

Mental Health In Crisis: A Case-Study Analysis of Syria

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The following paper implements a biosocial approach to answer 1) How has the ongoing conflict in Syria shaped the mental health crisis among internally displaced persons (IDPs)? and 2) What structural, political, and cultural barriers prevent effective mental health care delivery in low-resource and volatile settings? Using a framework which emphasizes the importance of social factors in shaping health outcomes, the study draws from reports from international organizations (e.g. WHO, UNHCR, and the IMC), academic literature, and statistical indices (e.g. Disability-Adjusted Life Years), to critique neoliberal ideologies, western-centered approaches to care, and bureaucratic constraints that limit impactful mental health intervention. The findings demonstrate how systemic failures—funding misallocation, lack of culturally adaptive tools, and disconnects between local and international actors—exacerbate psychological distress and perpetuate health inequities for Syrians, IDPs, and others in conflict zones around the world.

Introduction

Armed conflict destabilizes every dimension of public health, causing death, physical injury, and destroying vital health infrastructure (Murray et al., 2002). The most invisible toll of conflict is on mental well-being. Two billion people live in conflict-affected areas. The rates of those suffering from psychological distress or with a diagnosable mental illness such as schizophrenia, depression, or post-traumatic stress disorder (PTSD) are incredibly high (Archie, 2020; World Health Organization, 2022). However, 80% of people in conflict zones with mental disorders do not receive mental health services (Bayard et al., 2019). The disconnect between urgent need and inadequate response persists despite decades of global recognition by institutions and medical professionals on the importance of mental health care in humanitarian settings (Jenson, 1996).

In Syria, the mental health outcomes of internally displaced populations (IDPs) have only worsened since the onset of the country's Civil War in 2011 (The Editors, 2023). While the war and subsequent displacement contributed to the onset of psychological harm, the continued deterioration of mental well-being is attributed to structural factors that limit access to effective care. I argue that the lack of effective mental health care provision to IDPs in Syria is due to entrenched ideas of scarcity, the dominance of Western mental health paradigms which neglect cultural context, and rigid bureaucratic practices that limit collaboration between international and local partners. These problems are not unique to Syria and can be used to explain broader patterns of mental health care delivery in conflict and low-resource settings.

To best understand the interdisciplinary factors contributing to the state of mental health in Syria and locations across the world, a biosocial approach is necessary. A biosocial framework assumes that health outcomes are inextricably linked to the social contexts they exist within. Human biology, the experience of illness, and medical interventions are shaped by social factors such as inequality, poverty, education, and housing. (Farmer, 2013). For instance, one cannot understand the spread of the Covid-19 pandemic in the United States only by analyzing the rate of infection or the strength of vaccine resistance for

different mutations of the disease. The impact that geography, poverty, education, and culture had on vaccination rates of different populations in the nation significantly shaped disease outcomes (Albrecht, 2022). Similarly, in Syria, mental health outcomes are not simply a result of trauma exposure, but also of global power dynamics rooted in capitalism.

This paper seeks to understand how social, political, and economic factors have interacted to create the current state of mental health in Syria and how structural barriers limit culturally responsive and sustainable mental health treatments in conflict zones. Through a case study of Syria, the paper hopes to uncover how global health care systems reproduce inequity and how these challenges can be addressed to advance mental health outcomes globally.

Context In Syria

After a series of pro-democracy protests erupted in 2011 demanding a change to the dictatorial rule of the Assad regime, the government responded violently by cracking down on protests, silencing the media, and torturing dissidents. In response, militia groups formed to oppose the government and a civil war began that persists until this day (The Editors, 2023). Although millions of Syrians have been forced to flee, 23 million currently still reside in the nation; 6.7 million people are internally displaced, and 14.6 million are in need of humanitarian assistance (Syria, 2023). The violence of the civil war, dire lack of resources, and the protracted nature of the conflict have contributed to abysmal mental health outcomes in this population.

Data from the United Nations High Commissioner for Refugees (UNHCR) and the International Medical Corps (IMC) show that 61% of Syrians have severe emotional disorders, with that figure growing over time (Hijazi & Weissbecker, 2023). A survey conducted by the Syrian American Medical Society (SAMS) found that 37.7% of those surveyed had been turned completely inactive because of significant distress sometime in the past two weeks of the survey date. 14.4% of respondents experienced such intense feelings of hopelessness they would rather not continue to live. In children between the ages of 8

and 15, 60% were expected to have one probable psychological disorder; 35.1% of children were expected to have PTSD, and a high proportion of them, depression and anxiety. Despite the protracted nature of the conflict in this country and the wealth of knowledge in the field of mental health treatment, there were no significant improvements in mental health outcomes for this population (Hamza & Hicks, 2021; Institute of Health, 2019).

