Who is Doing What, Where and When (4Ws) in Mental Health & Psychosocial Support in Jordan

Interventions Mapping Exercise
October 2014

World Health Organization

Ministry of Health

International Medical Corps

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Introduction

The Inter-Agency Standing Committee (IASC), a global humanitarian body devoted to the improvement of humanitarian coordination, established an IASC Task Force in 2005 on Mental Health and Psychosocial Support (MHPSS) in emergency settings, to address the need for concrete guidance on how to organize mental health and psychosocial support in emergencies. Its members consist of UN agencies, the International Federation of Red Cross and Red Crescent Societies, a large consortium of NGOs such as the International Council of Voluntary Agencies and Interaction, as well as NGOs. In 2007, the Task Force achieved its initial goal of developing a practical, inter-agency, multi-sectoral guidance with the publication of the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. The guidelines were launched in Geneva on 14 September 2007.

Furthering its work, the IASC Global Reference Group and the World Health Organization (WHO) developed a "4Ws" tool (Who, What, When, Where) to map MHPSS services in emergencies. The purpose of the tool is to gain a clearer picture of **who** is doing **what**, **where** and until **when**. Unlike other "3Ws" mapping tools often used across sectors, this tool also provides a comprehensive overview of the size and nature of an emergency response with respect to MHPSS. WHO and International Medical Corps (IMC) first piloted the tool in Jordan in 2009 in cooperation with UNICEF. A refined tool was applied for the second mapping in 2010, based on emerging issues and lessons learnt from previous mappings conducted in Jordan, Nepal and Haiti. Subsequent mappings were conducted in Jordan in 2010/2011, 2012, and 2013 with the last 2 mappings including Protection elements (specifically Gender-Based Violence and Child Protection) alongside MHPSS. Using the data and feedback collected by agencies that piloted the tool, the IASC Reference Group developed a manual for conducting 4Ws mappings. This manual was published in 2013 and is available for download from the Mental Health and Psychosocial Support network, *mhpss.net*.

The 2014 4Ws mapping specifically focuses on MHPSS interventions only, collecting information about the range of MHPSS activities provided to all beneficiary groups in Jordan. As such, this mapping aims to provide a more comprehensive picture of MHPSS services available in Jordan. The list of MHPSS activities as recommended by the IASC Reference Group, which include by category; community-focused MHPSS, case-focused MHPSS, and general support for MHPSS, is provided in Annex 2.

This mapping took place during a significant time of turmoil within the Eastern Mediterranean Region, with ongoing strife in Syria, Gaza and Iraq. In less than three years, the Syrian conflict has forced well over 3 million of the country's citizens to take refuge in neighboring countries. To date, it is estimated that over 600,000 displaced Syrians reside in Jordan[1]. Exposure to violence, loss and displacement, in

[1]UNHCR Syria Regional Refugee Response: Inter-Agency Information Sharing Portal.

addition to social and psychological stressors after displacement, as well as pre-existing MHPSS problems, have various implications on the MHPSS sub-sector and services in Jordan.

Timeframe

The assessment took place between the months of July to September 2014. The estimated data collection timeframe was initially two weeks; however, as fieldwork coincided with last week of Ramadan and subsequent Eid/summer holidays, the deadline was extended three times to accommodate additional inputs by agencies.

Objectives

The overarching aims of the interventions mapping exercise center around enhancing coordination, collaboration, referral systems and accountability for all involved agencies, improving the transparency and legitimacy of the MHPSS sub-sector through structured documentation, and providing data on patterns of practice to inform lessons for future responses. The information provided by the 4Ws mapping can feed into national plans for emergency preparedness, and can be used to identify gaps in service provision, geographic and target group coverage, human resources and technical expertise. It can also be used by participating organizations to plan for their programming and funding appeals.

The specific objectives of the 2014 MHPSS mapping are to:

1. Compile an updated profile of MHPSS programs and services in Jordan for women, girls, boys and men, in particular their reach and capacity;
2. Facilitate an assessment of the gaps in MHPSS activities, the provision of support to target groups, workforce capacity and skills, and funding of the sub-sector;
3. Raise awareness of and increase stakeholder engagement in preparing a coordinated MHPSS response plan;
4. Disseminate findings and recommendations of the mapping to the MHPSS working group and other stakeholders.

