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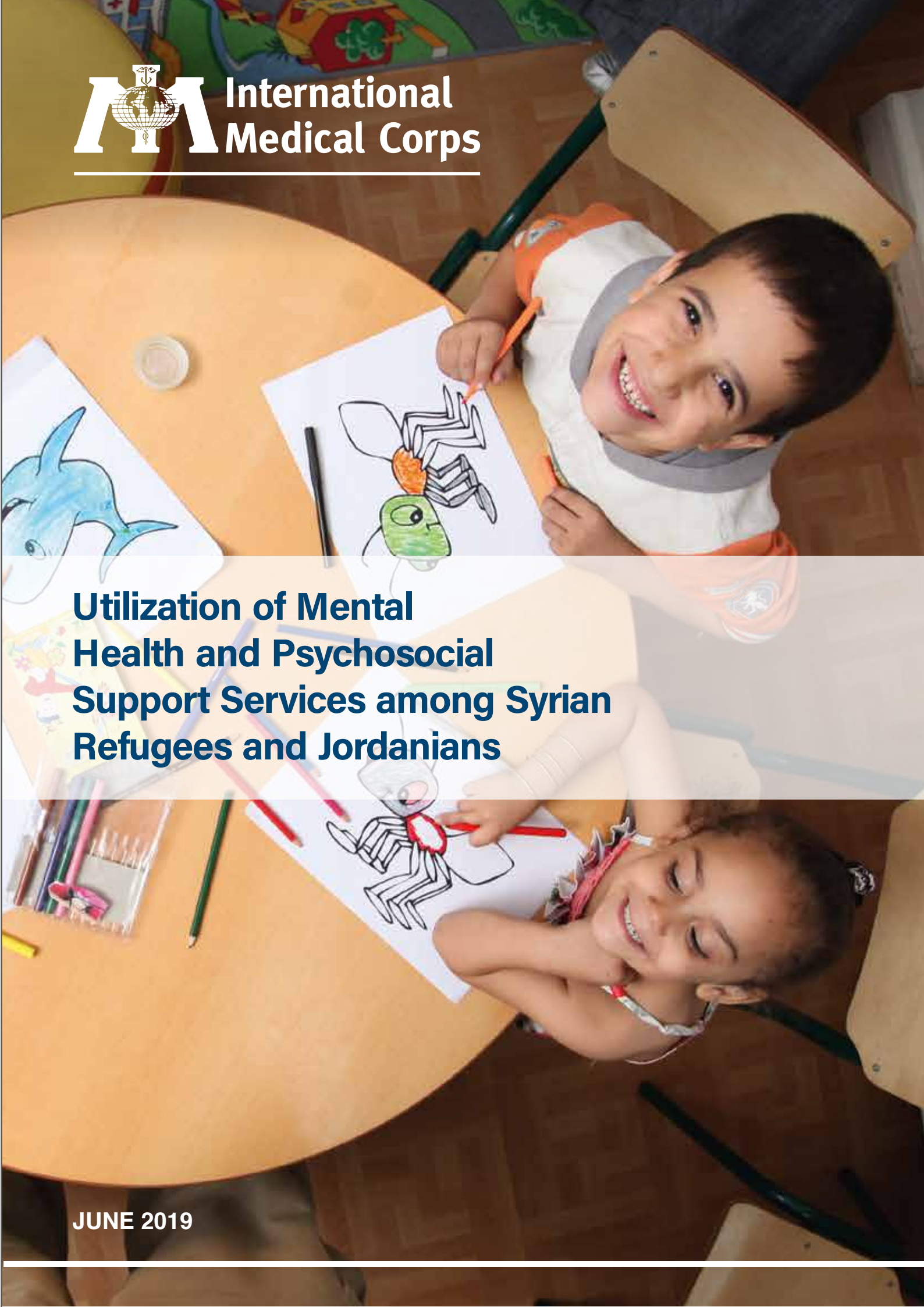

International Medical Corps

Utilization of Mental Health and Psychosocial Support Services among Syrian Refugees and Jordanians

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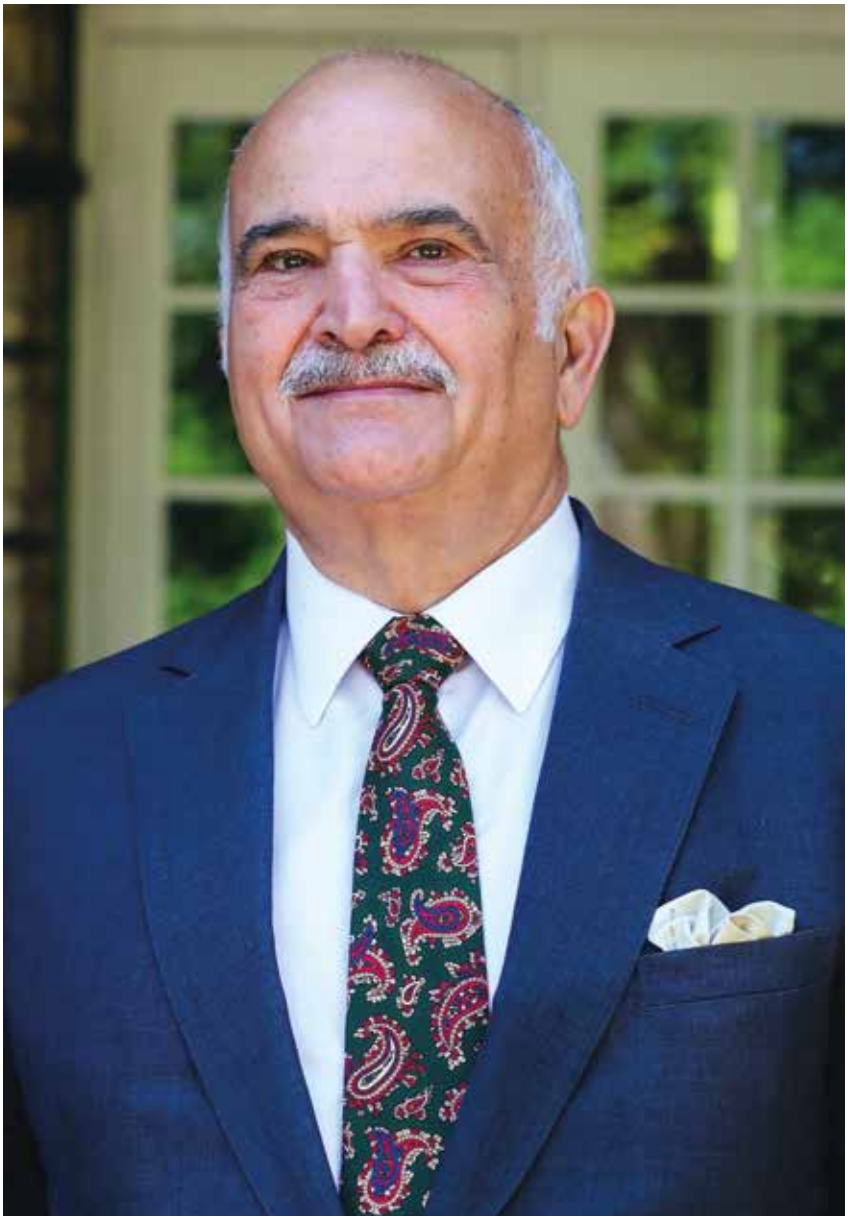

His Royal Highness Prince El Hassan Bin Talal

Foreword

The vast majority of us will experience some form of mental illness at some point in our lives, or know someone who has, yet all too often we lack the strategies to promote quality interventions to support mental well-being, prevent disorders, and to protect the human rights and ensure the care of those affected.

I would like to express my gratitude to the International Medical Corps, The Ministry of Health, The Higher Council for Science and Technology, UK Aid and to all those involved in the publication of this insightful body of work. Its detailed findings and recommendations break new ground in pointing the way forward in our approach to all aspects of mental and psychological well-being and intellectual disability and will have a significant impact for both Jordanians and refugees in our country, as well as for society as a whole.

A society is judged by the manner in which it helps those who are unable to look after themselves. In line with cultural and religious teachings, in particular those of Islam, we have a responsibility - at the national and international levels - to act and support others, especially those who are scorned, shunned, or feared.

This year, the world marks the centennial of the signing of the Treaty of Versailles and the 70th anniversary of the Geneva Conventions. The commemoration of these events is an opportunity for us to recommit to upholding the dignity of all.

In the realization of these rights, a new 'Principle of Humanity' should be placed at the center of national and international policymaking. The Responsibility to Protect, an internationally recognized norm, should be augmented with the Responsibility to Respect, requiring governments to pursue a comprehensive and socially responsible approach to mental health.

For too long, the discourse surrounding mental health has been narrowly focused on its management, away from the public arena, in a top down approach whose initiatives all too often overlook or exclude the voices of the very people, or their carers, that are intended to help. This report puts cultural, community driven, rights based initiatives to the fore, by offering concrete suggestions for the alleviation of mental distress which will advance the rights of the individual and their families, and it is to be hoped, dispel the current fears and stigma surrounding mental health. It offers a beacon of hope and a roadmap towards ending the social exclusion of those with mental health issues and intellectual disabilities.

Ultimately, the topic of mental health in Jordan touches upon the question of 'who' and 'what' we choose to be as a country. A crucial matter that transcends boundaries, like tribal loyalties and political affiliations, mental health must be set at the forefront of national and global policy agendas. I hope that the recommendations expressed in this assessment are readily [OR rapidly] adopted by both our national and international policymakers as we go forward.

EL HASSAN BIN TALAL

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Executive Summary

The extended crisis in Syria coupled with the ongoing stressors related to displacement, have had a significant impact on the mental health and psychosocial wellbeing of Syrian refugees as well as Jordanian residents.

This study aimed at exploring if any changes or trends could be identified within the last five years, regarding the level and type of perceived distress, main strategies of help-seeking behavior and common coping mechanisms among Jordanians and Syrians. In order to do so, different factors were taken into considerations: the perceived symptoms of severe distress and impaired functioning, help-seeking behaviors, the most common coping mechanisms, the barriers to access mental health services, assess the needed services among Syrian refugees and Jordanians within Jordan, and assess how they have changed over the last five years.
In regards to the overall findings of this assessment, the assessment noted higher rates of symptoms of mental distress and functional impairment among urban refugees compared to those reported in earlier assessments. Particularly:

• Overall, the proportion of participants with distress was 43.4%; 38.9% among the host population, 57.0% among refugees in urban communities, and 23.0% among refugees in camp ($p < 0.005$). More than half of respondents who perceived to be experiencing distress in all communities reported seeking help from a friend (56.4%), followed by 47.2% and 41.1% of respondents who reported seeking help from family members, and a spouse, respectively.

• The primary barriers to seeking help identified by this paper were: feelings of helplessness, lack of financial means, unawareness and poor recognition of mental health problems, cost of treatment, the need for privacy, and stigma.

• Overall, this assessment found that seeking comfort in faith and spiritual beliefs was the most common coping mechanism reported by those who were perceived to be experiencing distress; described here as a status of a person's internal life that are commonly deemed to be troubling, confusing and leading to sufferance.

