



**International
Medical Corps**

ASSESSMENT REPORT

Understanding the Mental Health and Psychosocial Needs, and Service Utilization of Syrian Refugees and Jordanian Nationals

A Qualitative & Quantitative Analysis in the Kingdom of Jordan (2017)



Gift of the United States
Government

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Omar Asfour MD, MPH (*Consultant*)
Mary Jo Baca LISW, MPH (*Consultant*)

Special thanks to: The Community Psychology Evaluation and Research Lab at Concordia University - Portland

Reed Mueller PhD (*Chair, Psychology Department*)
Stephanie Lam (*Design, Analysis, and Reporting*)
Ernesto Vasquez III (*Design, Analysis, and Reporting*)
Ciara Lang (*Editing Team Member*)

Contributors

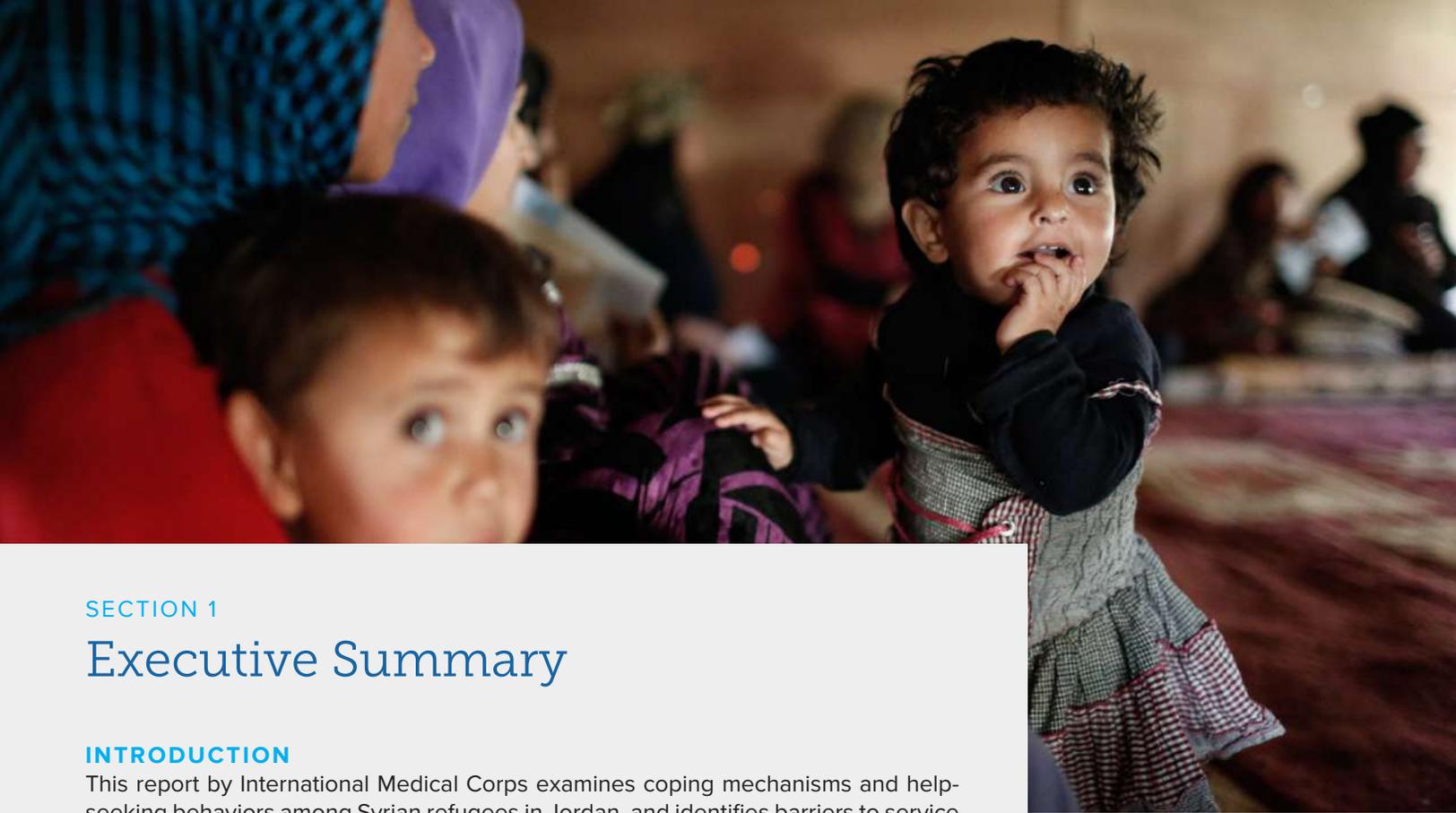
Nour Al-Saaideh, Ahmad Bawaneh, Benjamin Schulte, Michelle Heidrun Engels, Claire Whitney, Ashley Leichner and Inka Weissbecker

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GLOSSARY

CBO	Community Based Organization
FGD	Focus Group Discussions
GoJ	Government of Jordan
GP	General Practitioner
HRD	Human Resource Development
IASC	Interagency Standing Committee
IDP	Internally Displaced Persons
IMC	International Medical Corps
INGO	International Non-Governmental Organization
JORISS	Jordan Information System for the Syria Crisis
JRF	Jordan River Foundation
KII	Key Informant Interviews
MHPSS	Mental Health and Psychosocial Support
MoE	Ministry of Education
MoH	Ministry of Health
MoPIC	Ministry of Planning and Cooperation
MoSD	Ministry of Social Development
NCMH	National Center for Mental Health
NGO	Non-Governmental Organization
PHC	Primary Healthcare Centre
RMS	Royal Medical Services
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees in the Near East
WHO	World Health Organization



SECTION 1

Executive Summary

INTRODUCTION

This report by International Medical Corps examines coping mechanisms and help-seeking behaviors among Syrian refugees in Jordan, and identifies barriers to service utilization. This assessment aims to inform a wider discussion among relevant national and international actors in Jordan on improving Mental Health and Psychosocial Services. Information is also presented in relation to the Jordanian host community and their coping and help-seeking behaviors to ensure an increased understanding within the humanitarian community on the needs of vulnerable Jordanians.

METHODS

The assessment relies on both quantitative and qualitative methods of data collection and analysis including: a desk review, individual interviews with community members, focus group discussions and key informant interviews. The quantitative arm of the assessment explored help-seeking behaviors, coping skills, barriers to receiving services, and perceived needed services. The quantitative survey reached out to over 6000 participants over the age of 18 years, in 10 governorates. These participants proportionately represented Jordanian nationals, as well as Syrian refugees in both camp and urban settings.

RESULTS

Syrian refugees have demonstrated remarkable resiliency in the years since the crisis began in their home country. Meanwhile, the people of Jordan continue to host and share scarce resources with refugees from Syria and with those who have fled to safety in Jordan from other conflicts in the region as well. The analysis in this document demonstrates that the Syrian refugee community in Jordan continues to face significant stressors, with children and older persons within the community being viewed as the most vulnerable. Respondents described a range of coping mechanisms, both positive and negative, and refugees in urban settings described more barriers to, and lack of information about services, than those in camps. Both Jordanians and Syrians shared concerns about access to healthcare and the inability to reach services.

Stigma surrounding mental health issues was frequently reported by respondents, which appeared to represent a significant barrier to help seeking behaviors. Women in particular, reported an increased need for privacy when accessing mental health services, for fear of experiencing stigma within the community. A sense of helplessness and hopelessness was strongly reported amongst the Syrian refugee community, with the Jordanian host community reporting lower levels of helplessness and a stronger tendency to use work as a distraction from emotional distress. For both the Syrian and Jordanian population, economic instability was found to be a source of great concern for both adult males and females, leading to a reported decline in mental wellbeing and the capacity to care for young children and older adults, particularly in light of the protracted nature of the crisis. Such themes with respect to financial concerns were common in camp and urban settings. Finally, key informant interviewees noted the importance of ensuring mental health and psychosocial service staff are well-trained and equipped to manage the complex presentations with which they are faced.



Recommendations

Key recommendations include the following:

1. Increase awareness about mental health issues with a goal toward reducing stigma and encouraging those in need, to access available services.
2. Support access to services where it may be impeded by factors such as transportation and expense, particularly in more dispersed urban settings.
3. Consider methods that allow affected persons, especially women, to access information about mental health privately.
4. Standardize and conduct mental health case management, ensuring a component of community outreach, to build trust among individuals and communities.
5. Promote positive coping strategies which focus on fostering a sense of empowerment, self-reliance and resiliency.
6. Prioritize developmental needs of children and youth (emotional, social, educational, physical, and cognitive), including support to parents desperate to ensure the wellbeing of their children.
7. Consider the needs of vulnerable populations, such as older adults, when designing programs, with an emphasis on increasing access to appropriate services.
8. Increase the focus on staff training and supervision to ensure high-quality service provision.

These recommendations build upon IMC's existing programming, partnerships, organizational capacities, and well-developed relationships with refugee and host communities in Jordan. The recommendations are interrelated and should not be considered in isolation. IMC's presence in Jordan is longstanding and this assessment demonstrates that it continues to bear a significant responsibility in supporting and promoting the health and wellbeing of the communities it serves.



SECTION 2

Assessment Overview & Objectives

The objective of this assessment is to collect pertinent information to inform MHPSS service design and delivery. For the Syrian refugee community, the current assessment aimed to determine:

1. What are the most prevalent problems and stressors affecting adults and children?
2. What individual, familial and community coping mechanisms and strategies exist to help manage emotional distress?
3. How do the stressors, needs and coping abilities differ between camp settings and those in urban settlements?
4. Where do Syrian refugees seek help for mental health and psychosocial problems?
5. What are some barriers to help-seeking behaviors for mental health concerns?
6. Who typically accesses MHPSS services?
7. Are there populations which are underutilizing MHPSS services (such as older people, adolescents etc.)?

The following questions will be addressed for the Jordanian host community:

1. What are the most prevalent problems and stressors affecting adults and children within the host community?
2. What are some of the major causes of these stressors as identified by the host community?
3. What is the impact of the protracted Syrian refugee crisis on the host community?
4. What individual, familial, and community coping mechanisms exist within the host community to help manage emotional distress?
5. Where do members of the host community seek help for mental health and psychosocial support, and what barriers do they face in help-seeking/service utilization?



SECTION 3

Sociocultural Context

3.1 Overview of the Syrian Crisis Context

The conflict in Syria is currently in its seventh year and 13.5 million of its people are in need of humanitarian assistance, including 7.2 million people with protection needs. Over half of the Syrian population have been forced to flee their homes, and multiple instances of displacements is a relatively common experience for Syrian families. Children and youth comprise more than half of those in need of humanitarian assistance. Among conflict-affected communities, life threatening needs continue to grow. There are presently 13 locations inside Syria described by UNOCHA as besieged.¹ Entry of humanitarian assistance is frequently denied into these areas and blockage of urgent medical evacuations has resulted in civilian deaths and suffering.

According to UNHCR, as of August 6th 2017, there are currently 660,582 thousand persons of concern registered as refugees from Syria residing in Jordan, which represents 7% of the population in Jordan.² Over 80% of Syrian refugees currently live outside refugee camps. According to UNHCR, as of 30, June 2017, there were 3.8% (24,822) older Syrian persons, 45.2% (298,980) Syrian adults and 51.0% (337,034) Syrian children or youth under the age of 17 years, in Jordan.³

After years of crisis, refugees from Syria are losing hope that a political solution will 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.⁴ In Jordan, the influx of refugees from Syria has compounded already existing challenges resulting from hosting refugees from additional countries, including Iraqis, Palestinians and Yemenis.

