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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This project by International Medical Corps obtained IRB approval from the Jordanian Ministry of Health- Al Basheer Hospital Committee

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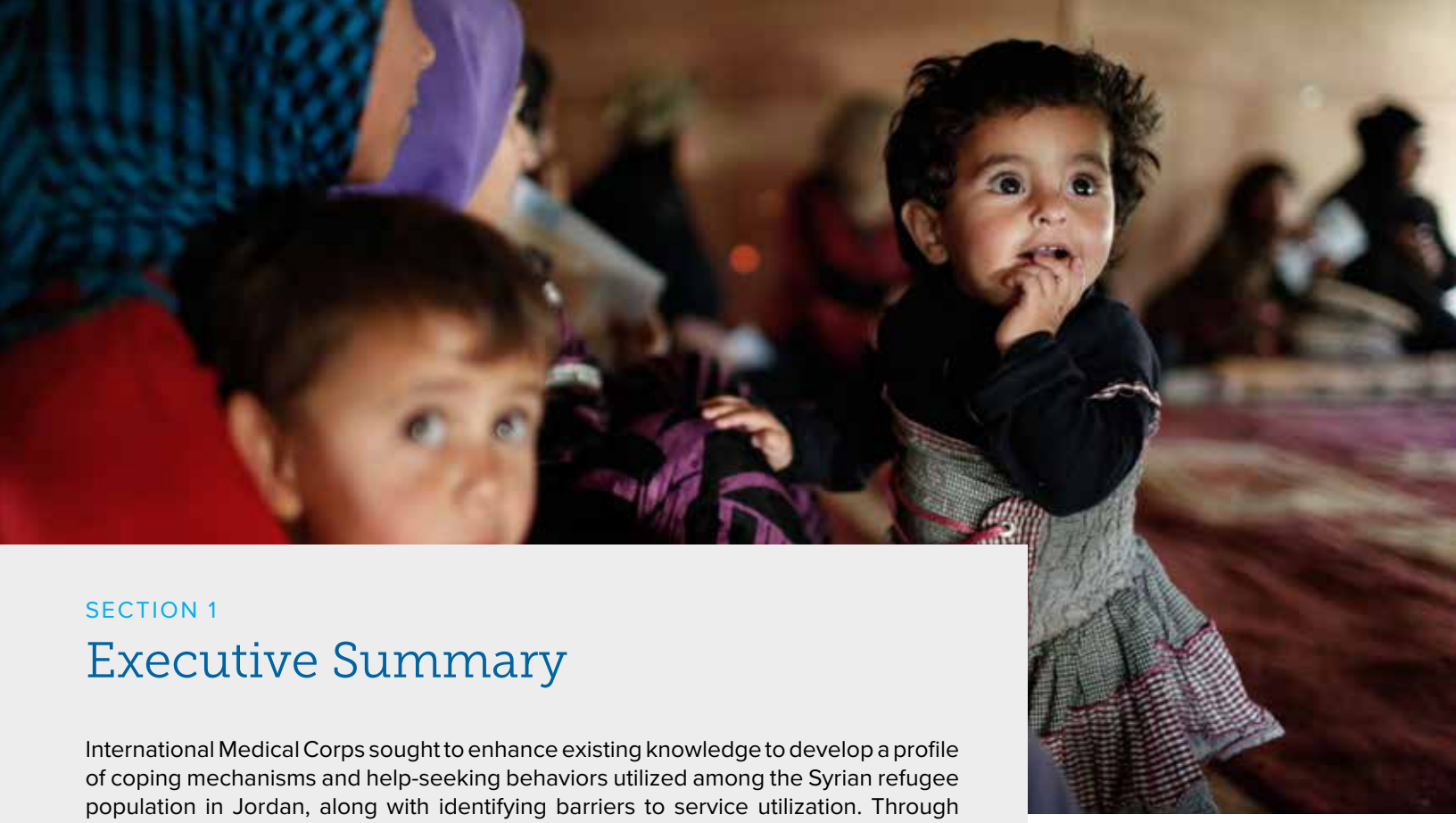
GLOSSARY

CBO	Community Based Organization
HRD	Human Resource Development
JRF	Jordan River Foundation
IASC	Interagency Standing Committee
IDP	Internally Displaced Persons
GoJ	Government of Jordan
GP	General Practitioner
IMC	International Medical Corps
MoE	Ministry of Education
MoPIC	Ministry of Planning and Cooperation
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoSD	Ministry of Social Development
NGO	Non-governmental Organization
NCMH	National Center for Mental Health
RMS	Royal Medical Services
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees in the Near East
UN	United Nations
WHO	World Health Organization



SECTION 1

Executive Summary

International Medical Corps sought to enhance existing knowledge to develop a profile of coping mechanisms and help-seeking behaviors utilized among the Syrian refugee population in Jordan, along with identifying barriers to service utilization. Through this assessment, International Medical Corps also seeks to provide information that may contribute to a wider discussion as relevant national and international actors consider how to further promote Mental Health and Psychosocial Services in Jordan.

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. MaxQDA was used to assist in the analysis of the qualitative arm of the research. 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 in 10 governorates. These participants proportionately represented Jordanian nationals, as well as Syrian refugees in both camp and urban settings. Quantitative data was analyzed by SPSS.

