aleppo Governorate

Aleppo Governorate is the most populous governorate in Syria with a population of more than 4,868,000 (2011 Est.), almost 23% of the total population of Syria. The capital is the city of Aleppo, which has been subject to well publicized fighting. In early 2016, IS continued to occupy strategic locations in Jarablus, a border town in the governorate, near Gaziantep, Menbij (main access route to Al Raqqa) and also Al Bab. During a sustained offensive in late July/early August 2016, SDF with US led coalition support took control of Menbij. IS fled to Jarablus and senior leaders retreated to Al Raqqa. In what then could be the most significant move during the year, the Turkish Armed Forces (TAF) and the Free Syrian Army (FSA) seized an opportunity to engage with IS in the border town of Jarablus. This was also seen as a move to restrict the onward advances made by the predominantly Kurdish SDF towards linking other pockets of Kurdish controlled areas and therefore forming a contiguous territory between Iraq and Afrin. This was the first time that Turkey had entered the war in Syria, albeit claiming to protect their borders as they tried to establish the buffer zone along their southern boundary with Syria. Skirmishes followed and even air strikes on SDF positions were reported which brought both US and Turkey into a more hostile dialogue.

Kobane

The population of Kobane Canton has increased to over 260,000 people with approximately 46,000 in Kobane town. From September 2014 to January 2015 the city was under siege by ISIS. In February 2015 YPG took control, with an estimated 70% of the town having been damaged. In 2014 it was declared to be the administrative centre of the Kobane canton part of the self-declared federation of northern Syria. Kobane symbolises for the Kurdish population the Kurdish resistance and is from a political view a center and stronghold for the PYD/YPG. Political tension between the Kurdish parties increased which leads to arrests and demonstrations and small violence. Kobane is currently around 90km from the ISIS frontline. West of Kobane (30km) FSA controls the border area from Jarablus onwards. The relation between Turkey and North Syria is deteriorating since the ceasefire quit between Turkey and the PKK; acquiescing the YPG to cooperate and support the PKK which led to the building of a wall on the border, regular demonstrations and cross border shooting and in the border and aerial bombings of Turkey on YPG military locations.

Menbij

From August 2013 until August 2016 Menbij has been under IS control until they were driven out by SDF (Syrian Democratic Forces, largely Kurdish YPG) and US coalition forces. The MSF team which entered Menbij in October 2016 found all basic infrastructure and health systems to be in disrepair and not functioning. It is currently surrounded by frontlines. The Russian backed-GoS troops advance south of Menbij against IS has been rapid leading to large scale displacement in Menbij town and in rural areas to the south of the city. Estimates of the numbers displaced vary widely from 40,000 to 120,000 persons. The SDF and the Menbij Military Council have turned over a significant amount of territory to the GoS/Russia west of Menbij, effectively creating a buffer zone between SDF and the Turkish-backed FSA forces near Al Bab. Turkey continues to make claims to take over Menbij, Russian forces are claiming delivery of humanitarian aid in Menbij, GoS has declared they will resume administrative responsibilities, and the American forces have increased their visible presence in and around Menbij. The multiplicity of actors with competing agendas in close proximity to each other raises concerns for conflict escalation as well as casts doubts and high levels of uncertainty regarding the political and security future of Menbij.

2.2 Mental Health in Syria

The effects of conflict on Syrian mental health and psychosocial wellbeing are profound. Experiences of conflict-related violence and concerns about the situation are compounded by the daily stressors of displacement, including poverty, lack of basic needs and services, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future. Populations affected by situations of unrest, violence, loss, separation, and drastic changes in social and living conditions, are likely to experience a number of distressing psychological reactions such as hopelessness, helplessness, anxiety, as well as behavioral and social problems (1).

A central issue in armed conflict settings is loss and grief, whether for deceased family members or for other emotional, relational and material losses. Psychological and social distress among refugees from Syria and IDPs in Syria manifests in a wide range of emotional, cognitive, physical, and behavioural and social problems, which have been well documented (2,3,4,5). These are common and normal reactions to abnormal events with experience and research indicating that the majority of people will exhibit resiliency, and recover over time using natural coping mechanisms which can be fostered by supportive environments. For most Syrians, the first source of support is the circle of family and friends, however due to displacement and the dynamics of the conflict these social support structures are frequently disrupted. A minority of people will develop more enduring mental health problems such as depression or anxiety and such problems make it difficult for people to attend to their physical health needs, routine daily tasks, and maintain good relationships with others (1).

In July & August 2017 MSF conducted a health access survey in both Menbij and Ain Issa IDP camps. From Menbij camp 478 households completed the survey. Of the population 17.7% was < 5 years, 36.1% 5-14 years and 38.1% between 15-45 years. Head of households reported feeling afraid (14.5%), angry (27%), uninterested (23.5%), hopeless (29.5%), severely upset (22%) and unable to carry out essential activities (25%) either all of the time or most of the time. When asked about household members > 2 years old (N=2,306) 29.88% were reported as being distressed, disturbed or upset that s/he was completely inactive or almost completely inactive, because of any such feelings. For household members >12 years of age (N=1065) 24% had stop caring properly for his/her self because s/ he is feeling distressed/ disturbed /upset and 9.6% had stop caring properly for children s/he is responsible, because s/he is feeling distressed/disturbed /upset. For household members between 2 and 12 years (N=1280) it was reported that 29% had bedwetting in the past 2 weeks, of which 23% had the problem a year ago (32).

From Ain Issa 410 households completed the survey; of the population 18.3% were children aged <5 years, 33.3% 5-14 years and 39.6% between 15-45 years. Head of households reported feeling afraid (28%), angry (34%), uninterested (29%), hopeless (25%), severely upset (22%) and unable to carry out essential activities (30%) either all or most of the time. When asked about household members > 2 years old (N=2,306) 29.88% were reported as being distressed, disturbed or upset that s/he was completely inactive or almost completely inactive, because of any such feelings. For Household members > 2 years old (N=1,766); 34% reported being distressed/disturbed or upset that s/he was completely inactive or almost completely inactive, because of any such feelings. For Household members between 2 and 12 years (N=1280); 7% of under 5’s and 8% of 5-12 year olds were reported as bedwetting in the last 2 weeks compared to 32% of under 5’s and 30% 5-12 year olds one year ago. For Household members >12 years of age (N=1065): 28.5% have stopped caring properly for his/her self because s/ he is feeling distressed/ disturbed /upset. 32% had stopped caring properly for children s/he is responsible, because s/he is feeling distressed/disturbed /upset (32).