• In regards to the most needed and favored services, respondent expressed the need for: affordable mental health care (27.5%), affordable medications (26.1%), and transportation to access services (24.4%).

Based on the findings of this study, the following recommendations can be considered relevant for both Syrian refugees and the Jordanian host population:

1- Expand and implement additional outreach activities to provide psychosocial support and mental health services;

2- Train community and social workers adequately and structurally, and expand their roles to provide different services; such as, providing vital education on available healthcare options, in order to increase public awareness on the availability of mental health services and institutions, and providing culturally appropriate health education on topics related to mental health and psychosocial needs;

3- Minimize stigma associated with MHPSS by incorporating mental health services into broad-based community settings, such as schools, primary prevention or services at primary health care level;

4- Implement school-based interventions, integrate psychosocial support activities into the education sector, and build the capacity of teachers and school counselors to provide psychosocial support to schoolchildren;

5- At schools and among youth institutions more specifically, promote activities that promote social cohesion and social support such as increasing opportunities for extra-curricular activities, which helps to occupy young people in healthy activities, developing critical thinking skills and fostering a positive whole school ethos, and providing equal access to educational opportunities for students from all socio-economic and ethnic backgrounds;

6- Increase the number, and, build the capacity of non-specialized health workers to be able to deliver low-intensity psychological intervention for mild to moderate mental disorders; and increase the capacity-building opportunity of evidence-based scalable psychological intervention.

01 Introduction

Since the start of the Syrian conflict in 2011, the United Nations High Commissioner for Refugees (UNHCR) has registered large displacements of Syrians, particularly into the neighboring countries (1). By 2019 there were over five million registered Syrian refugees; over three million hosted in Turkey, nearly one million in Lebanon, and approximately 662,000 Syrian refugees in Jordan, with children less than eighteen years accounting for approximately 50% of the Syrian refugee population in Jordan (2).

After years of crisis, refugees from Syria are losing hope that a political solution can be found to end the conflict in their homeland. In addition, the crisis in Syria continues to have an enormous social and economic impact on the countries hosting Syrian refugees, with many national services, such as health, education, and water under severe strain (3). In Jordan, the influx of refugees from Syria has compounded already existing challenges resulting from hosting refugees from other neighboring countries, including Iraqis, Palestinians, Somalis and Yemenis.

As noted within the 2017 report: 'Jordan's Way to Sustainable Development', Jordan has made significant achievements over the past decades, witnessing economic, social, human and political transformations encompassing all areas of life. These developments have translated into tangible improvements in education and health, and the availability of comprehensive quality infrastructure and services covering transportation, electricity, communications, water supply security and municipal services.

However, the country has faced a number of challenges. Most notably, these have included: the 2008 global financial crisis and the rise in oil and food prices, generalized instability throughout the region and the spillover effects on investment, trade and tourism, and finally, the tremendous impact of the Syria crisis and resulting population growth, which have impacted upon overall development gains in Jordan.

02 Study Objectives

The main objectives of this study were to:

- Identify the perceived symptoms of severe distress and impaired functioning amongst Syrian refugees and host population, and assessing how they have changed in the last five years.
- Identify primary help-seeking behaviors amongst population, and assess how they have changed in the last five years.
- Identify the most common coping mechanisms adopted by populations, and assess how they have changed in the last five years.
- Identify the main barriers for populations in accessing mental health services.
- Assess needed services, as perceived by Syrian refugees and Jordanians.

03 Literature review: 2012 - 2017

Identified mental health symptoms, stressors, and psychosocial problems, concerns and needs amongst Syrian refugees and host communities residing in Jordan:

Within the last couple of years, global literature on mental health and psychosocial problems has significantly increased. Within Jordan, recent literature has highlighted how the prolonged nature of the Syrian crisis has had a profoundly negative impact upon both Syrian refugees and host community members (5). Recent literature has also noted how conflict-related violence coupled with ongoing stressors related to displacement can have a significant and lasting impact on the mental health and psychosocial wellbeing of Syrian refugee adults and children. Further to the above, authors highlighted how the crisis in Syria is not only exacerbating pre-existing mental disorders among Syrian refugees, but is also potentially triggering the emergence of new mental and psychosocial problems (6).

Since the onset of the Syrian crisis, several assessments were conducted by various humanitarian actors to assess the situation of Syrian refugees in Jordan.
In 2012, an assessment conducted by CARE Jordan highlighted how Syrians suffered significant hardships in securing basic life necessities, and demonstrated a lack of psychosocial activities for

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These stressors include poverty, shortage of basic needs and services, a risk of exploitation, loss of family support and discrimination (7, 8).

adults and children (9). In the same year, a Rapid Mental Health and Psychosocial Support Assessment conducted by United Nations Children's Fund (UNICEF) and International Medical Corps (IMC) identified the following mental health concerns amongst Syrian refugees: worry, camp conditions, aggressiveness, psychological distress, and boredom (10). Further to this, in 2012, the Jordan Health Aid Society (JHAS) in collaboration with IMC conducted an MHPSS assessment incorporating focus group discussions, and key informant interviews of displaced Syrians in the north of Jordan (11). The study showed that displaced Syrians reported various concerns related to mental health; including fear, worry and grief.

In early 2013, CARE Jordan conducted an additional participatory assessment and baseline survey of Syrian refugee households in Irbid, Madaba, Mafraq, and Zarqa (12). The assessment also reported feelings of isolation, increased feelings of depression and negativity, and increased levels of family violence (both verbal and physical).

In June 2013, UNICEF published an assessment presenting key challenges faced by Syrian children and women in Jordan. In the domain of MHPSS, the report recommended the need for; increased provision of basic services and security, increased support for families and communities as a means of reducing threats to their mental health and psychosocial well-being, improved quality of 'focused non-specialized support' for children and their families, and improved provision of specialized assistance for girls, boys and women with ongoing anxiety, aggression, depression, or 'profound stress' (14).

In July 2013, the WHO and IMC in collaboration with the Jordanian Ministry of Health and Eastern Mediterranean Public Health Network, conducted a study to assess the MHPSS problems, services, and needs of displaced Syrians in Jordan (15). The 2013 WHO and IMC assessment demonstrated high rates of mental health symptoms (present 'most of the time' and 'all of the time' in the last 2 weeks), with 53.9% and 49.4% of camp and non-camp respondents expressing feelings of anger and loss of control. Feelings of being unable to carry out essential activities of daily living as a result of fear, anger, fatigue, disinterest, hopelessness or upset was expressed by 46.6% and 38.1% of Syrian refugees living inside and outside the camp respectively. The assessment showed that 47% of Syrian refugees living in the camp and 29% of those living outside the camp reported being distressed, disturbed or upset during the two weeks

preceding the assessment. Displaced Syrians involved in the 2013 WHO and IMC assessment reported a variety of mental and psychosocial problems, including: worry and concern over the situation in Syria, fear of environmental threats, nervousness, anxiety, stress, psychological pressure, depression, sadness, grief, stigmatization and mistreatment.

In 2015, the IMC and Sisterhood Is Global Institute (SIGI) study (16) showed that 33.5% of Syrian refugees and 20% of Jordanian respondents "felt so afraid that nothing can calm them down". Almost 47% of Syrian refugees and 25% Jordanians respondents "felt so angry that nothing could calm them down"; 32% of 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. The 2015 assessment concluded with a set of recommendations to inform future

planning and implementation of MHPSS programs and interventions, including: 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 a sense of community, involvement and belonging; and integrating MHPSS considerations in cross-sectorial programming and initiatives.

In 2017, IMC conducted a study to assess mental health and psychosocial needs and service utilization among Jordanians and Syrian refugees (17). The study showed that refugees in urban communities reported more frequent symptoms of distress, compared to those in camps and host population, and frequency of distress was similar amongst both camp refugees and the host population.

More specifically, 27% of urban refugees reported experiencing fear, all, or most of the time, in the 2 weeks preceding the interview, compared to 19% and 18% for host populations and camp refugees, respectively. Furthermore, 35% of urban refugees reported reduced functioning in their daily activities due to their experience of emotional distress, compared to 24% of the host population, and 23% of refugees in camps.

The 2017 IMC assessment evidenced that the inability to pursue education was a primary stressor affecting children and youth. In adults, family tension was expressed as a problem by both men and women. For men, a concern was financial conflict and struggles. For women, stressors were mainly related to the experience of discrimination, and the demands of raising children. Sources of tension among refugees were: the financial situation, loss of family members due to illness or war, lack of employment opportunities for men and women, and lack of recreation for adults and children.

Coping Strategies amongst Syrian refugees and host community members residing in Jordan

Within the literature, since the onset of the conflict in Syria, 'coping strategies' among Syrian refugees were investigated by some humanitarian agencies and authors operating in Jordan. Coping strategies or mechanism are described as specific behavioral and or psychological effort, used to control, tolerate, reduce or minimize the impact of stressful events.

The Rapid Mental Health and Psychosocial Support assessment conducted by UNICEF and IMC in 2012 (10) showed that praying or reading the Quran, and talking to people were the most commonly identified coping mechanisms among study participants. Following this, the 2013 WHO and IMC assessment (15) highlighted that the study participants reported different coping strategies; such as, socializing (15%), praying or reading the Quran (13%), fighting and getting angry (11%), crying (6%), walking or going out (5%), sleeping (5%), and smoking (3%).

In the 2017 IMC assessment (17), men reported a higher likelihood of receiving support from specialists for distress, or to keep busy as an active coping mechanism. In contrast, females were found to have a higher likelihood of finding comfort in faith and religion. On the other hand, the host community were found to more likely utilize "keeping busy" as a primary coping skill, and were more likely to utilize proactive problem solving techniques, compared to both urban, and camp refugee communities. For Syrian refugees in camp settings, the assessment found that respondents were most likely to endorse avoidance of thoughts in relation to their stressors, as a primary coping mechanism.

Mental health and Psychosocial support resources available to Syrian refugees and host community members in Jordan

To date, the Jordanian Ministry of Health's (MoH) National Center for Mental Health (NCMH) is the lead government service provider of mental health services, treatment and awareness, supervision, and training, in addition to the issuance of judicial reports for cases referred from all civil and military courts. The NCMH also provides services to non-governmental institutions, such as the Jordan River Foundation (JRF), elderly shelters, and orphanages (18).

Treatment is conducted through KARAMA hospital for psychiatric rehabilitation, which can accommodate up to 150 beds, and the National Center for the rehabilitation of 'persons with substance-abuse issues', which can accommodate up to 40 beds. The Royal Medical Services (RMS) provides Mental Health Services through the psychiatric department in MARKA hospital, and can accommodate up to 34 beds. Other inpatient units are available in general hospitals, including King Abdullah Hospital, Jordan University Hospital and MA'AN Governmental Hospital with a total of 47, 20, 12, and 15 beds, respectively.

In addition to the above, there is a network of psychiatrists under the NCMH, covering a total of 49 hospital outpatient clinics, health centers and prisons, delivering treatment in all governorates for an average of 2-3 days per week.