3.2 Jordan Demographics and Facts

The Hashemite Kingdom of Jordan is a small middle-income country in the Eastern Mediterranean Region bordering Syria, West Bank, Iraq and Saudi Arabia, with an approximated geographical area of 89,000 square kilometers⁵. Jordan is a country that has limited natural resources, low to middle-income rates, and high population growth. The Department of Statistics has shown that the population of Jordan has steadily increased from 586,000 people in 1952 to about 2.1 million in 1979 to about 4.2 million in 1994 and to almost 6.5 million people in 2013. According to the latest national census

1 UNHCR, Syria Profile Global Focus, 2017
2 UNHCR, Information Sharing Portal, 2017
3 UNHCR, Information Sharing Portal, 2017
4 3RP Refugee Regional & Resilience Plan, 2016-2017
5 World Bank, 2016

released in May 2017, Jordan's population was 9,921,992, including 2.9 million guests (non-Jordanians).⁶ The country's official language is Arabic and the main ethnic group is Arab. More than 95% of the population is Muslim, and less than 5% is Christian. Approximately 78% of the Jordanian population resides in urban areas.⁷

Despite the decline in the crude birth rate of about 50 births per thousand population in 1952 to 27.6 births per thousand of the population in 2013, the reproduction levels in Jordan are still among the highest compared with developed countries.⁸ Life expectancy at birth is 74 years. The total fertility rate per woman has been estimated at 3.2. According to the Ministry of Health, Public Health Department, the neonatal and infant mortality rate per 1000 live births are 11 and 15 respectively, while the maternal mortality rate per 100,000 live births is 58.11.⁹

3.3 Economic Context and Social Structure

Over the past decade, Jordan has pursued structural reforms in education and health. The Government of Jordan has introduced social protection systems and reformed subsidies, creating the conditions for public-private partnerships in infrastructure and tax reforms.¹⁰

Adverse regional developments, in particular the Syria and Iraq crises, remain the largest events affecting Jordan. This is reflected in an unprecedented refugee influx, in disrupted trade routes, and in lower investments and tourism inflows. The large number of Syrian refugees entering the country is having a strong impact on the country's economy and social structure, with many Jordanians facing job shortages, and strong competition for scarce resources. Other major challenges facing Jordan include high unemployment, a dependency on grants and remittances from Gulf economies as well as continued pressure on natural resources.¹¹

About 14.4% of the Jordanian population falls below the international poverty line. For Syrians, the figure is even more staggering with a reported 82% of Syrian refugees living below the poverty line. While living in Jordan, 23% of Syrians reported eviction, or were forced to leave their housing at least once.¹²

3.4 Employment

Restriction of available job opportunities is increasing in Jordan, with the influx of refugees, and Jordan's growing population. For Jordanians, employment is higher among males than females (71% and 21%, respectively).¹³ Employment is a constant and increasing source of stress and concern for Syrians in Jordan. Syrian refugees have been integral to the construction and maintenance and development of Za'atari refugee camp, and quickly made it a thriving community. This has provided a source of economic gain for those living within Za'atari. However, those living outside of the camp can be faced with difficulties and discrimination in finding work. Youth and adults sell goods on the streets, find informal jobs in factories or manual work in construction. This trend in employment has caused concern for Jordanians, many of whom believe refugees are 'stealing' jobs from them.

In response to this employment crisis, the international community worked with the Government of Jordan to draft the Jordan Compact, a deal which aims to provide 200,000 jobs for refugees in exchange for preferential access to the employment market as well as access to conditional financing from the World Bank.¹⁴ Despite financial incentives provided through the Compact, progress has been slow: as of January 2017, only 37,326 work permits had been issued to refugees, with 4% going to women.¹⁵

3.5 Households

The average household size for Syrians is 4.7 persons in Jordan, of those 30% are women who head Syrian families in Jordan. Among Jordanians, the average family size is 4.8 persons. The illiteracy rate for Syrians (age 13 years and above) is 9.1%, while it is 6.7% among Jordanians.¹⁶

Compared with the statistics of pre-crisis Syria, the Syrian refugee population living in Jordan is younger (81% Syrians are under age 35, compared with 73% of Jordanians; comprises a higher share of children aged 0–4 years (close to 20% Syrians versus 11% Jordanians); and tends to be single (over 60% Syrian versus 40% Jordanians).¹⁷

Family size and housing are often the best predictors of poverty. In Jordan, the poverty rate almost doubles if the size of the family goes from one to two members and increases

6 Population and Housing Census, Jordan Department of Statistics, 2017

7 World Bank, 2016

8 The High Health Council, 2015-2019

9 Primary Health Care Department, 2017

10 World Bank Group, FY1Y-22, 2016

11 World Bank, 2016

12 CARE-Jordan, 2017

13 Population and Housing Census, 2016

14 Retrieved from, GoJ Presentation on Livelihoods for the HPDG, 2017

15 IRC, A Survey of Refugees, 2017

16 Population and Housing Census, Jordan Department of Statics, 2016

17 Population and Housing Census, Jordan Department of Statistics, 2016

by 17 percent from one to two children.¹⁸ The vast majority of Syrian refugees are either poor today, or expected to be poor in the near future, due to the aforementioned factors of limited employment and economic growth opportunities.¹⁹

3.6 Education

UNICEF, in cooperation with the Ministry of Education (MoE), take the lead in organizing and structuring educational services for Syrian children in Jordan. They currently provide 328,338 services to Syrian refugee children. In the most recent school year UNICEF reported, 167,820 Syrian refugee children, or around 71% of registered refugee children were enrolled in educational studies.²⁰ According to UNICEF, common barriers to education includes poverty, distance to school (safety for girls and younger children), violence in the classroom, unfriendly school environment, poor learning achievements, and poor employment prospects upon completion of basic education.

Families from marginalized socioeconomic backgrounds are not always able to prioritize education with competing financial priorities. Indirect school costs place additional pressures on families, including transportation, stationery and food. Public schools have no transportation options, such as buses. The Government of Jordan has committed to providing quality education for every child in Jordan. This will require closing the gaps faced by out-of-school children, including refugee children, children in mobile communities, children with disabilities and children from poor socioeconomic backgrounds.²¹

3.7 Healthcare

Primary healthcare center (PHC) services are managed through a wide network of Ministry of Health (MoH) primary health care centers in Jordan (99 comprehensive health centers, 378 primary health care centers and 198 health sub-centers in 2015). Jordan also provides maternal, childhood and dental health services (460 motherhood and childhood centers and 402 dental clinics). The Royal Medical Service (RMS) is involved in providing primary healthcare services through field clinics and eight comprehensive medical centers. UNRWA also provides primary health care services through 24 medical clinics predominantly targeting, although not exclusively, Palestinians. The Jordanian Society for Family Planning and Protection provides services through 19 clinics. This is in addition to the contribution of the private sector through hundreds of general medical and psychological clinics.²²

The Syrian crisis has resulted in an increased demand on the existing national health system and services, with Syrian refugees presenting with significant injury and chronic conditions. Following a decision made by the Cabinet in November 2014, Syrian refugees have stopped receiving free access to primary and secondary care, due to funding constraints.²³ Syrian registered refugees outside of camps now have to pay the uninsured Jordanian rates at MoH facilities. About 55% of the Syrian population in Jordan holds health insurance, while 68% of Jordanians are reportedly covered by health insurance.²⁴

At present, humanitarian funding is supporting the costs for essential health services in primary and secondary care predominantly targeting the Syrian refugee and other vulnerable communities. In 2015 it was estimated that 2,866 additional inpatient beds, 1,022 additional physicians, and 22 new comprehensive health centers were needed to meet the national standard.²⁵

According to the primary health care report, conducted in 2015, the following captures several primary concerns the MoH faces regarding the current state of their health system as a result of the Syrian crisis:

- Increasing demand for health services at an unprecedented rate exceeding the capacity of the public health sector, especially in the northern governorates.
- High pressure on human resources, medical staff, hospital infrastructure and health facilities.
- Lack of human resources and medical supplies.
- Negative impact on the Jordanian patients competing at times with Syrians for valuable and limited health resources, for example bed rate has become 15 beds per 10,000 Jordanians, when it was 18 beds per 10,000 citizens prior to the Syrian crisis.
- The fiscal deficit as a result of the lack of necessary financial resources and the failure of donor countries to provide the funding required for the Syrian response.
- Increased risks of the spread of disease among Jordanians (i.e. polio and measles), especially the host communities, and the need for additional vaccination campaigns.

18 The Jordan Joint Assessment Review, 2013

19 Regional Refugee & Resilience Plan, 2017-2018

20 Valenza, M. AlFayez, S. 2016

21 UNICEF, Situation Report, 2017

22 Primary Health Care Department, 2015

23 3RP Refugee Regional & Resilience Plan 2016-2017

24 Population and Housing Census Jordan Department of Statistics, 2017

25 Primary Health Care Department, 2015



SECTION 4

Mental Health & Psychosocial Context

4.1 Mental Health and Psychosocial Resources

The MoH National Center for Mental Health (NCMH) is the lead agency for the provision 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 MoH utilizes a biopsychosocial approach and partners closely with the NGO community in the provision of mental health services. Additionally, NCMH provides services to non-governmental institutions such as the Jordan River Foundation (JRF), the elderly shelters, orphans institutions and people with special needs.¹ 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.

Public Mental Health System

The MoH maintains three psychiatric hospitals under the umbrella of the NCMH, and a facility for substance abuse treatment. In total, these institutions hold approximately 460

psychiatric beds. The psychiatric unit under the Royal Medical Services (RMS) holds 34 beds.² The inpatient unit general hospitals (King Abdullah Hospital, Jordan University Hospital and Ma'an Governmental Hospital) have a total of 37 beds, with 10, 12 and 15 beds respectively. 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. The MoH, in collaboration with WHO also implement 3 MDTs in Amman, Ma'an and Irbid. With the exception of these types of outpatient services and clinics throughout the Kingdom resources are concentrated in the psychiatric hospitals.³

The number of psychiatrists does not exceed 2 per 100,000 citizens in Jordan and the number of nursing cadres is 0.04 per 100,000 citizens. The lack of insurance coverage for Syrian refugees and the Jordanian community with mental illnesses in the private sector and the high cost of private psychiatric treatment exacerbates affordability issues for the Syrian refugee community.⁴ All primary health care facilities in Jordan are physician-based. Nurses and other primary health care workers (excluding doctors) are not permitted to prescribe psychotropic medications. Primary health care doctors working in the public sector are allowed to prescribe

1 The National Strategy for Health Sector in Jordan, 2015-2019
2 WHO proMIND, 2013
3 WHO proMIND, 2013
4 Ajlounie, 2014

psychotropic medications but with restrictions. For instance, they can prescribe for follow-up treatment but cannot initiate treatment for moderate or severe mental health conditions.⁵ Despite, this restriction in psychotropic prescription, there are difficulties enforcing such regulations. As such training in WHO recommended mhGAP intervention guide is essential to support appropriate, evidence-based management of mental health conditions in primary care.

Mental Health Services Provided by NGOs and INGOs

The most recent mapping exercise conducted by the MHPSS Working Group in Jordan, co-led by IMC and WHO, documented the MHPSS activities of 35 organizations. The document outlines the 4Ws of MHPSS activities in Jordan; who is doing what, where, and when.⁶ In total, the document captured 1253 MHPSS-related activities provided by agencies to vulnerable Jordanian citizens and Syrian refugees. In general, MHPSS services provided by NGOs and INGOs were provided by mostly non-specialized staff (75%), and specialized national staff (20%). Most activities (38%) were aimed at strengthening community and family supports. A growing number of actors were found to offer specialized services provided by psychologists and psychiatrists, compared to that identified in previous years mapping. However, such specialized services still only represent 19% of services, with the remaining services focused on non-specialist service provision, strengthening family and social supports, and the integration of MHPSS considerations into other sectors providing humanitarian aid. A high number of services were provided in the governorates of Amman (21%), Irbid (17%), Zarqa (14%), and Mafraq (14%), with few MHPSS services being offered in the governorates of Aqaba (3%), Madaba (3%), and Tafileh (3%). Key findings from the mapping highlight the geographic bias to more centrally located governorates, with a strong need to increase service provision in the south. Furthermore, few to no services within the NGO and INGO community reported to be targeting persons with substance and/or alcohol use disorders, and persons with developmental delays and/or disabilities.

4.2 Child and Youth Mental Health Problems

Data shared by UNICEF indicates that 50% of Syrian children suffer from nightmares, various forms of sleep problems or bedwetting as a result of the distress they have been exposed to since the onset of the crisis. What is more troublesome is the limitations in the Kingdom in terms of child mental health services. Currently child and adolescent mental health services are not available at MoH. Jordan has one child psychiatry clinic at Princess Aisha Medical Complex. The RMS has three outpatient clinics also targeting child and adolescent mental health needs, while the Ministry of Social

Development (MoSD) has three residential institutions for children and adolescents with intellectual disabilities and severe mental disorders.⁷

4.3 Current Financing of Mental Health Services

The Jordan Response Plan (JRP) outlines funding needs, and funding received from the international community.⁸ In 2016, international donors committed \$ 1.02 billion USD for annual needs of Jordan, considering the additional burden placed on the country by the increasing refugee population. The amount committed represented only 37.5% of the actual needs anticipated by the JRP. Of the funding received by international donors, \$ 325.9 million USD was directed to the Government of Jordan and their general budgetary needs, whilst \$ 465.6 million USD was filtered to UN agencies, NGO, INGO, private and academic institutions through the Jordan Information System for the Syria Crisis (JORISS).

To date, no fixed budget is dedicated to health or mental health services due to the multiple sources of funding received by the MoH. Therefore, it is difficult to accurately estimate the percentage of the total health budget allocated to mental health. Despite recent efforts to shift attention and resources to community-based provision of services, the majority (estimated at over 90%) of financial resources for mental health are currently directed towards tertiary hospitals treating mental disorders.⁹ This has represented a large challenge to developing and expanding community-based services. Such services have only received ad-hoc funds for individual activities by external organizations, often with gaps or shortages, limiting the sustainability of such community-based rehabilitation interventions. It is common for a Jordanian citizen to use more than one health provider, or to be insured under more than one health insurance program.