The 4Ws Mapping Process

A team of personnel from the World Health Organization and the International Medical Corps were dedicated to facilitate this mapping exercise. IMC contracted a technical consultant to write up the final report, and WHO assigned two staff members to work part-time on the mapping. The WHO staff prepared both the English and Arabic versions of the 4Ws tool, revised according to recommendations from the 2013 mapping exercise.

The finalized 4Ws tool was attached to an informational package and sent via email to participating agencies. The package consisted of:

- A one-page introduction to the 4Ws exercise;
- An Excel data file with four sheets to: 1) capture information about the organization, 2) capture details of activities; 3) delineate the list of 11 MHPSS activities and corresponding sub-activities 4) capture information on target groups; and
- The 2013 4Ws mapping report.

The mapping team made initial contact with a total of 55 participating agencies by email (members of the MHPSS sub-working group), to request information for the 4Ws mapping through a contact person from each agency. Organizations were offered the option of self-completing the survey, or receiving support by a member of the project team through phone or face to face interview. Follow-up emails and phone calls were made over a three week period to collect the complete information for the mapping. Forty-seven out of 55 organizations listed in the database completed the survey, with the deadline extended three times to accommodate late submission requests. Two organizations replied as having no activities that matched the assessment components, and the remaining six organizations did not respond to email requests and subsequent contact attempts by project team.

Data collection tool

As in previous years, Microsoft Excel was utilized for data collection. The 4Ws tool was amended to focus on MHPSS activities and sub-activities, and to add additional features recommended from the 2013 mapping exercise (for example, to include a drop down list of governorates, and to include a specified list of target groups disaggregated by age, gender and nationality). Valuable feedback was provided by the data manager regarding the tool's "user friendliness", which was instrumental to ensure the method of data collection remained flexible to allow as many respondents as possible to complete the exercise.

Data collection for each organization was recorded onto an excel spreadsheet. Details of each spreadsheet were then copied to a larger predesigned aggregate spreadsheet, which formed the main database for the purposes of collating and synthesizing the mapping data. As ongoing data collection occurred, the aggregate sheet was continuously updated and amended. The final stage involved analysis and reporting of the findings.

A consultation workshop was held on 17 September 2014 for the MHPSS working group members, to disseminate preliminary mapping findings, consider implications of the emerging issues, themes and

recommendations (See Annex 4 for summary). Various discussions among MHPSS stakeholders were held, and recommendations were incorporated in the final report.

Findings

Who and What

The 2014 mapping encompassed a cohort of 47 organizations that collectively deliver MHPSS services, programs and activities for communities across the Kingdom. A list of organizations contributing to the mapping is found in Annex 1.The mapping identified that the agencies collectively deliver more than 450 services, programs and activities for citizens and displaced populations living in various governorates. Their profile was diverse, with organizations varying in their scale of operations, the mix and type of services they deliver, and the locations which they serve.

Moreover, there was considerable diversity in the length of time organizations have operated on the ground. Some had accrued decades of experience operating in the country, while at the other end of the spectrum; others had been operating for no more than one or two years. Table 1 lists organizations with the reported activities in each category.

Table 1: Organizations and focus of activities

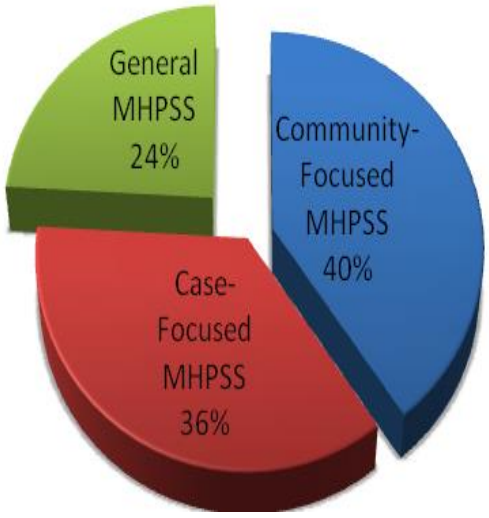
Name of organization	Community-Focused MHPSS	Case-Focused MHPSS	General MHPSS
ActionAid Arab regional initiative	√	√	√
Al Kitab Wa Sunna	√	√	
Al Takaful	√	√	√
ARDD-Legal Aid	√	√	√
Bright Future for Mental Health	√	√	√
CARE International/ Jordan	√	√	√
Caritas Jordan	√	√	√
DRC: Danish Refugee Council- Jordan	√	√	√
Fida International	√		√
Finn Church Aid (FCA)	√		
Handicap International (HI)		√	
The International Catholic Migration Commission (ICMC)	√		
International Medical Corps (IMC)	√	√	√
INTERSOS	√		
Islamic Charity Society Center (ICSC)	√	√	√
Jesuit Refugee Service (JRS)	√	√	
Jordan Red Crescent	√	√	√
Danish/ Italian Red Cross	√	√	√
Jordanian Psychological Association (JPA)	√	√	√
Jordanian Society for Widow and Orphan	√		

