Mental Health and Psychosocial Support (MHPSS) Needs Assessment of Displaced Syrians and Host Communities in Jordan

International Medical Corps

Sisterhood Is Global Institute/ SIGI-JO

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List of Acronyms

MHPSS: Mental Health and Psychosocial Support
IFH: Institute for Family Health.
IMC: International Medical corp.
IRD: International Relief and Development.
ISCA: International Standing Committee Agency.
HESPER: Humanitarian Emergency Settings Perceived Needs Scale.
HIS: Health Information System.
MH: Mental Health.
MHC: Mental Health Care.
MoH: Ministry of Health.
MoSD: Ministry Of Social Development.
NGO: Non-governmental organization.
SIGI: Sisterhood is Global Institute.
PHC: Primary Health Care.
PTSD: Posttraumatic Stress Disorder.
PWD's: Person with Disability.
UNHCR: United Nations High Commissioner for Refugees
WASS: WHO – UNHCR Assessment schedule of serious symptoms in Humanitarian settings.

Executive Summary

Jordan is one of the largest recipients of displaced Syrians since the outbreak of conflict in Syria in 2011, with more than 646,700 refugees registered in Jordan with the United Nations High Commissioner for Refugees (UNHCR)[1].

This report presents findings of a study undertaken to assess the mental health and Psychosocial (MHPSS) problems, services, and needs of displaced Syrians in Jordan as well as the Jordanian in host communities. The assessment was based on quantitative and qualitative tools adapted from the WHO-UNHCR Toolkit for Assessing MHPSS Needs and Resources in Humanitarian Settings[2].The study was conducted across Jordan between July and September 2015, this study was conducted by Sisterhood Is Global Institute (SIGI) and the International Medical Corps (IMC).

Findings are based on data collected from 968 individuals (626 Syrian Refugees and 342 Jordanians), and from 10 key-informant service providers and decision makers from governmental and non- governmental organizations. Most of the Syrian refugees participants were from the northern region (including Zaatari Camp), with females comprising 56% compared to males comprising 44%. Majority of the respondents were youth between 20-29 years old. As for the Jordanians sample, most of the participants were from the southern region, with females comprising 52% compared to males 48% of the sample.

The study was conducted using qualitative and quantitative data collection, for the quantitative part of the study the research team utilized two of the tools provided in the WHO/UNHCR toolkit; Tool 2: "WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings" (WASSS- Field Test Version 2012) which was used for both refugees and Jordanians in host communities, and Tool 3: the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) which was used for refugees only. In addition to Tool 10 to gather local community perception of problems facing them. The qualitative part included in depth interviews with 10 key respondents who are providing MHPSS services in Jordan to help in identifying the gaps.

When reporting mental health symptoms present 'all of the time' or most of the time" in the last 2 weeks, 33.5% of Syrian refugees and 20% of Jordanian respondents felt so afraid that nothing can calm them down. 47% of Syrian refugees and 25% Jordanians respondents felt so angry that nothing could calm them down; 32% Syrian Refugees and 19% Jordanians felt so hopeless that they did not want to carry on living; and 33% Syrian Refugees and 25% Jordanians felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset. These figures represent average responses for both Syrian Refugees in and outside camp settings and the Jordanians in host communities with Syrians in camps reported significantly higher proportions of mental health symptoms.

Perceived needs were assessed using the Humanitarian Emergency Settings Perceived Needs Scale (HESPER), for the Syrian Refugees sample only. The most frequently cited serious problems included separation from home country (89.2%) income and livelihood (83.2%), separation from family members (72%), in addition to lack of adequate aid (68%).

The assessment concludes with a set of recommendations to inform future planning and implementation of MHPSS programs and interventions. These include: promoting the early detection of mental health conditions; strengthening specialized MHPSS services and outreach; developing interventions that promote resiliency, skill-building, self-efficacy and adaptive coping strategies; supporting the development of community social support programs to foster positive family and interpersonal relationships, and promote a sense of community, involvement and belonging; and integrating MHPSS considerations in cross-sectoral programming and initiatives.

Part I: Background

1.1 Introduction & Context

Jordan is a relatively small country with a population of 6.4 million people (excluding Syrian refugees)[3]. As the conflict in Syria enters its fifth year, Jordan is hosting 646,700[4] officially registered Syrian refugees. Eighty-five per cent of refugees live outside camps in some of the poorest areas of the country, and a significant proportion are classified as extremely vulnerable;[5] mainly women and children. In some municipalities, refugees outnumber residents, and the impact of that on inflation, employment, and access to public services and community resources has fuelled local tensions and threatened to spark wider social unrest.

It was believed at the beginning of the Syrian crisis that refugees settled in northern parts of Jordan. However, based on UNHCR data accessed on September 17th, 2015, 26.7% of the refugees are registered in Amman, 50 % in Irbid, Mafraq, Jerash and Ajloun, 17% in central cities such as Zarqa, Balqa'and Madaba, and 3.3% are registered in the southern cities of Kerak, Maan, Tafieleh and Aqaba. Nevertheless, refugees in the South (approximately 20,000 individuals) are among the most vulnerable due to insufficient services provided in what are already underserved communities.

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.[6] It should be noted that these are common and normal reactions to abnormal events.

These psychological and social problems make it difficult for people to attend to their physical health needs, routine daily tasks, and maintain good relationships with others. Therefore, it is important to identify and address these problems early on in order to avoid deteriorations in mental health psychosocial wellbeing[7]. Within this context, it is of high importance to provide adequate information about the scope of MHPSS problems, how to access available services, and to have a strong referral mechanism in place.

The IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings classifies mental health and psychosocial problems in emergencies as either being predominantly social or psychological in nature[8].The Reference Group identifies family separation, safety, stigma, disruption of social networks, destruction of livelihoods, community structures, resources and trust; and involvement in sex work, as examples of significant emergency-induced social problems. Furthermore, grief, non-pathological distress, alcohol and substance abuse, depression and anxiety disorders

including post-traumatic stress disorder, are identified as examples of major emergency induced psychological problems. Other MHPSS problems in emergencies are classified under humanitarian aid-related social problems, (such as overcrowding and lack of privacy in camps, undermining community structures or traditional support mechanisms, aid dependency), and humanitarian aid-related psychological problems (such as anxiety due to a lack of information about food distribution)[9].

Jordan has been identified as a country in need of intense support for strengthening the mental health system by WHO in 2008[10], which means that the country's formal MHPSS services and facilities are still in need of reform and development, even without the pressure of the emergency setting of the Syrian Refugees influx.

1.2 Previous Studies

Several studies, assessments and reports were conducted by various organizations to assess the situation of the Syrian Refugees in Jordan during the past few years. It is of high importance for this assessment to relate to these previous studies in order to be able to track changes in situation, needs and services provided. The following are summaries of the studies conducted in the past few years:

In 2014, WHO, IMC and MOH conducted 4Ws Intervention Mapping Exercise, the mapping specifically focuses on MHPSS interventions only, collecting information about the range of MHPSS activities provided to all beneficiary groups in Jordan. The key findings of the 4Ws were as follow: Who and What: The 2014 mapping encompassed a cohort of 47 organizations that collectively deliver MHPSS services, programs and activities for communities across the Kingdom, The mapping identified that the agencies collectively deliver more than 450 services, programs and activities for citizens and displaced populations living in various governorates; 40% of them were community focused MHPSS, and 36% were cased managed MHPSS and 25% general MHPSS activities and services. Where: the largest percentage of MHPSS activities concentrated in the three governorates of Amman (19.5%), Irbid (17.6%) and Mafraq (16.5%), followed by the Central governorate of Zarqa at 14.2%. The Southern governorates of Aqaba, Tafileh, Ma'an and Karak, in addition to the Central governorate of Madaba, had the least concentration of MHPSS activities, with the lowest being in Aqaba. When: Results indicate that the majority of funding cycles (46%) were in the '1 year or more' category. These results evidence a marked change from the 2013 mapping, in which the majority of funding, approximately 52%, was in the shortest cycle of one to six months. Longer funding cycles are desirable for MHPSS actors as they enable more efficient planning towards service provision, sustainability and continuity of care[11].

In 2013, WHO, IMC in collaboration with Ministry of Health and Eastern Mediterranean Public Health Network carried a study to assess the mental health and psychosocial

(MHPSS) problems, services, and needs of displaced Syrians in Jordan. The assessment was based on quantitative and qualitative tools adapted from the WHO-UNHCR Toolkit for Assessing MHPSS Needs and Resources in Humanitarian Settings. Key findings of this study indicated that Syrians in Jordan are suffering from MHPSS problems. The assessment recommended promoting the early detection of mental health conditions; strengthening specialized MHPSS services and outreach; developing interventions that promote resiliency, skill-building, self-efficacy and adaptive coping strategies[12].