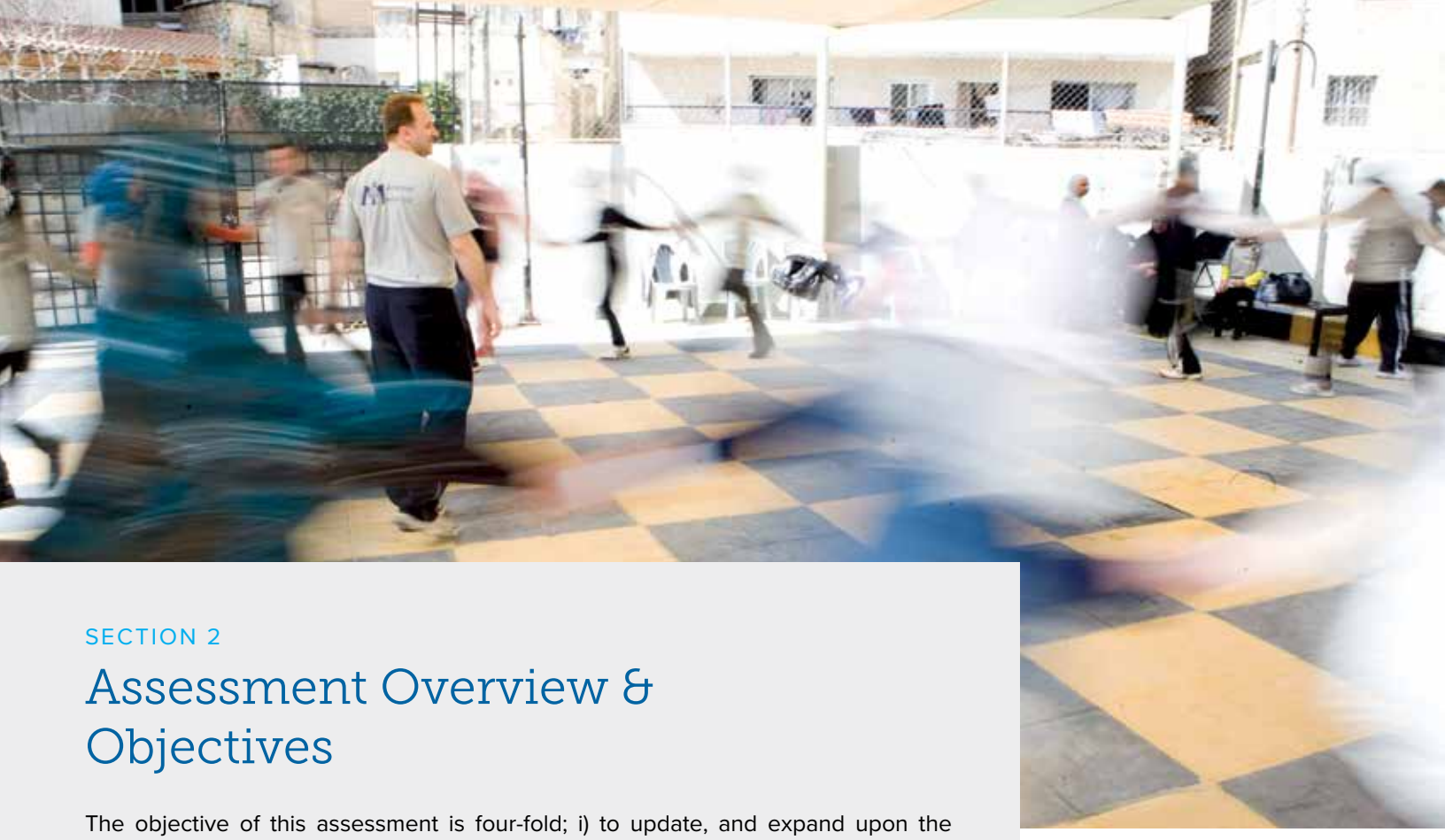
Syrian refugees have demonstrated remarkable resiliency in the years since the crisis began in their home country. Meanwhile, the people of Jordan continue to host and share scarce resources with refugees from Syria and with those who have fled to safety in Jordan from other conflicts in the region as well. The analysis in this document demonstrates that the Syrian refugee community in Jordan continues to face significant stressors, with children being viewed as the most vulnerable. Respondents also 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 (i.e. transportation expenses). Stigma surrounding mental health issues was frequently reported by respondents, which appeared to represent a significant barrier to seeking help and accessing services.

For the Syrian population currently residing in Jordan, economic instability was found to be a source of great concern for both adult males and females, causing a 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. Financial anxiety, including access to and competition for jobs, and concerns about burdened resources due to the influx of refugees in Jordan, was frequently expressed by Jordanian respondents as well. Interestingly, the reported relationship between Syrian refugees and the Jordanian host community varied from highly negative to highly positive. With no end in sight to the crisis in Syria, it is vital to support and promote positive relationships between refugees and the host population

Key recommendations borne out of this assessment 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. Standardize and conduct case management, ensuring a component of community outreach, to build trust among individuals and communities.
4. 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.
5. Consider the needs of vulnerable populations, such as older adults, when designing programs, with an emphasis on increasing access to appropriate services.

These recommendations build upon International Medical Corps' 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. International Medical Corps' 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 four-fold; i) to update, and expand upon the knowledge gained from previous International Medical Corps assessments, ii) to develop a profile of coping mechanisms and help-seeking behaviors that the Syrian refugee population utilize, along with identifying barriers to service utilization, iii) to describe the typical profile of Syrians who access International Medical Corps services, and iv) to learn more about the challenges faced by the host community in the context of the current economic crisis, and the protracted Syrian crisis. It is envisaged the assessment will collect pertinent information to inform MHPSS service design and delivery.

The following questions will be addressed for the Syrian refugee community:

1. What are the most prevalent problems and stressors affecting adults and children, and how have they changed over time?
2. What individual, familial and community coping mechanisms exist, and has this changed over time?
3. Where do Syrian refugees seek help for mental health and psychosocial problems?
4. What are some barriers to help-seeking behaviors and coping strategies?
5. How do the stressors, needs and coping abilities differ between camp settings and those in urban settlements?
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 current crisis on the host community?
4. What individual, familial, and community coping mechanisms exist within the host community?
5. Where do members of the host community seek help, and what barriers do they face in help-seeking/ service utilisation?

SECTION 3

Sociocultural Context

3.1 Overview of the Syrian 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 from 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, with an estimated 643,780 people in need of humanitarian assistance, being denied basic rights, including freedom of movement, and access to adequate food, water, and health care.[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.[2] 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.[3] 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 kilometres.[4] 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. 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.[5] According to the latest national census released in May 2017, Jordan's population

1 UNHCR, Syria Profile Global Focus, 2017
2 UNHCR, Information Sharing Portal, 2017
3 3RP Refugee Regional & Resilience Plan, 2016-2017
4 World Bank, 2016
5 The High Health Council, 2015-2019

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 population resides in urban areas.[7]

Currently, Jordanians represent 69.4% of the total population (6,613,587), while non-Jordanians account for approximately 30%. 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.[8]

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 re-formed subsidies, creating the conditions for public-private partnerships in infrastructure and tax reforms.[9] Restriction of available job opportunities is increasing in Jordan, with the influx of refugees, and Jordan's growing host population.