Jordan's total per capita expenditure on health is \$336 USD, and the general governmental expenditure on health as a percentage of general governmental expenditure is 13.5%. While the out-of-pocket expenditure as a percentage of the total health expenditure is 23.5%. The public sources of funding comprise tax revenue allocations from the Ministry of Finance to the MoH, RMS and Government University Hospitals, as well as user fees, payroll deductions, donor assistance and World Bank loans. The private health insurance covers 6.9% of the population, which includes health insurance companies and health insurance funds of the trade unions and some institutions.¹⁰

5 WHO-AIMS, 2011

6 Mental Health and Psychosocial Working Group and IMC (2017). Who is doing What, Where and When (4Ws) in Mental Health and Psychosocial Support in Jordan: 2017 Interventions Mapping Exercise.

7 National Strategy for Health Sector in Jordan, 2015-2019

8 Jordan Response Platform, The Jordan Response Plan for the Syria Crisis: 201-2019

9 WHO-AIMS, 2011

10 National Strategy for Health Sector in Jordan, 2015-2019

4.4 Desk Review of Mental Health Publications

Conflict-related violence coupled with the ongoing stressors related to displacement, can have a significant and ongoing impact on the mental health and psychosocial wellbeing of Syrian refugee adults and children. Furthermore, the Syrian crisis has undoubtedly impacted the resources and resilience of Jordan and its host community, as a result of an increased economic burden and increased competition for scarce opportunities. The protracted crisis has led to a strong need for strengthened understanding of culture-specific expressions of distress, healing practices and coping strategies.

Mental Health and Psychosocial Problems

In various cultures throughout the Middle East mental health problems can be initially expressed as physical complaints within a medical setting.¹¹ ¹² In a literature review aiming to document the common mental health and psychosocial problems faced by Syrians, Hassan et al (2015) noted that physical symptoms commonly associated with psychological distress include: fatigue, problems sleeping, loss of appetite, abnormal cardiac sensations, gastrointestinal complaints, and other medically unexplained physical symptoms.

In 2012, 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.¹³ Results showed that displaced Syrians reported various concerns related to mental health, especially fear, worry and grief. In 2015 IMC published an updated report on mental health and psychosocial needs and trends based on data collected through service provision in various countries throughout the Middle East, which host Syrian refugees. The most common mental health diagnoses reported were severe emotional disorders (54%), including depression and anxiety. Furthermore, rates of epilepsy (17%), and psychotic disorders (11%) were high across the region. For children, the most common mental and neurological conditions were reported to be epilepsy (27%), intellectual and developmental disorders (27%), and severe emotional disorders (4%).¹⁴

Local Expressions of Distress and Culture-Specific Concepts of Mental Health

In the Middle East it is noted that the experience of mental health can sometimes be culturally explained through the concept of Jinn (“evil spirits”). Hassan et al (2015) noted

that clients experiencing mental health issues may describe themselves as “possessed, attacked, or slapped by Jinn” as a way to rationalize their experience of mental health disturbances.

The strong importance of Islam in the region, also impacts the way mental health can be viewed and in turn, how it is managed. The concept of fate in Islam is essential, as the submission to fate is seen as obedience to God’s will. Life is believed to be a “testing phase” before death and eternity, as a result, for some Syrians difficulties in life can be viewed as an opportunity to strengthen faith and to prove oneself.¹⁵ This could lead to religion being considered a protective factor by strengthening each individual’s resilience, however conversely it may also lead to internal dissonance by those who suffer mental health as it could cause a reluctance to seek out mental health services.

Coping Strategies

Traditionally throughout the Middle East, social coping mechanisms appear to be more highly prioritized than coping strategies at the individual level. Thus culturally, gathering as a community, and maintaining strong links with extended families and friends are an essential component of maintaining a healthy life balance and to help support positive coping. Hassan et al (2015) noted that when positive and healthy coping mechanisms are unavailable and disintegrated, individuals may resort to more unhealthy and unhelpful methods of coping. Such methods might include, and lead to, abuse of alcohol and other substances, increases in the instance of family violence and isolation from social supports. Furthermore, negative coping mechanisms appear to be more likely to be engaged in when persons report strong feelings of helplessness and hopelessness.¹⁶

Due to the reportedly strong link between positive coping and community engagement, literature concerning MHPSS service-delivery recommends the promotion of community efforts to support resilience. This is further supported by the 2015 IMC report titled ‘Addressing Regional Mental Health Needs and Gaps in the context of the Syria Crisis’ which emphasizes the importance of building the capacity of Syrian persons to engage in community-level activities that promote resilience and a sense of community.¹⁷

With respect to coping, unique considerations should be given to children and youth. In 2013, IMC and UNICEF conducted an assessment on the mental health and psychosocial wellbeing of Syrian children in Za’atari refugee camp. ¹⁸ The top coping

11 Hassan, G., Kirmayer, L.J., & Mekki-Berrada, A. (2015). Culture, context and the mental health and psychosocial wellbeing of Syrians: a review for mental health and psychosocial support staff working with Syrians affected by armed conflict.

12 IMC (2017). Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey: Sources of Distress, Coping Mechanisms and Access to Support.

13 Jordan Health Aid Society and IMC (2012). Displaced Syrians in Jordan: A Mental Health and Psychosocial Information Gathering Exercise – Analysis and Interpretation of Findings.

14 IMC (2015). Syria Crisis: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis.

15 Hassan et al. (2015).

16 Hassan et al. (2015).

17 IMC (2015). Syria Crisis: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis.

18 IMC and UNICEF (2013). Mental Health Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za’atari Refugee Camp, Jordan.

mechanisms reported by children surveyed were: withdrawal (71% of respondents), crying (38%), finding things to do to keep busy (31%), and going to parents for help (31%). The role of the family is also integral in supporting the wellbeing of children and youth. Parents specifically appear to play a large role in the wellbeing of the child/youth, with the report 'Insights Into Syrian Refugee Children's Mental Health Status and Coping Mechanisms' highlighting that the provision of livelihood opportunities for parents can positively influence the psychosocial outcomes of their offspring.¹⁹ Furthermore, the report found that children who resided in a family with no secure source of income, were more likely to show high levels of symptoms associated with mental health concerns.

Cultural Norms of Help-Seeking Behavior

Strong cultural norms around masculinity exist which can lead to the perception that men should not publicly express emotions, for fear of it being perceived as a weakness.²⁰ This can lead to an increased risk that men will not engage in social mechanisms that would typically support and promote positive coping. In a report evaluating coping strategies of Syrian refugees in Za'atari camp, IMC (2012) found a tendency for men to endorse more solitary coping strategies, while women were more likely to turn to family and friends for support.²¹ Providing MHPSS services and information through mediums that are naturally integrated into pre-existing community activities, was highlighted by Hassan and colleagues (2015) as a potentially helpful strategy to increase participation in MHPSS activities.

In the Middle East, stigma can often accompany mental disorders. Such inherent stigma is widely publicly expressed through open utilization of terminology such as 'crazy' and 'mad' to describe persons with mental disorders or high levels of psychosocial distress. Such unhelpful labels and consequent stigma are likely to lead to considerable "shame, fear and embarrassment", and thus serve as considerable barriers to help-seeking behaviors.

19 Caritas Lebanon Migrants Centre (2015). Insights Into Syrian Refugee Children's Mental Health Status and Coping Mechanisms

20 Hassan et al. (2015).

21 IMC (2012). Displaced Syrians in Zaatari Camp: Rapid Mental Health and Psychosocial Assessment – Analysis and Interpretations of Findings.



SECTION 5

Methods & Analysis

Data from the project was collected through qualitative and quantitative mixed method assessment measures over a one-month period in July, 2017. Quantitative data was collected through questionnaires administered to individuals in interviews, and qualitative data comprised key informant interviews (KII) and focus group discussions (FGD). Exclusion criteria for participation in the assessment included persons 17 years and under, people deemed under the influence of alcohol or drugs, and those with severe intellectual impairment. Depending on the aspect of data collection, sampling procedures for participant groups varied, as described below.

Sampling Procedures

Individual Interviews via Questionnaires

Participants for the quantitative individual questionnaire component of the assessment were selected through a 3-level snowball sampling strategy. Community members were randomly selected from a comprehensive list of beneficiaries in community service centers. These selected individuals were then contacted by IMC data collection staff and invited to participate in the individual questionnaire (first level). At the conclusion of each survey, respondents were asked to provide contact details of an additional three community members (second level). The recommended three community members were then surveyed and asked to provide contact details of an additional three community members (third level). This ensured those accessing MHPSS

services were included within the sample, and would also result in a more representative sample of persons not accessing such services. Interviews were conducted through teams of IMC case managers and newly recruited community volunteers. Prior to being sent out, teams of case managers and community volunteers underwent a one-day training on interviewing skills and research ethics.

Participants completing the individual questionnaires, were recruited from various community centers including primary healthcare centers, psychosocial spaces, distribution centers, and other community centers. Questionnaires were collected over a period of one month, during July 2017. Questionnaire data was collected from 10 different governorates including 11 main cities and 2 refugee camps. Locations selected for data collection were, Amman, Zarqa, Mafraq, Irbid, Ramtha, Jerash, Ajloun, Salt, Karak, Tafleeh, Ma'an, Za'atari camp, & Azraq camp. Questionnaire data for Jordanians was collected from the same locations with the exception of the two refugee camps.

Key Informant Interviews

Persons considered knowledgeable about MHPSS service delivery, utilization, and barriers to access were included in key informant interviews. These persons included IMC MHPSS specialist staff, MHPSS staff in other INGOs, Community Based Organizations (CBO) or MoH units' active in the locations of interest. Key informants were purposively selected due to their perceived levels of expertise and efforts were made to

sample key informants across the geographic locations of interest, however, level of expertise was prioritized.

Focus Group Discussions

FGDs with members of the Syrian refugee community were implemented in nine locations (two sites in Amman, Zarqa, Jerash, Ramtha-Irbid, Ma'an, Karak, Mafraq, Za'atari refugee camp, and the Azraq refugee camp). In each location 2 FGDs occurred (one for men, and one for women). Community members were randomly selected from a list of beneficiaries in community service centers. These selected individuals were then contacted by IMC data collection staff and invited to participate in the focus group discussions. In total, the assessment utilized data from 18 FGDs from the Syrian refugee community. Each focus group was gender segregated and included 8-10 persons per group. In an effort to improve triangulation of the data, FGD participants were not to have participated in the KIIs or the quantitative component of the assessment. Participants for the FGD were randomly selected via multi-stage cluster sampling from the community, to reflect diverse perspectives across age, education, occupation, and social status, and could also include some beneficiaries of IMC's MHPSS services (no more than 20%).

A similar process was followed to implement FGDs with Jordanian participants. The three focus group locations identified for Jordanians were Zarqa, Karak, and Irbid. Participants of the FGD were randomly selected and invited to participate, amongst those listed as accessing community service centers. In each location, one group was conducted for men, and one group for women. In total, the assessment utilized data from 6 FGDs from the Jordanian host community.

Measures

The World Health Organization (WHO) and The United Nations High Commissioner for Refugees (UNHCR) developed a toolkit for humanitarian settings which includes a battery of assessments used to gain a broad understanding of the humanitarian situation, to analyze people's problems and coping abilities, and the nature of any response required. These tools were used in a modified and adapted form to collect information for the individual interviews, KII and FGD.

Individual Interviews via Questionnaires

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 utilized to measure these constructs, consisted of three main sections. The first is a 6-item demographic section asking about age, gender, nationality, educational level, and marital status. The second part is a 6-item Symptoms Index adapted from the WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS). Each item asked about participants' perceptions of a certain symptom relevant to mental health in the previous two weeks. The symptoms

were defined as fear, anger, loss of interest, hopelessness, avoiding triggers of past events (avoidance), and reduced ability to carry on with 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, whereas those reporting less than three of the symptoms were considered to have low to no levels of distress. The third component of the questionnaire was composed of four different scales exploring help-seeking behaviors, coping skills, barriers to receiving mental health services, and perceived needed services. These domains were explored from two different perspectives; the perspectives of individuals currently in distress, and those experiencing low to no levels of distress (based on results of the adapted WASSS). For this purpose, there were two versions of each scale, each adjusted to capture the perspectives of the intended respondents.

Key Informant Interviews and Focus Group Discussions

Two participatory tools within the WHO-UNHCR assessment, tools 11 and 12, were modified to more heavily explore the topics of coping skills, help-seeking behavior, and barriers to MHPSS access within the Jordanian context. Following this process, the KII and FGD protocols were finalized by IMC.

Data Collection Process

Individual Interviews via Questionnaires

Quantitative data was collected by trained data collection staff. The questionnaire was read aloud to participants to ensure accurate understanding of items, and to account for illiteracy levels. The interviewer noted the responses of the participant and provided clarification on items as needed. Clarifications provided were in line with parameters highlighted during the interviewer training to avoid leading questions, or misinterpretation of questions. Following the interview, the interviewer would review the questionnaire to ensure there were no missing items. Data was then sent to the data entry team who entered data and checked the accuracy of collected information.