In 2012, CARE Jordan carried out a baseline assessment to provide information on the needs and gaps in services available to Syrian refugees living in the urban areas of Amman. The assessment utilized the "UNHCR Tool for Participatory Assessment in Operations". A main finding was that Syrians in Amman suffered significant hardships in securing basic life necessities. Psychosocial activities for adults and children were found to be inadequate. The assessment recommended carrying out an in-depth analysis of psychosocial needs, risks, and coping strategies in particular for women and girls[13].

In 2012, the United Nations Children's Fund (UNICEF) and IMC carried out a Rapid Mental Health and Psychosocial Support assessment to describe related problems and gaps in services among Syrian refugees in Jordan. The assessment also aimed to examine current and potential coping strategies, resources, and support needed. In presenting the most compelling problems, the report identified worry, camp conditions, aggressiveness, psychological distress, and boredom as the most common. Praying or reading the Quran, and talking to people were the most commonly identified coping mechanisms among participants of the study[14].

In early 2013, CARE Jordan conducted another participatory assessment and baseline survey of Syrian refugee households in Irbid, Madaba, Mafraq, and Zarqa. Results indicated that livelihoods and food security were areas of concern, and that Mafraq had the poorest households with the worst living conditions. The assessment also reported feelings of isolation, increased feelings of depression and negativity, and increased levels of family violence (both verbal and physical)[15].

1.3 Purpose & objectives of the study

The purpose of this comprehensive quantitative and qualitative assessment is to determine the scope of mental health issues & MHPSS needs among Syrian refugees in Jordan including both in camps and non-camps settings and across all regions of Jordan (including northern, central and southern areas), as well as the Jordanians in host communities. This study builds on previous studies and reports to enable informative decisions to be made in the field of MHPSS in Jordan that would target both Syrian Refugees and the Jordanian host community, same tools were used to look at trends over time. Carried out collaboratively by International Medical Corps (IMC) and Sisterhood is Global Institute (SIGI/JO).

It will also aim to identify major gaps in providing MHPSS services across Jordan. Results of both quantitative and qualitative methods presented in this report are expected to inform all active agencies involved with MHPSS humanitarian response to Syrian refugee crisis in Jordan. This report is also expected to contribute to the available knowledge regarding mental health needs for Jordanians. It should inform the design of programmatic interventions that support the MHPSS needs and resiliency of Syrians and Jordanians in Jordan.

The assessment was conducted to meet the following objectives:

- To determine the scope of MHPSS needs among Syrian refugees in all areas of Jordan as well as the Jordanians in host communities.
- To identify major gaps in providing MHPSS services across Jordan and determine the needs of refugees and host communities.

Part II: Methodology

2.1 Assessment tools

Quantitative Component:

The WHO and UNHCR have developed a toolkit to assess mental health and psychosocial needs and resources in humanitarian settings. This toolkit includes a set of data collection tools which can be used in conducting rapid assessments to provide public health actors with information that can guide in developing recommendations to improve the mental health and psychosocial well-being of people affected by humanitarian crises[16]. All questionnaire and in depth interview questions were reviewed by the mental health team at the IMC for face validity.

This assessment utilized two of the tools provided in the WHO/UNHCR toolkit; Tool 2: "WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings" (WASSS- Field Test Version 2012)[17] which was used for both refugees and Jordanians in host communities, and Tool 3: the Humanitarian Emergency Settings Perceived Needs Scale (HESPER)[18] which was used for refugee population only. Both tools were preceded by a section used to gather demographic information. Tool 2 was used to collect quantitative data in order to identify symptoms of severe distress and impaired functioning for both refugees and Jordanians. Tool 3 was used to collect quantitative data assessing the perceived serious needs of people affected by large-scale humanitarian emergencies. Perceived needs are needs which are felt or expressed by people themselves and are problem areas with which they would like help. Both tools were translated into Arabic by WHO & UNHCR and Arabic versions were used in this assessment. In addition, Tool 10 participatory assessment was used to gain quick

information from general community members living in humanitarian settings [19] was used. This tool utilizes the free listing technique, which is often useful in the beginning of an assessment to get an overview of the different types of problems and resources in a community, followed by the assessor selecting the type of problem of interest (that is, mental health and psychosocial problems) for more in-depth assessment on how the problem impacts daily functioning and how people may cope with it. This tool was used with around 200 individuals selected randomly from all participants.

Qualitative Component:

Semi structured in-depth interviews were conducted with key informant respondents (Table 1). Interviews were held by one or two staff members targeting various sectors that provide MHPSS services and activities in the non-camp setting such as Ministry of Health and its various departments in different regions, Ministry of Social Development in addition to national and international organizations. The interview guide was prepared to tackle four main themes: technical and human capacities, accessibility of services, availability of specialized services, in addition to coordination and referrals.

Governmental Institutiosn	International NGOs	National NGOs & CBOs
• The National Center for Mental Health; Ministry of Health • Primary Health Care Centre- Al Mafraq; Ministry of Health • Ma'an Governmental Hospital; Ministry of Health • Primary Health Care Centre- Al Karak; Ministry of Health • Ministry of Social Development - Irbid • Ministry of Social Development (MSD) - Amman	• Care International • Relief and development (IRD)International	• Al Farouq Society's Medical Centre • Institute for Family Health (IFH); Noor Al-Hussien Foundation

Table 1 Organizations represented by the in-depth interviews

2.2 Data Collection

2.2.1. Study Site

As this study targeted camp and outside camp settings across Jordan, the study was conducted in Za'atari Camp, and all governorates of Jordan. The study has focused on the southern region, since it has never been included with MHPSS assessments before. Data collection was conducted between July and August 2015.

2.2.2 Study Population

Syrian refugees living in Za'atari camp and urban and suburban communities in all Jordanian governorates as well as Jordanians living in same areas are the populations captured in this assessment.

2.2.3 Sampling Methodology

Participants were conveniently recruited from different communities through community leaders and community based organizations. The aim was to recruit total 1000 participants representing priority populations in all areas.

Za'atari Camp: The sample consisted of 147 refugees and they were approached by the research team randomly asked the first person encountered in the street by explaining to them the purpose and type of study conducted and had their approval for conducting the interview which took about 20-30 minutes with each person; it is worth noting that some individuals were interviewed in community areas, and safe spaces facilities of some international NGOs inside the camp, only 5% of people approached refused to participate or withdrew before completing the survey.

Communities: the sample of the Syrian refugees outside camps and the Jordanians in host communities were also conveniently recruited. The strata were divided according to the location and the size of the sample was higher in the southern region because it is believed the southern governorates such as Aqaba, Maán Tafileh and Kerak, which usually were left out. By referring to previous studies; the latest Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrians in Jordan, that was carried out in 2013 by IMC[20], was conducted in Amman, Irbid and Mafraq governorates, including Ramtha city only. The 4Ws mapping exercise carried out by IMC in 2014[21] showed clearly that the Southern governorates of Aqaba, Tafileh, Ma'an and Karak, in addition to the Central governorate of Madaba, had the least concentration of MHPSS activities. The surveyors would approach people on streets take their verbal consent (form attached in appendix 3) after explaining to them the purpose and type of study. About 10% of Jordanian and refuges approached in local communities refused to participate, or withdrew before completing the survey.

For the qualitative part, due to times and resources restrictions, we only conducted 10 in-depth interviews with purposively selected key informants representing governmental and non-governmental MHPSS services providers and their facilities (table 1). The key informants were chosen to represent both governmental and non-governmental organisations, and those who covered all three areas of Jordan.

2.2.4 Procedures

Quantitative Component

Seventeen surveyors were selected from governorates across Jordan; the surveyors are part of SIGI-JO's research team which has been trained on ethical and technical aspects of interviewing and collecting data. All of the 17 surveyor have prior experience in data collection and all of them were educated to the bachelor level. The surveyors were from all governorates of Jordan, both females and males. Although these surveyors had experience in collecting data and interviewing, SIGI-JO conducted a one day training workshop for all of them. The surveyors were trained on using the specific tools of this assessment. The surveyors were divided into four teams; Zaátari Camp, north, central and southern regions. One supervisor was assigned for each team, in addition to an operations leader. Camp officials and health agencies familiar with the camp and surrounding areas accompanied the data collection team while collecting data in Zatari camp.