2.3 Mental Health Literacy

Although poorly understood, factors such as cultural beliefs regarding the nature and treatment of mental illness, lack of insight, limited understanding of treatment options, and a lack of knowledge regarding risk factors for and causes of mental disorders have all been postulated to impede early and appropriate mental health service use (8). Mental health is a socially constructed and socially defined concept in that each society, group (class, gender, ethnicity, and age), culture, religion, institution and profession has different ways of conceptualizing its nature and causes. This can include determining what is considered mentally healthy, how people experience and express suffering, how they explain illness and misfortune, and deciding what interventions, if any, are appropriate (9). If people perceive the origins of psychological distress as somatic they will usually expect their treatment to follow medical lines and may not present at mental health services. Therefore, in order to devise an effective mental health promotion campaign, assessing the public’s knowledge and prevailing attitude towards mental health as well as sources of support and coping, and how these are changing as a result of conflict and displacement would be the prerequisites. As many of the previously-published studies were conducted in the West, it is important to understand and explore clients’ cultural idioms of distress (common modes of expressing distress within a culture or community) and explanatory models (the ways that people explain and make sense of their symptoms or illness), which influence their expectations and coping strategies.

2.4 Consequence of war and conflict on children

At least 3 million Syrian children under the age of six know nothing but war, and millions more have grown up in fear under the shadow of conflict. Studies into the mental health of Syrian refugee children have shown high levels of trauma and distress. However, much less is known about the impact on children still inside the country. A study by Save the Children reported found that 84% of adults and almost all children said that ongoing bombing and shelling is the number one cause of psychological stress in children’s daily lives and 89% said children’s behaviour has become more fearful and nervous as the war goes on. 80% said children and adolescents have become more aggressive and 71% said that children increasingly suffer from frequent bedwetting and involuntary urination. Two-thirds of children are said to have lost a loved one, or had their house bombed or shelled, or suffered war-related injuries. 51% said adolescents are turning to drugs to cope with the stress, 48% of adults have seen children who have lost the ability to speak or who have developed speech impediments since the start of the war. 49% said children regularly or always have feelings of grief or extreme sadness and 78% have these feelings at least some of the time. Half of interviewees said that domestic abuse has increased (6). The way parents care for their children during displacement plays a key role in children’s emotional and behavioural outcomes. A study by El-Khani et al (2016) (6) examining the parenting experiences of Syrian families living in refugee camps, focused on understanding how parenting had changed and the impact displacement had had on their parenting. Using interviews and FGD’s they found 3 themes which included 1) environmental challenges; 2) child specific challenges; and 3) parent specific challenges. Results clearly showed that parents struggled physically and emotionally to support their children (7). The needs are significant yet there is a critical shortage of mental health and psychosocial support in Syria

Research on the consequences of war and conflict on the mental health and development

of children has greatly increased in the last decade (18, 19).The majority of children exposed to armed conflict show signs of mental health difficulties (20, 21). A systematic review of child mental health in ongoing or post war situations revealed elevated levels of posttraumatic stress disorder (PTSD) (47%; 17 studies), depression (43%; four studies)(31). Other studies have shown that children exposed to war are also at high risk of developing various types of psychopathology (22, 23)

Extreme adversity in early childhood can hamper children’s healthy development and their ability

to function fully, even once the violence has ceased. However, these impacts are not inevitable and, if children have supportive relationships with caring adults early in their lives, the damaging

effects can be reversed (6). After six years of war, however, many of Syria’s children have lost much critical time for development, and the long-term damage has the potential to become irreversible

and permanent (24). Consequently, improved awareness of communities and parents regarding the mental health and psychosocial issues of children is vitally needed. Further, by highlighting that the symptoms being expressed by children in these situations are a normal response given the persistent violence to which they have been exposed (6) programs targeting stigma associated with mental health can be created.

Children need mental health and psychosocial support to improve their wellbeing in both the immediate term and for years to come. With support, and in a safe environment, children who have gone through trauma can recover (27). Research into PTSD among communities in post-conflict countries such as Sri Lanka (28) has shown that even after several years in conflict zones, behavioural therapy and support can significantly reduce symptoms. For this reason, this research will focus on children (defined as 8-12 years in this study), their parents and young people (13 to 17 years).

Whilst the needs have been identified there is however no existing research examining the Mental Health Literacy of Syrians within Syria or displaced to neighbouring countries who represent a wide diversity of social, socioeconomic, ethnic, and religious backgrounds among the population. The aim is to use the survey to assess the attitudes of populations in the project locations and use the knowledge and understanding of these local conceptualisations to allow better development of appropriate services and enable the design of interventions that mobilise individual and collective strengths, and resilience.

2.5 Current mental health services offered by MSF in northern Syria

MSF currently runs mental health activities in both Kobane Town and in Tal Abyad hospital.

In Kobane MSF is running a community centre that provides psychoeducation and psychosocial activities, primarily for children as well as individual counselling. The plan for 2018 is to increase the counselling activities, both individual and groups, for children and adults. In Tal Abyad hospital MSF is providing psychoeducation and psychosocial activities, primarily for children as well as individual counselling for patients in the hospital. The plan for 2018 is to increase the counselling activities, both individual and groups, for children and adults, within the hospital and the town. In Menbij MSF are currently not running any MH activities but the plan for 2018 is to start activities with 6 counsellors working in various locations in and around the city. Furthermore, MSF is not currently providing any activities in Raqqa, however on the 17th October, ISIL in Raqqa was defeated. Due to this defeat, and the change of context, at this time it is not possible to know even if the camps will still be populated in a few months’ time given that the majority of the population come from Raqqa and are likely to return in the coming period. MSF is currently reviewing its operations in line with the movements of the population and so if the population moves back to Raqqa, then it is likely that MSF will shift the focus its activities to this location. If this is the case then it is proposed that the research will take place in Raqqa town, which is currently not populated, with the newly returned population.

1. **Justification**

Displaced people, and in particular the young, are a particularly vulnerable group. They have very high levels of mental health problems, such as trauma-related disorders, but traditionally a very low uptake of mental health care. Whilst this is changing, evidence suggests that poor “mental health literacy”, namely, poor knowledge and understanding of the nature and treatment of mental health problems is a major factor in low or inappropriate treatment-seeking among individuals with mental health problems. Hence, worldwide there have been efforts to identify specific aspects of mental health literacy likely to be problematic in different demographic subgroups and to use this information to develop mental health promotion programs.

The term “mental health literacy” (MHL) was introduced by Jorm and colleagues (10) as an extension of the concept of “health literacy”. It is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (10). By measuring and quantifying levels of MHL, mental health promotion programs can be developed with intention empower individuals in need of mental health care with the means by which to make an informed decision about accessing this care (11).

The most relevant previous work was undertaken by Dr Slewa-Younan who investigated the MHL of two of the largest populations of refugees being resettled in Australia, namely, those from Iraq and Afghanistan [12, 29, 30]. In this research, adult participants were presented with culturally adapted vignettes of fictional characters – resettled refugees – experiencing symptoms of PTSD and asked to give their opinions about a range of issues concerning the nature and treatment of the problem described, such as problem recognition, beliefs about the helpfulness of different possible treatment providers and perceived barriers to treatment. Findings from these studies indicated that key aspects of mental health literacy, such as awareness of the symptoms of PTSD and beliefs about treatments likely to be helpful, were indeed found to be problematic for those populations [12, 29, 30]. Further, participant’s beliefs were found to vary as a function of participants’ demographic characteristics, such as their level of education and the time since resettlement.