Key Informant Interviews and Focus Group Discussions

For the KII and FGD portions of the study, trained IMC staff members collected key informant data and conducted FGDs. For timely completion of focus groups and key informant interviews, two IMC staff were selected and trained to complete these tasks at each location. Staff were paired with one staff acting as a transcriber and the other the interviewer, for each component of the assessment. Qualitative information was to be written down verbatim by the transcriber during the interview, and 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

Quantitative 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 categories; host population, urban refugees, and refugees in camps. These outcomes were also compared across gender, education levels, marital status, and age groups. To examine differences across groups for statistical significance, a chi-square test of independence was performed for proportion comparisons, while independent t-tests were performed for two-level mean comparisons such as gender groups, and one-way ANOVA tests performed for mean comparisons with more than two levels, such as community types. All analyses were tested for statistical significance at the $p < .05$ level. For reporting purposes, some variables were recoded into categorical variables.

Qualitative Analysis

Qualitative data was coded and analyzed to explore the predominant themes that arose during the FGD and KII with Syrian refugees, and Jordanian host community members. Qualitative data was analyzed using MAXQDA. Prior to actual coding for the study, the assessment team, worked together over three trials to achieve adequate application of the codebook to data. Initially, kappa coefficients were insufficient ($< .30$) to assume integrity in the application of codes to manuscripts across all members of the team. After each trial, the team members discussed the coding process, refined code definitions to support better application to data, and then reassessed with kappa coefficients. After the third trial, reliability in applying codes was assessed as “substantial” ($> .61$; Landis and Koch, 1977) and a decision was made to begin coding of project data.



SECTION 6 Results

Respondent Characteristics

In total, for the qualitative and quantitative components combined, 6,375 participants completed either the FGD, individual questionnaire, or KII. Overall, 6,152 participants completed an individual questionnaire, 194 participated in focus group discussions, and 29 participants engaged in key informant interviews (including 6 service providers, 12 knowledgeable community members and 11 service consumers). The assessment had a diverse range of study participants across the variables of age, gender, and education.

Approximately, 7,198 participants were invited to participate in the questionnaire component of the assessment. Of them, 6,152 participants consented to participate and complete the questionnaire. The overall response rate was 85.47%. Samples were proportionate to populations in all governorates with higher proportions of participants in governorates of Amman (24.5%), Irbid (21.9%), Zarqa (15.6%) and Mafraq (15.8%). Overall, 53.7% of respondents were female.

The mean age for all respondents was 34 years (SD=11.49). The average length of stay in Jordan up to and including the time of assessment, was 53 months (SD=15.89) for urban refugees, and 42 months (SD=17.2) for refugees in camp. For reporting purposes, age was recoded into 4 categories (see Table 1). Overall, each of the age groups, young adults, early adults, and late adults, constitute around 30% respectively, of the respondents, while around 10% of the sample are older adults. See Table 2 for a breakdown of demographic data.

Table 1. Categorization of age ranges.

Category	Age Range
Young Adults	18 to 25 years
Early Adults	26 to 35 years
Late Adults	36 to 50 years
Older Adults	51 years and above

Participants in the FGDs were diverse, and represented different sectors of community, including but not limited to, services users. A total of 18 focus group transcripts were utilized in the analysis. Of those, 11 were focus groups with women and 7 were focus groups with men.

Levels of Reported Distress

Urban refugees reported more frequent symptoms of distress, compared to those in camps and the host population (see Figure 1 and Table 3). When looking at the various symptoms associated with distress, 27% of urban refugees reported experiencing fear, all, or most of the time, in the 2 weeks

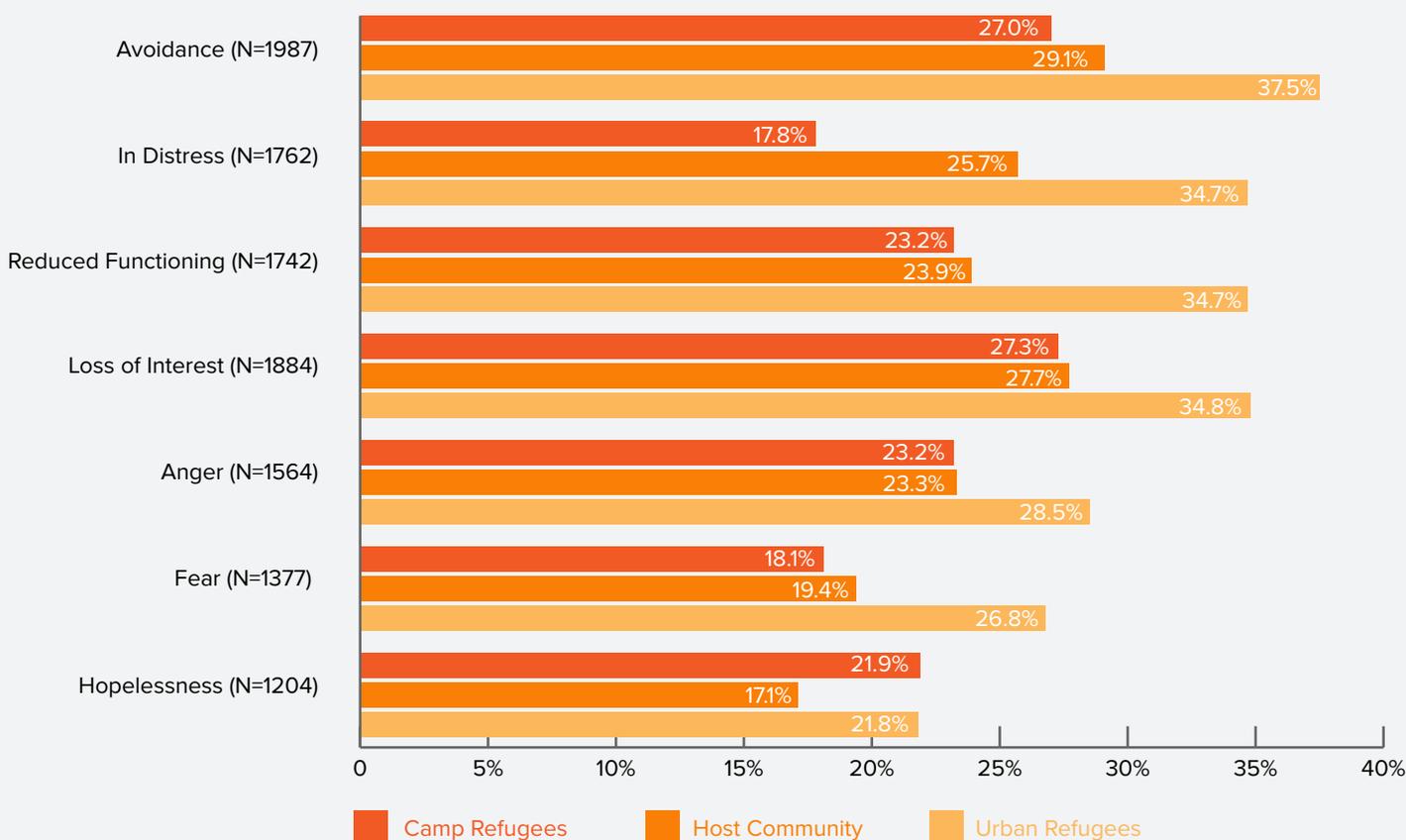
Table 2. Demographic data of respondents.

		Host Community %	Urban Refugees %	Camp Refugees %
Age Groups	Young Adults (18-25 years)	31%	27%	18%
	Early Adults (26-35 years)	33%	32%	37%
	Late Adults (36-50 years)	26%	31%	35%
	Older Adults (+51 years)	10%	10%	10%
	Total	100%	100%	100%
Gender	Male	47%	41%	61%
	Female	53%	59%	39%
	Total	100%	100%	100%
Education	No Formal Education	3%	10%	21%
	Primary School	12%	39%	51%
	High School	26%	30%	18%
	Vocational	7%	6%	3%
	University or College	52%	15%	7%
	Total	100%	100%	100%
Marital Status	Single	40%	20%	11%
	Married	54%	68%	84%
	Widowed	3%	8%	4%
	Divorced	2%	3%	1%
	Other	1%	1%	0%
	Total	100%	100%	100%

Table 3. Proportions of symptoms of distress by community, gender and age.

		Fear (N=1377)	Anger (N=1564)	Loss of Interest (N=1884)	Hopelessness (N=1204)	Avoidance (N=1987)	Reduced Functioning (N=1742)	In Distress (N=1762)
Community	Host Community	19%	23%	28%	17%	29%	24%	26%
	Urban Refugees	27%	28%	35%	22%	37%	35%	35%
	Camp Refugees	18%	23%	27%	22%	27%	23%	18%
Gender	Male	20%	22%	28%	16%	31%	25%	26%
	Female	25%	28%	33%	22%	34%	31%	31%
Age Groups	Young Adults	20%	23%	28%	18%	30%	25%	25%
	Early Adults	24%	27%	33%	20%	34%	30%	31%
	Late Adults	23%	27%	32%	21%	34%	31%	31%
	Older Adults	21%	23%	26%	18%	29%	27%	23%

Figure 1. Distress reported across type of community.



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.

Symptoms of distress were also found to be significantly associated with education level. Participants with no formal education appeared to show increased frequency of distressing emotions, compared to respondents with a college-level education. In addition, symptoms were found to be significantly associated with marital status, with divorced respondents consistently having higher proportions of distress.

Psychosocial Stressors and Identified Vulnerable Groups

The many problems and stressors faced in the Syrian and Jordanian communities were well evidenced during the review of the FGD and KII transcripts.

Children Identified as Vulnerable

Compared to other demographics (e.g., older adults, adult

males, adult females), children and youth were identified as being most identifiably affected in the FGD and KII transcripts. A member of the Syrian Azraq community explained that children are perceived to be the most vulnerable to mental distress *“because they are in the process of acquiring ideas, beliefs, and learning, everything that happens affects children, while adult men and women are less affected because they can balance things and can adapt.”* This statement expresses the participants understanding of the current conditions children may be facing and their perceived lack of adaptive capacity, given their age. It is important however to note, that although children might be easily identified as vulnerable by community members, many possess remarkable resilience, thus such community perceptions may not be generalizable to all children.

Stressors Among Children

The inability to pursue studies was raised as a primary stressor impacting Syrian refugee children and youth. A member of the Ramtha community expressed that *“many Syrian children are beaten and humiliated while going to school, to the point where they say ‘we are not Syrians’ to protect themselves.”* This quote from a key informant typifies the discrimination Syrian students can experience in the school environment. Furthermore, it was reported during

focus group discussions that a wide range of students are impacted by the effects of displacement, namely interruption to their education, *“most of the students are not able to keep on track, they lose their future and the continuation of studies; some have lost at least three years of their study period.”*

Jordanian children as well, were said to have been impacted by the influx of Syrian refugees into their communities. A community member from Irbid stated, *“previously (Jordanian) children were going to school normally, and now they have to go very early, so Syrian kids can go after them. Now it’s two standing periods, each class contains 40 students, all because (some) Syrian children are joining the morning studying period. One of the problems caused by this is the lack of academic achievement reached by (Jordanian) children.”* This statement highlights the lack of space, time, and resources in schools to support both the Jordanian and Syrian community, which leads to larger class sizes and changes in scheduling, thus potentially impacting family routines and academic achievement.

Expressions of Distress Among Children

During focus group discussions, community members were asked how a child in distress can be identified. A number of reported identifiable behaviors and traits were mentioned by respondents. A member from the Amman community noted some observable characteristics in distressed children, *“The unhappy child seems to behave as follows: hyperactivity or social isolation, not going to school, lack of academic achievement.”* Another member from the Ajloun community noted, *“cases of uncontrolled urination and isolation.”* In addition, a comment from a member from the Za’atari camp context indicated that they had observed cases of *“aggression and breaking objects”* in children, indicating that some children might exhibit antisocial behaviors as a way of manifesting distress experienced.

Older Adults Identified as Vulnerable

Older adults within the community were also identified as vulnerable through review of the FGD and KII transcripts. Participants noted that older adults in families risked being neglected due to the need for scarce resources to be distributed to younger family members. As such, older persons within the community may be left without access to necessary medications to manage chronic conditions, and with limited financial support to help promote their quality of life. Furthermore, older persons with poor physical health may also experience challenges related to mobility due to harsh living conditions.