Qualitative Component

Interviews for the qualitative part of this assessment were conducted by SIGI/JO staff members who are trained and experienced on conducting qualitative interviews. On average, interviews lasted for about 70 to 80 minutes. Interviews were all recorded with the consent of the interviewees. Interviews were transcribed and matched with handwritten notes the interviewers that were taken during the interviews on a guided questions forms, all qualitative data was categorized by themes, all data with similar content was put under one theme, the analysis of all data was done by the research team. Interviews used the semi-structured technique to collect qualitative data on MHPSS needs and provision of services. The guided discussion and questions prepared for these interviews aimed at identifying the gaps in the MHPSS services provided in all regions across Jordan.

2.1 Ethical Considerations

All participants joined this assessment voluntarily. Participants were told that they could withdraw from the assessment at any time during the interview, and were requested to provide informed consent. The consent form was read and verbal consent was obtained. Detailed information and responses were kept confidential. Respondents were not required to provide personal identifying information, such as name and phone number. Respondents were reassured that their responses were not to be discussed outside of the assessment team nor linked to any sort of identifiers. Assessments were stored in a secure location at SIGI-JO offices. Interviews were conducted in a manner respectful of confidentiality, as interviews were done individually and not within groups.

When encountering persons with possible MHPSS problems, the surveyors provided them with full information and contact details for appropriate services and organisations to help with their problem.

Official letters from SIGI were sent to the governmental and non-governmental organizations to obtain approval to conduct the interviews and the consent was obtained verbally. All surveyors and interviewers were trained on ethical codes of conduct for research. An approval for conducting the interviews in the Za'atari Camp was obtained from the Directorate of general security. All other necessary official approvals were obtained by SIGI/JO.

Part III: Results

Results of this study are based on data collected from quantitative and qualitative questionnaire and interviews.

3.1 Quantitative Assessment:

Interviews were conducted with females and males respondents using the questionnaire (Tools 1 and 2). Below are the main results describing the interviewees and participants' profile, as well as description of key findings from the assessment questionnaire.

	Syrian Refugees (%)	*In-camps Syrian Refugees (%)*	*Jordanians (%)*	*Syrians outside camps (%)*
Gander				
Male	43.9	27.9	48	48.2
Female	56.1	72.1	52	51.8
Regions				
North	45.4		29.1	29.8
Center	23.6		27.7	30.4
South	30.9		43.1	39.8
Governorates				
Amman	9.4	...	10.3	12.2
Zarqa	4.6	...	5.7	6.0
Balqa	4.8	...	6	6.2
Madaba	4.6	...	5.7	6.0
Irbid	9.1	...	11.7	11.8
Mafrq	31.6	...	11.7	12.0
Jarash	4.6	...	5.7	6.0
Karak	9.4	...	11.7	12.2
Tafila	9.1	...	11.4	11.8
Maan	9.3	...	11.4	12.0
Aqaba	3.3	...	8.6	4.2
Age Group				

18-19	8.6	2.6	8	10.2
20-29	32.4	22.4	40.4	35.0
30-39	30.3	42.2	26.9	27.2
40-49	18.7	21.6	15.4	17.9
50-59	6.9	7.8	6.4	6.6
60 and above	2.3	3.4	2.2	2.0
Literacy				
Do not read and write	14.2	10.4	5.2	15.2
School (basic)	37.9	37	12.4	38.1
School (secondary)	31.2	42.2	26.5	28.3
Diploma / High Institute	10.3	5.9	12.4	11.4
University / Bachelor	4.3	2.2	36.9	4.8
University / Graduate	2.2	2.2	6.6	2.2
Marital status				
Single	24.7	17.9	44.7	26.5
Married	59.8	67.9	47.9	57.7
Widowed	10.1	8.2	4.6	10.6
Divorced	4.9	6	2.9	4.6
other	0.5	...	...	0.6

Table (3) Socio-Demographic Variables of Participants

These results are based on the data collected from 626 Syrian refugees displaced in Jordan; (Diagram 1). Out of these 626 refugees, 147 were living in Za'tari camp. In addition, data were collected from 342 Jordanians living in host communities across Jordan.

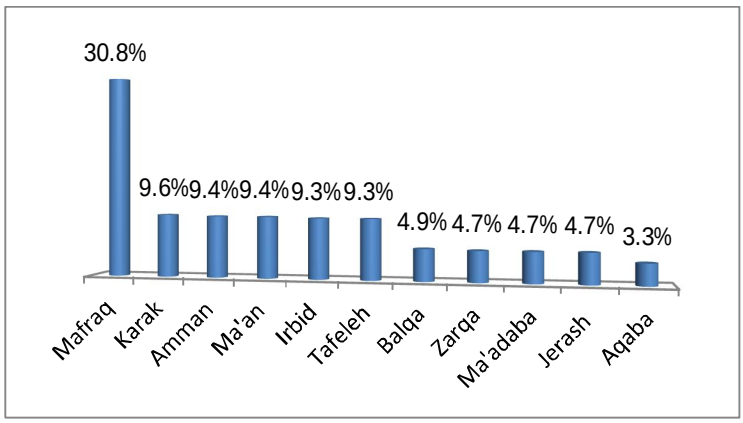


Figure 1 - Syrian Refugees study sample disruption according to governorate area

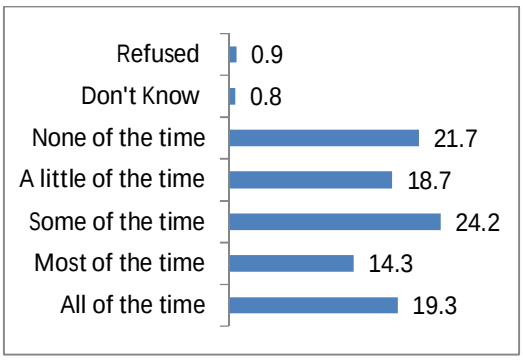
Around one third (37.8%) of the Syrians respondents reported having primary schooling and 14% reported their inability to read or write. Only 2.2% reported completion of university degrees. On the contrary, more than one third of Jordanians participating in this assessment have a bachelor's degree (37%), as the percentages from northern region of bachelor's degree holders was 42.2%, central region 32.2% and 36.2% of respondents from the southern region.

Results also showed that around 65% of Syrian respondents reported individual monthly income less than 200 JDs, while around 40% of respondents reported their family monthly income to be less than 200 JDs, and around 28% of families have their monthly income between 200 & 300 JDs. Meanwhile, 34% of Jordanian respondents reported individual monthly income less than 200 JDs, and only 7% of participants' families have monthly income below 200 JDs according to respondents. Moreover, around 45% of Jordanian participants reported family monthly income more than 600 JDs compared to only 4% of Syrians refugees who reported such family income.

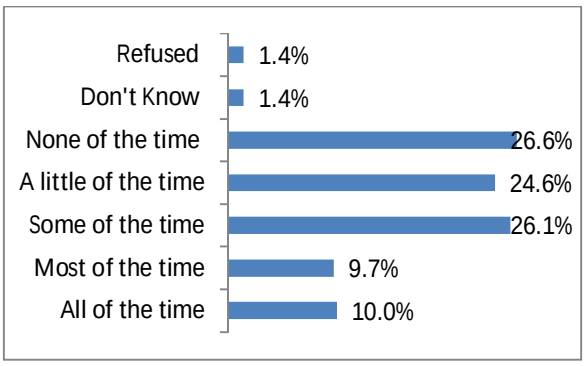
3.1.2 Mental Health Symptoms

We used as the WASS tool (tool 2) to estimate and measure mental health symptoms. Responses were analysed according to the scale provided by the WHO/UNHCR toolkit[22]. This tool was administered to both Jordanians and Syrian refugees. The tool consists of 6 items, each item asks about experiencing a mental health symptom within the past two weeks. Each item has 5 possible answers ranging from none of the time to all of the time. Interviewers have also two additional options indicating whether the clients didn't know the answers or didn't wish to answer the question. However, these options were not offered explicitly to participants. Generally, Syrian refugees reported high proportions of experiencing mental health symptoms in the past two weeks. Interestingly, when results were broken down, refugees in urban settings showed proportions of mental health symptoms comparable to those of Jordanians in host communities, while refugees in camps showed obviously higher proportions of symptoms. Detailed results for each item are demonstrated below.

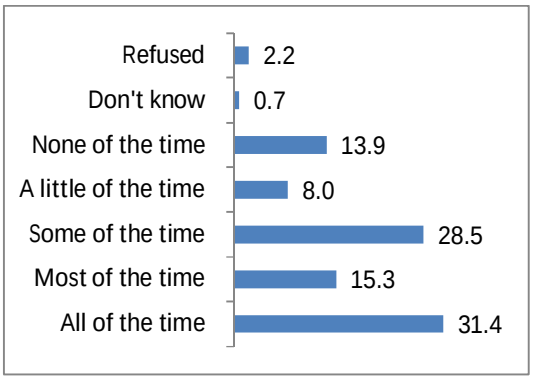
Question 1: About how often during the last 2 weeks did you feel so afraid that nothing could calm you down — would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?