One metric used to measure the impact of individual illness is Disability-Adjusted Life Years (DALYs). DALYs quantify the loss in health through both premature mortality and morbidity. In Syria, mental health disorders in the population contributed to a DALY increase from 1574.6 to 1621 from 2011 to 2019 (Institute of Health, 2019). Many might expect that declining mental health outcomes are to be expected in a population that has experienced war for so long. However, while this may be the case, it does not fully encompass the historically entrenched causes of abysmal mental health outcomes.

Throughout the literature, it has widely been identified that to effectively address mental health in conflict zones, providers should ideally be from the local community; the care that is given should be adaptable to the rapidly changing context; and the care should be community-driven, combining both scientific and traditional methods (Hamza & Hicks, 2021). However, this solution is not implemented. Reinforced norms of scarcity, a lack of culturally competent health care provision, and challenges arising from bureaucratic difficulties contribute to a disconnect between local and international organizations providing mental health care, leading to worse mental health outcomes.

The Beginning of Humanitarian Mental Health

Although occurring more than three decades apart and in vastly different contexts, the Spitak earthquake in Armenia and the Syrian Civil War reflect the impact that trauma and displacement have on mental health. The field of humanitarian mental health as we know it today was not established until the devastating aftermath of the 1988 earthquake in Armenia. By examining the psychological impact these events had, we can trace the evolution—and persistent shortcomings—of humanitarian mental health care delivery.

The Spitak earthquake, a 6.8 on the Richter scale, led to the death of 25,000 people, injury of more than 20,000, and displaced 360,000 (Kiureghian, 2025). Humanitarian organizations such as *Medicins Sans Frontiers* (MSF) and *Medicins du Monde* (MDM) responded to the natural disaster by providing the resources and staff necessary to treat the physical wounds of the victims. However, no organization considered addressing the psychiatric distress Armenians were experiencing, despite the tremendous psychological impact the natural disaster had. Researchers from UCLA found that 50% of those observed suffered from PTSD, 28% from depression, and 26% from anxiety. In response, Armenians from across the globe flocked to their homeland to help their kin through this time of hardship by connecting with the survivors of the earthquake and leveraging their shared history and culture. This was the first time an official evaluation of trauma neurosis and PTSD was administered in response to a humanitarian crisis (Fassin et al., 2011).

Over the following years, the vocabulary and tools to treat

the mental health of those in humanitarian zones developed; when the Yugoslav Wars began in Europe two years later, the implementation of mental health programs was a priority (Fassin et al., 2011). In 1994, the first World Health Organization Regional Model on Mental Health was implemented in Sarajevo. This model, a coordinated set of mental health projects meant to serve certain geographic areas and populations of 400,000, emphasized 1) the collaboration between intergovernmental, non-governmental, and national mental health organizations, 2) establishing a regional coordination center 3) training of local professions and 4) promoting a community-oriented mental health approach—objectives still agreed upon by researchers to be effective to address psychological trauma (Jenson, 1996). By 1995, nearly 200 psychosocial projects were in progress in Bosnia and Herzegovina and Croatia, seeking to address the widespread psychological impacts of trauma. A study conducted on the war-afflicted populations in Croatia found that more than 30% of inhabitants accessed specialized mental health services, with evidence suggesting that general practitioners also served as mental health support for much more of the population. The persistence of mental health disorders in this population for fifteen years led the researchers to conclude that while psychological support is essential, other forms of informal, community-based social support are also necessary (Francisković et al., 2008).

In Syria, much like in Armenia and Yugoslavia, the impact of trauma is not merely physical, but deeply psychological. However, in the case of Armenia and Yugoslavia, mental health interventions in humanitarian contexts were only beginning to be developed, a potential explanation for the shortcomings of effective treatments; in Syria, despite the growing recognition and evolution of culturally sensitive and trauma-informed mental health tools, humanitarian systems have failed to effectively integrate into emergency responses. Understanding this historical pattern is critical to addressing the ongoing mental health crisis occurring globally.