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. 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.[10]

Employment is higher among males than females (71% and 21%, respectively).[11] About 14.4% of the population falls below the international poverty line. 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.[12]

3.4 Employment

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 that 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.[13] 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.[14]

3.5 Family and Gender Relations

The average household size for Syrians is 4.7 persons in Jordan, of those 30% are women who head Syrian families in Jordan. Older persons represent 15% of Syrian refugees. A staggering 82% of Syrian refugees live below the poverty line, and 23% were evicted or forced to leave their housing at least once while living in Jordan.[15] Prior to becoming refugees, many had suffered repeated disruptions within Syria, leading them eventually to abandon their assets, property and capital, to seek safety in the neighboring countries. 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]

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.[17] 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

6 Population and Housing Census, Jordan Department of Statistics, 2017
7 World Bank, 2016
8 UNHCR, Information Sharing Portal, 2017
9 World Bank Group, FYIY-22, 2016
10 World Bank, 2016
11 Population and Housing Census, 2016
12 Primary Health Care Department, 2017
13 Retrieved from, GoJ Presentation on Livelihoods for the HPDG, 2017
14 IRC, A Survey of Refugees, 2017
15 CARE-Jordan, 2017
16 Population and Housing Census, Jordan Department of Statics, 2016
17 Valenza, M. AlFayez, S. 2016

transportation, stationery and food. Public schools have no transportation option, 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.[18]

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 Jorda-nians; comprises a higher share of children aged 0–4 (close to 20% Syrians versus 11% Jordanians); and tends to be single (over 60% Syrian versus 40% Jordanians).[19]

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 by 17 percent from one to two children.[20] 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.[21]

3.6 Health Care for Jordanians

Health care service delivery stems from Jordan's Primary Health Care Clinics (PHC). Primary health care services are managed through a wide network of MoH primary health care centers (95 comprehensive health centers, 375 primary health care centers and 205 health sub-centers in 2013), in addition to providing maternal, childhood and dental health services (448 Motherhood and Childhood Centers and 387 dental clinics). The RMS is involved in providing primary health care services through field clinics and eight comprehensive medical centers. UNRWA also provides primary health care services through 24 medical clinics. The Jordanian Society for Family Planning and Protection provides services through 19 clinics. This is in addition to the contribution of the private sector in these services, through hundreds of general medical clinics.[22]

Health services in the Kingdom are characterized by ease of access, equitable distribution amongst governorates, and the actual needs of the population, so as to cover the needs of remote areas.

3.7 Health Care for Syrians in Jordan

Jordan, due to its political stability and security, has hosted hundreds of thousands of refugees from neighboring countries such as Palestine, Iraq, and Syria, these ref-ugee influxes have caused a rise in the population growth generating considerable pressure on the health system, especially services provided to citizens, including health services and infrastructure. The 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. While more than a quarter of Jordanians do not have health insurance coverage, 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 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. It has been estimated that 2,866 additional inpatient beds, 1,022 additional physicians, and 22 new comprehensive health centers are 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 when looking at 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 Jordanian, when it was 18 beds per 10,000 citizens prior to the Syrian crises.
- 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 UNICEF, Situation Report, 2017
19 Population and Housing Census, Jordan Department of Statistics, 2016
20 The Jordan Joint Assessment Review, 2013
21 Regional Refugee & Resilience Plan, 2017-2018
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 Psychosocial Problems and 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.

Child Mental Health Services

Jordan has one child psychiatry clinic at Princess Aisha Medical Complex. The university hospitals provide mental health services through clinics in each of the Jordan University Hospital, and King Abdullah University Hospital. In 2012 King Abdullah Hospital allocated 10 beds to manage cases presenting with mental illness and 12 beds were allocated for treatment of mental illness in University of Jordan hospital during 2014. The private sector is a key provider of mental health services through Al Rasheed mental health hospital with a capacity of 120 beds (MoH, Primary Health Care Department 2014).

Public Mental Health System

Jordan's public mental health system relies strongly on the biopsychosocial model of care. 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 second is a psychiatric unit under the Royal Medical Services it holds 43 beds.[2] The third is an inpatient unit general hospitals (King Abdullah Hospital, Jordan University Hospital and Ma'an Governmental Hospital) have a total of 47 beds, with 20, 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 and Irbid. With the exception of these types

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

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 one hundred thousand citizens in Jordan and the number of nursing cadres is 0.04 per 100 000 citizens. The lack of insurance coverage for Syrian refugees with mental illnesses in the private sector and the high cost of psychiatric treatment in this sector exacerbate the problem 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 psychotropic medications but with restrictions. For instance, they can prescribe for follow-up treatment but cannot initiate treatment for severe mental health conditions.[5]

4.2 Child and Youth Mental Health Problems

As of August 6th, UNHCR stated they had registered 660,582 thousand persons of concern documenting them as refugees from Syria: over 80% of them currently live outside refugee camps. Of these, approximately 265,000 are children under 18 years of age. Further data shared by UNICEF indicates that 50% of children suffer from nightmares, various forms of sleep disorders 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. 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 mental disabilities.[6]

4.3 Current Financing of MoH Services

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 hospitals treating mental disorders.[7] 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 (including International Medical Corps), 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. [8]

3 WHO proMIND, 2013
4 Ajlounie, 2014
5 WHO-AIMS, 2011
6 National Strategy for Health Sector in Jordan, 2015-2019
7 WHO-AIMS, 2011
8 National Strategy for Health Sector in Jordan, 2015-2019

SECTION 5

Methods & Analysis

Data from the project was collected through qualitative and quantitative mixed method assessment measures. Data was collected over a one-month period in July, 2017. Qualitative data collected comprised Key Informant Interviews (KII) and Focus Group Discussions (FGD). To collect qualitative data with the Syrian refugee population, 13 sites were identified: Amman (two sites), Zarqa, Jerash, Ajloun, Ramtha-Irbid, Balqa, Ma'an, Karak, Tafileh, Mafraq, Za'tari refugee camp, and the Azraq refugee camp. Qualitative data for the Jordanian community was collected in three locations: FGD in Zarqa, Karak, and Irbid, and KII in Zarqa, Mafraq, and Amman. The design and analysis of quantitative data will be discussed in section 4.6 of this report 'Quantitatiuve Survey'.

Sampling Procedures

Participants for the questionnaire component of the assessment were selected through a 3-level snowball sampling strategy. First, a simple random sample of community members were selected and surveyed (first level) through community service centers. 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. Interviews were conducted through teams of International Medical Corps 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.

Persons considered knowledgeable about MHPSS service delivery, utilization, and barriers to access were included in key informant interviews. These persons included International Medical Corps MHPSS specialist staff, MHPSS staff in other International Nongovernmental Organizations (INGO), Community Based Organizations (CBO) or Ministry of Health (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.

FGDs with members of the Syrian refugee community were implemented in nine locations of assessment (two sites in Amman, Zarqa, Jerash, Ramtha-Irbid, Ma'an, Karak, Mafraq, Za'tari refugee camp, and the Azraq refugee camp). In each location 2 FGDs occurred (one for men, and one for women). In total, the assessment utilized data from 18 FGDs from the Syrian refugee community. Each focus group was gender segregated and was to include 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 International Medical Corps' 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. 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 Commission for Refugees (UNHCR)[1] 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. 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 asks about participants' perceptions of a certain symptom relevant to mental health in the past two weeks. The symptoms are defined as fear, anger, loss of interest, hopelessness, avoiding triggers of past events (avoidance), and reduced ability to carry on daily activities (reduced functioning). For the assessment, participants who reported having three or more of these symptoms, always, and/or most of the time, were considered individuals currently perceived to be experiencing distress. 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 general community views. For this purpose, there are two versions of each scale, each adjusted to capture the perspectives of the intended respondents (see Annex 1).