Therefore, the aim of this project is to utilise an appropriately modified version of Dr Slewa-Younan et al MHL survey, to investigate levels of MHL of displaced adolescents and parents of young children in the project locations and use the knowledge and understanding of these local conceptualisations to allow better development of appropriate services and enable the design of interventions that mobilise individual and collective strengths, and resilience.

There is no existing research examining the MHL of Syrians (adult or children) in Syria, particularly displaced people, who represent a wide diversity of social, socioeconomic, ethnic, and religious backgrounds among the population. Importantly, this lack of information is hindering the development of mental health promotion programs and the goal of this study is to redress this situation.

1. **Objectives** 
   1. Primary objective

To determine levels of MHL relating to trauma related mental health disorders, namely posttraumatic stress disorder (PTSD) and depression among the displaced Syrian young people in northern Syria (see study population) .

4.2 Specific objectives

1. To estimate MHL relating to PTSD (and Depression) in a group of displaced Syrian young people (13-17 years old) and the parents of children (age 8-12 years old) pertaining to:
2. Problem recognition (including “self-recognition”)
3. Beliefs about the severity of the problem described and its prevalence in the target population
4. Beliefs about causes and risk factors
5. Beliefs about how best to support someone with PTSD/depression
6. Beliefs about the helpfulness of specific treatments and treatment providers
7. Beliefs about likely outcome with and without treatment
8. Beliefs about possible barriers to treatment
9. Stigma and perceived discrimination towards someone with PTSD/depression
10. To determine associations between specific aspects of MHL as outlined above, and individuals’ demographic characteristics (age, gender, religion, ethnicity, lengthen of displacement etc.) and symptom levels.
11. To estimate the prevalence of mental health distress (major depression, anxiety disorders or suicidality ) using the Self Reporting Questionnaire (SRQ-20) in care takers of children 8-12 years old;
12. To estimate the prevalence of constructs of intrusion, avoidance and arousal in children 8-17 years of age in the study population;
13. To estimate the prevalence of self-reported depression in children 8-17 years old.

The categories specified in objective 1 above were chosen because they were considered to be the aspects of MHL most likely to be of interest in informing the determinants of mental health and quality of life in the proposed population. Objective 2 which seeks to examine the associations between specific aspects of MHL and individuals’ demographic characteristics and symptoms levels is important because associations of this kind can indicate specific targets for health promotion programs.

**5. Methodology**

5.1. Study design and area

Due to the changing security and context situation in Syria, it is not possible in advance to confirm exactly where the survey will take place, hence all possible locations are listed. We will aim to conduct the survey in the locations as described below; however, it is possible that certain locations will be considered off-limits at the last moment due to security concerns.

MHL relating to trauma related mental health disorders, namely posttraumatic stress disorder (PTSD) will be conducted with the population in Ar-Raqqah town, Tal Abyad town and if this is not possible in Ain Issa camps in Ar-Raqqah Governorate. The PTSD vignette will be completed with this population as they were living under ISIL control for several years, fleeing with the escalation of violence in 2017 so are likely to have experienced significant violence and hence be more susceptible to PTSD.

MHL of depression will be conducted with the population in Kobane town, Aleppo Governorate and if this is not possible then in the Manbij town camps, Ar-Raqqah Governorate, Syria. The Depression vignette will be completed with this population as the majority has been living without direct violence for some time but are more susceptible to depression due to living with uncertainty and in difficult living conditions for a number of years.

In all locations where we are able to implement the survey, it will be population based and cross sectional using simple random sampling.

5.2. Study Population

The study population includes persons between 8 and 17 years of age divided into two groups.

For the first group (Group 1) we will aim to interview the parents/caretakers of those persons 8-12 years old with regards to their (the caretaker’s/parent’s) knowledge and attitudes (i.e. levels of MHL) relating to trauma related mental health disorders of their children.

For the second group (Group 2) which will include persons aged 13-17 years old, we will question them directly in order to determine their own levels of MHL relating to trauma related mental health disorders.

5.3. Eligibility criteria

General inclusion criteria:

A person will be included in the survey if he / she satisfy the following criteria:

* Currently living in the randomly selected household

AND

* Informed consent for inclusion in the survey is provided by the head of the household and the person participating (the parent, if not the head of the household and assent for the young person).

Inclusion criteria Group 1: (parents/caretakers of children aged 8-12 years old):

1. A child must be residing in the household that meets the age criteria

2. In cases of households with multiple children aged 8 to 12 years, responses will be recorded from the parent/caregiver pertaining to a randomly selected child in the target age group.

Inclusion criteria Group 2 (adolescents aged 13-17 years)

1. An adolescent must be residing in the household that meets the age criteria

2. In cases of households with multiple adolescents aged 13-17 years, responses will be recorded from a randomly selected the adolescent in that household.

In the case where there are both adolescents and children in one household, only one from each group will be surveyed and will be selected as outlined above. That means only a maximum of two surveys will be collected from each household.

Exclusion criteria:

A person will be excluded from the survey if he / she satisfy any one of the following criteria:

* Inability to locate the potential participant after two attempts of tracing

OR

* Refusal to participate in the survey.

5.4. Definitions

A household is defined as a group of people who live together under the same roof and are under the responsibility of one person (head of household). A head of household is defined as:

* The person accepted as the head by the other members of the household, and
* Can give consent for the person identified for the survey to participate

A household will be excluded from the survey if none of the household members fulfill all these criteria.

5.5. Sample size

Sample size requirements were based on the need to ensure sufficient completed surveys to permit analysis of associations between specific aspects of MHL, demographic variables and symptom status. In the absence of data on the proportion of participants giving responses to the MHL survey that could be considered to be indicative of “good mental health literacy”, sample size calculations assumed a 50% proportion, for this indicator in order to provide the largest sample size that will potentially be required. The below calculated sample size estimates would be for each location in which we are able to conduct the survey.

Thus, in order to estimate a 50% prevalence of ‘good mental health literacy’ with a precision of 8% and an alpha of 0.05 a minimum of 150 completed interviews will be required in each of the two target groups (Group 1 and Group 2). With this sample size, the study will also have 80% power to detect a medium effect size of between 0.23 to 0.27 using 1 to 3 degrees of freedom Chi-square test of associations between key demographic variable, symptom levels and specific aspects of MHL.

Based on recent data from a health access survey that was conducted in Ein Issa and Menbij camps in northern Syria (MSF, unpublished data, August 2017), the average household size in these locations was between 6.38 and 6.66 persons. Of these, 20.5-22.4% (equating to approximately 1.6 children per household) of total household members include children 8-12 years and 11.1-12.3% are adolescents aged 13-17 years (equating to approximately 0.8 persons per household).