Further to this, a handful of NGOs in Jordan provide mental health services and psychosocial support to Syrian refugees in camps and urban settings. In 2014, WHO, IMC and MOH along with partner agencies conducted a 4Ws Intervention Mapping Exercise (19). The mapping specifically focused on MHPSS interventions, and collected information on the range of MHPSS activities provided to all beneficiary groups in Jordan. The 2014 mapping encompassed a cohort of 47 organizations that collectively delivered MHPSS services, programs and activities for communities across Jordan. 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 programming, 36% were case- managed MHPSS activities, and 25% were general MHPSS activities and services. The mapping found that the largest percentage of MHPSS activities was concentrated in three governorates:

Amman (19.5%), Irbid (17.6%) and Mafraq (16.5%), followed by the central governorate of Zarqa at 14.2%. The mapping results indicated that the majority of funding cycles (46%) were in the category of '1 year or more'. These results showed marked change from the 2013 mapping, in which the majority of funding, approximately 52%, was in the shortest cycle of one to six months.

In contrast to the above, the 2017/18 mapping (20) encompassed a cohort of 35 organizations that collectively delivered MHPSS services, programs and activities for Jordanian citizens and displaced populations living throughout Jordan. The mapping captured approximately 1,253 MHPSS activities; 60% "community-focused" activities, 28% "case-focused" interventions, and 12% general activities to support MHPSS. This indicated a shift in focus of agencies from case-focused and general support activities, to community-focused activities. Reported funding sources ranged from government donors, to self-funding, and private donations. The last 4 years have witnessed an increase in Level 4 'specialized services', from 3% in 2013, to 12% in 2014, to 17% in 2015/2016 mapping, and to 19% in 2017/ 2018.

Utilization and access to health services

According to a study in 2016 on health services utilization among Syrian refugee children in Jordan, 90.9% of families with a youngster of less than 18 years received adequate health care 'the last time it was necessary'. The study also noted that families were usually receiving health care for their children via the public sector (54.6%), the private sector (36.5%) and through the non-profit sector (8.9%). Among child care seekers, 88.6% were prescribed medications during their latest visit, and of those, 90.6% of survey respondents endorsed the medications received (21).

A recent systematic review published in 2018 in Jordan, reported that overall access to healthcare is moderately useful for most enlisted Syrian refugees, but some groups still do not have access to services due to financial and structural obstacles (22). An absence of awareness of available mental health services, coupled with stigma, was demonstrated to be major barriers to effective access of mental health services. Women in particular, reported a greater need for privacy when accessing mental health services, due to fear of experiencing stigma within the community

This is further supported by IMCs' 2017 assessment, which noted a lack of awareness of mental health services alongside stigma and economic instability negatively contributing to effective access to mental health services (17).

Perceived needed services, and identified help-seeking Behaviors

The findings of a 2013 WHO and IMC assessment indicated a continued perceived need for support amongst Syrian refugees; where 71.7% expressed additional need for general services and support to help them with their problems. The most frequently mentioned needed services by camp residents were those related to: environment (14.5%), health (14.1%) and food (11.9%). Alternatively, refugees outside the camp mostly expressed the need for; financial services (14.6%) and health services (13.8%).

Further to the above, the need for counseling or MHPSS services was reported by 13% of respondents; with many repeatedly expressing a need for someone to talk and listen to, visit them, or comfort them

04 Quantitative data collection Methods

Study design

A mixed method research approach using qualitative and quantitative data was conducted. Data was collected over a two-month period: February to March, 2019. Qualitative data was collected via a Key Informant Interviews (KII) approach. Key informants from clinics and public were purposively selected due to their perceived levels of expertise. A total of 36 Individual interviews with health care providers, consumers and community leaders were conducted in six

sites, Irbid (12 interviews), Amman (6 interviews), Zarqa (6 interviews), TAFILEH (6 interviews), and ZA'TARI refugee camp (6 interviews).

A Snowballing technique was used to select key informants by asking the first interviewed experts to suggest persons from the health settings and from the community who had a strong knowledge of MHPSS service delivery, utilization, and barriers to access to care.

The quantitative section of the study took place in 14 sites: Amman (200 persons from two sites), Zarqa (147 persons), JERASH (42 persons), AJLOUN (23 persons), RAMTHA-Irbid (338 persons), BALQA (40 persons), MA'AN (18 persons), KARAK (25 persons), TAFILEH (150 persons), MAFRAQ (169 persons), and ZA'TARI refugee camp (272 persons).

Training interviewers and Ethical approval

Prior to data collection, a two-day training workshop was held at Jordan University of Science and Technology to train 15 research assistants on the necessary interviewing skills and research ethics; including respecting privacy, confidentiality, informed and voluntary participation, and the best interest of the interviewee.

Further to the above, the Data collectors were informed of the objectives of the study, the specific requirements for administering the MHPSS related questionnaires, the interview process, informed consent and, interview questions. They were also trained on how to conduct individual in-depth interviews. Ethical approval was obtained from the Institution Review Board of Jordan University of Science and Technology. Written informed consent was obtained from all participants.

Sampling Procedures

Participants of the quantitative study included Syrian and Jordanians selected from the catchment areas of IMC and MoH clinics. At the first stage, a systematic sample of households was selected from each of the 14 selected sites. A team of two research assistants (a female and a male) visited the selected households, listed the number of persons in the households, and selected one person from each household at random to be interviewed. The selected persons were invited to participate in the study after explaining the study objectives and procedures and signing the informed consent form.

The qualitative part of the study included persons who were knowledgeable on MHPSS service delivery, utilization, and barriers to access care. These persons included MHPSS specialist staff in International Non-governmental Organizations (INGO), Community-based Organizations (CBO) or Ministry of Health (MoH) units, who were active in the locations of interest. Key informants from the health settings and community were purposively selected because of their perceived levels of expertise.

Measures

A toolkit for humanitarian settings developed by the World Health Organization (WHO) and the United Nations High Commission for Refugees (UNHCR) was used for data collection (23). The tool included a wide range of assessments to gain a broad understanding of the humanitarian situation, to analyze people's problems and coping abilities, and the nature of any response required. The tools were designed to be applied in humanitarian crisis settings, and that could be administered by interviewers without specific mental health expertise. These tools were adapted, validated, and found useful in describing to which extent mental health problems, coping strategies, and help-seeking behaviors were apparent among Syrian refugees and host population communities in Jordan.

The quantitative component of this assessment sought to explore mental distress, help-seeking behaviors, coping skills, barriers to receiving services, and perceived needed services. The questionnaire, which aimed to measure the aforementioned, consisted of three main sections:

1. A 6-item demographic section asking about age, gender, nationality, educational level, and marital status.

2. A 6-item Symptoms Index adapted from the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) that had been used in previous assessments of similar Jordanian and Syrian refugee groups. Each item focused on participants' perceptions of a certain symptom relevant to mental health in the past two weeks. The symptoms included fear, anger, loss of interest, hopelessness, avoiding triggers of past events (avoidance), and reduced ability to carry on daily activities

(reduced functioning). For the assessment, participants who reported having three or more of these symptoms, always, and/or most of the time, were considered individuals currently perceived to be experiencing distress.

3. Four different scales exploring help-seeking behaviors, coping skills, barriers to receiving mental health services, and perceived needed services were utilized. These domains were explored from two different perspectives; the perspective of the individual currently in distress, and the general community views. For this purpose, there were two versions of each scale, each adjusted to capture the perspectives of the intended respondents. Three interview guides within the WHO-UNHCR assessment provided instruction on the development of interview for key informant interviews. These tools were modified to more deeply explore the topics of coping skills, help-seeking behavior, and barriers to MHPSS access within the Jordanian context. One interview guide was used to interview service providers, another one to interview patients, and the other one to interview key informants.

Data Collection Process

For the KII part, trained research assistants collected key informant data. Qualitative information was written down verbatim by the transcriber during the interview. At the end of each interview, the interviewer and transcriber would review the transcript, to ensure accuracy. As all data was collected in Arabic, qualitative data was first translated and then sent to the consultancy team for subsequent analysis and reporting.

Data Analysis

Data analysis was performed using SPSS 24.0 statistical software. Outcomes of symptoms, help-seeking behaviors, coping skills, barriers to help-seeking, and needed services were mainly compared across three main community categories: host population, urban refugees, and refugees in camps. These outcomes were also compared across gender, educational levels, marital status, and age groups.

To examine differences across groups for statistical significance, a chi-square test of independence was performed for proportions comparisons. Binary logistic regression was used to determine the factors associated with distress. For reporting purposes, some variables were recoded into categorical variables and treated as proportions. Qualitative data was coded and analyzed to explore the predominant themes that arose during the KII.

05 Results

Participants' characteristics

This study included a total of 1,424 participants; 533 Jordanians, 597 Syrian refugees living outside the camp, and 274 Syrian refuges living in ZAATARI camp. Their age ranged from 18 to 95 years, with a mean (SD) of 36.6 (13.7) year. Of all participants, 49.4% were males and 50.6% females. Table 1 shows the socio-demographic and relevant characteristics of the participants.

Other notable characteristics of survey participants, included:

- Participants differed significantly in their socio-demographic status.
- Camp refugees were significantly younger than other participants.
- Jordanian participants had a significantly higher level of education.
- Urban refugees reported a longer duration of stay in Jordan compared to camp refugees.

Table 1. The socio-demographic and relevant characteristics of the participants

	Participants						Total N = 1424	p-value
	Host population n = 553		Host population n = 597		Host population n = 274			
	n	%	n	%	n	%	n	
Age (year)								<0.001
18-25	136	24.6	128	21.4	102	37.2	366	
26-35	155	28.0	159	26.6	71	25.9	385	
36-50	177	32.0	200	33.5	67	24.5	444	
>50	85	15.4	110	18.4	34	12.4	229	
Gender								<0.004
Male	281	50.8	268	44.9	155	56.6	704	
Female	272	49.2	329	55.1	119	43.4	720	
Education								<0.001
No formal education	23	4.2	116	19.4	32	11.7	171	
Primary School	62	11.2	283	47.4	172	62.8	517	
High school	184	33.3	117	19.6	44	16.1	345	
Vocational training	57	10.3	24	4.0	7	2.6	88	
University/college	227	41.0	57	9.5	19	6.9	303	
Marital								<0.001
Single	177	32.0	90	15.1	104	38.0	371	
Married	340	61.5	422	70.7	140	51.1	902	
Widow	21	3.8	59	9.9	20	7.3	100	
Divorced	15	2.7	26	4.4	10	3.6	51	
Length of stay in Jordan (year)								0.004
≤5			164	27.7	103	37.6	267	
>5			427	72.3	171	62.4	598	

Symptoms of mental distress and functional impairment of all respondents:

- 2.8% felt so afraid that nothing could calm them down most or all of the time in the last 2 weeks;
- 41.3% felt so uninterested in things that they used to like that they did not want to do anything;
- 30.2% of respondents felt so hopeless that they did not want to carry on living;
- 44.5% of respondents felt so severely upset about the emergency/disaster/war or another event in their life, that they tried to avoid places, people, conversations or activities that reminded them of such events (avoidance);
- 39.3% of respondents felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset.