Two participatory tools within the WHO-UNHCR assessment, tools 11 and 12, provide instruction on the development of interview guides for focus group discussions and key informant interviews. These tools 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 International Medical Corps, and are available for review in the appendices at the end of this report (see Annexes 2, 3, 4, and 5).

Data Collection Process

For the KII and FGD portions of the study, trained International Medical Corps staff members collected key informant data and conducted FGDs. For timely completion of focus groups and key informant interviews, two International Medical Corps staff were selected and trained to complete these tasks at each location. Staff were paired with a transcriber 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, to interviewer and transcriber would review the transcript, to ensure accuracy. As all data were collected in Arabic, qualitative data was first translated and then sent to the consultancy team for subsequent analysis and reporting.

Data Analysis

Data analysis was performed using SPSS 24.0 statistical software. Outcomes of symptoms, help-seeking behaviors, coping skills, barriers to help-seeking, and needed services were mainly compared across three main community categories; host population, urban refugees, and refugees in camps. These outcomes were also compared across gender, educational levels, marital status, and age groups. To examine differences across groups for statistical significance, a chi-square test of independence was performed for proportions comparisons 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. For reporting purposes, some variables were recoded into categorical variables and treated as proportions.

Qualitative data was coded and analysed to explore the predominant themes that arose during the FGD and KII with Syrian refugee, and Jordanian host community members. Qualitative data was analysed 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.

1 WHO & UNHCR, Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (2012).

SECTION 6

Results

Respondent Characteristics

In total, for the qualitative and quantitative components combined, 6,375 participants completed either the FGD, individual questionnaires, or KII. Overall, 6,152 participatnts completed an individual questionnaire, 194 participated in focus group discussions, and 29 participants engaged in key informant interviews (including 6 service providers). 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, Jarash, Ajloun, Salt, Karak, Tafila, Maan, Zatari camp, & Azraq camp. Questionnaire data for Jordanians was collected from the same locations with the exception of the two refugee camps. 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 assessment. Of them, 6,152 participants consented to participate and complete the questionnaire. The overall response rate was 85.47%. Samplings 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 34.07 years (n=6,138, SD=11.49). The average length of stay in Jordan up to and including the time of assessment, was 52.82 months (n=2612, SD=15.89) for urban refugees, and 41.95 months (n=685, SD=17.2) for refugees in camp. For reporting purposes, age was recoded into 4 categories; young adults from 18 to 25 years, early adult from 26 to 35 years, late adult from 36 to 50 years, and older adults from 50 years and above. Overall, each of the age groups, youth, early adult, and late adults, constitute around 30%, respectively, of the respondents while around 10% of the sample are older adults. See Annex 6 for a breakdown of demographic data.

Around half of the host community respondents completed college or university level education, compared to 14%, and 7%, for urban refugees, and camp refugees, respectively. Around 70% of urban refugees, completed primary or secondary school, compared to 50% of camp refugees, who only received primary school education, and 20% who did not receive any formal education at all.

Participants in the FGDs were diverse, and represented different sectors of community, including but not limited to, services users. Key Informant were selected based on their knowledge of the communities, informants included 6 services providers, 12 general community members, and 11 service consumers. A total of 18 focus group transcripts were utilized in the analysis. Of those, 11 were focus groups with women and seven were focus groups with men, with focus group size ranging from six to ten participants. The average

age of KII respondents was 36.28 (SD = 10.64), 58% of those who reported their sex were female. Within the KII pool, education levels varied widely, from completion of primary school through graduate school attainment (education was recorded only for non-provider interviewees). Providers who were interviewed had varying roles, from caseworkers, to mental health supervisors, to psychologists.

Exclusion criteria for participation 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.

In the following pages, the review of the dominant themes within the corpus related to the Syrian refugee population will be discussed. Please note that all participant quotes are unaltered and taken directly from transcripts as provided to our team. The discussion begins with an overview of the problems and stressors experienced by the Syrian respondents, with an assessment of the impact of those problems and stressors. After this, the coping methods utilized by the Syrian respondents are explored. Finally, barriers to access and considerations of utilization and underutilization of MHPSS services are considered.