Taking into account this known data, we would need to approach the following number of households per group to achieve required number of (n=150 per group):

* Group 1, we would need approach 240 households (1.6 children 8-12 years per household) with non-response rate of 40% to achieve desired sample size of 150.
* Group 2 we would need approach 282 households (0.8 adolescents 13-17 years per household) with non-response rate of 40% to achieve desired sample size of 150.

As members of group 1 and 2 may reside in the same household, it is possible that the true number of households need to be approach may be lower.

5.6. Sampling and recruitment strategy

We will aim to sample all study participants from Group 1 and Group 2 from households that are randomly selected in the study site. Thus there will be two stages of sampling where the first stage includes simple random sampling of potential participating households and a second stage of sampling within the household to identify study participants for Group 1 and Group 2.

For the first sampling stage, as the precise locations of the study sites is yet to be determined we foresee two possibilities for the simple random sampling of households. These are shown below as option 1 and option 2:

**Option 1: Random selection from household list method**

This option may be used if a current and comprehensive household list for the study is available. Random numbers (between 1 and the total number of households in the study site) are generated to obtain the target sample size of (maximum) 282 households is achieved. Only these households will be visited.

**Option 2: GPS-based sampling method**

This option may be used if a current household list is not available. Using satellite imagery or conducting a perimeter walk around the study site, an electronic outline of the camp will be created. GIS software will be used to generate random points within the study site corresponding to the number of households to be visited. Teams using either GPS machines or Android phones with GPS localization functionality will visit the households that coincide exactly with the randomly-generated points (this is to reduce any potential bias due to households in less built-up areas being more likely to be selected than households in densely populated areas). So in fact surplus random points will be generated to allow for events in which households do not coincide with GPS points.

For the second stage of sampling we will make a list of all the persons in the household that meet the eligibility criteria for group 1 and group 2 separately. A participant will be randomly selected from these two lists and asked to participate in the study. Random selection will be done by choosing a random number between 1 and the maximum number of household’s members in that household within that group using a random number table. With this second stage sampling approach it is possible that two participants (one from each group) are selected in a single household.

**6. Survey Instruments:**

Below are tables that articulate what survey instruments are completed by whom:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PTSD MHL Literacy Study | Mental Health literacy Survey on PTSD in child / adolescent | Self-Reporting questionnaire (SRQ) | CRIES-13 | Annex |
| Group 1 (child 8-12 years and parent pair) |  |  |  |  |
| Child |  |  | √ | Annex 2 |
| Parent | √ | √ | √ (parent version) | Annex 3 |
| Group 2 (13-17 years) |  |  |  |  |
| Adolescent | √ |  | √ | Annex 4 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Depression MHL Literacy Study | Mental Health literacy Survey on Depression in child/adolescent | Self-Reporting questionnaire (SRQ) | MFQ (mood and feelings questionnaire) | Annex |
| Group 1 (child 8-12 years and parent pair) |  |  |  |  |
| Child |  |  | √ | Annex 5 |
| Parent | √ | √ | √ (parent version) | Annex 6 |
| Group 2 |  |  |  |  |
| Adolescent | √ |  | √ | Annex 7 |

Following obtaining informed verbal consent, individual interviews will be conducted where survey instruments are administered according to above protocol detailed in tables. Data will be collected in de-identified format (research code) and will collect socio-demographic information such as age, gender, ethnicity and religion

Following is a description of the survey instruments. Validity and internal reliability assessment results of the tools is provided in Annex 8.

6.1.1 Mental Health Literacy Survey (administration time 40mins)

Attitudes and beliefs concerning the nature and treatment of PTSD and depression will be examined using a modified version of the MHL survey developed for adult refugee populations (12). In order to investigate MHL related to PTSD, a case vignette of a fictional person suffering from PTSD will be presented, followed by a series of questions addressing the nature and treatment of the problem described, including: problem recognition; beliefs about the severity of the problem and its prevalence in the target population; beliefs about the likely helpfulness of various possible treatments and treatment providers; beliefs about causes of and risk factors for the problem described; beliefs about how best to support someone with PTSD, stigmatising attitudes towards someone with PTSD; and beliefs about likely barriers to treatment among individuals with a problem such as the one described. Appropriate modifications will be undertaken to ensure suitability of the survey instruments for the groups 1 and 2. Further, a similar survey will be undertaken to examine MHL related to depression however the case vignette will be of a fictional person suffering from depression with questions related to this.

6.1.2: SRQ-20 (administration time 5 minutes)

The SRQ-20 is a 20-item Self-Reporting Questionnaire, which has now been widely used and validated in many cultural contexts. SRQ-20 was developed by the World Health Organization (WHO) as a screening instrument to study mental health disturbances in developing countries (13). The SRQ-20 is effective in identifying participants with major depression, anxiety disorders or suicidality. For the vignette about the child; the person participating in the survey will be asked to complete the SRQ-20 to assess their own mental well-being. .

6.1.3a: CRIES-13 (administration time 10 minutes) (with PTSD MHL vignette)

The Impact of Events Scale (IES) was originally developed by Horowitz et al (1979) (14) to monitor the main phenomena of re-experiencing the traumatic event and of avoidance of that event and the feelings to which it gave rise. It was not originally designed to be used with children, but it has been successfully used in a number of studies with children aged 8 years and older. These separate studies identified identical factor structures of the IES and these were used to select eight items that best reflected the underlying factor structure and so produced a shortened version – the IES-8 for children. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance. An additional 5 items were developed that were designed to reflect the 5 DSM-IV Cluster D symptoms of arousal – hence it is called the CRIES-13. It is designed for use with children aged 8 years and above who are able to read independently.

Or

6.1.3b: Mood and Feelings Questionnaire (administration time 10 mins) (with Depression MHL vignette)

The short version of the Mood and Feelings Questionnaire (MFQ) was developed by Angold et al (1995) (15). The MFQ consists of a series of descriptive phrases regarding how the subject has been feeling or acting recently and is a screening tool for depression in children and young people aged between 6 and 17 years. There is a corresponding parent version, in which the parent is also asked to rate their child. Peer-reviewed studies have found the Mood and Feelings Questionnaire to be a reliable and valid measure of depression in children (16, 17). The MFQ has been translated into Arabic.

6.2 Administration

The interviewers will read the psychological scales, survey items and response choices aloud to overcome limitations in literacy, and to provide further clarification as necessary. The interview will last approx. 60 minutes. Participants who show signs of distress, with scores on the SRQ20 that reach the cut off and/or express an interest in advice or treatment will be referred to appropriate care in the existing MSF services.

6.3 Interview Language

The interviews will take place in Arabic. All psychological screening tools are available in Arabic and have been validated in such populations. The MHL survey was developed by Slewa-Younan et al (2014) [12] and was modeled on Jorm [11] protocol, with appropriate cultural considerations. Care was taken to ensure the vignette was culturally valid and the final survey was translated into Arabic and independently back-translated into English, using the services of nationally accredited translation and interpreting service. The questionnaires are available in English in the Annexes.