The survey also noted that refugees in urban communities reported more frequent symptoms of distress, compared to those in camps and the host population (Figure 1). Camp refugees were less likely than host population to report symptoms of mental distress and functional impairment. Avoidance, loss of interest, and anger

were the most common symptoms reported by urban and camp refugees. Anger and loss of interest were the top mentioned symptoms by the host population.

Female participants and older participants were more likely to report distress symptoms than male and younger participants, respectively. Singles, with a university/college education, and Syrian refugees who stayed in Jordan for ≤5 years were less likely to report symptoms of mental distress and functional impairment.

For the assessment, participants who reported having three or more of these symptoms, always, and/or most of the time, were considered individuals currently perceived to be experiencing distress. Overall, the proportion of participants with distress was 43.4%; 38.9% among host population, 57.0% among refugees in urban communities, and 23.0% among refugees in camp ($p < 0.005$). The proportions of participants who perceived to be experiencing distress according to socio-demographic characteristics are shown in Table 2.

Figure 1. The frequency of symptoms of mental distress and functional impairment among host population, urban refugee, and camp refugees.

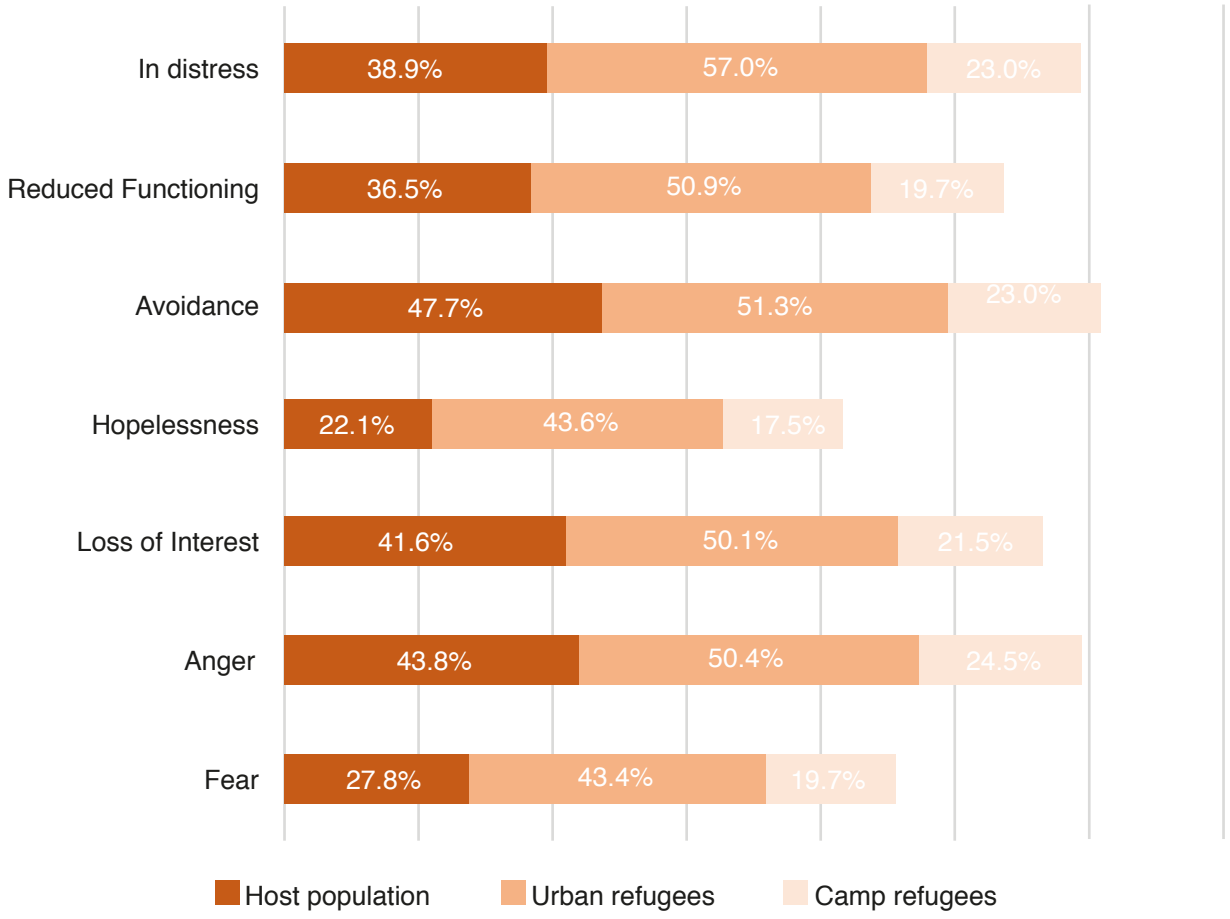


Table 2. The proportions of participants who perceived to be experiencing distress according to socio-demographic characteristics

	Distress				p-value
	Not distressed		In distress		
	n	%	n	%	
Age (year)					
18-25	233	63.7	133	36.3	.000
26-35	223	57.9	162	42.1	
36-50	215	48.4	229	51.6	
51+	135	59.0	94	41.0	
Gender					
Male	419	59.5	285	40.5	.028
Female	387	53.8	333	46.3	
Region					
ZAATARI Camp	211	77.0	63	23.0	.000
North	265	47.3	295	52.7	
Middle	264	55.3	213	44.7	
South	66	58.4	47	41.6	
Group					
Population					
Host population	338	61.1	215	38.9	.000
Urban refugees	257	43.0	340	57.0	
Camp refugees	211	77.0	63	23.0	
Education					
No formal education	88	51.5	83	48.5	.000
Primary School	286	55.3	231	44.7	
High school	181	52.5	164	47.5	
Vocational training	46	52.3	42	47.7	
University/college	205	67.7	98	32.3	
Marital					
Single	247	66.6	124	33.4	.000
Married	489	54.2	413	45.8	
Widow	46	46.0	54	54.0	
Divorced	24	47.1	27	52.9	
Length of stay in Jordan (year)					
≤5	158	59.2	109	40.8	.029
>5	306	51.2	292	48.8	

In the multivariate analysis (Table 3), age, education, and type of participants were the only variables that showed significant association with distress. Compared to host population, urban refugees were significantly more likely to experience distress (OR = 1.8, p <0.001), and camp refuges were significantly less likely to report distress (OR = 0.4; p <0.001) after adjusting for age and education. Compared to young adults (18-25 years), only late adults (36-50 year) were significantly more likely to have distress (OR = 1.6; p < 0.001). Compared to those with no formal education, participants with university/college education were less likely to report distress (OR = 0.6, p = 0.015).

Table 3. Multivariate analysis of factors associated with distress

	Or	95% confidence interval		p-value
Age (year)				
18-25				.003
26-35	1.2	0.9	1.7	.190
36-50	1.6	1.2	2.2	.001
>50	1.0	0.7	1.4	.967
Population				
Host population				.000
Urban refugees	1.8	1.4	2.4	.000
Camp refugees	0.4	0.3	0.6	.000
Education				
No formal education	1			.005
Primary School	1.0	0.7	1.4	.934
High school	1.1	0.7	1.6	.683
Vocational training	1.0	0.6	1.8	.944
University/college	0.6	0.4	1.9	.015

The in-depth interview with health care providers showed that the most common mental health conditions they encountered in their clinics; included, depression, anxiety, obsessive-compulsive disorders, intellectual disabilities, and epilepsy. Community members reported that Syrian refugees suffer from many mental health and psychosocial problems, such as anxiety, depression, feeling nervous or tense, sadness, helplessness, aggressiveness, and sometime suicidal thoughts. The community leaders mentioned that the stressor for many Syrians is loss and grief.

A female Syrian community leader said “We feel most stressed when our people in Syria are under the bombings, and we are unable to do anything for them. My husband in Syria and I am worried about him”.

Changes of common symptoms of distress and mental disorders overtime

The 2015 (IMC and Sisterhood Is Global Institute (SIGI) study) and 2017 (IMC) assessments showed almost similar frequencies of symptoms of mental distress and functional impairment in the host population (Figure 2). In comparison, the current assessment showed much higher frequencies of symptoms of mental distress and functional impairment.

In urban refugees, the frequencies of most symptoms of mental distress and functional impairment in the 2015 and 2017 were significantly lower than that in 2013 (Figure 3). In contrast, the current assessment showed much higher rates of symptoms of mental distress and functional impairment among urban refugees. In addition, the rate for some symptoms in 2019, such as anger, loss of interest, and avoidance were comparable to those reported in 2013.

For camp refugees, the frequencies of most symptoms of mental distress and functional impairment in 2017 were much lower than those in 2013 and 2015 (Figure 4). Some symptoms were more frequent and others less frequent in 2015 compared to those in 2013. In 2019, the rates of symptoms of mental distress and functional impairment were much lower than those in 2013 and 2015 assessments, and, comparable with those found within the 2017 assessment.

Figure 2. The frequency of symptoms of mental distress and functional impairment in the host population in 2015, 2017, and 2019

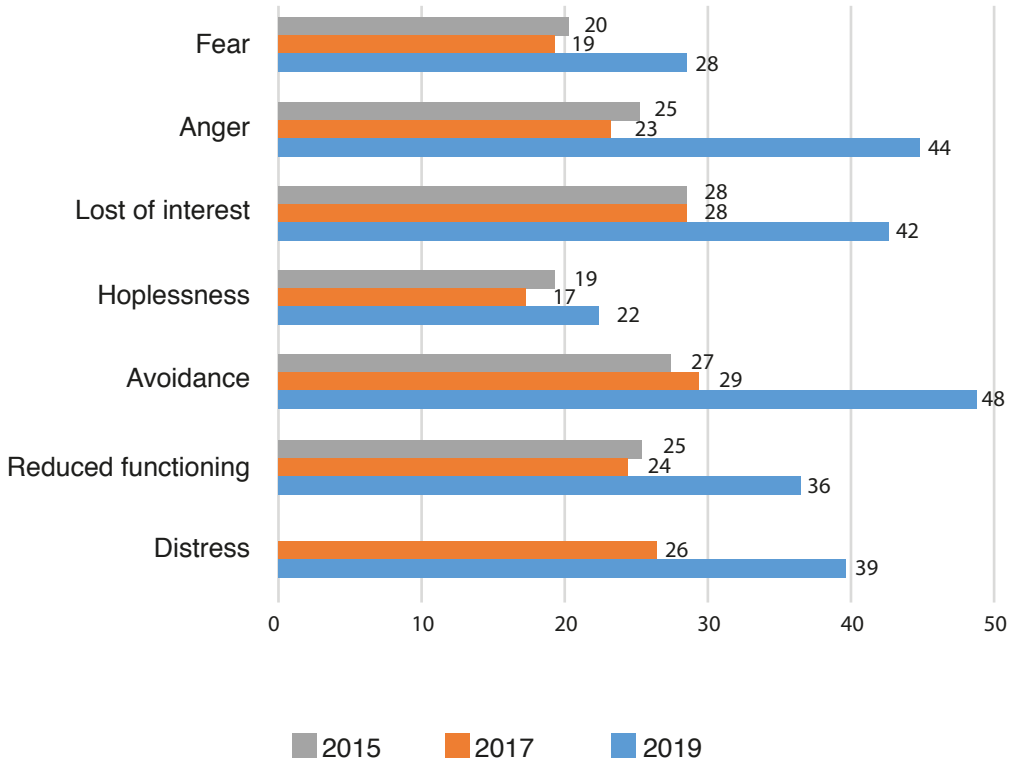


Figure 3. The frequency of symptoms of mental distress and functional impairment among urban refugees in 2013, 2015, 2017, and 2019