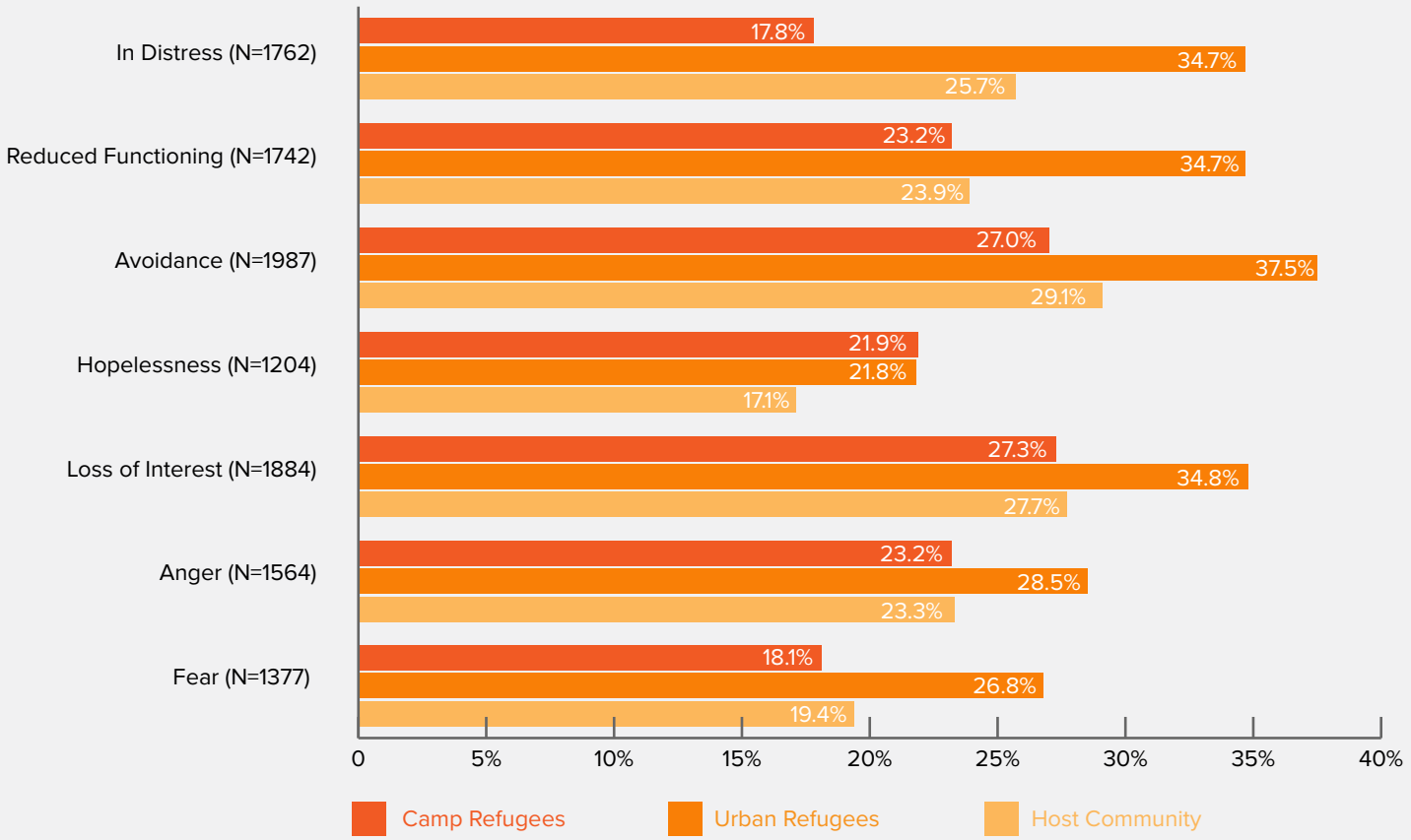
Problems, stressors, and impact

Every respondent who perceived having the correspondent symptom all of the time or most of the time during the past two weeks is categorized into a positive symptoms group. All other respondents who reported having the correspondent symptom less frequently than most of the time are recoded into a negative symptoms group. To identify individuals with high levels of distress, all participants who reported having 3 or more positive symptoms during the past two weeks, were considered individuals in distress.

Refugees in urban communities reported more frequent symptoms of distress, compared to those in camps and the host population (see Figure 1). Frequency of distress was similar amongst both camp refugees and the host population. More specially, 27% of urban refugees reported experiencing fear, all, or most of the time, in the 2 weeks preceding the interview, compared to 19% and 18% for host populations and camp refugees, respectively. Furthermore, 35% of urban refugees reported reduced functioning in their daily activities due to their experience of emotional distress, compared to 24% of the host population, and 23% of refugees in camps.

Symptoms of distress were also found to be significantly associated with education level. Participants with no formal education appeared to show increased frequency

Figure 1. Distress reported across type of community.



of distressing emotions, compared to respondents with a college-level education. In addition, symptoms are found to be significantly associated with marital status with divorced respondents consistently having higher proportions of distress.

Syrians

The many problems and stressors faced in the Syrian community were well evidenced during the review of the FGD and KII transcripts. Compared to other demographics (e.g., older adults, adult males, adult females), children and youth were identified as being most affected, 73.5% of the time.

A member of the Syrian Azraq community explained that children are vulnerable to mental distress "...because they are in the process of acquiring ideas, beliefs, and learning, everything that happens affects them while ....Men and women [are] less affected because they can balance things and can adapt." This statement expresses the understanding of the current conditions children are facing and their lack of adaptive capacity, given their age. A member from the Amman community expressed the manifestation of a child they have observed facing issues as "The unhappy child seems to behave as follows: extra activity or isolation, lack of going to school, lack of academic achievement." Another member from the Ajloun community expressed "cases of urination and isolation." In addition, a comment from a member from the Za'tari camp context indicated that they had observed cases of "aggression and breaking tools" in children.

The inability to pursue studies was also raised as a primary stressor impacting children and youth. A member of the Ramtha community expressed that "many Syrian children are beaten and humiliated while going to school, where they say (we are not Syrians) to protect themselves." This example typifies the discrimination Syrian students experienced at school. Finally, as expressed by a member from the Jerash community, a wide range of students are impacted by these issues "most of the students were not able to keep on track, they lose the future and the continuation of studies; some have lost at least three years of their study period."

In adults, family tension was expressed as a problem by both men and women. For men, a concern was financial conflict and struggles. For women, most of the problems and stressors were related to mental distress, the experience of discrimination, and demands of raising children.

A community member from Amman explained "sources of tension are 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 of health and psychological aspects because of this." 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 are also related in the comment by Syrian men residing in Zarqa, explaining that their "...necessary needs are not available-[they] are forced to adapt to the conditions." In a relating experience of the work condition: "some of the refugees obtain work permits but, they got 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 extended to 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."

Jordanians

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 shared the lack of space, time, and resources in schools to support both the Jordanian and Syrian community, which led to larger class sizes and changes in scheduling, thus impacting family routines.

Jordanian respondents stated that for adults, and families, the primary causes of stress were financial in nature, with Jordanains 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.

Coping mechanisms

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 (p-value $=0.006$), and a higher likelihood of finding comfort in faith and religion (p-value<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). 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.

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 utilise 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.