Mental Health Apportionment in Syria

Currently, mental health services in Syria are apportioned by both INGOs and local health care organizations; however, there is little collaboration between the two entities, leading to ineffective health provision (Hamza & Hicks, 2021; Hijazi & Weissbecker, 2023). International agencies, led by the International Medical Corps (IMC) and UNHCR, provide psychological first aid services, basic counseling for individuals, groups, and families, pharmacological and non-pharmacological management of mental disorders, and limited psychotherapy services. A study from the IMC found that in the areas IMC and other partners operated, 60.1% of women and 69% of children were receiving mental health treatments. However, despite the INGOs' presence since the start of the war, mental health outcomes have remained stagnant or worsened. The IMC has identified that challenges in mental health care provision stem from lack of funding, instability, and government restrictions. Local NGOs in the area face unique challenges as well (Hijazi & Weissbecker, 2023).

Research conducted on mental health apportionment describes the difficulties experienced by organizations and networks such as SAMS who work locally in the area (Hamza

& Hicks, 2021). Due to limited mental health staff before the onset of the war, it was impossible for small organizations to establish sustainable mental health programs in the midst of conflict (Assalman et al., 2008; Hamza & Hicks, 2021). This reality led to the formation of significant barriers to overcome at the start of the war that continue to impede these organizations' capacity to address the mental health need in Syria.

INGOs and local organizations contribute to Syrian mental health provision in different ways. From the perspective of local agencies, large, institutionalized humanitarian organizations are more focused on treating physical injuries that are immediately life-threatening rather than mental health concerns. Even when mental health concerns are addressed by these organizations, the intervention is ineffective because of the lack of investment into appropriate culturally relevant training. While local organizations are more equipped to provide culturally competent treatment, they do not have the same reach as large INGOs because of limited resources (Hamza & Hicks, 2021). While the scarcity of resources experienced by local organizations is understandable, the scarcity mindset adopted by large INGOs who have millions, if not billions, in their budget, is not.

Scarcity

The rise of neoliberalist ideals, an economic ideology characterized by the privatization of social services to counteract socialist and communist models in the post-Soviet era, in the 1980s fundamentally altered the global health agenda by international NGOs (INGOs). Powerful international agencies, such as the World Health Organization (WHO), recognized the inability of low- and middle-income countries to provide necessary health care for their citizens and began to shift the responsibility of financially securing health care to individuals. These agencies believed that encouraging individuals to cover their personal medical expenses would encourage ideals of a democratic economy based on the tenets of capitalism. This system was deeply rooted in and reflected colonialist ideas—incidentally wealthy former colonial countries who control these agencies would rather not finance treatments for the expensive diseases afflicting those in poorer nations. There would be a negligible return of investment; investing in non-Western lives was simply not worth it. The revolutionary changes to the field of global health allowed neoliberalist ideas to permeate the agendas of INGOs, contributing to the stagnation or worsening health outcomes across the globe (Keshavjee, 2014).

Constructed ideas of scarcity—resource constraints not attributed to a lack of materials but a consequence of political and economic decisions—present within large INGOs are used to justify their failures in adequately addressing the mental health challenges (Schrecker, 2013). By claiming there are insufficient funds and resources, organizations like the WHO, the UNHCR, and the IMC are without fault when significant areas of humanitarian need are not effectively addressed (Hijazi & Weissbecker, 2023). This lack of funding has contributed to the increase in DALYs for mental health illnesses in Syria despite the passage of more than a decade since the start of the conflict, time when the existing knowledge to effectively address mental health could have been leveraged to develop impactful programs (The Editors, 2023; Institute of Health, 2019).

Funding and Inappropriate Funding Priorities

INGOs such as the IMC and the UNHCR provide substantial funding to Mental Health and Psychosocial Support (MHPSS) programs in Syria; however, the allocation of this funding does not align with the needs of the population. Although it was difficult to acquire financial data on a country-level scale, financial data on the regional scale provides key insights into the situation. The IMC allocates 28% (\$40.7 million) of its operating budget to programs in the Middle East (Financial Reports, 2022). The UNHCR dedicates 36% (1.638 billion) of its regional operating budget to the Middle East and North Africa, more than any other area (Funding UNHCR, 2023). Despite this significant investment, the inadequate implementation of community-driven, culturally informed, bottom-up approaches have yielded limited improvements to mental health outcomes (Hamza & Hicks, 2021; Institute of Health, 2019).