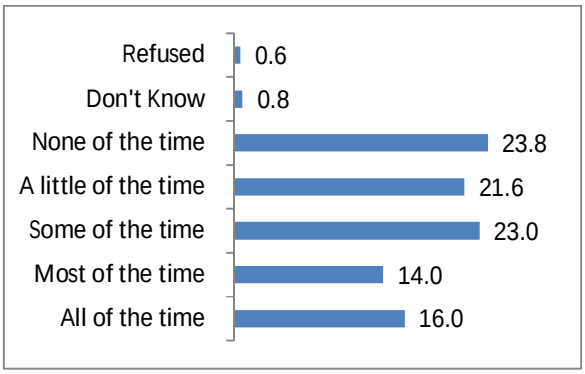
Syrians in Total



Jordanians in Host communities



Syrians inside Camps

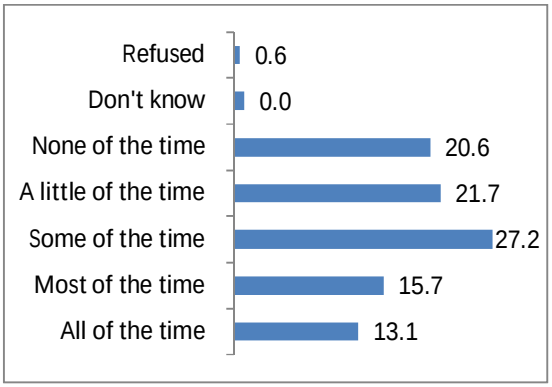


Syrians in Communities

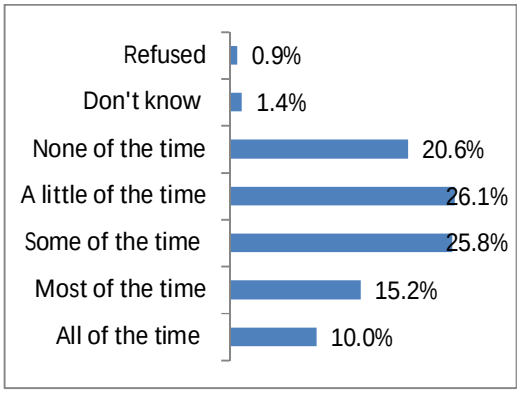
Figure 2 – Responses of the First question

For this question, 33.5% Syrians in total felt so afraid that nothing could calm them down all or most of the time during the past two weeks. It is notable that Syrians felt this way more than the Jordanians (19.7%), However, 46.7% of the Syrian refugees respondents in Za'atari camp felt this way all or most of the time.

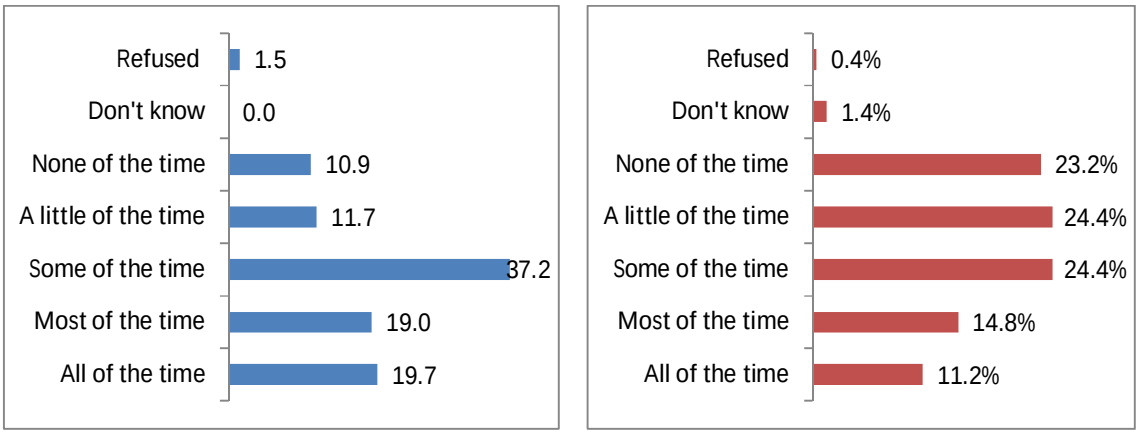
Question 2: About how often during the last 2 weeks did you feel so angry that you felt out of control — would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?



Syrians in Total



Jordanians in Host Communities

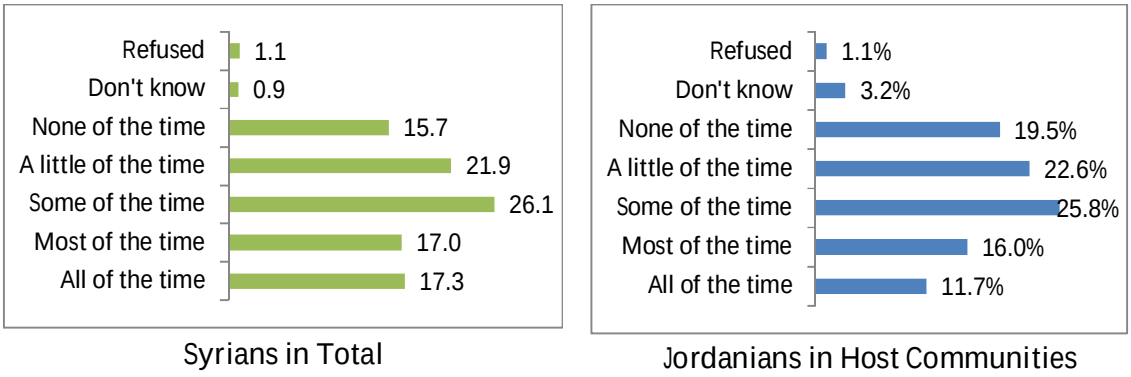


Syrians Inside Camps Syrians in Communities

Figure 3 – Responses of the Second question

For this question, 46.8% of the total Syrian respondents felt so angry that they felt out of control all or most of the time during the past **2** weeks, in comparison to 25.2% Jordanians in host communities. /in this questions as well, Syrians inside the camp responded with a higher percentage (38.7%) than those living in the communities (26%).

Question 3: During the last 2 weeks, about how often did you feel so uninterested in things that you used to like, that you did not want to do anything at all?



Syrians in Total Jordanians in Host Communities

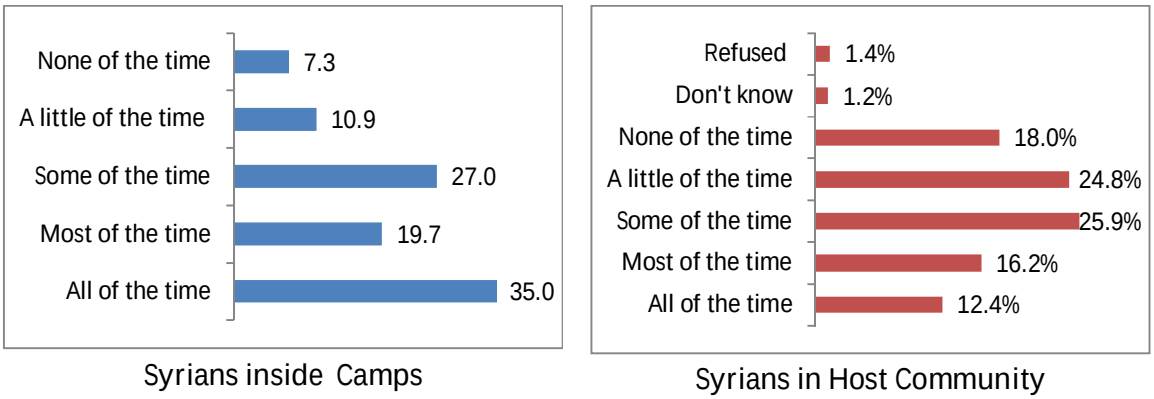


Figure 4 – Responses of the Third question

For this question, 34.3% of Syrian respondents felt so uninterested in things that they used to like, that they did not want to do anything at all most or all of the time in the past **2** weeks with a higher percentage of them inside the camp (54.7%). Jordanians in host community who reported having this feeling all or most of the time were 27%.

Question 4: During the last 2 weeks, about how often did you feel so hopeless that you wanted to be dead?