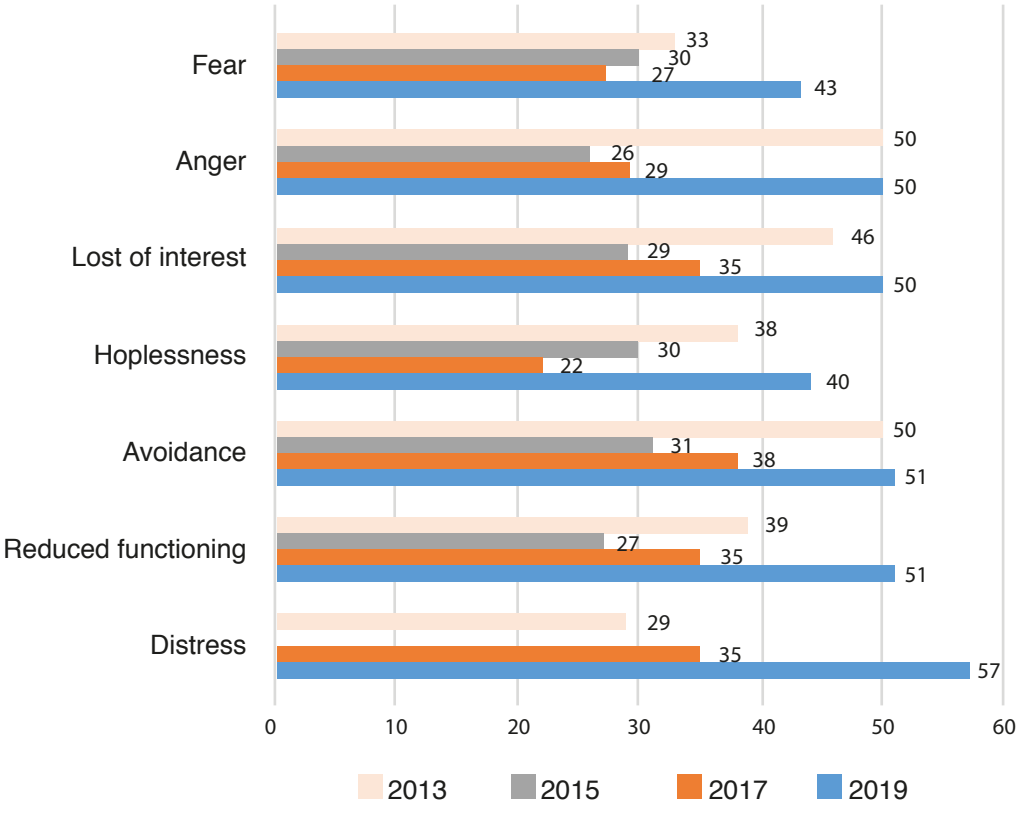
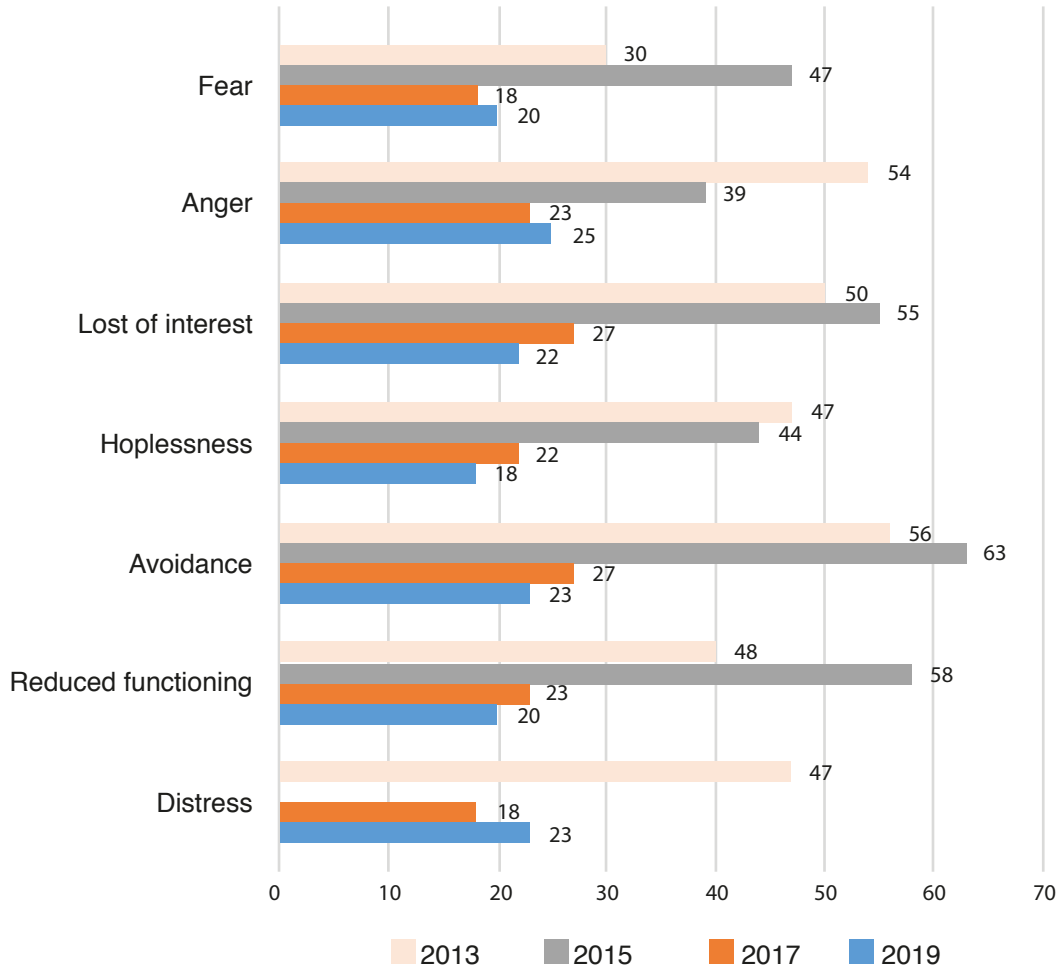


Figure 4. The frequency of symptoms of mental distress and functional impairment among camp refugees in 2013, 2015, 2017, and 2019



Help-Seeking Behavior

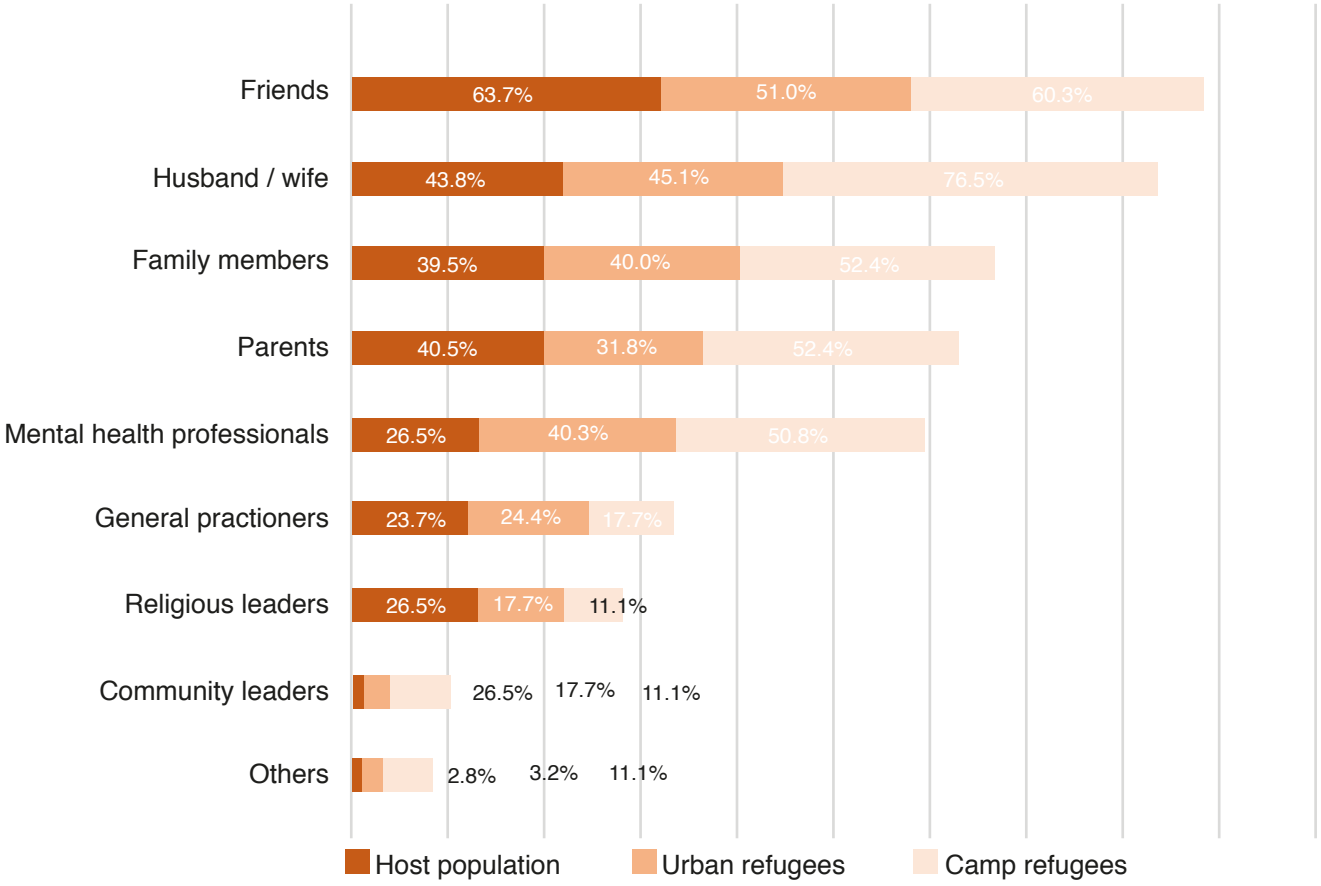
Over half of respondents who perceived themselves as experiencing distress in all communities reported seeking help from friends (56.4%), followed by 47.2% and 41.1% of respondents who reported seeking help from family members and spouse, respectively. Almost one third reported seeking help from parents (36.9%), and the same proportion reported seeking help from mental health professionals (36.6%). Less than one quarter reported seeking help from general practitioners (23.5%), and religious leaders/ representatives (20.1%). Community leaders (5.3%) were the least sought for help.