INGOs have the financial resources and infrastructure to implement extensive, wide-reaching and sustainable interventions. In areas where the IMC operates, the plurality of women and children use mental health resources the organization provides. These organizations also have the capacity to build extensive resource networks, train individuals, assess programs, and garner international attention. However, these organizations adopt top-down, western-centric approaches that neglect local values and valuable non-clinical local resources which are known to positively impact mental well-being.

Instead of using their budgets to empower local actors in providing culturally relevant care, INGOs train mental health professionals and implement programs based on the WHO Mental Health Gap Action Programme (mhGAP) Guidelines for mental, neurological and substance use disorders (Hijazi & Weissbecker, 2023). For the most part, these guidelines only suggest that variations in cultural context should be considered. The most extensive references to cultural sensitivity are for dementia. Here, the guidelines highlight prior research which indicates that interventions that are adapted for cultural context, rather than being developed with the target culture in mind, are less effective. Furthermore, regarding the treatment for drug dependence, the guideline highlights that spiritually oriented interventions and peer support are culturally sensitive and reduce treatment stigma. Nowhere in the guidelines does it provide any instruction for how a culturally sensitive approach should be implemented (Mental Health, 2025). An assessment of the interventions enacted by INGOs reveals that these guidelines contribute to programmatic rigidity, and most “culturally sensitive adaptations” simply constitute language translation. A bottom-up approach to mental health care provision would enhance the efficacy and suitability of mental health interventions and research (Hamza & Hicks, 2021).

The progress that can be made toward improving Syrian mental health is being impeded by the inadequate use of funds. Currently, the IMC working group does not facilitate (1) communal spaces for members to organize and provide support to each other, (2) traditional, spiritual, or religious supports, including communal healing practices, (3) community worker mental health referrals and follow-ups, (4) teacher- and school-based psychosocial support, (5) non-pharmacological care, or (6) research (Hijazi & Weissbecker, 2023). An analysis of a book published by a Syrian-American medical neuropsychologist

who worked in Syria for nine years delivering clinical care and developing medical programs in active combat zones and besieged areas to IDPs and refugees, has denoted the importance for care to be community-driven, drawn from shared cultural, religious, and traditional experiences, and provided continuously (Hamza & Hicks, 2021).

By not funding interventions that prioritize the cultural and communal foundations upon which effective mental health provision in Syria must be built, the rampant trauma the population has and continues to experience is not being addressed. Although these organizations possess positive intentions to reduce harm, gaps in care due to a scarcity mindset stemming from neoliberalism ideologies comes at the expense of Syrian mental health and reinforces systems of structural violence.

Lack of Culturally Appropriate Care & Culturally Adaptive Tools

Although large INGOs profess to strive to incorporate local context in their work and engage closely with community partners, significant strides need to be made until both local and international entities work cohesively together. INGOs concede that the burden of mental health care falls primarily on their shoulders, with little to no mention of smaller local nonprofits providing similar services (Hijazi & Weissbecker, 2023). However, the lack of cooperation between local partners and large INGOs is concerning and impedes the progress of psychiatric outcomes. While large INGOs have the ability to administer care to more people, organizations operating locally are more effective in the culturally competent care they provide (Hamza & Hicks, 2021).

Overcoming the stigma surrounding mental health in Syria is a significant issue INGOs must overcome. Culturally, people with mental illness are considered unstable and weak; individuals who other members of society seek to distance themselves from (Badawi et al., 2022). Men are taught to suppress the outward expression of emotion and women are fearful of discussing mental health issues for fear of being deemed unsuitable for marriage (Hassan et al., 2015; Badawi et al., 2022). Across religious traditions, faith serves as an important source of resilience (Hamza & Hicks, 2021). Islamic teachings, the most common religion in Syria, profess that those who surrender to God accept their fate as the will of God; their hardship is an opportunity to strengthen their devotion to Him (Hassan et al., 2015). One narration describes a woman who lost five of her children, lived in a refugee camp, and worked for one dollar a day. When asked how she was doing, she had a peaceful look on her face and praised God (Hamza & Hicks, 2021), reflecting her belief that this world is transient and only a test from God (Hassan et al., 2015). Struggling to progress past trauma may reflect a form of spiritual and moral weakness, leading to both self and community stigmatization. These cultural and religious nuances are better understood by fellow community members than by Western physicians (Hamza & Hicks, 2021).