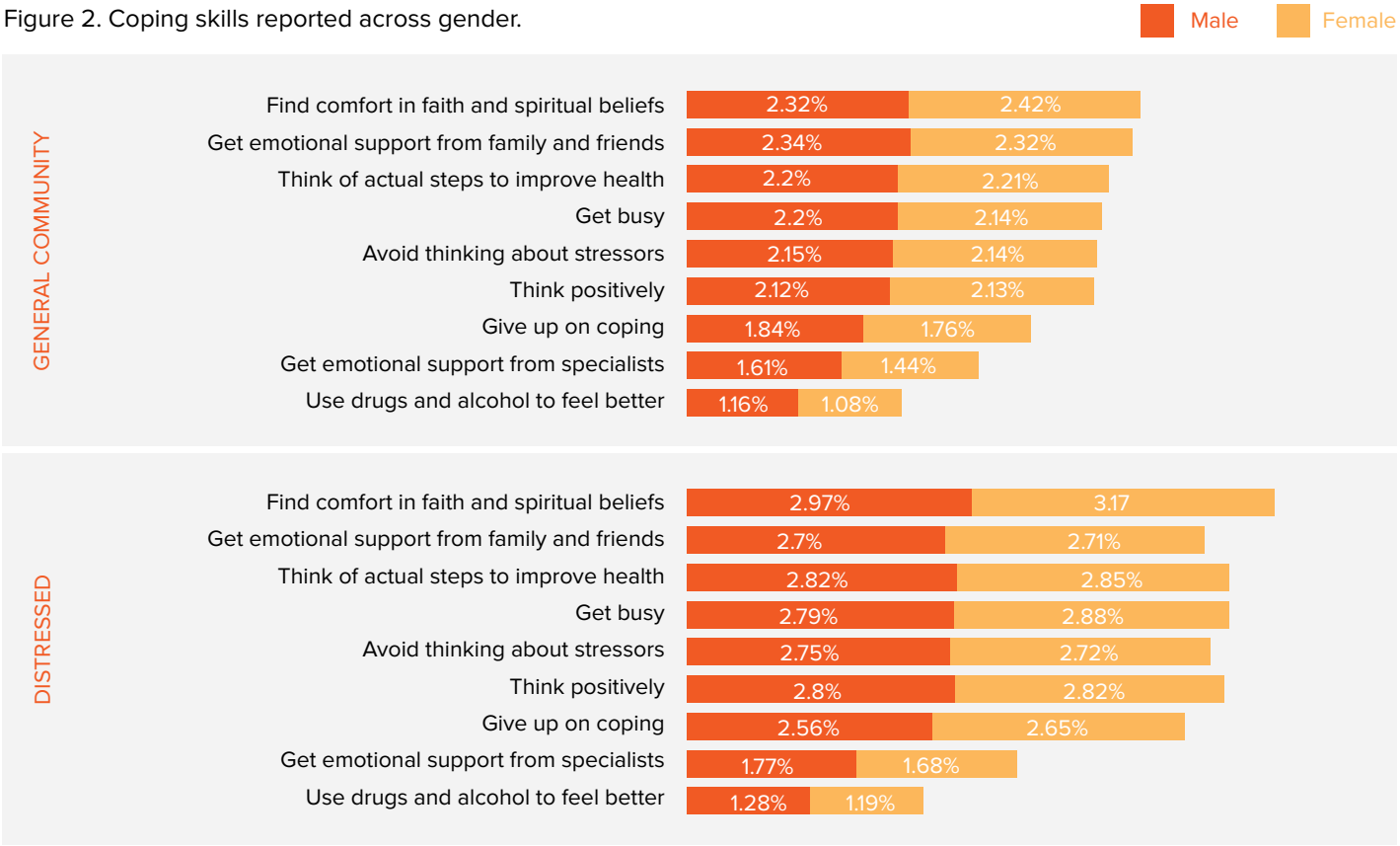
Syrians

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: partner 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).

Negative coping mechanisms reported included violence within the family household as a result of a family member experiencing high levels of stress, 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 for 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. Common positive coping mechanisms included increased social engagement with surrounding community members, recreational activities, and visiting religious leaders and engaging in religious rituals.

Family-level protective factors were more commonly noted, rather than community- or individual-level factors. In the narratives, having a close family support system, when confronted with problems and stressors, was an essential, and often identified support for KII and FDG participants. For example, in a narrative from a member from Tafileh: "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".

Figure 2. Coping skills reported across gender.



Jordanians

Many positive coping mechanisms were reported within the Jordanian community. 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 a primary positive coping mechanism utilized by many.

There was a gap in resources available to help support positive coping strategies, as stated by an Irbid community member: "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 protective factors to help support children, youth and families to strengthen coping at the familial level.

Help-Seeking Behavior

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. 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%). See Table 1 for 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 have reported significantly higher levels of seeking help from general practitioners. Gender is

Table 1. 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 61.1% Urban 63.9% Camp 72.1%
65.2% 52.2% 44.9%	Host Urban Camp	N=785, 56.4%	Friend	N=2727, 66.6%	Host 69.8% Urban 66.2% Camp 56%
64.3% 58.8% 32.4%	Host Urban Camp	N=835, 57.7%	Parents	N=2865, 70%	Host 70.3% Urban 72% Camp 62.1%
55.2% 51% 38.1%	Host Urban Camp	N=715, 51%	Relatives	N=2479, 60.6%	Host 58.6% Urban 65.1% Camp 52.8%
29.3% 32% 18.5%	Host Urban Camp	N=395, 29.2%	Specialist	N=1874, 46%	Host 42.7% Urban 47.7% Camp 52.4%
32.6% 31.4% 22%	Host Urban Camp	N=416, 30.7%	GP/Doctor	N=1692, 41.5%	Host 39.2% Urban 45.9% Camp 35.4%
30% 25.7% 15.6%	Host Urban Camp	N= 349, 26%	Spiritual Leader	N=1423, 34.9%	Host 35.3% Urban 39.2% Camp 19.5%
23.4% 10.7% 4%	Host Urban Camp	N=193, 14.7%	Community Leader	N=1021, 25.1%	Host 25.4% Urban 25.1% Camp 23.6%

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

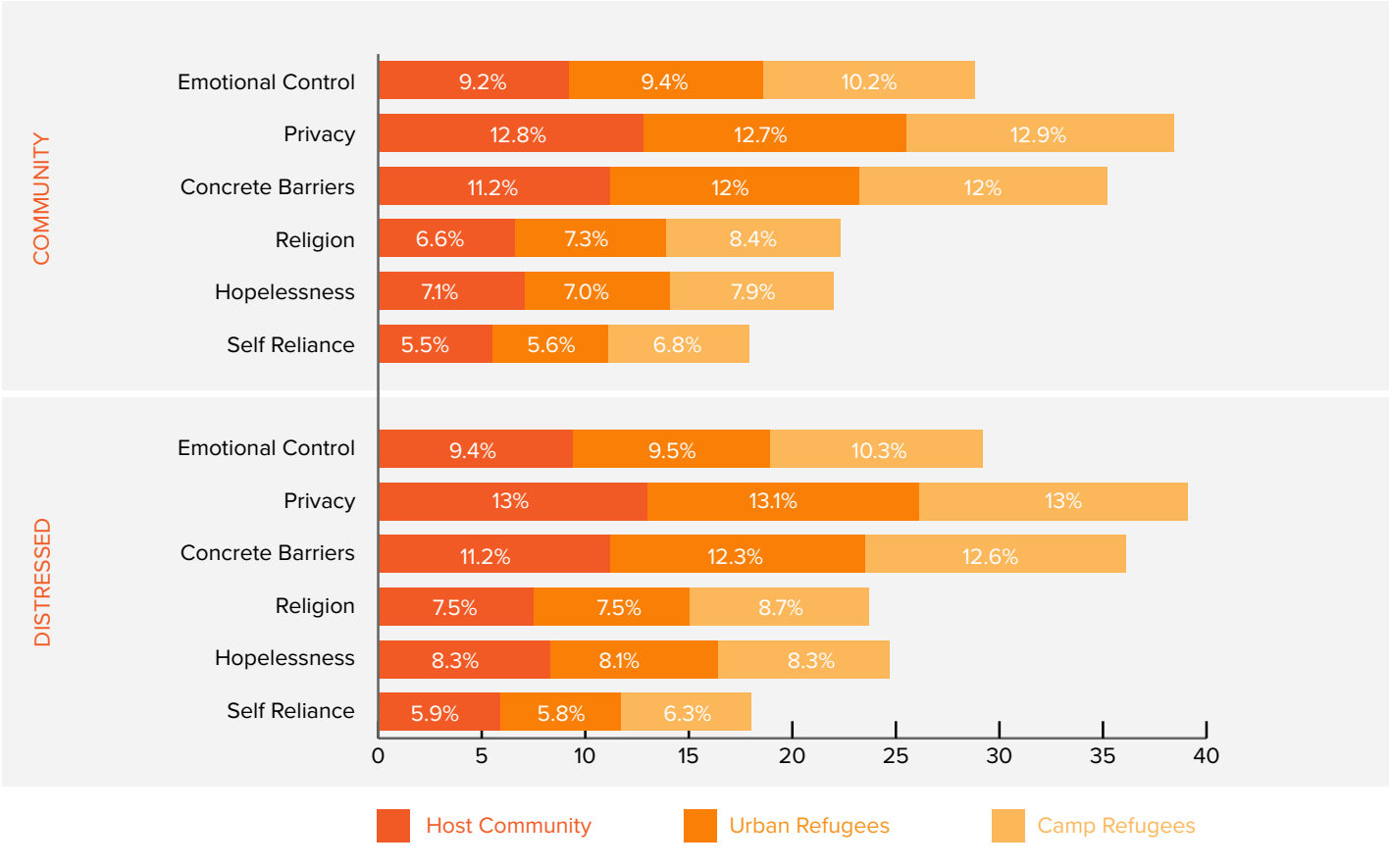
Analysis of the questionnaire data revealed that for women, the need for privacy, and feelings of helplessness and hopelessness were primary barriers to seeking help. Interestingly, refugees in camp settings were most likely to say a desire to remain self-reliant was a barrier to seeking help from others, 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 to resolve their issue. Refugees in camps, also stated that a feeling of hopelessness, and helplessness was a barrier to seeking help and support. Concrete barriers to accessing support (sych 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. This indicates that young adults between the ages of 18 to 25 years old, do not appear to have similar religious challenges to help seeking as reported by older persons. See Figure 3 for a further breakdown of perceived barriers to accessing services by type of community examined.