Among those who perceived themselves to be experiencing distress:

- Camp refugees tended to seek more help from spouse, parents, mental health professionals, and community leaders (Figure 5).
- Urban refugees were the least likely to seek help from a friend and parents.
- Males were significantly more likely to seek help from parents (42.1% vs. 32.4%; p = 0.013), a friend (64.2% vs. 49.7%; p <0.001), and community leaders (7.7% vs. 3.3%; p = 0.015) compared with females.
- Respondents with a university education were less likely than those with a lower education to report seeking help from a mental health professionals (p = 0.003).
- Respondents with a high school level of education were more likely than less educated and higher educated people to report seeking help from religious leaders.
- Singles were significantly more likely to report seeking help from parents, and least likely to report seeking help from General Practitioners.

The vast majority of respondents who were in distress and sought help from a spouse (95.3%), parents (96.5%), family members (94.8%), friends (95.4%), and mental health professionals (96.3%), reported that the help sought was useful. General practitioners, religious leaders, and community leaders were reported to be helpful by 89.0%, 87.2%, and 87.9% of respondents in distress, respectively. Camp refugees were less likely to report help from family members and friends as compared to other participants.

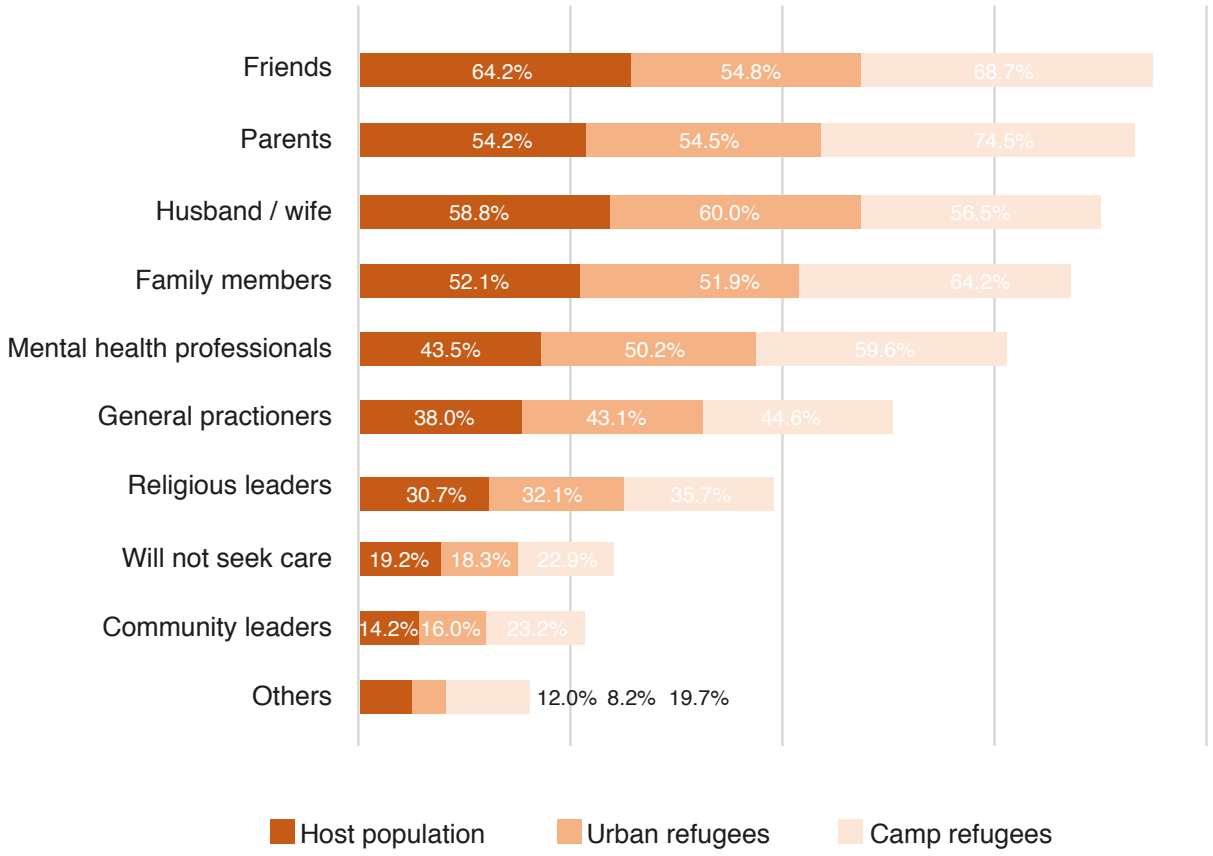
Figure 5. Help-seeking behavior among those who perceived to be experiencing distress.
In Distress Group



Help-seeking behaviors were also explored among those who did not perceive to be experiencing distress by asking them about the probability of seeking help if they experience distress (Figure 6). More than half of them reported that they will probably seek help from friends (62.1%), parents (59.6%), spouses (58.3%), and family members (55.1%). One tenth (19.8%) reported that they will not seek help.

Not in Distress Group

Figure 6. Help-seeking behavior among participants who are not in-distress



Changes in help-seeking behavior over time

The rate of seeking help among those who perceived to be experiencing distress in 2019 was lower than that in 2017 for host population and urban refugees. However, camp refugees in 2019 assessment were more likely to seek support compared to those in 2017 assessment. Seeking help from friends was the most common seeking behavior in host population and urban refugees in both 2017 and 2019. In the year 2019, host population and urban refugees were less likely to seek care from parents and community leaders. In 2019, host population and urban refugees were more likely to seek support from specialist compared to that in 2017.

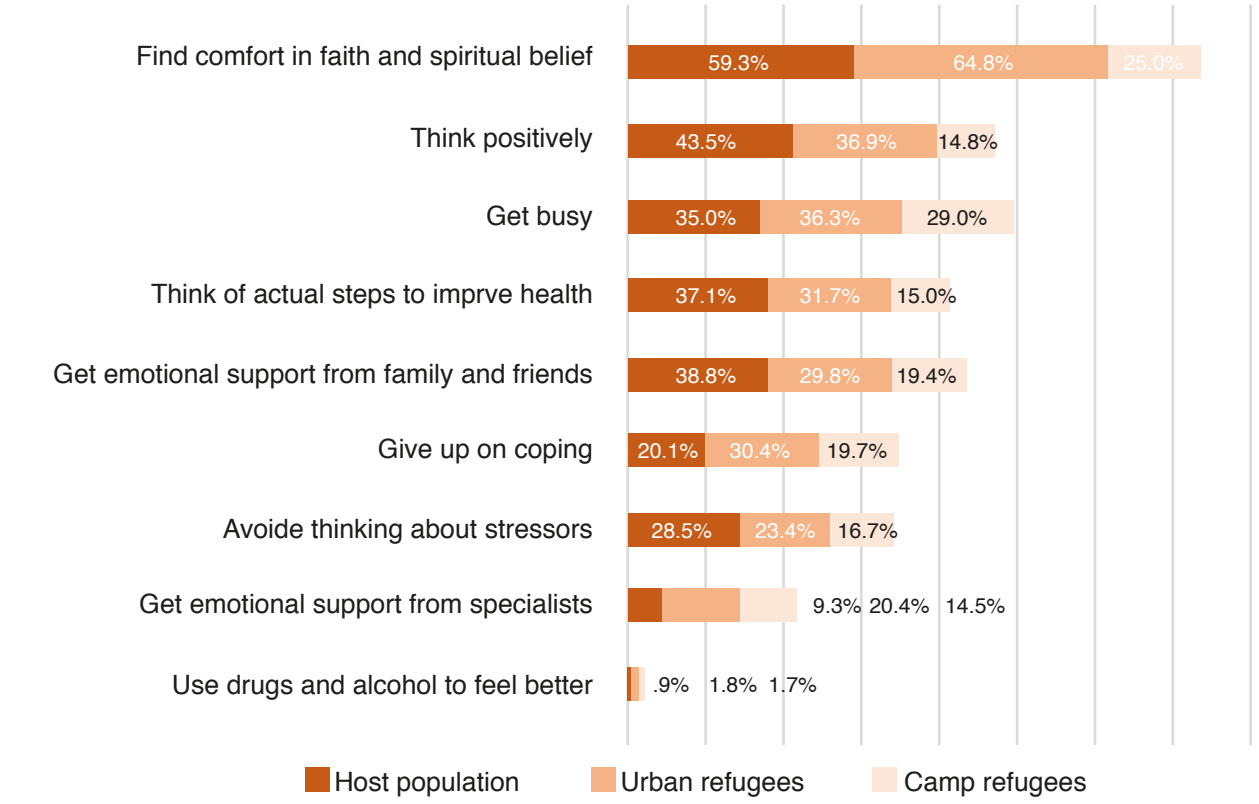
Coping mechanisms

Overall, finding comfort in faith and spiritual beliefs was the most common coping mechanism reported by those who perceived themselves as experiencing distress; reported by 59.0% (59.3% of host community, 64.8% of urban refugees, and 25.0% of camp refugees). Thinking positively

(37.0%), getting busy (35.1%), thinking of actual steps to improve health (31.9%), and getting emotional support from family and friends (31.9%) were reported by almost one third of participants who perceived themselves as experiencing distress (Figure 7).

Further to this, almost one quarter reported giving up on coping and avoiding thinking about stressors. In regards to the least reported coping strategies, only 15.9 of respondents noted: 'getting emotional support from specialists', and 1.5% stated 'using drugs and alcohol to feel better'.