SAMS stresses the importance of training non-professionals and refugee peers to address the mental health concerns in Syria. There is greater trust between the patient and provider when care comes from a community-member instead of an implanted "Western Doctor." Feelings of mistrust have been cultivated in the local population since Syrians feel INGOs do

not consult the community on its needs. A bottom-up approach to mental health care provision would be more effective at addressing patient concerns and better received (Hamza & Hicks, 2021).

Local organizations staffed by community members are better able to recognize unique ways mental health challenges present themselves. The usual symptoms that a Western practitioner would expect to see in various mental health conditions may be significantly different in Syria where physical complaints, such as "I'm so tired," may reflect deeper psychological issues (Hamza & Hicks, 2021). For instance, the top five expressions of PTSD among people from different backgrounds vary widely. The most common symptoms of PTSD in order of frequency for individuals from North America, Europe, and Australia are negative emotional state, detachment from others, fear, lack of social support, alienation/isolation, and intrusive distressing memories. For those from the Middle East and North Africa, the most common symptoms are negative emotional state, fear, alienation/isolation, detachment from others, inability to experience positive emotions, and a sense of loss (Michalopoulos & Meinhardt, 2018). As is evident, there are both similarities and differences between expressions of trauma across cultures and local providers are better equipped to recognize these unique expressions (Hamza & Hicks, 2021).

Cultural differences also impact which practices are best when providing care. A study found Syrians were willing to engage in a discussion about their concerns not when a mental health professional claimed that they wanted to "support" them or to provide them with therapy, but when in the midst of a conversation, a provider asked about the "challenges" they were facing in their lives. This is reflective of the fact that Syrians have limited prior exposure to mental health care and may consider seeking mental health treatment both stigmatizing and incomprehensible (Hamza & Hicks, 2021). Further, as a deeply religious society, Syrian populations find strength and resilience through a higher power. This therapeutic practice is not provided by Western INGOs, reflecting a rigidity in treatments rooted in Western methodology that does not effectively leverage cultural knowledge to provide the most appropriate care, leading to worse outcomes (Hamza & Hicks, 2021; Hijazi & Weissbecker, 2023).

Lack of Accurate Data

In addition to the fact that transplanting western models of care leads to inadequate mental health provision in Syria, the centrality of the western perspective, medical terminology, and tools also leads to inadequate research results for diverse populations.

First, few sources of data detail the state of mental health in Syria. From the data available, the integrity of select findings are questionable. For example, in 2019, the Institute of Health Metrics and Evaluation published data on the estimated number of DALYs due to different categories of mental illness. It is evident that the data was centered around Western nations. For all countries, the only mental disorders evaluated are depressive disorders, anxiety disorders, bipolar disorder, schizophrenia, or eating disorders. While these are the most prevalent conditions prevalent in western, industrialized nations, this is not the case for nations experiencing war and conflict, as Syria is

(Michalopoulos & Meinhart, 2018).

Second, there is a significant issue in terms of how the DALYs are assessed. While the DALY is the internationally accepted measure of the impact of mental health concerns, it is important to interrogate this metric. As is argued in *Reimagining Global Health: An Introduction*, the DALY was defined based on western research methodologies (Farmer et al., 2013). Thus, the use of it as a basis of evaluating the impact of mental health in a nation must be questioned. According to the data, the measured burden of disease in Syria for the measured mental disorders (1621 DALYs per 100,000) is smaller than that of Australia (2062 DALYs per 100,000), the United States (1796 DALYs per 100,000), and the United Kingdom (1625.4 DALYs per 100,000) (Institute of Health, 2019). Considering Syrians are actively engaged in a civil war and the Australian, American, and British populations are not currently experiencing the same death, destruction, and persecution, the integrity of the DALY must be questioned. These metrics do little to account for the full scope of suffering and how the suffering of an individual has peripheral impacts on the larger community (Farmer et al., 2013).

One reason the data presented by traditionally reliable sources is not accurate in the Syrian context is because of a lack of cultural competence. For instance, foreign mental health professionals use non-rigorously translated English-language surveys (Hamza & Hicks, 2021). The intricacies of mental health experiences cannot be assessed effectively using something such as Google Translate, since some concepts may not exist or may be expressed differently in the Arabic language and Syrian dialect.