6.4 Implementation

In order to improve the engagement with the research project assistance will be sought in form of discussion with potential community and/or camp leaders and permission to conduct the study in the camps will be requested.

The survey will be piloted with 10 children (and their parents and caretakers) and 10 adolescents for consistency of language and for cultural acceptability by the survey team before the implementation of the study. Any suggested modifications to the questionnaires will then be implemented before the roll out of the study.

In the households randomly selected according to the above methodology, the head of the household and the participant will be provided with an information sheet explaining the survey purpose, data to be collected, risks and benefits, how confidentiality will be maintained and how the data will be used. The trained survey staff will read and/or explain the information sheet if required and answer any questions in the language the head of household and the participant are familiar with.

Verbal consent will be sought from all heads of household and documented by the person obtaining the consent. The young person will then be approached and asked to provide verbal assent. If either the head of household or the selected participant decline to participate this will be accepted, written down and the next household approached; the number of household refusals should be noted on the survey control form.

If an eligible participant is absent at the time of the visit, it will be noted on the data collection and survey control forms and the team will revisit the household later in the day.

If a household is empty, the neighbours will be asked about the family that lives there. If the residents are likely to return that day the team should also return later in the day. If the residents do not return before the team leaves, a note will be made on the data collection and survey control forms. The household should not be replaced as a non-response rate was factored into the sample size calculations.

**7. Data management**

7.1 Data Collection

All questionnaires will be printed and data collected will be done by hand.

No identifiable (name-related) data will be collected during the survey. The interviews will take place in the participant’s home, if possible, with only the interviewer and the participant being present for protection of privacy and confidentiality. Participants will have the option not to participate if it is not possible for them to be alone.

We are conscious that in the event we use GPS based sampling for the household sampling stage, that the GPS coordinate corresponds to an address of the household. The study coordinator will ensure that GPS coordinates are provided to teams on a daily basis and that these are deleted from their GPS machines or phones at the end of each data collection day. This way only the Study Coordinator will have access to the GPS coordinates for the duration of the survey at all times. At the end of the survey and once all data has been checked and validated, the file containing the household GPS coordinates will be deleted.

The electronic database used for data entry will be password protected. The paper versions of the questionnaires and the electronic database will be stored at the MSF-OCA headquarters or country management level for 5 years after the survey. After 5 year, the paper copies of all the questionnaires will be destroyed. The electronic database will be stored in the headquarters in Amsterdam and will be available on appropriate request based on MSF’s Data Sharing guidelines.

For the duration of the survey, the analysis of the data and the writing of the report access to the electronic and paper version of the survey will be restricted to the Study Co-coordinator, the co-investigators of the study and the Medical Coordinator.

7.2 Data entry

A data entry mask will be prepared in EpiData Manager for the electronic entry and storage of all collected data. This file will be password protected and only accessible to the Study Coordinator, the study co investigators, the medical coordinator and the data entry clerk. . All data from paper questionnaires will be entered into this password protected file by a trained Data Entry clerk. Data cleaning will be done to check for inconsistencies in data entry and responses. The Study Coordinator will review 20% of all questionnaires at random and compare them to the original paper format to ensure that the data quality is of sufficient quality.

7.3 Data analysis

All data cleaning and statistical analysis will be carried out using IBM SPSS Statistics version 22.0 (33). For all continuous variables the survey participants will be described in terms of means, medians and ranges. Data from categorical variables will be reported in proportions and respective 95% confidence intervals. . Associations between responses to specific questions (e.g. problem recognition, perceived helpfulness of specific treatment providers), demographic characteristics and symptom levels will be examined by means of correlational analysis (Pearson or Spearman’s rho coefficients), independent samples t-tests or ANOVA, chi-square tests and/or non-parametric methods, depending on the response options for the outcome of interest concerned. Where appropriate, multiple linear and/or logistic regression analysis will be employed to examine associations between variables (e.g. symptoms levels, MHL and use of health services) while controlling for potential covariates (e.g. demographic variables)

7.4 Data protection and management

Data will be coded by participant numbers and the questionnaires will only have the basic demographic information. Confidentiality is paramount, and no information about individual participants or their household members will be accessible to any individuals not directly involved in data entry. Participant identifiers will not be included in results and disseminated reports. The research team will be required to sign a non-disclosure and privacy form stating that they will not discuss information about individuals participating in the study outside of the research team. The research team will ensure the ethical principles of beneficence, non-maleficence, justice, autonomy and respect of persons are adhered to throughout the study.

Documents will be coded by participant numbers, no identifying data will be kept on individuals.

Although the results of this study may be published, no information that could identify any of the participants will be included. All reports and publications will refer only to anonymous or aggregated data. Nominal data will not be distributed outside the study location or appear in any report or publication.

7.5 Quality assurance

During the field work, supervision of field teams will be ensured by the Study Coordinator. All data collection forms will be checked by one supervisor at the end of each study day to ensure that there is no missing or unclear data.

**8. Ethical Considerations**

The study will be conducted in accordance with the Council for International Organisations of Medical Sciences (CIOMS) International Ethical Guidelines, 2016 and the World Medical Assembly (WMA) Helsinki Declaration on Ethical Principles for Medical Research Involving Human Subjects.

The protocol will be approved by the Ethical Review Board of Médecins san Frontières before implementation. In addition official permission will be requested from Directorates of Health for both Aleppo & Ar-Ar-Raqqah Governorate and the Ministry for Displacement and migration, Aleppo & Ar-Ar-Raqqah Governorate, Syria.

The camp/town administrator and the relevant authorities (including identified community leaders) will receive a letter one week prior to the start of the survey explaining the purpose of the survey and its procedures, specifically also explaining how the survey ensures anonymity of respondents and their right to refuse participation in the interview. If feasible, a meeting with camp administration and relevant authorities (including identified community leaders) will be held to answer questions and address any concerns regarding the survey two weeks before the implementation. This will also enable input from community leaders about mental health issues that matter most to them.

Due to the uncertainly of the location that the survey will be conducted it is not possible to define which relevant authorities, including community leaders will be approached prior to conducting this survey. This will be defined when the precise study location is identified.

The MSF mental health responsible in the field will advise the study team on the referral practices when finding survey participant who show signs or symptoms of psychological distress requiring immediate clinical attention or in the event that a study participant or member of a participating household expresses the desire to access mental health care services.