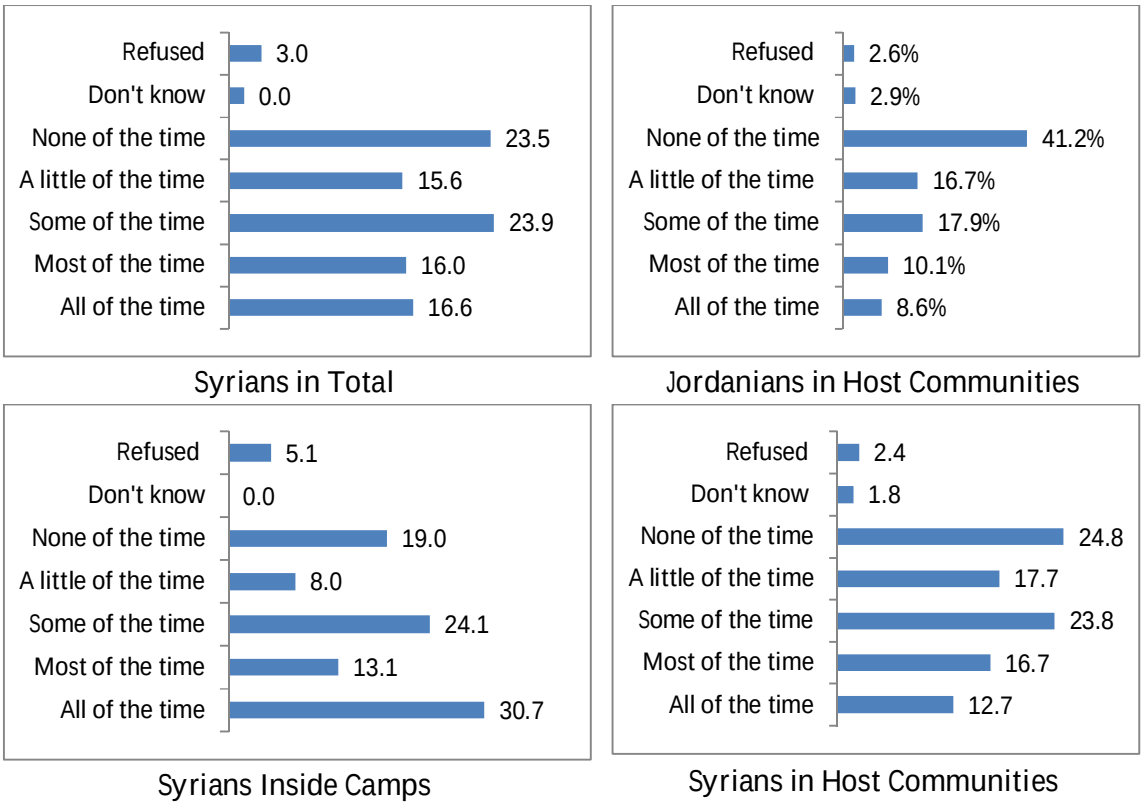


Figure 5– Responses of the Fourth question

For this question, 32.6% of Syrian respondents felt so hopeless that they wanted to be dead all or most of the time in the past **2** weeks, again with **a** higher percentage among the camp residents (44%). Jordanians who felt this way were 19%.

Question 5: You may have experienced one or more events that have been intensely upsetting to you, such as the recent war. During the last 2 weeks, about how often did you feel so severely upset about the war or another event in your life, that you tried to avoid places, people, conversations or activities that reminded you of the event?

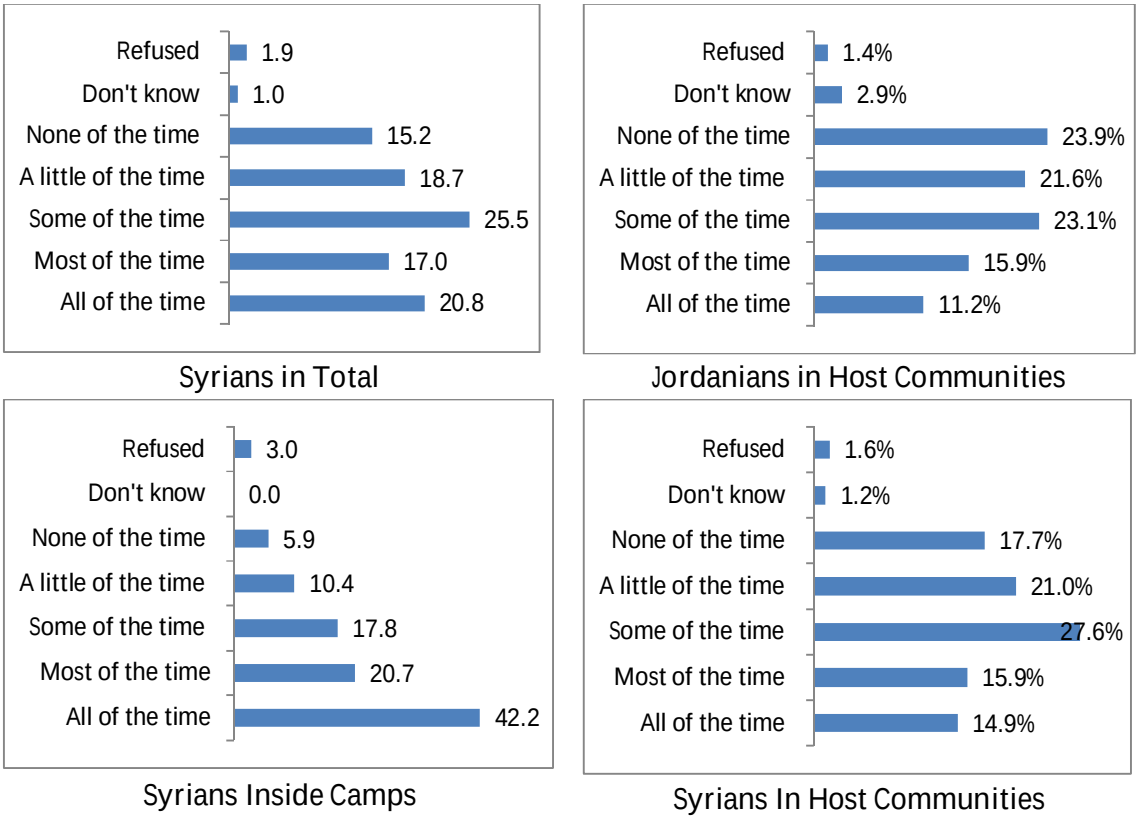


Figure 6– Responses of the Fifth question

For this question, 38% of the Syrians respondents felt so severely upset about the war or another event in their life, that they tried to avoid places, people, conversations or activities that reminded them of the event all or most of the time in the past 2 weeks. 63% of Syrians respondents inside the camp reported being severely upset all or most of the time.

Question 6: The next question is about how these feelings of fear, anger, fatigue, disinterest, hopelessness or upset may have affected you during the last two weeks. During the last two weeks, about how often were you unable to carry out essential activities for daily living because of these feelings?

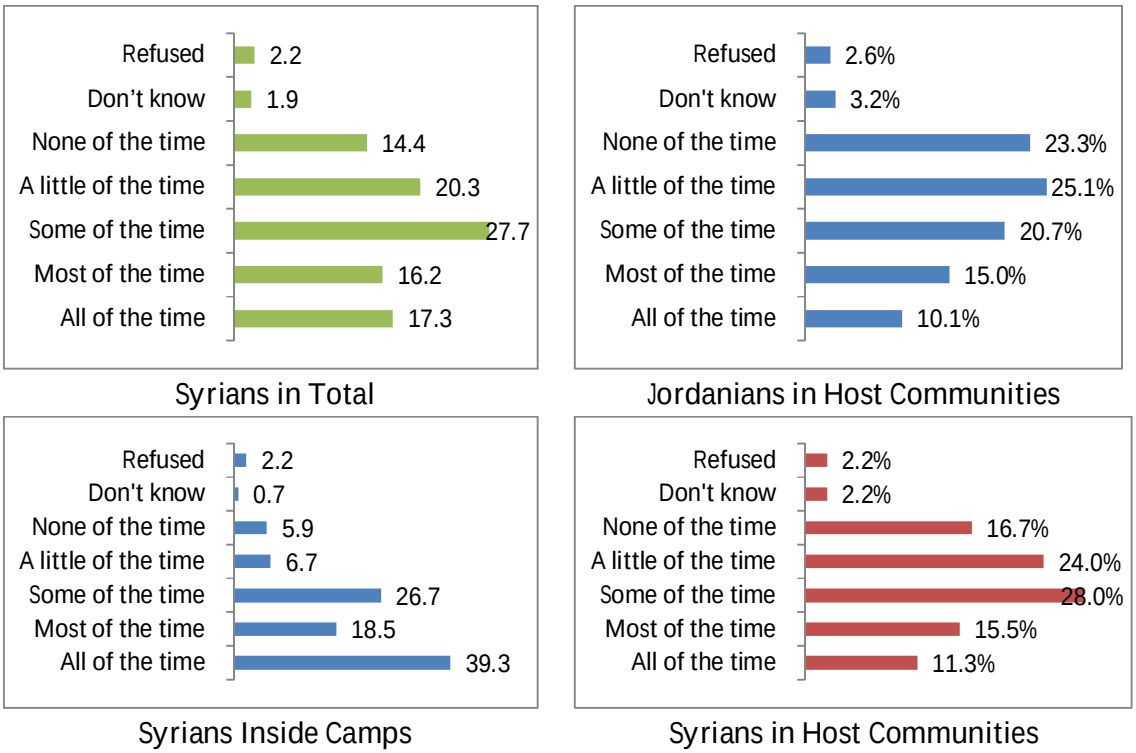


Figure 7– Responses of the Sixth question

For this question, 33.5% of Syrian respondents were unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset all or most of the time in the past **2** weeks, **a** higher percentage was among the Syrians inside camps (58%).