Figure 7. Coping strategies among respondents who perceived to be experiencing distress

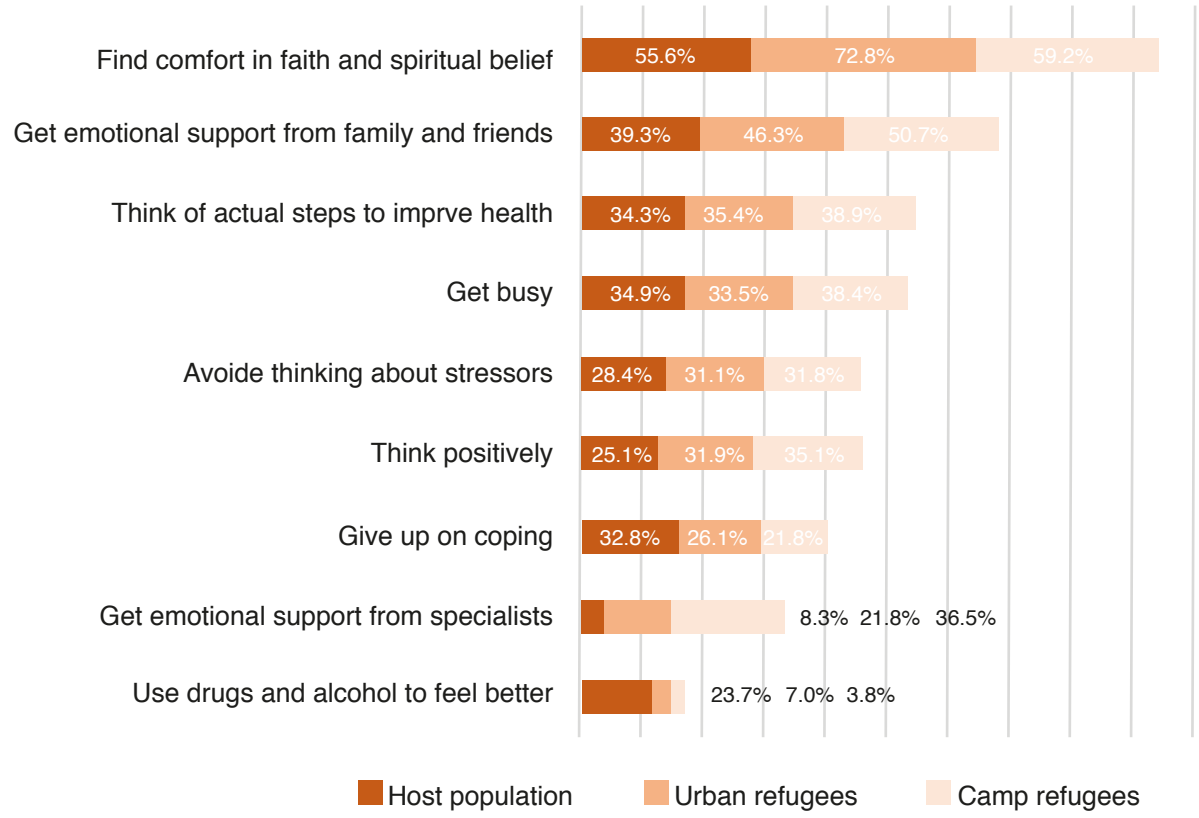


Of the survey respondents who did not state that they perceived themselves to have distress:

- About two thirds (62.0%) of respondents reported that people in their communities find comfort in faith and spiritual beliefs
- 44.5% reported that people get emotional support from family and friends.

Figure 8. The respondents' perception of copying strategies that are used by people in their communities

Not in distress Group



Assessment also noted that camp refugees were less likely than host populations and urban refugees to report the above-detailed coping strategies, except getting emotional support from specialists, which was least reported by the host population.

Among those who perceived themselves as experiencing distress:

- Women reported a higher likelihood, than men, of finding comfort in faith and religion (67.5% vs. 49.4%, p-value<0.001), and keeping busy, as an active coping strategy (39.5% vs. 31.5%, p = 0.017). Moreover, females had a higher likelihood to report giving up on coping than males (29.6% vs. 21.2%, p = 0.018).

- Persons with higher education levels were more likely to report getting busy, think positively, avoid thinking about stressors, thinking of actual steps to improve health, and finding comfort in faith and spiritual beliefs, and were less likely to report giving up on coping.

- Finding comfort in faith and spiritual beliefs was less likely to be reported by singles.

- Refugees with ≤5 years stay in Jordan reported a higher likelihood of giving up as a negative coping strategy, giving up on coping (32.3% vs. 19.6%, p = 0.013), finding comfort in faith and spiritual beliefs (63.2% vs. 47.2%, p = 0.004), than those with >5 years stay.

- Women had a higher likelihood of reporting that people find comfort in faith and spiritual beliefs than men (65.9% vs. 58.5%, p = 0.030).

- A higher percentage of men compared to women (16.0% vs. 10.1%, p = 0.013), reported that people use drugs and alcohol to feel better.

  Community leaders reported that it is common for people to cope with distress by participating in gatherings with friends and family members as well as communicating with their relatives in Syria.

Barriers to accessing mental health services

When survey participants were asked about the probability of seeking specialized mental health services:

- 28.4% of participants with distress (18.3% of host population, 37.9% of urban refugees, and 10.3% of camp refugees), reported that they definitely will ask for help;

- 24.9% stated that they will probably ask for help.

In regards to barriers to accessing mental health services, table 4 details the perceived barriers to accessing mental health services among people who perceived themselves as experiencing distress. The primary barriers to seeking help were as follows:

- Feelings of helplessness (70.9%),
- Cost of treatment (69.6%),
- The need for privacy (67.0%),
- Relying on faith to resolve their issue (65.8%),
- Being embarrassed to ask for help (61.6%).

Interestingly, refugees in camp settings were the least likely to report these barriers compared to others. Feelings of helplessness were the most commonly reported barrier by camp refugees and host populations, while the cost of treatment was more commonly reported by urban refugees.

Table 4. Perceived barriers to accessing mental health services among people who perceived to be experiencing distress

	Host population (%)	Urban refugees (%)	Camp refugees (%)	Total (%)
Feelings of helplessness	72.9	70.7	64.4	70.9
Cost of treatment	.52.6	85.5	41.0	69.6
Concern of privacy	67.3	69.9	50.0	67.0
Rely on faith to resolve their issue	68.2	67.2	50.0	65.8
Embarrassed to ask for help	51.9	71.4	41.9	61.6
Concern that the community will know the problem	50.5	65.1	50.0	58.5
Desire to be self-reliant	60.7	56.8	50.0	57.5
Lack of transportation	32.7	69.6	40.3	53.8
Not capable to deal with this kind of problems	42.9	55.2	35.7	49.1
Don't like to talk about other's feeling	48.8	50.3	35.5	48.3
Embarrassed of not being able to solve own problems	38.9	55.0	37.1	47.6
Not aware of where to seek help	39.7	47.8	32.8	43.5
Belief of that seeking help is a weakness	34.1	47.2	25.8	40.5
Concern that the family know the problem	37.4	44.0	24.2	39.7
Don't like to be emotional	40.3	39.1	27.4	38.3
Belief of that no one can solve the problem	28.0	29.3	30.0	28.9
Feeling of hopelessness	22.0	32.0	30.6	28.3
Lack of trust in mental health specialists	26.3	24.6	20.0	24.8

Table 5 details the perceived barriers to accessing mental health services among people who did not perceive themselves as suffering from distress. People who did not perceive themselves as experiencing distress were asked about possible barriers that they would face if they required

mental health services. The primary barriers were similar to those reported by respondents who perceived themselves as experiencing distress (Table 5).
In particular, the survey noted that females were more likely to report barriers to accessing mental health services compared to males; including:

- Hopelessness (31.8% vs. 24.3%, P = .039);
- Not being capable to deal with mental health problems (53.5%vs. 43.8%, P =.018);
- Belief in that only God can help (72.9% vs. 57.5%, p = 0.000);
- Lack of transportation (62.8% vs. 43.3%, p = 0.00);
- Cost of treatment (76.1% vs. 62.1%, p = 0.000);

- Concerns for Privacy (73.4% vs. 59.5%, p = 0.00);
- Being embarrassed to ask for help (68.6% vs. 53.5%, p = 0.00);
- Stigma faced from the community (62.4% vs. 53.9%, p = 0.032).

Table 5. Perceived barriers to accessing mental health services among people who did not have distress

	Host population (%)	Urban refugees (%)	Camp refugees (%)	Total (%)
Feelings of helplessness	67.2	68.1	56.4	64.7
Cost of treatment	60.1	82.0	38.3	61.5
Concern of privacy	77.2	73.3	48.5	68.5
Rely on faith to resolve their issue	59.3	62.9	54.5	59.2
Embarrassed to ask for help	56.2	64.5	35.3	53.5
Concern that the community will know the problem	59.2	66.4	42.1	57.2
Desire to be self-reliant	63.9	54.8	47.8	56.8
Lack of transportation	36.3	66.9	28.1	43.9
Not capable to deal with this kind of problems	39.2	36.0	18.0	32.7
Don't like to talk about other's feeling	58.3	54.6	38.6	52.0
Embarrassed of not being able to solve own problems	47.9	54.4	31.2	45.7
Not aware of where to seek help	34.4	40.6	20.2	32.7
Belief of that seeking help is a weakness	38.0	37.2	16.1	32.0
Concern that the family know the problem	44.7	46.6	28.5	41.2
Don't like to be emotional	53.2	49.4	26.7	45.2
Belief of that no one can solve the problem	25.7	19.6	12.2	20.2
Feeling of hopelessness	20.6	21.6	15.7	19.6
Lack of trust in mental health specialists	32.9	13.6	15.3	22.2

In addition to the above results, the interviews with health professionals, patients, and community leaders revealed the following barriers for accessing or receiving care:

Unawareness and poor recognition of mental health problems

Some health professionals reported that some patients with mild mental health problem were more likely to better cope with their problems. A mental health social worker/ case manager said “It is possible that the patient with mild mental health problems may cope with his or her condition and adapt to it … … Many patients feel good when they go to the mosque to pray and socialize with people”. However, they added that sometimes the condition got worse because patients were unaware of the seriousness of their condition, or they only accessed at a late stage (and therefore their symptoms worsened). Refusal to receive the treatment was also mentioned to be a problem for some patients.

In regards to awareness, many channels leading to awareness were cited. For example, one mental health nurse stated that, "patients knew about us through awareness campaigns”. Another mental health social worker/ Case Manager said, “For the UN they have a booklet that is provided to every refugee which includes all organizations and their services with phone numbers. Also we have a Facebook page and many cases communicate with us through this page”. Beyond this, many of the practitioners noted a complete lack of awareness of mental health services available amongst population in general.

In regards to recognition of mental health issues, some practitioners reported that some patients did not recognize the symptoms of their mental health conditions, and they did not accept that they were experiencing a treatable mental health condition. For example, one patient said “I was very tired…I did not eat or sleep… I stayed in the room all the time… I did not think that I had a psychological problem ... Finally, the physician told me that I have depression and I need a treatment”. Another patient said: “The last thing I expected was that, my problem was a mental health, and it needed treatment”.

Mental health services affordability

The medical practitioners also noted the affordability of mental health services as another important barrier. Specifically, relatives of some patients reported that the long distance to health center and cost of transportation hindered accessibility. For example, a mother of a patient stated: “The center is far away from us. Sometimes the transportation coverage is not available. Today we suffered a lot until we arrived”. One client in TAFILEH said "I don't have money to come here every time and sometimes I miss my appointment. Why don’t they bring us here using their van”? In addition, a female client in TAFILEH stated: “I am staying far from the health center. Why don’t they come to our village to treat us there?”

Stigma and social discrimination

Stigma was commonly mentioned by health professionals interviewed. This exemplified via the following accounts:

- One psychiatrist mentioned: “Only 50% with mental health problems ask for help and only 20% of them follow up the treatment. Stigma is the main reason for that”.
- A mental health case-manager said: “Stigma is the main reason for not attending mental health clinics especially for Jordanians… But for Syrian refugees, stigma is less affecting because they consider themselves as having better justifications for seeking mental health services because of the displacement, and, they consider themselves as strangers and nobody knows them”.
- Another Case Manager said: “Although we tried to minimize stigma, and with all the efforts done by agencies, they still exist”.
- A female patient said: “The community is looking at us as crazy. My husband does not know that I am seeing mental health professional and I am afraid to get divorced if my husband knows my problem”. Almost all community leaders reported the same statement.
- A female client in RAMTHA city stated "I know several people in need for this service but they are afraid that the community will talk about them”.
- A community leader said “Some people refuse to use the service; because they are afraid of that no one will marry their daughters if the people know that they visit the psychiatric doctor because they think they are crazy”.