Further, as seen by the programs and initiatives provided for by the INGOs, research is not prioritized (Hijazi & Weissbecker, 2023). Without the proper research infrastructure, there cannot be a robust evaluation of mental health needs or the effectiveness of interventions. This limits the ability of INGOs to adapt treatments or advocate for programs with no evidence to justify the use of funds, contributing to the default implementation of Western models of care which are ineffective and culturally misaligned.

In fact, the WHO, whose work centers around research and leading innovation in the field of global health, only spends 1.14% of its budget in the Eastern Mediterranean region (Mazumdar, 2020). This incredibly limited investment at least partially explains why there exists a significant gap in research on Syria. This creates a vacuum where the state of health cannot be adequately assessed, nor can methods be developed to improve it.

Bureaucracy

The impact that large humanitarian organizations have is constrained by the rigid adherence to bureaucratic practices that restrict effective service delivery (InterAgency, 2022). One of the most pressing examples is the reliance of INGOs on coordinating aid provision with the national government; however, the national government is the entity primarily responsible for enacting violence against the Syrian people (The Editors, 2023; Kayyali, 2019). For instance, the WHO regularly works with national health ministries to implement programs, operating under the assumption that national programming will reach the

most people in this way because of the government's ability to resource, distribute, and plan projects on a large scale (World Health Organization, 2023). This strategy is not effective in Syria—through legitimizing relations with the government responsible for the trauma they are trying to treat, INGOs are undermining their legitimacy with the Syrian people. Further, individuals in need of assistance in rebel-controlled or besieged territories outside of Damascus cannot access any aid because the state refuses to operate in these locations (Hijazi & Weissbecker, 2023).

Bureaucratic restrictions also restrain the services INGOs provide because of stringent approval processes dictating the types of programs offered, the number of staff, and the locations which organizations are allowed to work in (Hijazi & Weissbecker, 2023; Kayyali, 2019). If unsatisfied with the project proposal or the organization, the government arbitrarily refuses to grant INGOs permission to operate. Thus, INGOs succumb to the requirements of the government and implement programs that are based on the government's desires and not on an unbiased appraisal of the population's needs (Kayyali, 2019). The programming that is enacted neglects vulnerable populations in the north of the country, an area not under government control (Hijazi & Weissbecker, 2023). However, to explain the lack of health care provision in these areas, the IMC has cited "security concerns" and "limited capacity" (Hijazi & Weissbecker, 2023). These explanations mask the deeper issue of government interference which restricts INGOs ability to serve those most in need.

In Syria, INGOs can only operate if they partner with government-approved, humanitarian actors. These actors include human rights abusers who are not vetted properly by INGOs. In one instance, a local organization founded by a member of the National Defense Forces, information the UN was aware of, was paid by a UN agency to enact a project. Months later, it was revealed the organization used the funds for other purposes and was forging their reports to the UN. Even when projects are implemented by local, pre-approved actors, information on the program's beneficiaries is accessible by security forces, a breach of patient confidentiality that threatens the lives of those who seek medical care (Kayyali, 2019).

Local, independent organizations are better suited to address the gap in service provision created by this system. Organizations like SAMS and SEMA (Syrian Expatriates Medical Association) can flexibly adapt to changing circumstances and are able to provide mental health interventions in besieged areas (Hamza & Hicks, 2021). Yet global bureaucratic processes prioritize funding the work of larger, more recognized INGOs, sidelining and delegitimizing the work of smaller organizations. Despite filling a critical service gap, organizations like SAMS are not given the money, resources, or support they need to expand operations and maximize their impact (Hamza & Hicks, 2021; Hijazi & Weissbecker, 2023).

These various forms of bureaucratic rigidity, including (1) policies which force INGO collaboration with the government, (2) policies that dictate which programs are implemented and locations receive care, (3) regulations that force INGOs to collaborate with pre-approved organizations, and (4) global administrative biases against independent, local organizations create an inequitable health care delivery system in Syria that

undermine the values of neutrality and equality humanitarian organizations claim to uphold (HRW).