A variety of barriers exist in receiving mental health services within both the Syrian and Jordanian host communities. Throughout KII and FGD, four major barriers were conveyed for both Syrians and Jordanians: negative stigma associated with mental illness, a lack of mental health awareness, insufficient services, and costs.

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 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 respondent from Azraq noted that mental health services were only for "crazy people" and for the "mentally 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.

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



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: a lack of awareness of mental health services and 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 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.

Insufficient 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 that "...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.

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 International Medical Corps 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".

In sum, both Syrian and Jordanian respondents have noted both non-physical and physical barriers to mental health service utilization. Non-physical barriers included mental health stigma associated with mental illness and a lack of mental health awareness. Mental health stigma puts pressure on both the individuals with mental health issues, as well as those around them. Mental health stigma is so pervasive that family members associated with an individual are also affected by the stigma. Negative attitudes and perceptions associated with mental illness have contributed to an increasingly negative stigma; however, indifferent and sympathetic attitudes were reflected towards those with mental illness, which may suggest the diminishing of the mental health stigma. A lack of mental health awareness was reflected in two forms: a lack of awareness of mental health services and a lack of self-awareness in needing mental health services. Respondents noted that they were unaware of mental health services in their community, as well as the denial of needing mental health treatment. Physical barriers included both insufficient services, such as a lack of clinics and transportation hindrances, and high costs of treatment.

Perceived Needed Services

Respondents were asked during the questionnaire which services, or methods of support, they would most prefer to have access to. 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 were also popular choices for refugees in camps, and urban settings. Specific within the camp setting, respondents reported social activities and parental supports were useful and needed services.

SECTION 7

Discussion

Combining the quantitative and qualitative components of the assessment, reveals interesting findings about the experience of emotional distress, activation of various coping skills, and help-seeking behaviours 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 activities, to ensure that refugees living in urban settings are aware of available services to support wellbeing. Furthermore, MHPSS actors should ensure they adequately target urban locations, especially rural areas, to ensure those experiencing moderate to high levels of distress are reached.

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 protective coping strategy utilised. 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 coping. However, a majority of females sampled during this assessment, claimed they are less likely to seek specialist support. Women report 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 on the 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. Targeting stigma within the community is a key strategy that might help address this reported need for privacy. By mainstreaming the importance of positive mental health, as a universal need for all individuals, women may feel less worry about being "seen" accessing a MHPSS service. Furthermore, ensuring that MHPSS team members engage not only with the client presenting for services, but also with the wider family of the client, to provide psychoeducation, might also help to address such stigma, and increase understanding of normal reactions to stressful events.

Based on findings from the quantitative, and qualitative components of this assessment, MHPSS programs should account for concrete accessibility barriers such as transportations costs, and financial barriers, to increase

service accessibility. Many respondents echoed two primary barriers to service accessibility were concrete barriers, and stigma. It is important to take such findings into account when developing proposals for MHPSS services within Jordan that target vulnerable Jordanians, and Syrian refugees as both appear to suffer from such barriers. Where possible, funding should be assigned to facilitate transportation for cases in rural/remote areas that otherwise would not be able to access such services. 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 or general practitioners. Given these findings, it might be helpful to raise awareness through community initiatives and social activities to increase awareness of service availability, and to increase community acceptance.

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 which is acting as a barrier to accessing mental health services by those in need, or by the families of those in need. This sentiment was expressed by both Syrian refugees, and members of the host community. 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.). Such strategies will help to, not only increase awareness of mental health, but also help to address the strong stigma which appears to still surround the topic within both the Syrian and Jordanian communities.

On top of awareness campaigns, community outreach appears to be integral to engaging persons in need with required services. 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 MHPSS presentations. 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.

Differences in coping strategies employed were evident between the host community, and the Syrian refugee community. 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 well-being. 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 in their approach to problem-solving psychosocial concerns. The Syrian refugee community, appears to suffer more from feelings of helplessness, and hopelessness, and thus is more inclined to seek professional support for managing psychosocial concerns, rather than relying on their own abilities to problem-solve. This is likely to be reflective of the strong sense of hopelessness experienced by the Syrian refugee community, in that they appear to feel less empowered to manage, and problem-solve in a self-reliant manner. Whilst, accessing professional support is a strength, and should continue to be encouraged within the Syrian refugee community, the sense of helplessness should be a focus of MHPSS programming. 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.