Stressors Among Adults

In adults, family tension was identified as a problem by both Syrian refugee men and women. For men, a concern was financial conflict and struggles. For women, most of the problems and stressors were related to mental distress, the experience of discrimination based on their gender, and the demands of raising children. A community member from Amman explained, *“sources of tension within families relate*

to the financial situation, loss of family members due to illness or war, lack of employment opportunities for men and women, lack of recreation for adults and children. The results of these tensions have had a negative impact on social and family relations in addition to the impact on health and psychological aspects.” Consistent with this, a woman from an Azraq focus group described the financial conflict that is a cause for family tension in her life and others: *“Our financial situation is not stable. Our husbands are not working, and they are staying in the house, sometimes they blow off their anger on us.”*

The lack of resources and financial conflicts were echoed by Syrian men residing in Zarqa, explaining that their *“necessary needs are not being met.”* Relating experiences of poor work conditions, one member of the focus group noted, *“some refugees obtain work permits but, they get only half payment than the actual workers’ pay.”* Additionally, women indicated that they have experienced discrimination and tensions relating to raising children. During an Irbid focus group, a woman told a story that documented the discrimination of her and her children *“they [a Jordanian male neighbor] started to mistreat my children and prevented them from playing, so I had to wear a Niqab because of their treatment, to not let them recognize me when I go or come back to the house.”*

Jordanian respondents stated that for adults, and families, the primary causes of stress were financial in nature, with Jordanians facing challenges accessing housing and other basic needs. A member from the Irbid community stated, *“Syrian workers take a lower wage than Jordanians, and therefore Jordanians cannot compete in the job market.”* Beyond employment availability and income struggles, Jordanian community members also noted that a housing shortage is an outcome of the Syrian crisis. Overall the influx of refugees into communities has taxed infrastructures that, according to the host community, now fail to fully support the host community.

Expressions of Distress Among Adults

Family conflict was highlighted as a key outcome of distress, with both Syrian and Jordanian respondents noting what they perceived to be increased divorce rates. At times the conflict was reported to be expressed through physical violence towards family members, in particular women and children. Social isolation was also noted as a key identifier of distress. Due to inherently social coping mechanisms, adults who are seen to isolate themselves from the community and their family, are perceived as being distressed.

Coping Mechanisms

Coping mechanisms were explored through the implementation of individual interviews via a questionnaire. The questionnaire was a modified and culturally adapted version of the BriefCOPE that asked people a variety of items to determine most common types of coping mechanisms

employed. Participants were asked to rate on a Likert scale from 1 'I haven't been doing this at all', to 3 'I do this a lot'. Figure 2 highlights reported differences in coping between persons experiencing distress, and those with low to no levels of distress 'general community' for Jordanians and Syrian combined.

Overall finding comfort in faith and spiritual beliefs was endorsed as a primary coping method of many respondents, followed by approaching family and friends for support and a general tendency to keep busy to avoid thinking too much about factors causing distress. Coping skills were not found to be statistically associated with gender, with the exception of using drugs and alcohol as a source of coping, and finding comfort in faith and spirituality. Females were found to have significantly lower prevalence of using alcohol and drugs as a coping skill, and a higher likelihood of finding comfort in faith and religion ($p < 0.001$). Also, men reported a higher likelihood of giving up as a negative coping strategy in response to distress, compared to their female counterparts. Men interestingly, also specifically reported a higher likelihood than women, of getting support from specialists for distress, or to keep busy as an active coping strategy (see Figure 2 for a further breakdown of coping skills by gender).

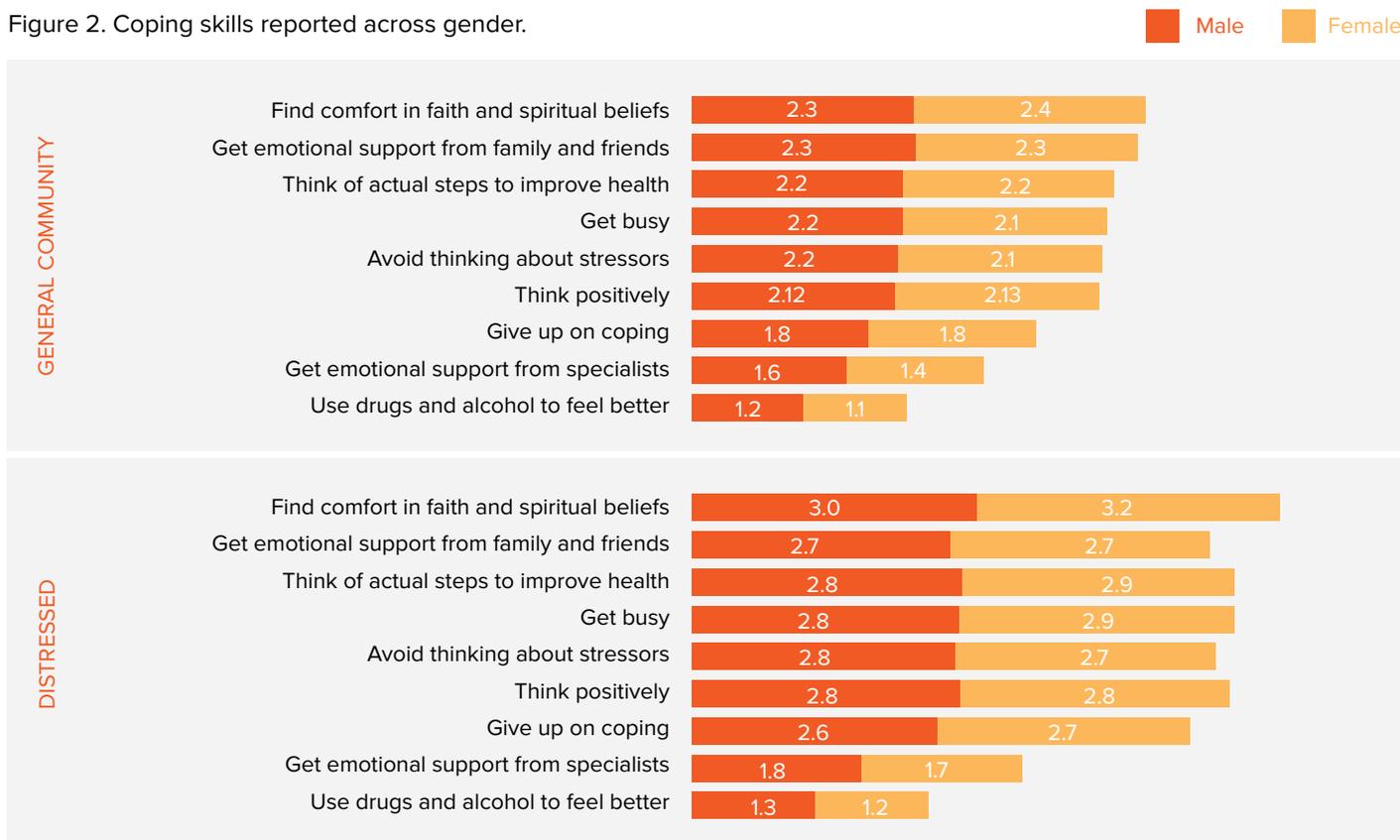
Figure 2 also highlights some distinct differences between members of the community who reported low to no distress, and those who reported moderate to strong levels of distress. In particular, distressed persons reported 'giving up' as a coping mechanism, more so than non-distressed

respondents. Interestingly, persons with higher education levels were more likely to endorse using drugs and/or alcohol as a coping strategy they use, to manage emotional distress. Persons who were unmarried, or divorced, reported they were most likely to turn to substances as a coping method, in comparison to married or widowed respondents. Figure 2 demonstrates the mean scores on each category assessed through the modified BriefCOPE scale. Means were calculated by gathering the average of participants' score for each item on the Likert scale, from 1 'I haven't been doing this at all', to 3 'I do this a lot'. Higher means in Figure 2, demonstrate a stronger tendency for respondents to engage in that form of coping.

Comparisons of Coping Among Urban and Camp Refugees and Host Community

Analysis found that the host community was more likely to utilize "keeping busy" as a primary coping skill, compared to both urban, and camp refugee communities. Furthermore, the host community was most likely to utilize proactive problem-solving techniques, as a coping method, in comparison to Syrian refugees in the urban and camp settings. On the other hand, Syrian refugees in the urban and camp settings, were more likely to seek specialist support, compared to the host community. Syrian refugees in the camp setting were also found to be the most likely to endorse avoidance of thoughts in relation to their stressors, as a primary coping mechanism, in comparison to refugees in the urban setting, or the host community.

Figure 2. Coping skills reported across gender.



Coping Mechanisms Endorsed by Syrians

Key informant interviews and focus group discussions were analyzed to further outline trends in coping mechanisms. Syrian participants' coping mechanisms, both positive and negative in nature, were most often expressed at the family level (e.g., positive: pursuing leisure activities as a family; negative: domestic violence) and community levels (e.g., positive: engagement with religious community; negative: early marriage) rather than at the solitary, individual level (e.g., positive: meditation or prayer; negative: self-harm). Coping strategies engaged in at the individual level were noted less frequently, indicating that persons preferred to utilize coping strategies that were collective in nature and reinforced strong social ties within the community.

Negative coping mechanisms reported included violence within the family household and early marriage which was described as a form of protection for young women to ensure physical and financial security. As one respondent eloquently stated, *"The early marriage of our daughter is a kind of protection for her"*. Though evidence of negative coping existed within the KII and FGD data, positive forms of coping at both the community and family levels were expressed as well.

Having a close family support system, when confronted with problems and stressors, was an essential, and often identified support, for both KII and FGD participants. For example, in a narrative from a member from Tafleeh: *"The people who helped me are my wife and my children. They have tolerated the severe nervousness that I have had."* Family support was also noted as a factor in encouraging utilization of available MHPSS, *"My wife and my mother helped me to seek treatment, they stopped me from (committing) suicide, (they reminded me) it is forbidden by religion (haram), and they reminded me of my children"*.

Coping Mechanisms Endorsed by Jordanians

Many positive coping mechanisms were reported within the Jordanian community through the key informant interviews and the focus group discussions. In particular, Jordanian respondents mentioned that religion was a primary source of comfort during times of distress. One respondent stated, *"it has nothing to do with the financial situation, the important part is the parent's culture and their proximity to God."* This example narrates that the culture and religion is still intact as a macro and community level protective factor. Furthermore engagement with family was seen as a primary positive coping mechanism utilized by many.

A gap in resources available to help support positive coping strategies, was identified by many, with an Irbid community member stating, *"There is no support from schools or associations, and the family is the only place supportive of children. The community needs playgrounds for children, counseling services in schools."* This highlights important factors to help support children, youth and families to strengthen coping at the familial level.

Help-Seeking Behavior

In the individual interviews conducted through the questionnaires, both Syrian and Jordanian participants reported a significant association between help-seeking behaviors and type of community. Over half of all respondents in all communities reported seeking help from a spouse. In host communities and urban refugee communities, over half of respondents reported seeking help from parents, relatives, or friends. However, these proportions drop for camp refugees, as is displayed in Table 4. Respondents from host communities and urban refugees were also more likely to seek help from doctors, specialists and spiritual leaders, compared to refugees in camps. Moreover, host communities tend to seek more help from community leaders (23%), compared to refugees, whether in camps (4%) or urban settings (11%). Persons experiencing distress in camps were less likely to seek support from specialists (18.5%), compared to those experiencing low to no levels of distress in camps (52.4%). See Table 4 for a further breakdown of help-seeking behavior across community type.

Younger age groups reported significantly higher help seeking proportions from parents and friends. Older persons and late adults reported significantly higher levels of seeking help from general practitioners. Gender is significantly associated with seeking help from friends and relatives, with men reporting to be more likely to seek help from friends, and women reporting increased likelihood of seeking help from relatives.

Barriers to Accessing Mental Health Services

Barriers to accessing mental health services was assessed by a questionnaire through individual interviews that asked participants to comment on various barriers that might prevent them from accessing mental health services. Analysis of the individual survey data revealed that for women, the need for privacy, and feelings of helplessness and hopelessness were primary barriers to seeking help. Interestingly, refugees in camp settings were most likely to say a desire to remain self-reliant was a barrier to seeking help from others, compared to those in urban settings, or the host community. Refugees in camp settings were also most likely to say they do not seek help as they rely on their faith. Refugees in camps stated that a feeling of hopelessness and helplessness was a barrier to seeking help and support.

Concrete barriers to accessing support (such as transportation issues, and cost of services), was understandably more of an issue for refugees in urban and camp communities, compared to the host community who did not perceive such factors as a barrier to accessing help or support. When investigating different barriers to accessing help across various ages, it was found that older adults, were more likely to rely on their religious beliefs, rather than actively seek support, which was less likely in younger adults. Older adults were more likely to endorse that rather than actively help seeking through professional mental health services,

Table 4. Help-seeking behaviors by community.