Care (JSWOC)			
King Hussein Cancer Center (KHCC)	√	√	
Lutheran World Federation (LWF) Jordan	√	√	√
Medecins du Monde - MDM	√	√	
Ministry of Health (MoH)	√	√	√
Ministry of Social Development (MoSD)*	√	√	
Moroccan medical-surgical field hospital		√	
Nippon International Cooperation for Community Development (NICCOD)	√	√	
Noor Al Hussein Foundation, Institute for Family Health (NHF /IFH)	√	√	√
Palliative Care & Pain Management Clinic	√	√	
Qatar Red Crescent (QRC)	√		
Save the Children International (SCI)	√		
Save the Children-Jordan (SC-J)		√	
Terre des Hommes – Lausanne (Tdh- L)	√	√	√
The Center for Victims of Torture (CVT)	√	√	√
UPP	√	√	
War Child UK	√	√	√
World Health Organization (WHO)	√	√	√

** including Dar Al Wifaq, Child Care Center/Hashemi Shamali, Child Care Center/Shafa Badran/Amman, Dar Al Hanan Girls Care Center/Irbid, Girls Care Center/Rusaifeh, Girls Education and Rehabilitation Center/Amman, Juvenile Education and Rehabilitation Center/Amman, Juvenile Education and Rehabilitation Center/Ma'an, Al Hussein Social Institute/Amman, Juvenile Education and Rehabilitation Center/Irbid and Juvenile Education Center/Rusaifeh.*

Figure 1 below illustrates the concentration of services according to the three major categories of activities in the 4Ws mapping (list of activities and sub-activities can be found in Annex 2).

Figure 1: Concentration of activities per focus



Results indicate that 40% of the reported activities are "community-focused" activities such as information dissemination, community mobilization, safe spaces, psychological support in education and supporting the inclusion of social/psychological considerations in other sectors. While, 36% of activities concentrated on "case-focused" interventions such as psychosocial work, psychological interventions, and clinical management of mental disorders by specialized and non-specialized health care providers. About 25% of activities, are "general activities to support MHPSS," and include activities covering assessments, training, research, and supervision.

Figure 2: Concentration of activities and organizations on the IASC MHPSS intervention pyramid