Recommendations

To address the systemic barriers to effective Syrian mental health care provision highlighted in this paper, I propose the following recommendations:

1) Fund programs which prioritize community-based, culturally competent care

From the inception of humanitarian mental health, global leaders have identified the importance of culturally relevant interventions. From the coordinated mental health approach used in Croatia during the Yugoslav wars to the WHO mhGAP guidelines, culturally relevant interventions are necessary to effectively treat mental health issues in Syria. However, INGOs are failing to provide traditional, religious, and spiritual support, communal healing spaces, school-based psychosocial support, and mental health follow-up services. In light of this, I advocate for:

a) Fund community-led initiatives:

Interventions that are created with the target-population in mind, as opposed to being adapted for cultural-relevance, are more effective. INGOs and local organizations should involve Syrian communities and front-line mental health providers to 1) design mental health programs and 2) determine how budgets are spent. Including the input of Syrians in program development and implementation is integral to creating effective services and will allow service providers to better understand unique expressions of trauma within the population.

b) Diversify Funding Recipients:

Local organizations such as SAMS may have less institutional capacity than INGOs such as the IMC, however, they are able to reach often-neglected populations in volatile areas and have greater community trust. Further, local organizations engage with non-clinical interventions and invest in training trusted community members, often with limited health background, to provide support services to those in the local area. It is therefore necessary to reorient global funding schemes to provide significant resources to these local organizations, highlighting their role in filling in critical gaps in care.

c) Incorporate Spiritual Practices in Care Models:

Although Western mental health frameworks do not emphasize spiritual and religiously informed practices, faith is central to the lives of many Syrians, serving as a source of support and resilience. Thus, it is crucial to 1) develop workshops for implanted physicians which incorporate both scientific and religious practices, 2) train non-professional community members (who are already versed in the spiritual tradition) in providing psychosocial support, and 3) create treatment programs which leverage the knowledge and cultural background of the two aforementioned stakeholders to provide informed and comprehensive care.

d) Address Research Gaps:

With little investment in mental health research in the

region, it is difficult to develop evidence-informed approaches, measure programmatic efficacy, or adapt treatments effectively and responsibly. The established metric, DALYs, were developed with a western audience in mind, and are ineffective in properly assessing the extent of the mental health burden in Syria. Increases in funding to create, and not simply adapt, measurement tools with the intended population in mind are imperative.

2) Increase Collaborative Efforts Between INGOs and Local Partners

To provide the most effective care, the resources from INGOs must be coordinated with local organizations such as SAMS to provide care that is culturally relevant, well-received, and impactful. Although the Assad regime is no longer in power, the future of Syria remains uncertain (Abdulrahim, 2025). In this volatile time, commitments to organizational change can be most effective.

a) INGOs must conduct independent needs assessments and program implementation:

Humanitarians who have worked in the crisis in Sudan, the Congo, and Yemen have described the unique hardships INGOs face to have a substantial impact in Syria due to the government's restrictions (Kayyali, 2019). To improve mental health outcomes, INGOs must negotiate with any future government to conduct independent needs assessments and rigorous investigations on any local partners, as well as retain the ability to choose which partners to engage with, which programs to implement, the receiving population, and the dedication to protecting patient information. Dictatorial regimes require the presence of INGOs to provide basic services, especially in conflict settings (Heiss, 2017). INGOs must leverage their importance to negotiate terms which prioritize the health of all Syrians.

b) Establish Clear Coordination of Care Models:

Coordination of Care Models, a structured approach to ensure effective communication and collaboration among healthcare providers and patients to facilitate seamless communication and improve patient models, are integral between INGOs and local organizations (Duan-Porter, 2022). Considering the finite aid Syria receives, this model allows the various organizations in the nation to 1) engage in mutual learning, 2) coordinate which services they are best equipped to provide, and 3) limit extraneous resource use which provide services to some and neglect others.

3) Advocate for International Change on the Structural Level

The broad-sweeping changes required to restructure entire care systems cannot occur without a fundamental shift in global consciousness. Localized interventions are helpful, and improvements to the global systems that have perpetuated inequities in the apportionment of Syrian mental health care are necessary. In order to address constructed ideas of scarcity, the marginalization of non-Western and culturally impactful interventions, and bureaucratic exclusion, the following is required:

a) Interrogate Aid Models Rooted in Neoliberalism:

INGO care models prioritize cost-efficiency, individual responsibility, and short-term impact. An operational agenda rooted in neoliberalism has allowed for the permissibility of stagnant or worsening mental health outcomes in Syria under the guise of “unsustainability” or “financial constraints.” Deconstructing deeply rooted neoliberalism ideologies is needed to increase financial investment into the nation to implement long-term, culturally informed care.

b) Develop Interventions Centering Biosocial Frameworks:

Viewing the mental health burden Syrians experience only as a health issue resulting from the trauma of war is impeding meaningful outcome improvements. Legitimizing the impact that power dynamics and state violence, economic precarity and a lack of agency, social stigma, and other factors have can better inform interventions. By better understanding how to develop relevant measurement metrics, include cultural practices in treatment, and leverage religious resilience, care in the Syrian context and beyond can drastically improve. Adopting biosocial frameworks in the creation of interventions is necessary to address the social and medical roots of illness.