Individuals in distress N= 1765			Will likely seek help or sought help from...	General Community N= 4373		
Proportions by Community		Total N, %		Total N, %	Proportions by Community	
50.6% 59.7% 53.7%	Host Urban Camp	N=802, 55.4%	Spouse	N=2588, 63.7%	Host Urban Camp	61.1% 63.9% 72.1%
65.2% 52.2% 44.9%	Host Urban Camp	N=785, 56.4%	Friend	N=2727, 66.6%	Host Urban Camp	69.8% 66.2% 56%
64.3% 58.8% 32.4%	Host Urban Camp	N=835, 57.7%	Parents	N=2865, 70%	Host Urban Camp	70.3% 72% 62.1%
55.2% 51% 38.1%	Host Urban Camp	N=715, 51%	Relatives	N=2479, 60.6%	Host Urban Camp	58.6% 65.1% 52.8%
29.3% 32% 18.5%	Host Urban Camp	N=395, 29.2%	Specialist	N=1874, 46%	Host Urban Camp	42.7% 47.7% 52.4%
32.6% 31.4% 22%	Host Urban Camp	N=416, 30.7%	GP/Doctor	N=1692, 41.5%	Host Urban Camp	39.2% 45.9% 35.4%
30% 25.7% 15.6%	Host Urban Camp	N= 349, 26%	Spiritual Leader	N=1423, 34.9%	Host Urban Camp	35.3% 39.2% 19.5%
23.4% 10.7% 4%	Host Urban Camp	N=193, 14.7%	Community Leader	N=1021, 25.1%	Host Urban Camp	25.4% 25.1% 23.6%

they rely on their religious beliefs and have a faith that supports them through challenging times. Emotional control barriers, meaning persons do not seek professional mental health services due to a strong desire to remain personally in control of their distress, including active attempts to deny mental health issues, were equally reported for refugees and the host community. Interestingly barriers to help seeking for mental health concerns were similarly reported by persons experiencing moderate to high levels of distress, and those with low to no reported distress. See Figure 3 for a further breakdown of perceived barriers to accessing services by type of community examined.

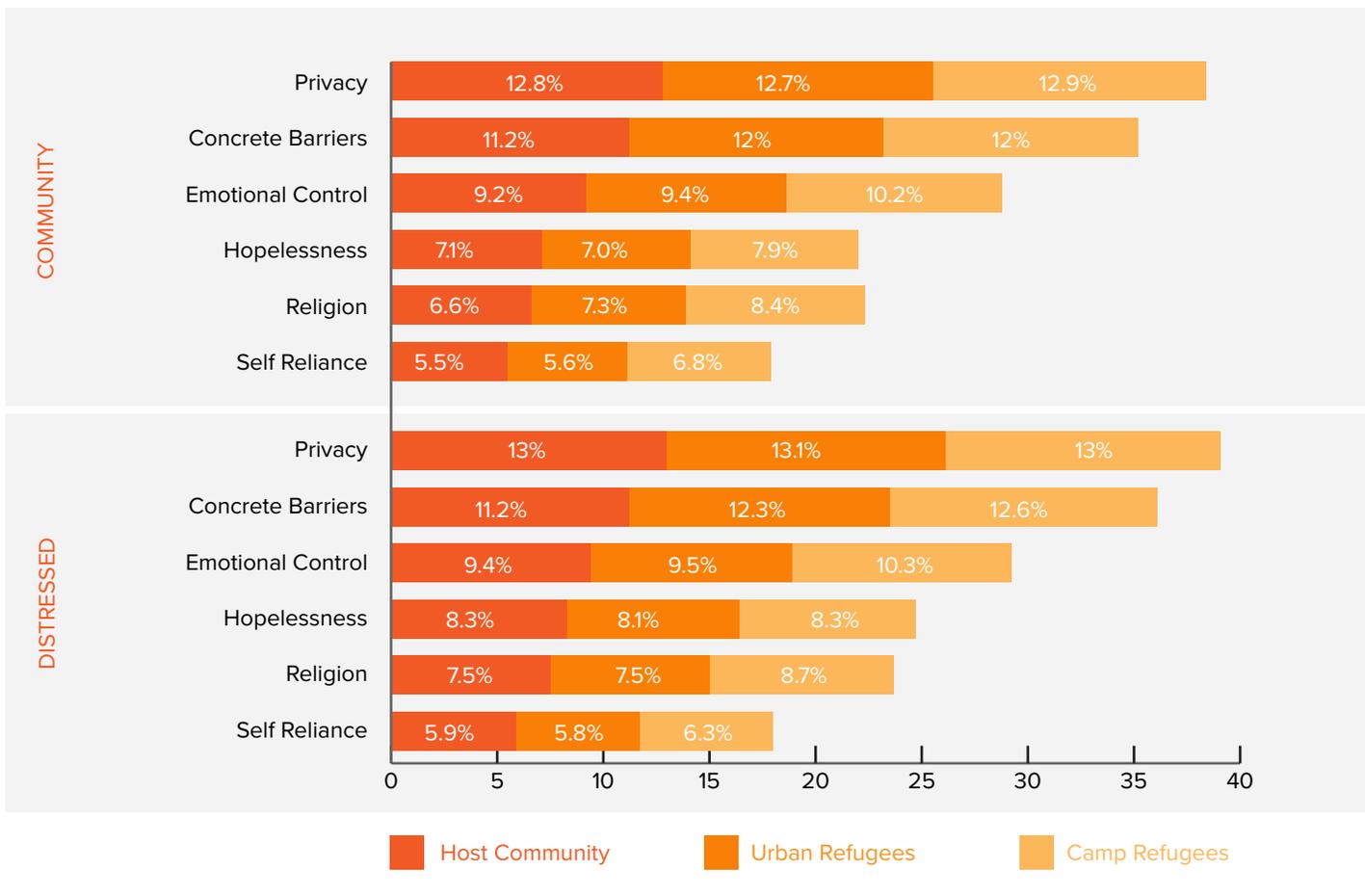
During discussions held during the key informant interviews and focus group discussions, a variety of barriers were highlighted to receiving mental health services within both the Syrian and Jordanian host communities. The four major

barriers conveyed by both Syrians and Jordanians were, negative stigma associated with mental illness, a lack of mental health awareness, insufficient services, and costs. Each of these barriers are discussed in more detail below.

Mental health stigma

Reflected across all respondent types (except for provider informants), community and individual perceptions of mental illness carried a negative stigma, which was slightly more prominent in non-camp settings. Respondents noted that society's perception of mental illness hindered individuals' ability to utilize mental health services. A Jordanian respondent from Ramtha noted that, *"One of the biggest reasons that prevent people with mental disorders from seeking treatment is the stigma of society"*. Additionally, a Syrian respondent from Azraq noted that mental health services were only for *"crazy people"* and for the *"mentally*

Figure 3. Barriers to help-seeking compared across community type examined.



disabled”. A focus group participant from Irbid noted, *“stigma accompanies their family too.”* Specifically, a focus group participant stated *“Even if his sister wants to get married and people knew that there is a psychiatric patient in the family, they will discontinue, they are afraid that the disease will reach them”*. Such stigma is highly likely to influence service utilization, and thus represents a major barrier to access.

Lack of mental health awareness

Reflected across all respondent types (except for provider informants), a lack of mental health awareness was associated with, or interpreted as, a barrier to mental health services and help-seeking behaviors, in which representation was more prominent in non-camp settings. The lack of mental health awareness within responses was represented in two forms; i) a lack of awareness of mental health services, and ii) a lack of self-awareness in needing mental health services. A community informant from Irbid noted, *“there is no information and awareness about mental health in my community.”* Additionally, a Syrian consumer of services from Mafraq noted, *“I do not know about the existence of specialized mental health organizations for the Syrian refugees near my home.”* These perspectives represent a lack of knowledge of mental health issues in general and a lack of understanding of where to receive services.

Availability of services and costs

A lack of available services was also mentioned as a barrier to service utilization. Furthermore transport barriers and cost of services were two major barriers influencing the perceived accessibility of a service. Several respondents noted difficulties in reaching mental health services due to a lack of transportation. In certain areas, the clinics available have been described as insufficient and lacking compared to others. A community informant for Balqa stated *“one clinic for each governorate is not enough.”* A consumer from Za’tari also stated that service providers should be *“opening more clinics in all governorates”*. An increase in clinics in all geographical areas, and in general, could increase mental health utilization. Additionally, mental health service providers might consider offering outreach services, transportation options or financial allowances for beneficiaries with challenges accessing clinics.

Several respondents noted high treatment costs as a barrier to mental health service utilization. These perspectives were most prevalent within community and consumer informant interviews in non-camp settings. A community informant from Ma’an expressed a *“fear of the cost of medicine”* and another community informant from Jerash noted *“the inability to cover the costs of treatment (for specialized centers)”*. Although high treatment costs have been noted several times

throughout participant responses, one interviewer noted that IMC provides mental health services free of charge. One community informant from Ma'an indicated that *“families do not go to the government sector because of stigma, and not to the private sector because of financial difficulties”*.

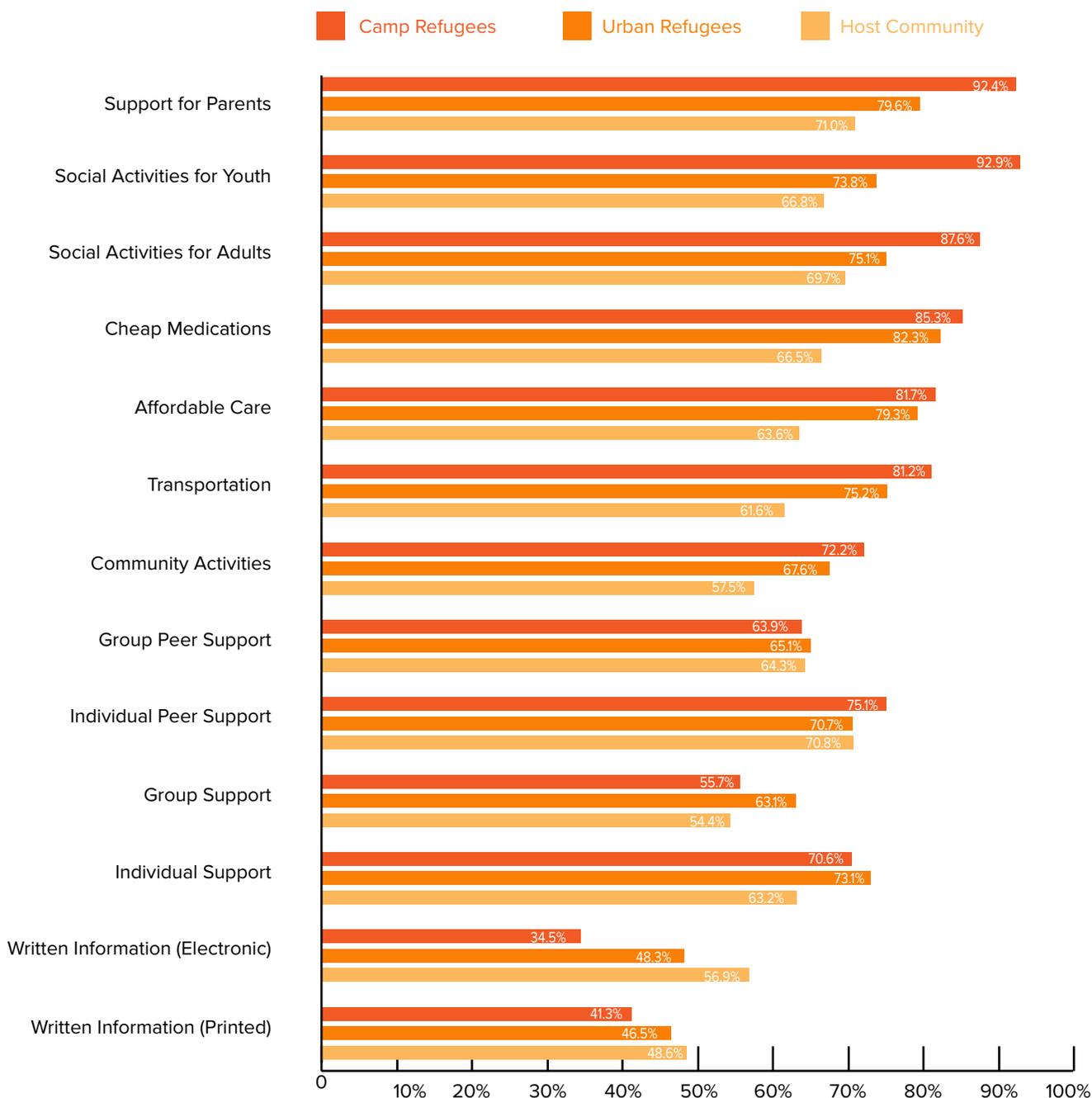
Perceived Needed Services

Respondents who reported strong levels of distress (as measured by the WASSS), were asked during the individual interviews via questionnaire what services, or methods of support, they would most prefer to have access to. Participants were asked to endorse a variety of options such

as written educational materials, individual support services, and access to affordable medications, amongst others. Figure 4 provides an overview of the various responses segregated by host community, urban refugee community, and camp community.