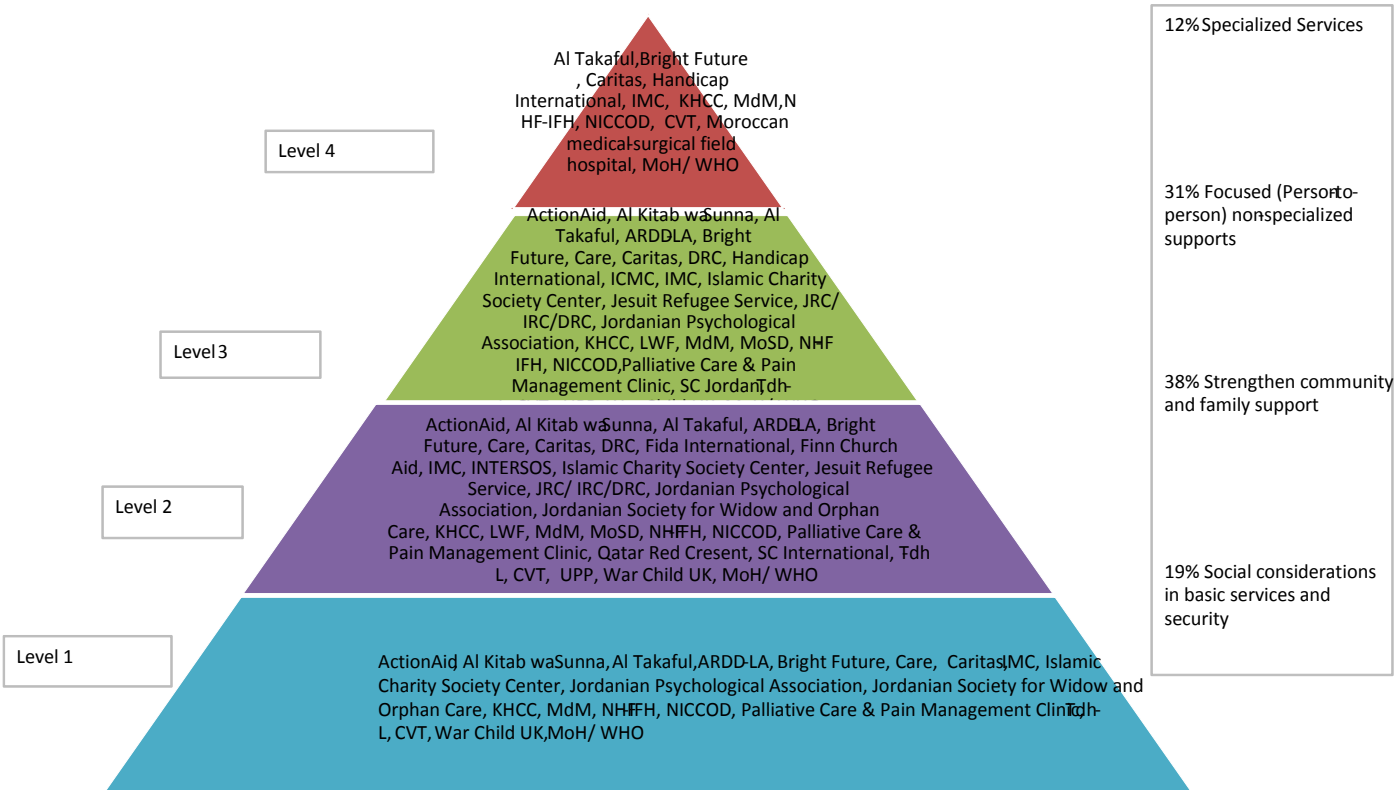


Figure 2 displays concentration of organizations and activities on the IASC MHPSS intervention pyramid. The pyramid depicts the continuum of MHPSS services ranging from general/basic services to specialized interventions.

The majority of activities surveyed (38%) fell under Level 2 of the intervention pyramid "strengthen community and family support". This represented a minimal decrease of 1% from the 2013 mapping but a significant decline of 17% when compared to 2012.

Level 3 activities "focused (person-to-person) non specialized supports" accounted for 31% of total interventions, corresponding to respective decreases of 10% from 2013 and 16% from 2012.

Level 1 activities "social considerations in basic services and security" amounted to 19% of total activities and have increased 2% from 2013, but decreased 6% as compared to 2012.

Level 4 activities "specialized services" amounted to 12%. Level 4 registered highest increase of 9% as compared to the 2013 mapping at 3% of total activities. These findings mirror Level 4 activities reported in the 2009 mapping. A total of 13 organizations are currently involved in the provision of