Perceived Needs of Syrian Refugees

The HESPER scale provides a quick, scientifically robust way of assessing the perceived serious needs of people affected by large-scale humanitarian emergencies. Responses to questions obtained through the assessment questionnaire (tool 3) were analysed according to the scales and scoring provided by the WHO/UNHCR toolkit[23]. Tool 3 was piloted with volunteers from the host community and they were not comfortable answering these questions as they felt it is not relevant to them. Therefore, we used the HESPER with Syrian Refugees only.

HESPER asks about perceived serious problems in 26 different issues including income, shelter, food, water, as well as physical and mental health among other issues refugees might face. High proportions of respondents perceived serious problems related to mental illnesses, violence, schools, and access to healthcare. Similar to findings from tool 2 (WASSS) respondents from camps reported higher results. For example, 51% of respondents from camp reported serious problems in mental illnesses compared to 35% in non-camp settings. In addition, 75% of respondents in camps reported serious problems because they are very distressed compared to 65% in non-camp settings.

Also, 47% of respondents in camps reported perceived serious problem in the community in violence against women and children. Table 4 summarizes the proportions of most relevant issues.

	Proportion of respondents who perceived serious problem		
	Total	Camp	Non-camp
Mental illness	39%	51%	35%
Physical health	52%	56%	49%
Healthcare services	58%	66%	57%
Very distressed	68%	75%	65%
Alcohol & Drug use	36%	37%	34%
Children Schools	43%	52%	39%
Violence (physical and sexual)	37%	47%	33%
Community support	55%	65%	51%
Income	83%	81%	83%
Displacement	90%	90%	87%
Inadequate aid	68%	74%	65%

Table 4 Perceived Needs of Refugees according to HESPER Tool

On other issues that could lead to distress, feelings of uneasiness and may affect their sense of security and stability; 83% of respondents reported having a serious problem because they do not have enough income, money or resources to live; 72% of respondents reported having a serious problem because they are separated from family members; 61.2% of respondents reported having a serious problem because they do not have enough information; 56% of respondents have a serious problem because they do not have enough water that is safe for drinking or cooking; 53% of respondents believe that there is a serious problem in their community because there is not enough care for people who are on their own, For example, care for unaccompanied children, widows or elderly people, or unaccompanied people who have a physical or mental illness, or disability; 50% of respondents reported having a serious problem because they do not have enough, or good enough, clothes, shoes, bedding or blankets.

When asked if they have any other serious problems that they were not yet asked about, most respondents; around 64%, reported that they don't have other problems. Few problems that were stated by some respondents are lack of electricity, lack of job opportunities, and high cost of living.

Figure 8 shows the frequency with which each of the 26 HESPER areas were rated as the most serious problem according to the participants : 'Income or livelihood' was rated by 17.7% of participants as the most serious problem, more than any other problem area. Other areas which were named by more than 10% of participants as their most serious problems included 'Drinking Water' (13.7%), 'Being displaced from home' (12.8%).

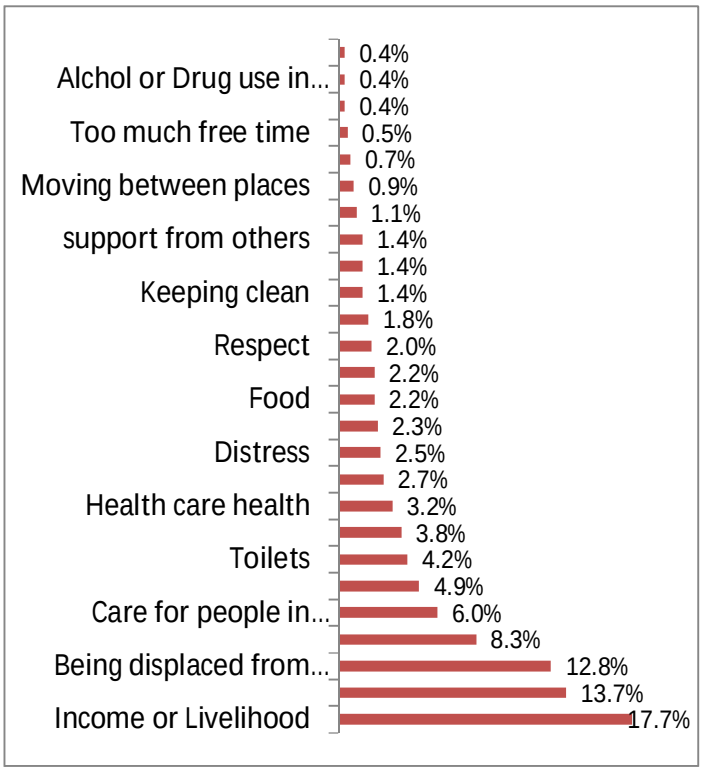


Figure 9 shows the frequency with which each of the 26 HESPER areas were rated as the second most serious problem according to the participants : 'Income or livelihood' was rated by 15.9% participants as the second serious problem. Other areas which were named by more than 10% of participants as their second serious problems included 'Being displaced from home' (11%), The way aid is provided' (9.9%).

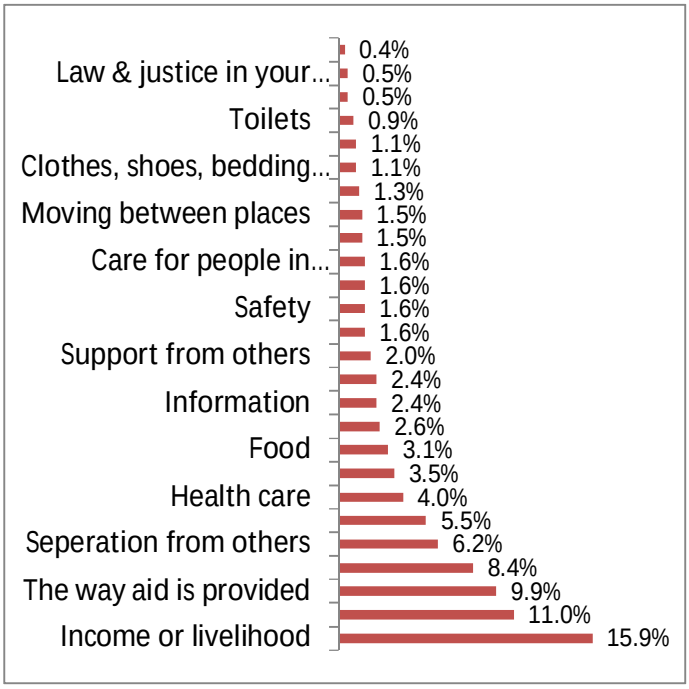
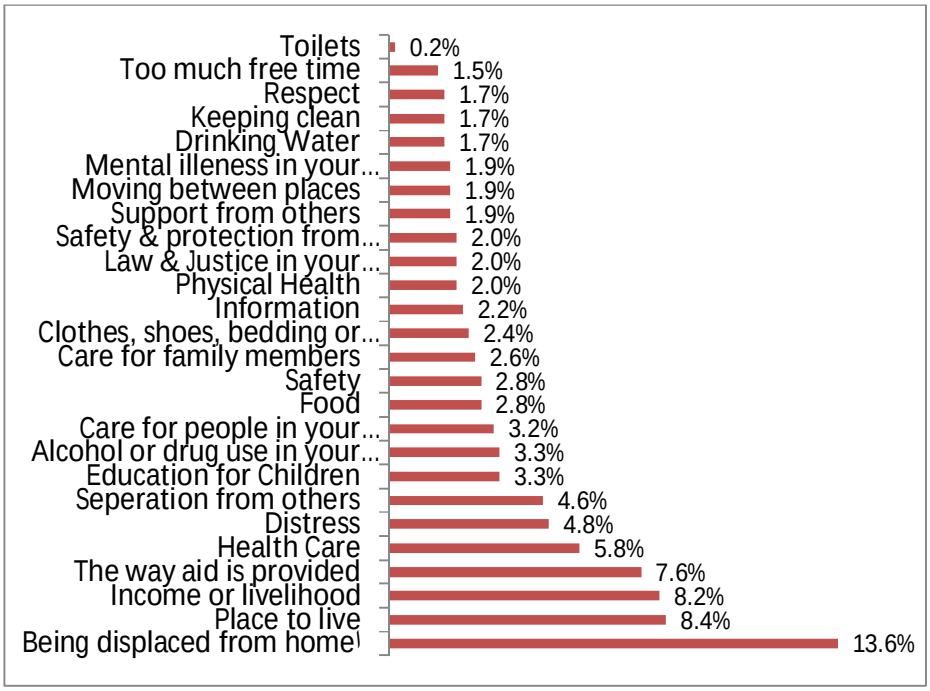