8.1 Informed consent

Heads of the selected households will receive oral and written information about the survey objectives, study procedures and a clear explanation of the risks and benefits derived from participation in the research through a trained study staff. In order to ensure each head of household provides informed consent, and in recognition of low literacy levels, an information sheet and consent form will be read out loud by the interviewer in and the main aims, nature and implications of the study will be explained (Annex 1). The trained survey staff will answer to any queries that they may have. Those head of households willing to permit the identified person to participate will have their verbal consent noted by the person obtaining consent. If permission is granted the same information and procedure will be applied to the identified participant for the survey. For all persons participating aged <18 years we will ask for informed consent for the parents/caretakers and informed ‘assent’ from the participating young person.

Participants will be informed that they have the right to withdraw from the study at any time during the research. Participants will be made aware that participating in the study is in no way linked to the care they will receive from MSF, and that no incentives will be given for participation in the study.

8.2 Risks and benefits related to survey participation

Risks

The study participation is not expected to convey any risks to the participants. The interview will be conducted in privacy by trained survey staff. The questionnaire has been designed to deal the sensitive topics delicately. However, participating in this study may include possible anxiety induced by the interview (MHL survey and psychological scales), psychological discomfort related to the disclosure of personal information, and the inconvenience to the participants as a result of taking the time to participate in the research. To minimise any such possible discomfort or anxiety related to the data collection for this study, the data collection procedures will be clearly explained so that participants are well informed about what to expect from the study.

This risk will be mitigated by ensuring well trained staff conducts the interviews and care is taken during instrument design to minimize risk. Interviews will be terminated if the interviewer observes that the respondent is under undue stress. Regular briefings and debreifings will be held with interviewers throughout the research process to identify issues and provide further training as required. We will try to mitigate this by ensuring that our interview teams are appropriately trained in psychological first aid. In the event of a visibly traumatized individual, the team will conclude the interview and will offer appropriate referral to the MSF Mental health service. Each respondent will be assured of the confidentiality and privacy of the interview, and individuals will be informed that they are able to cease their participation in the study at any time should they feel uncomfortable and refuse to answer any questions. Furthermore, information on MSF counseling services will be made available to all participants.

For MSF, the risk would be that the security situation may deteriorate to a level that we would not safely be able to deploy the survey team. The project locations are based in areas of fluctuating insecurity. In order to mitigate security risks, all interview teams and researchers will be asked to comply with MSF security guidelines. These guidelines might limit the ability to move to camps to collect appropriate information. The security implications for the implementation of the study cannot be planned beforehand and will require adjustments at various stages to ensure all risks are mitigated. Changes in security context might impact on ability to collect the data and if teams cannot work safely then it may require the survey to be abandoned at one or more locations.

Benefits

This study represents the first of its kind worldwide to adapt the MHL paradigm to explore displaced community’s understanding of PTSD and depression. This information will then be used to inform culturally relevant health promotion and early intervention programs, while also indicating future research initiatives likely to be of interest in for the populations. First, the findings from this study will have the immediate benefit of improving our knowledge and understanding of how Syrian populations view, understand and respond to trauma-related mental health problems for themselves, their social and family networks, health professionals, other service providers and the community as a whole. Second, findings from this study will lay the foundation for the development and implementation of health promotion programs - both prevention and early intervention - designed to improve MHL at the individual and community levels.

A direct benefit to the at-risk population will come from the strengthening of MSF's current programming by providing essential information from which more effective intervention strategies can be developed. There will be no immediate or direct benefit to the participant as a result of participating in the study, with the exception that participants who score highly (over the clinical cut-offs) on the psychological scales can be referred to MSF clinical services. Additionally, they will be informed that their participation will generate knowledge that may improve the health and wellbeing of its members and of other Syrians. Similarly, dissemination of results will help inform other actors and other organizations involved in mental health care in Syria by contributing to the body of knowledge around mental health. Direct benefit to the individual participant is limited to the overarching benefit to the population as a whole.

8.3 Outcome

The expected outcomes include;

* Improved understanding of local beliefs, traditions and language used in relation to mental health amongst the surveys target population groups;
* To lay the foundation for the development of targeted, culturally appropriate mental health programmes in the MSF project locations, including mental health promotion and the development of culturally appropriate services that meet the needs of the specific beneficiaries.
* Estimates of mental health distress in child and adolescent displaced Syrians and caregivers of the children.

**9. Collaboration**

This survey will be conducted by MSF OCA, with cooperation of the Directorate of Health, Aleppo & Ar-Ar-Raqqah Governorate, the Ministry for Displacement and migration, Aleppo & Ar-Ar-Raqqah Governorate, Syria and the School of Medicine, Western Sydney University, Australia.

MSF OCA is the study sponsor and is responsible for funding. It is in charge of the field part fo the study, the analysis and report writing, with latter to be undertaken in collobration with Western Sydney University. Permission for publication must be obtained from the MSF OCA, the Directorate of Health Syria, Ministry for Displacement and migration, Syria and The School of Medicine, Western Sydney University, Australia. Study results will belong to MSF OCA, the Directorate of Health, Aleppo & Ar-Ar-Raqqah Governorate, Syria and the Ministry for Displacement and migration, Aleppo & Ar-Ar-Raqqah Governorate.

9.1 Dissemination of findings

The findings will be written up under the supervision of the Principle Investigator (Eleanor Hitchman) into an internal report which will be shared with all collaborators for their input. The report will be translated from English into Arabic. At project level, the findings will be disseminated with the project / mission and shared with the staff at the project locations (MHAM, MTL and MedCo) and with the Health Adviser and Operational Manager at headquarters. MSF-OCA commits to sharing study results with everybody who has participated in the survey. Study results will be shared with key stakeholders including camp leaders and other health actors. The local community will be involved and informed though posters at the MSF clinics. The MSF medical team will decide about the best venues to display the results.

The data collected from the overall project will give rise to publications in peer-reviewed journals relating to: 1) the level of PTSD and depression related MHL amongst internally displaced Syrian young people and their parents in each of the project locations (Aleppo & Ar-Raqqah Governorates); 2) the prevalence of clinically significant PTSD / depression symptoms in the study population. Likely outlets for publication include the BMC Psychiatry and World Psychiatry. There will also be ample basis for presentations at peak academic forums such Refugee conferences the International Mental Health Conference and the World Congress of Social Psychiatry. In addition to these traditional means of dissemination, a report comprehensively covering the findings of the study and the key research, policy and practice implications reports will be prepared for dissemination to a broad range of non-academic audiences.

**10. Recruitment, training and implementation**

10.1 Selection and tasks of study teams

The task of the interviewers will be to collect the necessary data for the study.

Each survey team is composed of two interviewers. To finalise the field part in a reasonable time we need ten survey teams of two people each

General selection criteria for all interviewers:

* Able to read and write in English *and*
* Fluent in the local language Arabic *and*
* Available for the ENTIRE time of the study (training and interview days), *and*
* Motivated to participate in the study, *and*
* Not biased in expectations of the outcome of the study
* Experience in social work, mental health interventions or previous humanitarian surveys will be an advantage
* Experience with interviews in difficult settings and study populations would be an advantage

In addition, two local supervisors will be employed to supervise the survey teams in the field. Recruitment will be done through the routine MSF recruitment strategies in northern Syria.