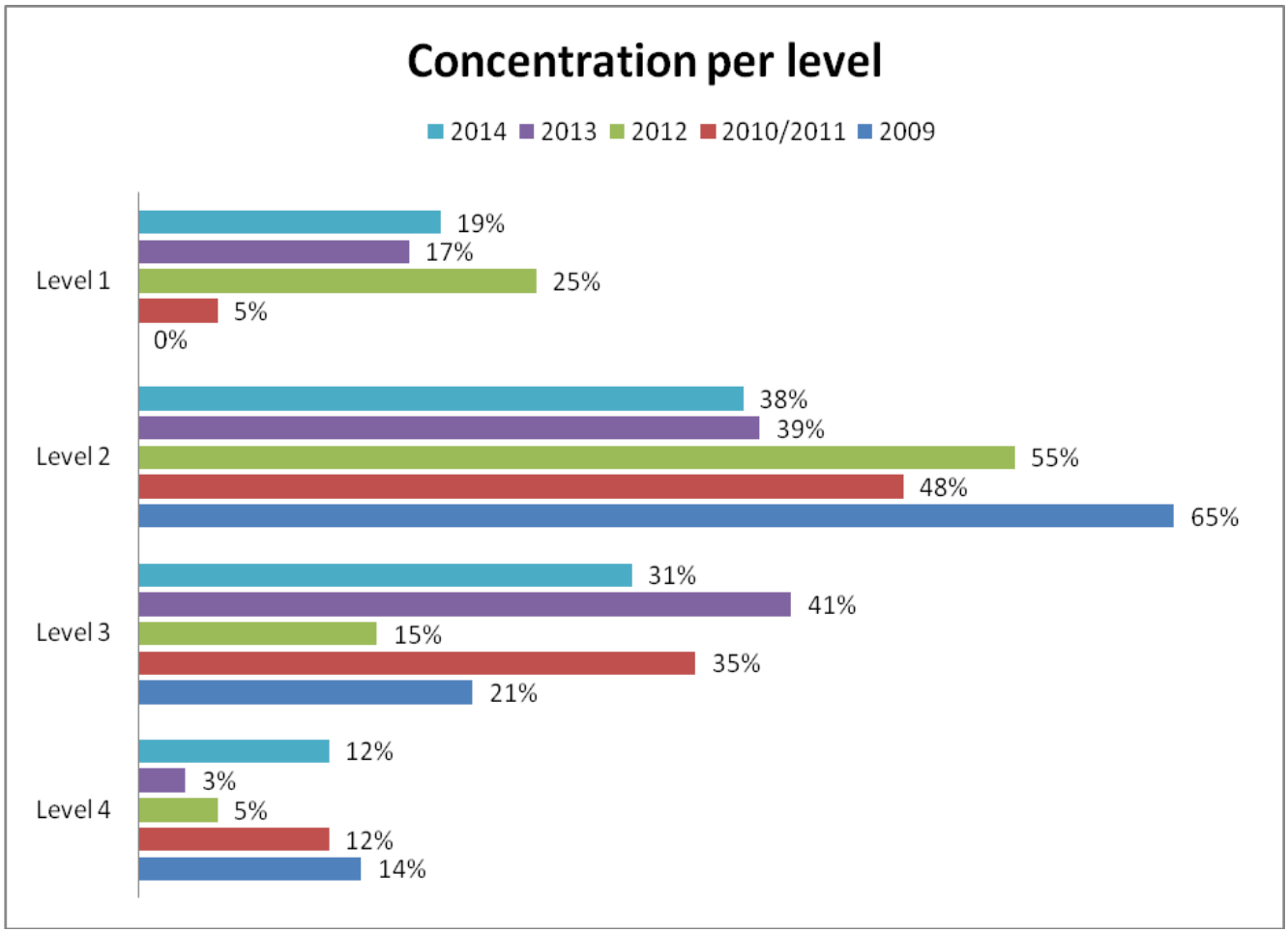
Level 4 “specialized services”. This number has nearly doubled from the 2013 mapping where the total number of organizations operating at level 4 stood at seven.

Table 2 and Figure 3 show the changes in concentration of activities across the pyramid level over the years.

Table 2: Concentration per level on IASC MHPSS intervention pyramid (2009-2014)

Pyramid Level	2009	2010/ 2011	2012	2013	2014
Level 4	14%	12%	5%	3%	12%
Level 3	21%	35%	15%	41%	31%
Level 2	65%	48%	55%	39%	38%
Level 1	0%	5%	25%	17%	19%

Figure 3: Concentration per level on IASC MHPSS intervention pyramid (2009-2014)