Receiving written information about service or care options was the least favored means among respondents with high levels of distress, with only half of them believing this would make a difference. The majority of respondents with high levels of distress, across all communities, selected individual support from specialists, and individual peer support, as the most needed and favored services. Transportation to access services, affordable care, and affordable medications

Figure 4. Types of perceived services needed, segregated by community type.



were also popular choices for refugees in camps, and urban settings. Specific within the camp setting, respondents reported social activities that allow opportunities to engage with the camp community, and parental supports in the form of parenting support groups and training opportunities for parents, were useful and needed services.

Quality of Services Provided

Interviews conducted with key informants who were MHPSS service providers' revealed important considerations for the strengthening of quality MHPSS services. Such service providers specifically focused more on enhancing capacity in mental health services in either staffing levels, or skill levels among providers. With regard to staffing levels, a provider of MHPSS services working in Amman captured one aspect of capacity enhancement noting, *"there is a shortage of skilled MHPSS staff so that the number of employees available now is not sufficient."* A provider of MHPSS services in the Za'atari camp noted this as well stating that *"attracting qualified scientific and practical workers in mental care services should be a priority."* In addition to adequate staffing, a call for training was clear, especially in interviews with providers in non-camp contexts. A provider in Ramtha called for *"the development of training for staff working in mental health, to train them to manage refugees and the trauma resulting from the war ... as the number (of qualified staff) is still limited in the psychological sector."*



SECTION 7

Discussion and Recommendations

This assessment sought to build upon knowledge acquired from previous IMC assessments, to develop a profile of coping mechanisms and help-seeking behaviors that the Syrian refugee population utilize, along with identifying barriers to service utilization. The assessment also sought to learn about the challenges faced by the host community in the context of the current economic crisis Jordan is facing. Each of these aspects has been covered through this assessment, which provides readers with information that may contribute to wider discussion, as the national and international actors, consider how to further promote MHPSS services. The results of the report should be read in light of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007), to highlight and promote best practice recommendations that will better serve the vulnerable Jordanian, and Syrian refugee communities.

Increase Service Accessibility and Outreach Activities

This assessment revealed interesting findings about the experience of emotional distress, activation of various coping skills, and help-seeking behaviors of the Syrian refugee

community, and the Jordanian host community. Overall, the quantitative component of the assessment revealed that Syrian refugees in urban settings reported significantly higher proportions of stress, and other psychological symptoms, such as the experience of fear, anger, loss of interest, avoidance, and reduced functioning, than refugees in camp settings. Furthermore, services are less accessible for urban refugees for a number of reasons, including a lack of accurate information about services, difficulties with transportation, and costliness of services offered. This is an interesting finding as although Syrian refugees in urban locations are experiencing higher levels of distress, they are reportedly less able to access, or be aware of appropriate services. This finding has programming implications as it highlights the need for increased community outreach and awareness activities, to ensure that refugees living in urban settings are aware of, and able to access, available services to support wellbeing.

In addition to awareness campaigns, community outreach appears to be integral to engaging persons in need with required services. Rather than solely offering mental health and psychosocial services through clinic-based activities, it is essential that MHPSS actors conduct home visits and attempt to reach remote and rural locations with service provision.

Outreach activities will ensure the identification of those in need, but also may support the inclusion of family members into the management of persons with mental disorders. Such outreach will also help to increase understanding of surrounding services that might support persons in need of MHPSS, and other services. The implementation of outreach activities must be done with the awareness of referral pathways active in the area of intervention, to ensure individuals become appropriately connected to available services. Outreach might also take the form of mobile teams, which provide services to rural and remote areas that are otherwise unlikely to be able to reach available services.

Key Recommendations

- Consider means to support access to services where it may be impeded by cost or unavailability of transportation, particularly in more dispersed urban settings. Barriers related to transportation and costliness of services can be mitigated by increased home visits, mobile clinics and transportation stipends.
- Standardize and conduct more home visits and outreach services for increased visibility, to build trust among individuals and communities, and as a key component of good case management practice. Case management and community networking require qualified MHPSS staff to frequently and predictably, be visible in the community, meeting face-to-face with people in homes, and other community spaces. This not only increases trust in MHPSS services, but it also increases the motivation of individuals and families to prioritize and seek appropriate care for themselves and others.
- MHPSS staff members and trained community members and volunteers conducting such outreach services should also ensure they are adequately familiar with existing referral pathways in the areas of intervention. All agencies active in MHPSS service provision should aim to engage in active coordination mechanisms and ensure referral pathways and procedures are clear to staff, trained community members and volunteers.

Address Stigma To Promote Mental Health Service Utilization

Many respondents reported two primary barriers to service accessibility including concrete barriers mentioned above, and the concern for privacy in accessing mental health services due to stigma. It is important to take such findings into account when developing MHPSS services within Jordan that target vulnerable Jordanians, and Syrian refugees, as both appear to experience such barriers. Tackling stigma is key to increasing access and participation of those in need of MHPSS services. The current assessment found that only one third of those who are in distress seek help from specialists. Compared to the general community, persons

experiencing distress were less likely to seek help from a specialist. Furthermore in camp settings, persons in distress reported especially low help seeking from specialists (under 20%). Within the qualitative component of the assessment, increasing awareness around mental health issues in the community was raised as an important strategy to decrease stigma. This sentiment was expressed by both Syrian refugees, and members of the host community. Consistent with the findings documented by Hassan and colleagues in 2015, stigma and the associated unhelpful labelling of persons exhibiting emotional distress, leads to considerable fear, shame and embarrassment, and thus continues to serve as a considerable barrier to help-seeking behaviors.

Key Recommendations

- Increase awareness of mental health issues with a goal toward reducing stigma and encouraging those in need of help, to access available services. Increasing awareness, especially in urban settings through outreach and creative distribution of IEC focused materials, is essential to decrease this barrier to service accessibility and to help reduce stigma. Such information provision is consistent with IASC recommended guidelines on the dissemination of information about available services, and positive coping methods.
- Increasing awareness around mental health may be achieved in a variety of ways such as, community seminars, distribution of pamphlets, and brochures not only providing information about the location of services, but also including positive coping messages, and the promotion of positive mental health and coping strategies through a variety of modalities within mass media (radio, television, internet etc.). Furthermore, as consistent with the report findings, it is important to ensure IEC materials are not only distributed in the form of pamphlets and other written forms, but that verbal messages are also delivered through peers and community leaders.

Ensure Confidentiality and Privacy

Females report a significantly higher proportion of emotional distress and psychological symptoms, compared to men. According to findings from this assessment, women find more comfort in faith and spirituality than their male counterparts which represents a positive coping strategy utilized. They are also less likely than men, to use alcohol and other substances for coping, and are less likely to have given up on attempting to cope. However, a majority of females sampled during this assessment, claimed they are less likely to seek specialist support, compared to men. Women reported increased feelings of helplessness and a higher need for privacy, when it comes to seeking help and support. The need for increased privacy is an understandable one, given the results of high levels of perceived stigma surrounding mental health issues. Whilst in practice all MHPSS services should ensure

confidentiality of clients at all times, it is apparent that service consumers might worry about others seeing them access buildings, or locations, known to provide such services. These findings are consistent with that of Hassan and colleagues (2015) who highlighted the importance of naturally integrating MHPSS services and information into pre-existing community activities to help increase participation in such services, and to help alleviate concerns around privacy for women.

Key Recommendations

- Methods that allow affected persons, especially women, to access information privately, may help to address this barrier to help-seeking and should be strongly considered by MHPSS actors. This can include providing information via flyers, helplines, and websites as well as through trusted community members and peers.
- MHPSS staff should attempt to achieve engagement with the family of each client where possible, to help reduce any stigma existing within the family unit. This might help to ensure their understanding of the experience of the affected family member, and to provide psychoeducation on how to best support the person in need.

Promote Positive Coping Strategies

Different coping strategies employed were evident between the host community, and the Syrian refugee community. Both positive and negative coping mechanisms were endorsed by respondents. Such findings are consistent with that of Hassan and colleagues (2015) who noted that when healthy coping mechanisms are disintegrated (as can be the case in a protracted crisis), individuals may resort to more unhealthy and unhelpful methods of coping. In general an exploration of coping mechanisms revealed that, the host community, were reportedly more likely to seek distractions in work from emotional distress, a coping strategy which may not be available to many Syrians due to the difficulties in gaining employment. The Jordanian host community, was also found to be most likely to consciously plan steps forward, to help problem-solve potential issues relating to emotional wellbeing. This is a positive coping strategy that programs should attempt to foster, and encourage. Interestingly though, the host community was less likely to seek help from doctors and specialists, which suggests they tend to be more self-reliant and reliant on community coping mechanisms.

Data collected appears to indicate that the Syrian refugee community, appears to suffer more from feelings of helplessness, and hopelessness. The findings of increased perceptions of helplessness and hopelessness amongst Syrian refugees is interesting, as Hassan and colleagues (2015) noted that such feelings are increasingly linked to negative coping mechanisms. The Syrian refugee community were also reportedly more inclined to seek professional support for managing psychosocial concerns or to seek support from friends and family, rather than relying

on their own abilities to problem-solve. Whilst accessing professional support is a strength, and should continue to be encouraged within the Syrian refugee community, the sense of helplessness reported by many, should be a focus of MHPSS programming and that of other sectors. MHPSS services, should wherever possible, aim to be empowering in nature, and help to create a sense of autonomy, control and self-reliance for the individual accessing services.

Key Recommendations

- MHPSS service delivery should be conducted in a manner that fosters and encourages empowerment, self-reliance and resiliency.
- Training on the IASC guidelines that relate to integration of MHPSS considerations into other sectors should be provided through coordination mechanisms. This is essential to ensure that other sectors such as food security, shelter, and education, provide services which are empowering in nature and do not further exacerbate feelings of helplessness.
- Syrian refugees and the Jordanian host community, both endorsed a variety of coping mechanisms to manage psychological distress. This variance in coping skills, and preferences, suggests that programming should be multi-layered with respect to supporting existing coping mechanisms, at the individual, familial, and community levels, whilst creating further opportunities to strengthen and foster alternative adaptive coping strategies and opportunities for community support.
- MHPSS actors can ensure a multilayered response that supports a variety of different coping methods by ensuring that MHPSS services both support the individual through traditional methods such as counselling and psychological intervention, yet also supports family and community-based coping mechanisms by strengthening and increasing activities that target level 2 of the IASC pyramid thus promoting community mobilization and support, as consistent with the IASC guidelines.
- Consistent with previous literature disseminated by IMC (2015), an emphasis should be placed on increasing the capacity on Syrian persons to engage in community-level activities that support resilience and a strong sense of community.
- MHPSS coordination mechanisms should focus on encouraging actors to develop community and group-based activities that could establish or strengthen social and community support. This might include community centers, group-based initiatives centered on activities (e.g. cooking, sports, art etc.), self-help, and supportive groups facilitated by trained MHPSS professionals.

Support Vulnerable Populations

Two key vulnerable populations identified by respondents included children, and older persons within the community. In relation to children, the inability to fluidly continue pursuing educational development was identified to be a persistent challenge for Syrian children and youth in Jordan due to unstable living conditions and limited access to schools. This causes immense strain on parents and other care providers who understand the negative impact a lack of quality education can have on children and youth. Similarly, Jordanian parents are concerned about the strain on school resources and increasing classroom sizes due to influxes of refugee students and the possible impact this can have on their children's educational development. Both Jordanian and refugee parents and caregivers also consistently expressed concern about their ability to afford basic needs for their children due to financial constraints.

Respondents noted that families often experience challenges caring for older persons due to limited resources available to seek medical care, afford medications for chronic conditions, and to support mobility issues for those with physical impairment. A concern was also expressed among MHPSS service providers that older persons within the community are often not specifically targeted in programming considerations, and therefore age appropriate interventions that support to maintain dignity, are challenging for this population to access.

Key Recommendations

- Prioritize educational and other developmental needs of children and youth, including support to parents desperate to ensure the wellbeing of their children. Concern for the wellbeing and developmental needs of children was predominant among both Syrian refugee and Jordanian respondents. MHPSS providers should make efforts to further work with partners in the Ministry of Education to offer services and provide MHPSS resources to school counsellors, teachers and to students themselves, building their capacity to feel secure in the midst of an insecure situation.
- Due to the key role of parental wellbeing in predicting the emotional wellbeing of children, as highlighted by Caritas Lebanon Migrants Centre (2015), it is recommended that supports for parents and caregivers is included as part of mental health and psychosocial services in Jordan. Such parental support might include parental skills training, but also support in livelihood initiatives to reduce the financial stressors that exist within many households.
- Ensure appropriate consideration for the needs of older adults and their access to appropriate services in all areas of relevant programming. Appropriate services and accessibility considerations are unique to older adults and must be tailored accordingly in MHPSS programming. This can be achieved by identifying older adults in community visits by MHPSS staff and trained community members, and ensuring that they are

connected with services that understand and serve their needs.

- A key finding highlighted that older adults were more likely to approach GPs and religious leaders for support for emotional distress. As such it is recommended that GPs and religious leaders are provided with adequate training to more comprehensively support the unique psychosocial needs of this population. Moreover, transportation needs must also be considered for this population, particularly for individuals with limited or no family support.