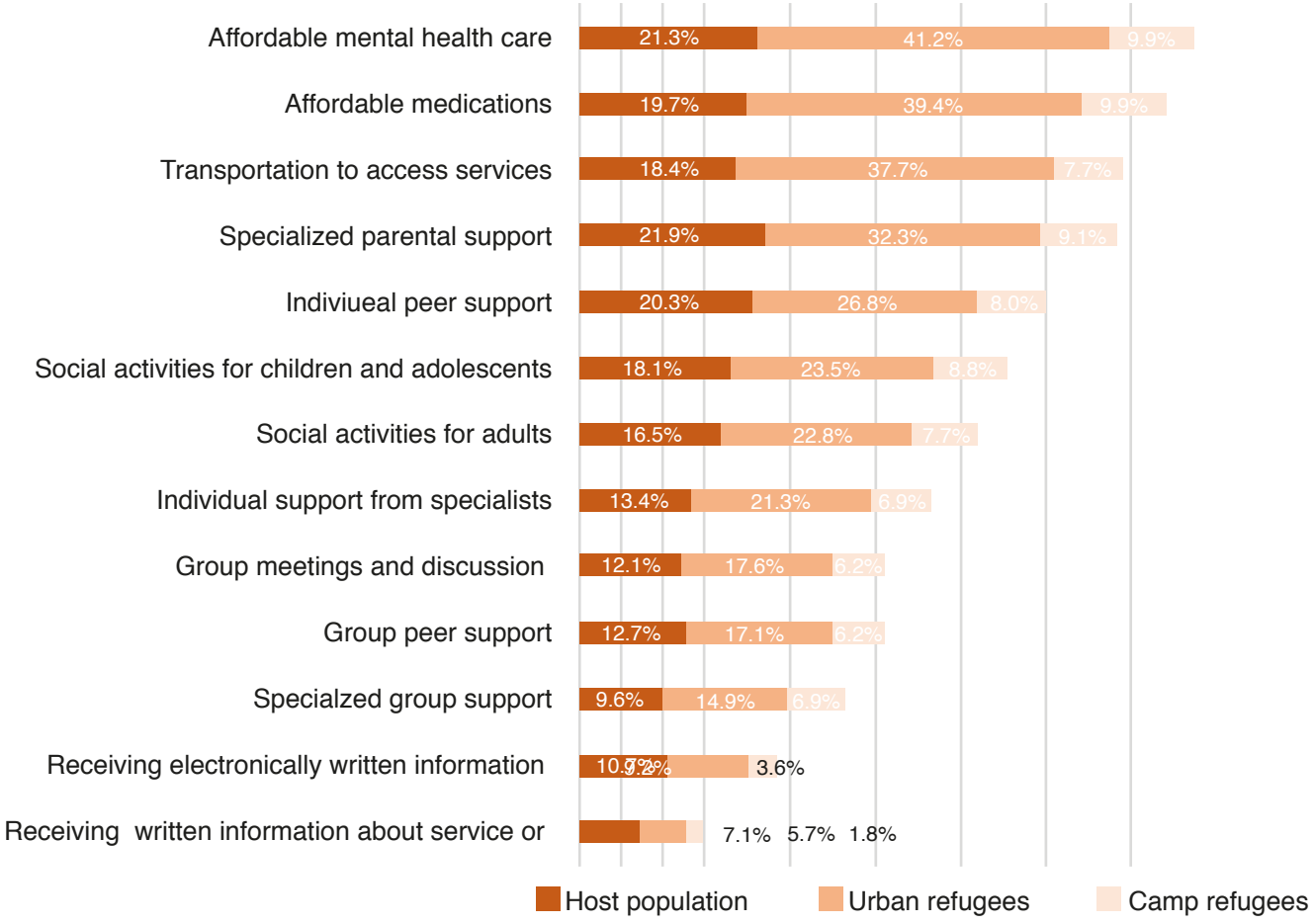
Perceived Needed Services

Respondents were asked during the questionnaire which services, or methods of support, they would most prefer to have access to and would help them most. Across all communities:

- 27.5% noted affordable mental health care,
- 26.1% noted affordable medications,
- 24.4% noted the need for transportation to access services as the most needed, and favored service.

The assessment noted that a much higher proportion of urban refugees required the above-stated services (Figure 9) compared with camp-residing respondents.

Figure 9. The perceived needed services by Syrian refugees and host population



06 Discussion

Health assessments in humanitarian crisis settings offer the opportunity to assess how common mental health problems are in the affected population.

This assessment evidenced that a high proportion of respondents had experienced different symptoms of distress, including loss of interest, fear, anger, hopelessness, avoidance, and reduced functionality. Further to this, the report noted that symptoms of distress were more likely to be reported by refugees in urban communities as compared to camp refugees and the host population communities.

In addition, camp refugees were less likely than host populations to report symptoms of mental distress and functional impairment.

Moreover, this report found that urban refugees were more likely to experience distress and wide range of symptoms, and in correlation, were less likely to be aware and effectively access appropriate services.

In correlations with the findings of IMCs' 2017 assessment (17), both Syrians and Jordanians expressed similar concerns related to access to MHPSS services, and the high-level of stigma attached to mental health. For both groups, this study highlights that economic challenges, as well as increased competition for jobs, schools, and country resources may enhance risk factors related to the development of mental health concerns.

Further to the above, this study also showed gender differences related to the perception of mental health symptoms and distress, coping strategies, and help-seeking behaviors. In particular, the study demonstrated that females were more likely to experience distress symptoms as compared with males. Moreover, this study showed that females were more likely to report giving up on coping than males. In addition, females were found to be significantly less likely to seek help from parents, friends, and community leaders than males. According to the literature, this finding can partly be explained by the country's cultural norms; leading to the restriction of women's movement and a lack of employment opportunities (26).

In addition to the above, the report also noted the continued high-level of stigma feared and experienced, especially amongst females. In turn, this report noted that such stigma acted as a barrier to effective access to required care, particularly for the host communities.

Finally, this study evidenced the differences in coping strategies between host community members, and Syrian refugees. In particular, camp refugees were less likely than host populations and urban refugees to report coping strategies, except getting emotional support from specialists, which was the least reported by host populations.

07 Limitations

One of the main limitations of this study is the selection of participants. Participants were selected from communities that are surrounding the primary health care clinics, whereby, mental health are served as part of these clinic services. Therefore, this sample might not be representative of Syrian and refugees who receive services from other NGOs an

d health care providers in the country and, this might limit the generalizability of the study findings. It is also worth mentioning that the distress symptoms used within this survey does not assess the rates of actual mental health disorders.

Although many decision-makers and community mental health programs would prefer to have data on rates of (probable) mental disorders, data on rates of diverse symptoms of severe distress and functioning are less likely to be disputed.

08 Recommendations

Based upon the above findings of this study, the following recommendations should be considered by government as well as NGOs:

1- The National Mental Health Policy should target Jordanians as well as all population to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span within a rights-based framework.

2- Mental health and psychosocial support is a cross cutting issue and requires a lot of coordination among national institutions, ministries, international agencies, community leaders to address it, and this is a continuation of efforts that starts from care at school,

3- A high proportion of respondents, mainly urban refugees, experienced a variety of distress symptoms, reported barriers to access MHPSS services, and was inadequately aware of existing MHPSS services. In response to these findings, this study recommends that while MHPSS services should continue in urban areas, additional focus should be placed on community outreach services for distant areas. Therefore, it is recommended:

- To expand community outreach activities and implement additional outreach activities,
- To increase public awareness on the availability of mental health services and institutions that offer help and care for mental health problems for their children. Increasing awareness around mental health may be achieved in a variety of ways such as, community seminars, distribution of pamphlets, and brochures which not only provide information about the location of services, but also include positive coping messages.
- The promotion of positive mental health and coping strategies can be achieved through a variety of modalities within mass media (radio, television, internet etc.). Such strategies will help to, not only increase awareness of mental health, but also help to address the strong stigma which appears to still surround the topic in both the Syrian and Jordanian communities.

4- To train community and social workers adequately and structurally, and expand their roles to provide different services, including:

- Helping patients with mental health and psychosocial problems to overcome barriers that prevent
- them from seeking vital healthcare, and encouraging community members to take charge of their own health. Community health workers are knowledgeable about local needs and sensitivities, and thus are in a position to gain their patients' trust and to support them in accessing treatment.
- Providing vital education on available healthcare options. Community and social workers can also provide awareness/educational messaging for individuals, families and wider communities; leading education campaigns in their communities and raising awareness among community members regarding mental health issues. The implementation of outreach activities must be done with the awareness of referral pathways active in the area of intervention, to ensure individuals are appropriately connected to available services.
- Providing detailed information on available resources.

5- Implement school-based interventions and integrate psychosocial support activities into the education sector in order to more effectively support the psychosocial wellbeing of students. Teachers have a crucial role in providing children with psychosocial support because they are interacting with school children on a daily basis, and informally act as part of a network of psychosocial support for children. Going forward, teachers can add activities into classrooms that can further promote growth and development of all children, and can identify children requiring additional mental health and psychosocial support (referring them to specialized services). Therefore, it is important to build the capacity of teachers and school counselors to provide psychosocial support to schoolchildren. Moreover, they should be trained to provide age and gender appropriate recreational activities and involve both Syrian and Jordanian children and adolescents through sporting activities, computer classes, and other activates. Lastly, it's recommended to support the increased integration and engagement between Syrian refugees and host communities in order to help refugees overcome their psychosocial problems. This can be achieved by ensuring that MHPSS programming includes activities that promote social cohesion, and social support. Further to this, the school environment (particularly for children and adolescents) can be an effective area for reducing social isolation. Interventions should aim to reduce social isolation, and could include community forums or peer-mentorship programs from already integrated members of the same refugee group. Social activity programs with volunteers of the host population may also facilitate social integration.

6- Increase the number of activities focusing on the management of mental health disorders by non-specialized health workers (e.g. general health/PHC staff), and a concurrent increase in the number of training opportunities. This should include the training of General Practitioners and paraprofessionals (social workers, counselors, etc.) on MHPSS case management; including basic counseling and other evidence-based interventions. Provide training and support for mental health professionals, to equip other trained actors involved in basic psychological and/or psychotherapeutic support, in identifying the needs and making appropriate referrals. All MHPSS staff, including those with specialized backgrounds, requires professional development opportunities in the form of ongoing training to develop their skills, and continuous supervision, to monitor their activities and outputs. Clinical supervision might take the form of on-the-job observations of practice, conducting file audits, structured and semi-structured individual or group discussions with practicing MHPSS staff.

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