Figure 10 shows the frequency with which each of the 26 HESPER areas were rated as the third most serious problem according to the participants : 'Being displaced from

home' was rated by 13.6% of participants as the third serious problem. Other areas which were named by participants as their third serious problem included "Housing" (8.4%), and 'Income or livelihood' (8.2%).



The last few questions refer to people in the refugees community, as 68.1% of the respondents believe that there is a serious problem in their community because of an inadequate system for law and justice, or because people do not know enough about their legal rights; 47.2% of respondents reported that there a serious problem for women in their community because of physical or sexual violence towards them, either in the community or in their homes; 51.4% of respondents stated that there is a serious problem in their community because people have a mental illness; 69.4% of respondents believe that there is a serious problem in their community because there is not enough care for people who are on their own, For example, care for unaccompanied children, widows or elderly people, or unaccompanied people who have a physical or mental illness, or disability.

3.2 Key Informant Interviews

These interviews were conducted with services providers and decision makers from governmental and non-governmental organizations and institutions that offer MHPSS services. Following are the main results presented to describe and identify the gaps in MHPSS services and facilities in the area.

3.2.1 Technical Capacities

Interviewees expressed their concerns regarding lack of specialized and qualified mental health workers. According to informants, this was reflected in restricting services to screenings, identifications, and referrals to specialized services providers. These specialized services' providers were not abundant according to the key informants, and sometimes there are delays in providing services to referred clients due to overload in these centres. Informants also reported that they do not have records of mental health cases.

Generally, key informants reported that health staffs in their services' centres, which include psychosocial spaces, primary healthcare centres, and community centres, are aware of the available resources. They are aware of specialized services locations and the procedures of referral for specialized mental health services; most organisations have their own referral system and work closely with other organisations that provide professional help. Furthermore, the health staff is aware of available support for cases with high levels of vulnerability (such as child abuse, GBV, domestic violence…etc.) and can refer those who need such services to other protection agencies, legal services or other needed service providers that can offer protection and/or social support.

Most of the respondents revealed that training opportunities in mental health are not adequate. Some organisations, according to interviewees, arrange subject-specific trainings for their staff to handle severe psychological cases concerning refugees (e.g. survivors of torture, rape and those who are suffering from trauma and related mental health problems), but these trainings were limited and specific to certain short-term projects. These trainings in general are not comprehensive, very well structured, and it lacked the follow up.

3.2.2 Accessibility to Services

Most of key informants reported that Primary Health Care Centres are located in safe areas and in different locations for easy access to the affected community of refugees (distance to nearest health care centre varies from 1km to 30km on average). Nevertheless the facilities inside the camp setting are more accessible and easier to reach by refugees, as other centres might be located in areas far away from the refugees. All measures are taken to ensure privacy and confidentiality of cases dealt with, in particular with cases of domestic violence, rape, torture etc. All interviewed key informants reported having their internal procedures to protect information and providing patients with protection and heath care.

3.2.3 Availability of Services

Many organizations that serve refugees in Jordan are following the case management approach in providing protection services that is integrated with psychosocial activities and programs. Key informants reported that they have at least one care provider in each of their facilities who is capable of identifying and referring clients with mental health concerns. All active organizations in the field of mental health and psychosocial support are involved in regular coordination, which exchange of knowledge regarding available services according to informants. For refugees, informants identified a gap in management of seizure disorders and epilepsy cases; most informants agreed that clear referral procedures for seizures disorders are lacking. Ministry of Health is clinically managing cases of drugs or substance abuse, but these centres mainly target addiction and substance abuse problems for Jordanians and not many refugees are referred to these services or receiving such services. Besides, informants reported that services for children with developmental disorders are not sufficient.

3.3.3 Coordination and Referrals

Some organisations have certain referral agreements between them according to their mandates, for example referring refugee clients who suffered psychological trauma and adverse events to specialized providers, which should be part of the overall coordination efforts taking place to offer services for refugees. Moreover, some vulnerable Jordanian clients who suffer from depression, anxiety, or have experienced GBV, and domestic violence were also referred between collaborating centres and organisations. Most of these referrals are made by health workers, school counsellors and/or other specialised centres.

According to the key informants, the main barriers to identifying and managing mental disorders are:

- Workers competency to deal with mental health problems. Lack of adequate and organized trainings.
- Lack of accreditation system and quality assurance for organizations, facilities and centers where MH services are provided.
- Documentation system in organizations and centers needs development to create a database.
- Cultural differences between providers and beneficiaries; particularly Syrian refugees and Jordanians from rural areas, where they still have some norms that favor behaviors, which might negatively impact psychosocial well-being of clients, such as believing in sorcery and encouraging early marriage and child labor.

- Long term nature of psychological services and support activities. This might result in poor follow up and commitment to care, which may influence outcomes of care.
- Relatively high cost of prescribed psychotropic medications to manage some neurological and psychiatric conditions.

Part V: Discussion & Recommendation

Recommendations are presented to aid informed planning of future MHPSS programs that would build on already existing capacities and resources. This assessment revealed that both refugees and host populations have significant amount of psychological distress and concerns related to mental health, with substantially higher levels among refugees and in particular among the refugees inside camps despite all available services and programmes in camps. This contrast in results between camps needs to be further explored in order to better plan and inform response services. This can be attributed to many reasons, including that respondents from camp might not be representative of the whole camp situation; particularly that we didn't survey Azraq camp. Nevertheless, refugees in camps have less diverse resources and choices available to them compared to refugees in non-camp settings. Also, there might be some differences in the demographic formation of the refugee camp population compared to non-camp populations. Besides, it is suggested that chronicity of the crisis has altered the expectations of refugees in camps, which might significantly impacted their perceptions toward future and toward services available and provided.

The Syrian refugee's respondents expressed worry about income and livelihood, worry over how the aid is being provided, and their basic needs such as drinking water, housing and medical care. The Jordanians respondents encountered less of these feelings but nevertheless they were reported by 10 – 20% of respondents as most or all of the time feelings. These reported problems are concerning and related to significant mental health disturbances. However it is worth noting here that the tools used for this assessment measure only the symptoms and they are insufficient to make any diagnosis.

Interestingly, this report has also pointed out that differences in symptoms between Jordanians and Syrians living in urban context are minimal. This can be explained in different ways; refugees might have adapted to the life in host community after 4 to 5 years of the crisis, or perhaps, the crisis has increased level of stress among host communities, and it is recommended that this topic is explored independently.

This assessment also provided insight of the needs and gaps in mental health & psychosocial support services in Jordan. There is still need to develop tools for early detection of symptoms, as service providers and practitioners highlighted the need for cultural sensitive tools for assessments, referrals, and diagnoses which can play a role in

reducing the negative impact of the situation and improve the psychological well-being and coping mechanism for refugees and host communities. These tools will need to be developed through cooperation between governmental and non-governmental entities in addition to trainings of service providers to ensure efficient use of resources .There is also an evident need in building MHPSS technical capacities on all levels. In addition to the limited resources such as human resources presented in experienced staff, financial resources to provide for the relatively expensive medications and relatively high cost of care for cases with mental health problems.