Emphasize The Importance of Training and Supervision

Several respondents from the key informant interviews, called for structural efforts to better utilize available resources to meet the demands of caring for the Syrian refugee population. Such structural efforts include improving training and supervision opportunities for MHPSS staff, and ensuring MHPSS services are adequately staffed. These findings suggest a heavy emphasis needs to be placed, not only on the training of MHPSS staff, but also on the implementation of quality clinical supervision to ensure high-quality service provision, and that staff feel supported in their clinical duties. Such findings are consistent with the IASC guidelines which promote the importance of aid workers being adequately trained in mental health psychosocial support.

Key Recommendations

- Increased focus on staff training and supervision is essential to ensure high-quality service-provision. Key informants acknowledged a skills-deficit existing within Jordan, meaning recruiting highly-skilled mental health professionals is a challenge faced by many actors. As such, MHPSS actors should place an increased emphasis on training existing staff to support the development of their capacity to manage complex cases.
- Furthermore, MHPSS staff should be adequately clinically supervised. Clinical supervision might take the form of on-the-job observations of practice, conducting file audits, and structured and semi-structured individual or group discussions with practicing MHPSS staff.
- Staff-care should be taken into account to ensure highly-trained staff, are retained in the long-term and to protect against the experience of burn-out and consequent staff attrition.

The economic hurdles and resource demands Jordan is facing in hosting refugees from multiple neighboring countries are significant. Both Jordanian and Syrian respondents expressed concern for limited access to jobs, affordable housing, as well as health and education resources. The government of Jordan and its national and international partners bear a responsibility to address the mental health situation and to

ensure that the short-term needs of refugees are paired with medium-and long-term strategies to support both Syrians and Jordanians so that both can manage the different stressors they have experienced. For Jordanians this means developing and recognizing the importance of having a long-term vision of mental health facilities, capacity, and policy for their country, as well as providing Syrian refugees access to necessary resources to assist their urgent mental health needs during their temporary, yet protracted, time in the Kingdom. IMC can continue sharing a key role in supporting related efforts through its programming in communities and through partnerships with other organizations, informed by rich, up-to-date information.

SECTION 8

References

- Almshosh, N. (2015). Exploring the Mental Health Needs and Suffering of Syrian Refugees. Royal College of Psychiatrists TPSIG Newsletter (London, England). Chisholm D, Lund C, Saxena S. Cost of scaling up mental health care in low-and middle-income countries. *British Journal of Psychiatry*, 2007, 191: 528-535
- Albertien, V., AbuKishk, R. Bushnaq, S., Muneghina, O., Rawdha, R., Pietersom, T. (2015); Evaluation of UNICEF's Psychosocial Support Response for Syrian Children in Jordan. United Nations Children's Fund (UNICEF). Jordan, 2015.
- Care International in Jordan Amman. (2017). 7 years into exile: How urban Syrian refugees, vulnerable Jordanians and other refugees in Jordan are being impacted by the Syria crisis. Retrieved from <http://reliefweb.int/sites/reliefweb.int/files/resources/2017%20CARE%20Jordan%20Syrian%20refugees%20Summary%20final%20web%20%28revised%29%2016062017.pdf>
- Caritas Lebanon Migrants Centre (2015). Insights into Syrian Refugee Children's Mental Health Status and Coping Mechanisms. Retrieved from <https://reliefweb.int/report/lebanon/insights-syrian-refugee-children-s-mental-health-status-coping-mechanisms>
- Crabtree, B. F., & Miller, W. L. (1992, May). Doing qualitative research. Paper presented at the annual meeting of the North American Primary Care Research Group, Quebec, PQ, Canada. Retrieved from <http://psycnet.apa.org/psycinfo/1992-97742-000>
- Creswell, J W. (2007). *Qualitative inquiry and research design: Choosing among five editions* (2nd ed.). Thousand Oaks, CA: Sage Design, N.K., & Lincoln, (Y.S.) (Eds.). (2005). *The saga handbook of qualitative research*. Thousand Oaks, CA: Saga
- Culbertson, S., Ling, T., Henham M.L, Corbett, J., Karam, R., Pankowska, P., Saunders, C., Bellasio, J., Baruch, B. (2014); Evaluation of Emergency Education Response for Syrian Refugee Children and Host Communities in Jordan.
- Creswell, J W. (2007). *Qualitative inquiry and research design: Choosing among five editions* (2nd ed.). Thousand Oaks, CA: Sage Design, N.K., & Lincoln, (Y.S.) (Eds.). (2005). *The saga handbook of qualitative research*. Thousand Oaks, CA: Saga
- DeCuir-Gunby, J. T., Marshall, P. L., & McCulloch, A. W. (2011). Developing and using a codebook for the analysis of interview data: An example from a professional development research project. *Fields Methods*, 23 (2), 136-155. doi: 10.1177/1525222X10388468
- Dukes, S. (1984). Phenomenological methodology in the human sciences. *Journal of Religion and Health*, 23(3), 197-203. Retrieved from <https://link.springer.com/article/10.1007%2FBF00990785?LI=true>
- Economic and social impacts of the Syrian Refugee Crisis, Dr. Khaled Wazani, 2014
- Funk M et al. Mental health policy and plans: promoting an optimal mix of services in developing countries. *International Journal of Mental Health*, 2004, 33(2):4-16.
- Ghazal, M. (Jan 30,2016). The Jordan Times: "Population stands at around 9.5 million, including 2.9 million guests" <http://www.jordantimes.com/news/local/population-stands-around-95-million-including-29-million-guests>
- Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development*, 29(2), 75-91. Retrieved from <https://link.springer.com/article/10.1007%2FBF02766777?LI=true>
- Hassan, G, Kirmayer, LJ, MekkiBerrada A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S. & Ventevogel, P. Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict. Geneva: UNHCR, 2015

International Medical Corps and UNICEF (2013). Mental Health Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Zataari Refugee Camp, Jordan. Retrieved from <https://data.unhcr.org/syrianrefugees/partner.php?OrgId=17>

International Medical Corps. (2015). Evaluating mental health case management services for refugees in Jordan.

International Medical Corps. (2015). Report: Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis.

International Medical Corps (IMC), Sisterhood is Global Institute /SIGI-JO (November 2015): Mental Health & Psychosocial Support (MHPSS) Needs Assessment of Displaced Syrians and Host Communities in Jordan.

International Medical Corps, (2017). Assessment to inform policy and operational guidance for strengthening integration of mental health into primary health care and community based service platforms in Ukraine.

International Medical Corps (2017). Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey: Sources of Distress, Coping Mechanisms and Access to Support. Retrieved from <https://internationalmedicalcorps.org/wp-content/uploads/2017/07/Mental-Health-and-Psychosocial-Support-Considerations-for-Syrian-Refugees-in-Turkey.pdf>

International Rescue Committee, (2017). Solving the Refugee Employment Problem in Jordan: A Survey of Syrian Refugees.

Joint Rapid Health Facility Capacity and Utilization Assessment (JRHFCUA): MoH Hashemite Kingdom of Jordan, WHO, the International Advisory, Products and Systems, the Massachusetts General Hospital Center for Global Health, Harvard University and the Jordan University for Science and Technology.

Jordan Health Aid Society and IMC (2012). Displaced Syrians in Jordan: A Mental Health and Psychosocial Information Gathering Exercise – Analysis and Interpretation of Findings. Retrieved from <https://data2.unhcr.org/en/documents/download/36230>

Karasapan, O. (2016). Syria's mental health crisis. Future Development. Retrieved from <https://www.brookings.edu/blog/future-development/2016/04/25/syrias-mental-health-crisis/>

Kaufman D, A.Kraay, and M. Mastruzzi (2010), The Worldwide Governance Indicators: Methodology and Analytical Issues. http://info.worldbank.org/governance/wgi/sc_chart.asp#

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, 159–174. Retrieved from <http://www.jstor.org/stable/2529310>

MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (1998). Codebook development for team-based qualitative analysis. *Cultural Anthropology Methods*, 10(2), 31–36. doi: 10.1177/1525822X980100020301

MaxQDA (Version 12.3.2) [Computer software]. Berlin, Germany: VERBI GmbH.

Mental Health and Psychosocial Working Group and International Medical Corps (2017). Who is doing What, Where and When (4Ws) in Mental Health and Psychosocial Support in Jordan: 2017 Interventions Mapping Exercise.

Miles, M. B., Huberman, A. M., & Saldana, J. (2013). *Qualitative data analysis: A methods sourcebook* (3rd ed.) [Kindle version]. Los Angeles: Sage.

MOPIC, UNDP (2011). Second National Millennium Development. Goals Report; Jordan, 2010.

Monitoring the implementation of the action plan of the implementation of National Strategy for the elderly “Monitor the achievements of institutions 2009 - 2011”, the National Council for Family Affairs.

Musa Ajlouni, the impact of Syrian crisis on the health sector in Jordan: Challenges and proposed health policies, the conference of “Refugees in Jordan: A Question of society and the media.” Jordan Media Institute in collaboration with the Norwegian Institute of Journalism, the Dead Sea: 8-10 / 12/2014.

Monitoring and evaluation of mental health policy and plans (mental health policy and service guidance package). Geneva, World Health Organization, 2007. National Team Report on Evaluation of Psychiatry Services and Psychiatric Patients. Higher Council for Science and Technology, Amman, 2008.

National Report on the mental health system and current services in Jordan, October 2010.

Onwuegbuzie, A. J., Johnson, R. B., & Collins, K. M. T. (2009). Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. *International Journal of Multiple Research Approaches*, 3, 114-139. doi: 10.5172/mra.3.2.114

Project Management Unit, Ministry of Planning and Cooperation, Government of Jordan. January 15th , 2017. "Presentation on Livelihoods for the HPDG." www.data.unhcr.org/syrianrefugees/download.php?id=12722. Jordan Times. January 26 th , 2017. "Six companies to export to the EU under new 'rules of origin.'" www.jordantimes.com/news/local/six-companies-export-eu-under-new-rulesorigin%E2%80%99

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, 63, 655-660. doi: 10.107/PNS2004399

Saraceno B, van Ommeren M, Batniji R et al. Barriers to improving mental health services in low and middle-income countries. *Lancet*, 2007, 370: 1164-1174

Schwandt, T. A. (1998). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzie & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 221-259). Thousand Oakes: Sage Publications. Retrieved from https://www.researchgate.net/profile/Thomas_Schwandt/publication/232477264_Constructivist_Interpretivist_Approaches_to_Human_Inquiry/links/557048d908aeab777228bfef/Constructivist-Interpretivist-Approaches-to-Human-Inquiry.pdf

Thanh, N. C. & Thanh, T. T. L. (2015). The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science*, 1(2), 24-27. Retrieved from <http://files.aiscience.org/journal/article/pdf/70380008.pdf>.

The Hashemite Kingdom of Jordan, The High Health Council (2015-2019); The National Strategy for Health Sector in Jordan.

The Hashemite Kingdom of Jordan, Ministry of Education (MoE) (04/08/2017); Statistics

The Hashemite Kingdom of Jordan, The High Health Council; Policy Brief, "Health Spending in Jordan", (05/2016)

UNDP, Economic and Social Council, and Spanish Agency for International Cooperation. 2013. "The Informal Sector in the Jordanian Economy." www.undp.org/content/dam/jordan/docs/Publications/Gov/The%20Informal%20Sector%20in%20the%20Jordanian%20Economy-jo.pdf

United Nations Children's Fund (UNICEF), Jordan 2015. Albertien van der Veen, Reem AbuKishk, Shadi Bushnaq, Orso Muneghina, Reem Rawdha and Tineke van Pietersom from Antares Foundation, Amsterdam, The Netherlands

United Nations Children's Fund (UNICEF), Jordan 2017 Situation report

Valenza, M. AlFayez, S. (2016) Running on Empty; The situation of children in host-communities in Jordan, UNICEF.

WHO-AIMS Report on Mental Health System in Jordan, WHO and Ministry of Health, Amman, Jordan, 2011.

3RP Refugee Regional & Resilience Plan 2016-2017; Progress Report of the Regional Refugee and Resilience Plan (3RP) in Response to the Syria Crisis.



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1313 L St. NW, Suite 110 | Washington, D.C. 20005
Phone: 202-828-5155 | Fax: 202-828-5156

International Medical Corps UK

Ground Floor, 161 Marsh Wall | London E14 9SJ
Phone: +44 (0) 207 253 0001 | Fax: +44 (0) 20 7250 3269

For more information or questions about this report, please contact:

Dr. Ahmad Bawaneh (Director of Programs) or
Dr. Michelle Engels (MHPSS Coordinator)

International Medical Corps – Jordan
Level 1, Global Investment House No 9
Abd Alhamid Sharaf St, Shmeisani, Amman

+962 (6) 5622429 / 5683265
abawaneh@InternationalMedicalCorps.org
mengels@InternationalMedicalCorps.org