An Example from Rwanda

A successful community-based mental health intervention developed in Rwanda to address the trauma from the Rwandan genocide lends support to the aforementioned recommendations. In 1994, a harrowing genocide against the Tutsis occurred in Rwanda, completely upending the nation’s social structure. Genocide survivors experienced nearly three times the rate of depressive disorders (35% v. 12%) and eight times the rate of PTSD (27.5% v. 3.6%) as compared to the general population in addition to feelings of fear and mistrust, isolation, and collective shame. Similar to the case of Syria, limited funding, a lack of adequately trained providers, and stigma impeded the mental health outcomes in Rwanda. In response, the Ubuntu Center for Peace (UCP) established a Community-Based Social Healing Model (CBSH) to address both the trauma from the war and continued social stressors the community faced.

The CBSH model acknowledges that western frameworks of mental health treatment largely overlook “communal, sociocultural, and historical factors” integral to addressing Rwandan mental health. The comprehensive model included three interventions: 1) Breath-Body-Mind (BBM) is a practice of breathing techniques known to shift state’s of fear and anger to one of safety and connectedness, shown to be effective in other conflict zones in South Sudan and Uganda; 2) creating communal safe spaces for narrative sharing and active listening rooted in Rwandan cultural rituals (e.g. singing, dancing, and drumming); 3) at the end of the intervention, empowering participants with the leadership skills necessary for independent socioeconomic activities, allowing them to assume agency over their own healing in a long-term and community-rooted solution. These interventions were implemented in small groups (approximately 20 participants) in 54 different rural communities. The implementation was led by Community Healing Assistants, community leaders who were provided with six weeks of training and supervision by trained psychologists.

The program’s design—led by community members in

partnership with trained medical professions, leveraging cultural practices in community settings, and providing long-term interventions empowering participants—represents one example of a biosocial model that can have significant impact in addressing the mental health needs in Syria and beyond (Jansen et al., 2024). At the time of publication, the study was still ongoing; however, analysis of a community-based pilot program previously run by the UCP significantly decreased the prevalence of depression, anxiety, and PTSD (Ubuntu, 2023). In Syria, if INGOs were to work with local organizations and effectively implement a CBSH model, similar progress may be achieved in Syria.

Structural Violence and Concluding Remarks

Enforced ideas of scarcity, the lack of culturally adaptive care, and bureaucratic rigidity that limits the scope of health care provision—create an environment of structural violence; Although INGOs provide psychological first aid, basic counseling, and various forms of pharmacological and nonpharmacological treatments and psychotherapy services, Syrians are still denied access to quality mental health care because of societal factors, leading to disastrous consequences for their well-being (Farmer, 2010; Hijazi & Weissbecker, 2023). These figures paint a picture of suffering which can be curtailed if the known methods of treatment were properly implemented in Syria, but this is not the case. Although the geopolitical context in Syria has shifted, the same mental health concerns remain.

As displayed in this paper, to better understand the current inequities that exist in Syria, a biosocial approach is necessary. On the forefront, it might seem that the present mental health challenges experienced by the population are attributable to the ongoing trauma of war. However, it is impossible to deny the significant, if not primary role, that other societal, political, economic, historical, and cultural factors play.

Through understanding the impact that ideas of scarcity, western-centric models of care which display a lack of cultural competency, and bureaucratic rigidity have, one can understand the barriers that exist to providing adequate mental health care to the Syrian population impacted by war. This understanding is integral in addressing the mental health outcomes in similar conflict zones throughout the world—Gaza, Sudan, Ukraine, Congo, Haiti, and dozens of other nations worldwide (Council, 2025). Only through understanding the issues at hand, can strides be made towards reducing the mental health burden experienced by this population and the needs of Syrians addressed in a way that is most supportive to their emotional betterment.

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