10.2 Supervision

The principal investigator is the overall responsible for the final version of the protocol, overall quality of the survey and data analysis, and the final report.

The principal investigator will ensure that the following tasks are performed:

* Preparation of all necessary documents (protocol, questionnaires, informed consent forms) for the study
* Briefing of the Study Coordinator in the field
* Data analysis
* Report writing

The survey will be facilitated in the field by the expatriate Study Coordinator based in the country. This person will be responsible for:

* Preparation of the field component of the study (training of the study teams, logistics, materials) together with the MSF team in the field
* Follow-up of the field component of the study
* Data collection and data entry
* Quality of data and consistency checks
* Cleaning of data

10.3: Suggested MSF support in the field

* Administrative support for study preparation at the field level and during field part, such as obtaining permission from the Directorate of Health, Aleppo & Ar-Ar-Raqqah Governorate, Ministry for Displacement and migration, Aleppo & Ar-Ar-Raqqah Governorate and payment of study teams, according to the final study locations.
* Human resources support, such as hiring study team/interviewers, a translator for the principal investigator, expatriate epidemiologist or mental health activity manager if needed.
* Logistic support for study preparation at the field level and during field part, such as organizing sufficient cars including drivers for the field part of the study, providing communication tools and MSF ID (e. g. aprons, vests or arm bands) to the study teams, stationary, printing the consent forms.

10.4 Training of study teams and pre-testing of the questionnaires

Four days training will be given to all interviewers to familiarise them with the background of the study, the questionnaires, the information sheet and the informed consent form. The training will be given in English with translation if needed by the Study Coordinator with support from the Principal Investigator. It consists of an intensive review of the questionnaires and the information sheet including role-plays. As the interviews will be held in Arabic, the Study Coordinator should ensure that all interviewers are using the same and correct wording for providing information to the households and for the interviews.

The 4-days training will finish with a pilot study. The pilot study allows for the testing and possible final adaptation of the questionnaires and informed consent to field conditions.

10.5 Timeframe in the field

Ten field teams of two staff will be deployed for data collection. It has been estimated that 10 field teams will be able to complete 30 households per day, assuming a working day from 9.30 am to 4 pm. (Table 1). To reach the desired number of participants (300 in total) will take ten days, although extra time will be allocated to allow for those who might refuse. However, due to the uncertainty of the location that the survey will be conducted, whether the population are in camps or not, and the security situation, the precise time needed to reach the desired number of participants will be defined when the precise study location is identified.

**Table 1**: Assumptions for calculating number of households/team/day

|  |  |
| --- | --- |
| Activity | Estimated time (minutes) |
| Daily briefings/feedback | 60 |
| Lunch and tea breaks | 60 |
| Community engagement/feedback | 15 |
| Time to complete survey & walk to next household | 75 |
| Total time available/day (9.30am – 4pm) | 390 |
| Time required for non-survey activities | 135 |
| Time available for surveys | 255 |
| Number of households/team/day | 3 - 4 |

**Table 2**: Field activities and days required for Study Coordinator

|  |  |
| --- | --- |
| **Activity** | **Number of days** |
| Travel days for arrival in Syria | 3 |
| Final preparation of the study (including briefing of relevant people) | 2 |
| Training including the pilot study (Kobane) | 4 |
| Availability to support implementation (Kobane) | 12 |
| Travel to Tal Abyad | 1 |
| Training including the pilot study (Tal Abyad) | 4 |
| Availability to support implementation (Tal Abyad) | 12 |
| Buffer days for data input / cleaning | 5 |
| Debriefing | 2 |
| Travel days to return | 3 |
| **TOTAL** | **48** |

**11. Logistics**

11.1 Supplies required

Supplies for the conduct of the study will be purchased locally. See table 3 for a list of required supplies. Some IT supplies may already be available within the Syria mission (from the health access survey).

**Table 3:** Supplies needed for the survey teams/supervisors

|  |  |  |  |
| --- | --- | --- | --- |
| **Item (number needed)** | **Per team** | **Per supervisor** | **Total** |
| Back pack/shoulder bag | 1 | 1 | 12 |
| Clipboard | 1 | 1 | 12 |
| Pencil | 3 | 2 | 34 |
| Rubber | 2 | 2 | 24 |
| Sharpener | 2 | 2 | 24 |
| Eraser | 2 | 2 | 24 |
| Aprons, vests, arm bands or similar with MSF identification / logo | 2 | 1 | 22 |
| Plastic sleeves (for protection of documents) | 3 | 3 | 36 |

**Table 4:** IT requirements

|  |  |  |
| --- | --- | --- |
| **Item** | **Number required** | **For whom** |
| Telephone & chargers for GPS | 10 (minimum) | Survey teams |
| Laptop | 1 | Field coordinator |

11.2 Transport

Transport requirements will depend on where the field teams are recruited from; if they are from outside of the camp, 2 taxi minibuses will be required. However, due to the uncertainly of the location that the survey will be conducted the transport requirements can only be defined when the study location is identified.

11.3 Budget

An estimated budget for the study is included in Annex 6. This is the budget for the Iraq study; however costs are similar in both countries, so it anticipated that the cost will be similar.

The cost for 1 location is 4,100 EUR. If the survey is conducted at the second location, once the first location has been completed then the price would be 2,450 EUR as the same mobile phones can be used. There will be an additional cost of 4000EUR if there is no Epidemiologist in the field when the research is due to take place and one has to be sent specifically for the survey to act as the Study Coordinator. However, due to the uncertainly of the location that the survey will be conducted the precise budget can only be defined when the study location is identified.

11.4 Study schedule

We have pre-defined the following time points in the implementation of this study:

|  |  |
| --- | --- |
| **Output** | **Estimate Deadline** |
| Submission to MSF ERB | December 2017 |
| Submission to ERB of Syria Ministry of Health | January 2018 |
| ERB approval MSF and Ministry of Health | February 2018 |
| Preparation field study (hiring of staff, training of staff, piloting of questionnaires and logistics for field implementation) | March 2018 |
| Study implementation | April - May 2018 |
| Analysis of data and report write up by PI | –June - July 2018 |
| Dissemination of report to stakeholders | August 2018 |
| Submission of manuscript to peer reviewed journal (if relevant) | October 2018 |

**12. Bibliography**

1. Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.
2. UNICEF, 2012; Humanitarian Action for Children. https://www.unicef.org/hac2012/
3. CARE, 2013: Syrian refugees in Urban Jordan: Baseline Assessment of Community-Identified

Vulnerabilities among Syrian Refugees living in Irbid, Madaba, Mufraq, and Zarqa.