Recommendations:

- *Mental Health Symptoms* were evident in all three groups of the sample; it was higher among the Syrian refugees in comparison with the Jordanian host communities; however the refugees inside camps showed a higher percentage of these symptoms in comparison to the Syrians refugees outside camps. With reference to the last MHPSS need assessment in 2013, the mental health symptoms had an increasingly higher percentage in this assessment.
  Recommendation:
  - Investigate differences in symptoms between camps and non-camps settings
  - Explore and evaluate the services provided within the camp to determine the gaps with services provided for the refugees inside camps.
  - Enhance coordination and continue to carry out mapping exercises to determine who is offering what, where and when for the refugees inside and outside the camps setting.
  - Explore and evaluate the services provided in host communities for refugees and Jordanian host community to determine the gaps within MHPSS services provided.
  - Meet the needs of host population; particularly in disadvantaged areas, which are comparable in magnitude and type to refugees needs.

- *Perceived Needs*: using the HESPER Scale to ask participants about 26 different types of problems faced by refugees in both camp and non-camp settings showed a feeling among the refugees that their basic needs are not being met; they have also reported mental illnesses, physical health and health care services, distress among the serious problems they face. When compared with results published in 2014[24] results of this assessment show that income and livelihood is still considered among the refugees the most serious problem, it was also noted that healthcare and other health related issues were present in both assessments. It was also noted that lack of information was also one of the serious problems faced by Refugees; whether information related to their legal status, Jordanian laws and regulations, MHPSS services provided, healthcare services, and

protection services provided by Jordanian government in addition to local and international organizations.

Recommendations:

- Meet the needs of the refugees populations both inside and outside camp settings, which should include quality healthcare services in addition to MHPSS services
- Raise awareness of refugees about their rights and responsibilities; with focus on Jordanian laws, services provided by both governmental and non-governmental organization, where can they seek help and addresses of services and protection providers, the population need to be aware of available mental health resources
- Develop community based interventions such as peer support program that can be implemented on individuals or support groups that focus on resilience, skill building, self-efficacy, and capacity building for refugees, and promote adaptive coping skills and strategies. Such interventions can increase motivation and hope, provide a sense of productivity, and replace negative coping behaviors with positive strategies that enhance wellbeing[25].
- Promote safety and security with social support to refugees in camp and outside camp settings; providing venues were refugees can meet for social activities would lessen their feelings of isolation and missing their home country.

- *Technical Capacities, Availability, & accessibility to services* it was noted through the key informants interviews, and through reviewing previous 4Ws Intervention Mapping Exercise that was carried out in 2014; the need to build the capacity of the service providers and organizations providing PSS and MHPSS services across Jordan, with specific attention to the southern regions which was the least region to receive such programmes and services.

Recommendations:

- Ensure quality and competence of MHPSS services through governing MHPSS professions and setting professional standards
- Provide structured specialized MHPSS trainings to non-specialized providers, and support and encourage integration of PHC, MH, & PSS services.
- Longer funding cycles to ensure continuity and sustainability of services provided.
- Develop culturally sensitive tools for assessments, referrals, and diagnoses.
- Need to increase availability of specialized MHPSS services especially in underserved areas.

- Integration is needed for improved availability and access.
- Improve the quality and quantity of MHPSS services provided for the Syrian Refugees and Jordanians in host communities.
- Pay attention to specific gaps in services for Syrian refugees as suggested by informants. This includes services for seizures and substances use.

- *Coordination & Referrals* although efforts are being made to ensure cooperation and coordination among organizations, these efforts sometimes lack structure and documentations.

  Recommendations:

  - Need for structured, evidence-based, & comprehensive PSS activities for both refugees and host communities
  - Additional PSS services are needed in south for Jordanians & refugees
  - Written agreements or MoU (Memos of understanding) among various service providers would ensure a better referral system, and more coordination.

Part IV: Limitation of the Study

Although all efforts were made to have a comprehensive and complete assessment study it is important to note the following limitations:

- The sampling methodology was one of the main limitations of this study as the convenience sampling method was recruited which might result in a biased sample that does not fairly represent the priority population.
- In such surveys there is also a bias risk that may result from inconsistent interviewing, or perhaps inconsistent interpretation of questions used in the tool. The interviewers were trained and validated tools were used to minimize potential bias.
- There might be an effect of social desirability where responses might have been exaggerated intentionally due to the belief that this will lead to obtaining increased assistance or this is the results surveyors would like to hear.
- Although all measures were taken to interview people with responsible and leadership positions for the in depth interviews, a limitation of using key informants is that information comes from a relatively small, select group of individuals. A broader group of key informants may have resulted in more diverse opinions and broader insight. Perhaps, this could have captured additional dimensions regarding MHPSS needs.
- Another major limitation of this study is that quantitative findings were not supported by in-person interviews or focus groups with the participants themselves. This was due to logistical constraints, and this would have added

further dimensions to our results, and possibly contributed to the explanations of the findings.

- Part of the data collection was conducted during the month of Ramada. It is possible that this has influenced answers of participants. However, there is no evidence as of such influence, and it cannot be told whether this would be a positive or negative impact, given the spiritual nature of Ramadan and the physical burden of fasting; particularly in the summer months.

Part V: Conclusion

This assessment revealed that many displaced Syrians in Jordan and Jordanians in host communities experience a variety of MHPSS problems including distress, sadness, fear, anger, nervousness, disinterest and hopelessness. Most notably, the reported MHPSS problems were identified to cause disruption in the daily functioning of Syrian refugees. It is recommended to prioritize MHPSS services when working with both refugees and host communities. A set of recommendations from this assessment were presented including: strengthening specialized MHPSS services and outreach; developing interventions that promote resiliency, skill-building, self-efficacy and adaptive coping strategies; supporting the development of community social support programs to foster positive family and interpersonal relationships, and promote a sense of community, involvement and belonging; and integrating MHPSS considerations in cross-sectoral programming and initiatives.

References:

[1] http://data.unhcr.org/syrianrefugees/regional.php - accessed Sep. 2015
[2] World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.
[3] Jordan in Figures: 2012. Department of Statistics. Government of Jordan, 2013. Amman, Jordan.
[4] Government of Jordan's official figures as of 18 October, 2014.
[5] Jordan Response Plan 2015 for the Syria Crisis. Ministry of Planning and International Cooperation, Government of Jordan, 2014. Amman, Jordan
[6] PTSD and depression in refugee children Associations with pre-migration trauma and post-migration stress, Heptinstall, E., Sethna, V., & Taylor, E.
[7] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.
Geneva: IASC.
[8] IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva: WHO, 2010.
[9] IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva: WHO, 2010.
[10] Mental Health in Jordan, WHO, http://www.emro.who.int/jor/jordan-news/mental-health-in-jordan.html. Accessed Sep. 2015
[11] Who is Doing What, Where and When (4Ws) in Mental Health & Psychosocial Support in Jordan. WHO, IMC & MOH. Interventions Mapping Exercise October 2014
[12] Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrains in Jordan. WHO, IMC, MOH and EMPHNET. Amman – Jordan, 2013
[13] Baseline Assessment of Community Identified Vulnerabilities among Syrian Refugees living in Amman.Care. October, 2012.
[14] Displaced Syrians in Za'atari Camp: Rapid Mental Health and Psychosocial Support Assessment: Analysis and Interpretations of Findings. IMC, Amman, Jordan. August 2012.
[15] Syrian Refugees in Urban Jordan: Baseline Assessment of Community-identified Vulnerabilities among Syrian Refugees Living in Irbid, Madaba, Mufraq, and Zarqa. Care, Amman, Jordan. April, 2013
[16] World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.
[17] World Health Organization & United Nations High Commissioner for Refugees. WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) (field-test version). In: Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.
[18] Source WHO & Kings College London. The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale. Geneva, 2011.
[19] IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. Participatory Assessment I: Perceptions by General Community Members. In: IASC Reference Group Mental Health and Psychosocial Support Assessment Guide, forthcoming.
[20] Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrains in Jordan. WHO, IMC, MOH and EMPHNET. Amman – Jordan, 2013
[21] Who is Doing What, Where and When (4Ws) in Mental Health & Psychosocial Support in Jordan. WHO, IMC & MOH. Interventions Mapping Exercise October 2014
[22] World Health Organization & United Nations High Commissioner for Refugees. Participatory Assessment III: Perceptions by severely affected persons themselves. In: Toolkit for the Assessment of Mental Health and Psychosocial Needs and Resources in Major Humanitarian Settings. Geneva: WHO, 2012.
[23] WHO & Kings College London. The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale. Geneva, 2011.
[24] Hidden victims of the Syrian crisis: disabled, injured and older refugees, HelpAge International and Handicap International, 2014.
[25] Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrains in Jordan. WHO, IMC, MOH and EMPHNET. Amman – Jordan, 2013