In addition to the need for community awareness to address stigma, and increase service accessibility, several respondents called for structural efforts to better utilize available resources to meet the demands of caring for the Syrian refugee population. One aspect of these efforts was described by a Za'tari camp provider, who noted that there was a need to raise "the awareness of supporting institutions such as UNICEF and UNHCR on the importance of mental health, prevention, and psychological programs." This suggestion represents a need to promote awareness, not only in the community to be served, but rather in governmental and non-governmental organizations working to provide services to those in need, advocating for their enhanced efforts in the mental health services domain. Key informant service providers 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 working in Amman captured one aspect of capacity enhancement, noting "there is a shortage of staff so that the number of employees available now is not sufficient." A provider in the Za'tari camp noted this as well when 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...because the number (of qualified staff) is still limited in the psychological sector." Such 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. In sum, elements of proposals for increased awareness campaigns were the most clearly noted across all participants in the interview and focus group participants,

though the providers extended this call to include efforts to reduce the stigma of mental illness in addition to the availability of services. Further, several enhancements were suggested, including service delivery, which was common across all stakeholders, and structural efforts such as staffing increases and additional training for mental health professionals, which was specific to key informants who were providers.

Children were identified by the host community and the Syrian refugee community, as the most vulnerable group affected by the protracted Syrian crisis. When considering the needs of children, respondent placed an emphasis upon the integration of psychosocial services within schools. For example, participants in a focus group in Irbid with Syrian women noted that "The possibility is there for psychosocial support in schools because it's hard to take them to a psychiatrist because they feel miserable and people might judge." In a second focus group with females in Irbid, this time with Jordanian women, one participant stated "the community needs playgrounds for children, and counseling services in schools." This is an important recommendation that might assist to provide much needed support to a highly vulnerable population. MHPSS programs should increase their efforts to integrate PSS within schools, by ensuring teachers are trained and sensitive to MHPSS issues, and also that education is provided with due consideration to safety, accessibility and the promotion of PSS wellbeing.

In this report of the qualitative arm of International Medical Corps' mixed method study, manuscripts and field notes from 18 focus groups and 31 informant interviews with both Syrian respondents and Jordanian respondents were analyzed. In the Syrian community, problems and stressors abound, especially in children, who were seen as the most vulnerable by respondents. Yet, the ability to cope was also expressed by the respondents, especially in leveraging the available protective factors in the community and in family units. Still, all coping was not positive in nature and negative coping expressions such as sleeping too much or not sleeping enough were evident in the narratives, as well. For those in need of MHPSS, both non-physical and physical barriers were evident. Non-physical barriers included mental health stigma and a lack of mental health awareness while physical barriers included both insufficient services and the high cost of treatment. Together, these barriers appeared to be key factors in the underutilization of MHPSS. In the Jordanian community, financial strain, coupled with resource scarcity, were themes that emerged in the interview and focus group data. Where children were considered, respondents noted strain on the school system as of particular concern. Jordanian respondents also noted both non-physical and physical barriers to mental health service utilization, with the non-physical barriers being stigma associated with mental illness and a lack of mental health awareness. Physical barriers to MHPSS utilization also included insufficient services such as transportation support and a lack of clinic and staffing capacity. Finally, two additional matters were reviewed in the report. First, in the relationship between Syrians and Jordanians, where experiences varied from highly negative to highly positive, among participants. Second, suggestions for improving mental health services were offered by respondents and dominant among them was the enhancement of awareness campaigns to reduce the stigma of mental illness and enhance knowledge about the availability of services.

SECTION 8

Recommendations

This assessment sought to build upon knowledge acquired from previous International Medical Corps 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 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.

The following key recommendations can be considered relevant for both Syrian refugee and Jordanian host populations:

- Syrian refugees and the Jordanian host community, both endorsed a variety of coping mechansims to manage emotional distress. This variance in coping skills, and preferences, suggests that programming should be multi-layered with respect to supporting existing coping mechanisms in place, at the individuals, familial, and community levels, whilst creating further opportunities to strengthen and foster alternative adapting coping strategies and opportunities for community support.

- Respondents from the Syrian refugee community reported a stronger sense of helplessness, and fewer tendencies to be self-reliant when managing psychosocial distress. Fortunately Syrian refugees were also reported to be more likely to reach out for help from specialized service providers. MHPSS services should account for this reported experience of helplessness, and hopelessness, by ensuring that service delivery is conducted in a manner that fosters and encourages empowerment, self-reliance and resiliency.

- Increase awareness about mental health issues with a goal toward reducing stigmatization and encouraging those in need of help to access available services. A continued lack of awareness may further contribute to maintaining a barrier to service utilization. Increasing awareness, especially in urban settings, is essential to decrease this barrier to service accessibility.

- Consider means to support access to services where it may be impeded by the cost or unavailability of transportation, particularly in more dispersed non-camp settings. Many respondents identified cost and lack of transportation as a barrier to accessing services. This can be mitigated by more field visits, mobile clinics and transportation stipends.

- Standardize and conduct more field visits for increased visibility, to build trust among individuals and communities, and as a key component to good case management practice. Case management and community networking require qualified MHPSS staff to frequently and predictably be visible in the field 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. This can be accomplished in camp and non-camp settings.

- MHPSS staff members conducting such outreach services should also ensure they are adequately familiar with existing referral pathways in the areas of intervention. Referral pathways should be strengthened across Jordan, especially within urban and remote locations. Pathways should be strengthened to promote community access to comprehensive services spanning mental health and psychosocial support, health, protection, and social services.

- Women were found to be less likely to seek help due to concerns over privacy and stigma. It is recommended that to address such stigma that MHPSS actors increase engagement with families and communities. Increasing awareness around MHPSS issues through awareness campaigns such as community awareness sessions, educational radio programming on MHPSS themes, and the distribution of information, education, and communication materials discussing services accessible, and proactive coping strategies, might help to reduce stigma surrounding MHPSS conditions. Furthermore, MHPSS staff should ensure engagement with the family of each client where possible, 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.

- 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. The inability to fluidly continue pursuing educational development is a persistent challenge for Syrian children and youth in Jordan due to unstable living conditions and limited access to schools. In addition, this causes immense strain on parents and other care providers who understand the negative impact lack of quality education has 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 care takers also consistently expressed concern about their ability to afford basic needs for their children due to financial constraints. 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.

- Ensure appropriate consideration for the needs of older adults and their access to appropriate services in all areas of relevant programming. Concern for the vulnerability and needs of older adults was expressed by respondents. 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 field visits and ensuring that they are connected with services that understand and serve their needs. Moreover, transportation needs must also be considered for this population, particularly for individuals with limited or no family support.

- 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, skilled workers should also be adequately clinically supervised. Clinical supervision might take the form of on-the-job observations of practice, conducting file audits, structured and semi-structured individual or group discussions with practicing MHPSS staff. Furthermore, 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.

- Ensure MHPSS programming includes activities that promote social cohesion, and social support. Respondents suggested that tensions exist between the Syrian refugee community, and the host community. There should be an emphasis on promoting community cohesion and social support, as well as enabling natural sources of coping and fostering on individual, family and community levels. To this end, 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.

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 in their urgent mental health needs during their temporary, yet protracted, time in the Kingdom. International Medical Corps 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 data and information.

SECTION 9

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