1. UNICEF, 2013; Syria’s Children: A lost generation?: Crisis report March 2011-March 2013.
2. IMC (2013): Syria Crisis: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis
3. Save the Children (2017): Invisible Wounds: The impact of six years of war on the mental health of Syria’s children.
4. El-Khani, A., Ulph, F., Peters, S., & Calam, R. (2016): Syria: the challenges of parenting in refugee situations of immediate displacement. Intervention 2016, Volume 0, Number 0, Page 1 - 15
5. Klimidis, S., et al. (1999). Mental health service use by ethnic communities in Victoria. Victorian

Transcultural Psychiatry Unit, Melbourne, Victoria.

1. Weare, K. (2000). Promoting Mental, Emotional, and Social Health: A Whole School Approach. Psychology Press.
2. Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia, 166(4), 182–186.
3. Jorm A.F. (2012). Mental health literacy: empowering the community to take action for better mental health. American Psychologist, 67(Suppl 3), 231–243. doi:10.1037/a0025957
4. Slewa-Younan S, Mond J, Bussion E, Mohammad Y, Uribe Guajardo M, Smith M, Milosevic D, Lujic S & Jorm A. (2014). Mental health literacy of resettled Syrian refugees in Australia: knowledge about posttraumatic stress disorder and beliefs about helpfulness of interventions. BMC Psychiatry. 2014 Nov 18; 14(1):320. doi:10.1186/s12888-014-0320-x
5. Harding, T.W. (1976): Validating a method of psychiatric case identification in Jamaica. *Bulletin of the World Health Organisation,* **54**, 225-231.
6. Horowitz, M. J., Wilner, N., and Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. Psychosom.Med., 41, 209 218
7. Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995): The development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. International Journal of Methods in Psychiatric Research, 5, 237 - 249.
8. Wood, A; Kroll, L; Moore, A; Harrington, R (February 1995). "Properties of the mood and feelings questionnaire in adolescent psychiatric outpatients: a research note.” Journal of child psychology and psychiatry, and allied disciplines. 36 (2): 327–34.
9. Daviss, WB; Birmaher, B; Melhem, NA; Axelson, DA; Michaels, SM; Brent, DA (September 2006). "Criterion validity of the Mood and Feelings Questionnaire for depressive episodes in clinic and non-clinic subjects.” Journal of child psychology and psychiatry, and allied disciplines. 47 (9): 927–34.
10. Betancourt, T.S. &Khan, K.T. (2008).The mental health of children affected by armed conflict: protective processes and pathways to resilience. International Review of Psychiatry, 20, 317-328.
11. Panter-Brick, C., Goodman, A., Tol, W. & Eggerman, M. (2011). Mental health and childhood adversities: a longitudinal study in Kabul, Afghanistan. Journal of the American Academy of Child & Adolescent Psychiatry, 50, 349-363.
12. Ozer, S., Irin, S., & Oppedal, B. (2013). Study of Syrian Refugee Children in Turkey. Available in www.fhi.no/dokumenter/4a7c5c4de3.pdf.
13. Marwa, MH (2013). Psychological distress among Syrian refugees: Science and Practice. El-Khani et al. Paper presented at the 12th World Congress on Stress, Trauma and Coping, Baltimore, US.
14. Shaw, J.A. (2003).Children exposed to war/terrorism. Clinical Child and Family Psychology Review, 6, 237-246.
15. Thabet, A.A., Ibraheem, A.N., Shivram, R., Winter, E. A. & Vostanis, P. (2009). Parenting support and PTSD in children of a war zone. International Journal of Social Psychiatry, 55, 226-237.
16. Nelson, C A, Fox, N A and Zeanah, C H (2013) ‘Anguish of the Abandoned Child’, Scientific American 308, pp. 62–67 http://europepmc. org/abstract/MED/23539791
17. Center on the Developing Child, Harvard University:

http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

1. Mollica, R F, Poole, C, Son, L, Murray, C, C and Tor, S (1997) ‘Effects of war trauma on Cambodian refugee adolescents’ functional health and mental health status,’ Journal of the American Academy of Child & Adolescent Psychiatry 36 ( 8), pp. 1098–1106; M Gerard Fromm (ed) (2012) Lost in Transmission: Studies of Trauma Across Generations, Karnac Books
2. American Psychological Association (2008) Children and Trauma: Update for Mental Health Professionals, http://www.apa.org/pi/families/resources/children-trauma-update.aspx
3. Somasundaram, D and Sivayokan, S (2013) ‘Rebuilding community resilience in a post-war context – a qualitative study in northern Sri Lanka’, International Journal of Mental Health Systems 7 (3) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3630062/
4. Yaser A, Slewa-Younan S, Smith C, Olsen R, Uribe Guajardo MG, Mond J. Beliefs and knowledge about post-traumatic stress disorder amongst resettled Afghan refugees in Australia. International Journal of Mental Health Systems. 2016. doi: 10.1186/s13033-016-0065-7.
5. Sleva-Younan, S Mond, J, Uribe Guajardo, M., Yasser, A., Smith, M., Milosevic, D., Smith, C, Lujic, S. & Jorm, A. (2017): Causes of and risk factors for post-traumatic stress disorder: the beliefs of Iraqi and Afghan refugees resettled in Australia. International Journal of Mental Health Systems 11:4: DOI10.1186/s13033-016-0109-z
6. Attanayake, V., McKay, R., Joffres, M., Singh, S., Burkle Jr, F & Mills, E. Prevalence of mental disorders among children exposed to war: a systematic review of 7,920 children. Medicine, Conflict and Survival Vol. 25, Iss. 1,2009
7. MSF Internal Document (2017). Understanding the health status and humanitarian impact of the recent events in the internally displaced population (IDPs) in Tal Abyad and Manbij districts, northern Syria, 2017 (Unpublished)
8. IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.

**13. Annexes**

Annex 1: Information sheet / Consent & Assent Forms

Annex 2: PTSD Group 1: Child (8-12 years)

Annex 3: PTSD Group 1: Parent (of Child 8-12 years)

Annex 4: PTSD Group 2: Adolescent

Annex 5: Depression Group 1: Child (8-12 years)

Annex 6: Depression Group 1: Parent (of Child 8-12 years)

Annex 7: Depression Group 2: Adolescents

Annex 8: Validity and internal reliability assessment results of the tools.

Annex 9: Estimated study budget

Annex 10: CVs Eleanor Hitchman and Dr Shameran Slewa-Younan

**Annex 1**: Information sheet / Consent & Assent Forms



**Annex 2:** PTSD Group 1: Child (8-12 years)



**Annex 3:** PTSD Group 1: Parent (of Child 8-12 years)



**Annex 4:** PTSD Group 2: Adolescent



**Annex 5**: Depression Group 1: Child (8-12 years)



**Annex 6:** Depression Group 1: Parent (of Child 8-12 years)



**Annex 7:** Depression Group 2: Adolescents



**Annex 8:** Validity and internal reliability assessment results of the tools.



**Annex 9:** Estimated study budget



**Annex 10:** CVs Eleanor Hitchman and Dr Shameran Slewa-Younan