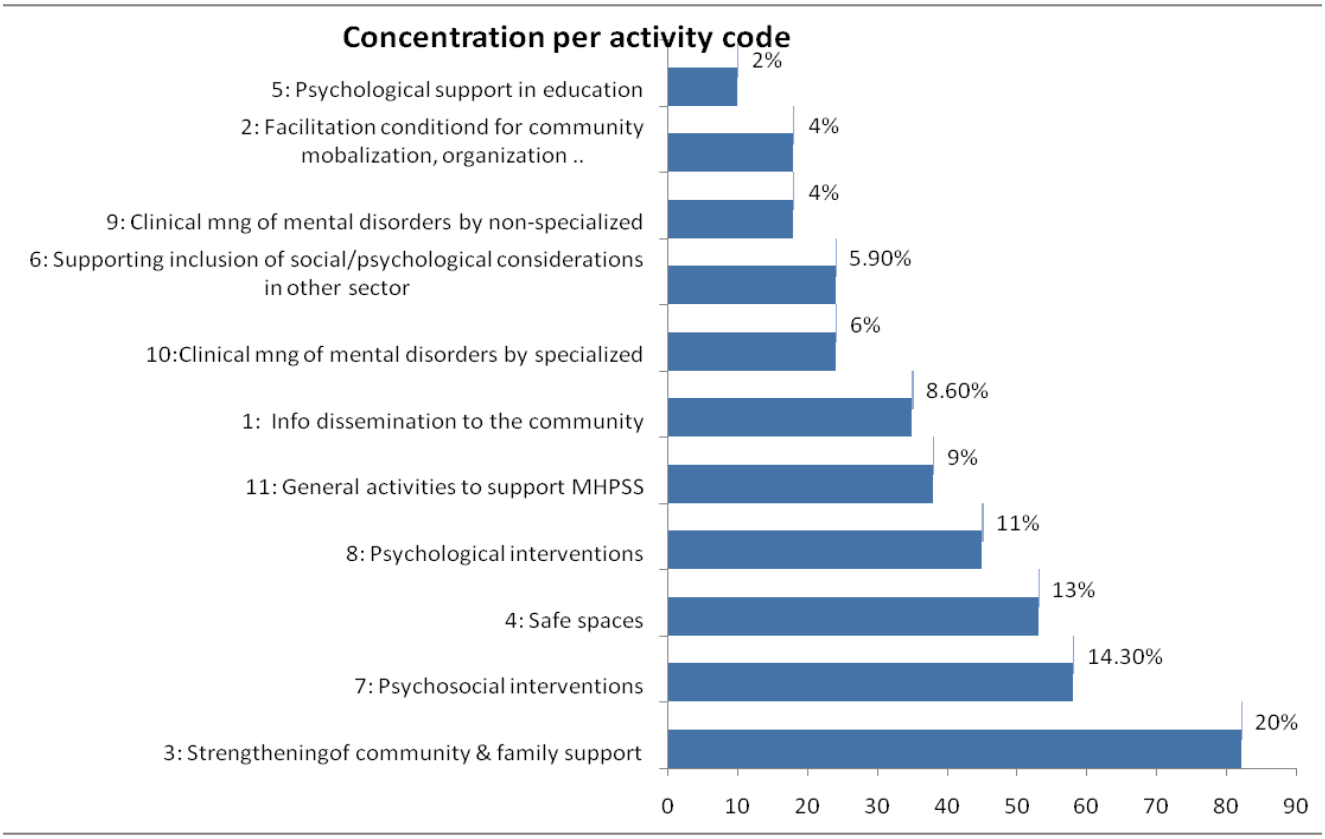


Concentration of services by activity type

Figure 4 below displays the frequency of activity categories per activity code (in total 11 main activity codes). The most frequently reported activities included 'strengthening of community and family supports' (activity 3) with 20%, followed by 'psychosocial interventions' (activity 7) with 14% and 'safe spaces' (activity 4) with 13%. The most under-represented services were 'clinical management of mental disorders by non-specialized health care providers' (activity 9) with 4%, 'facilitation of conditions for community mobilization, community organization, community ownership, or community control over emergency relief in general' (activity 2) with 4% and 'psychological support in education' (activity 5) with 2%.

It is important to note however, that a lower concentration of specialized services is expected, as activities which are at a higher level of the pyramid target a smaller percentage of the population (for example, the clinical management of mental disorders by specialized health professionals). Similarly, it is recommended that lower level activities will have a higher comparative frequency, which means that findings captured through this mapping suggest that level 1 and 2 activities should be more represented (for example, facilitation of conditions for community mobilization and organization, supporting the inclusion of social/psychological considerations in other sectors).

Figure 4: Concentration of activities per code

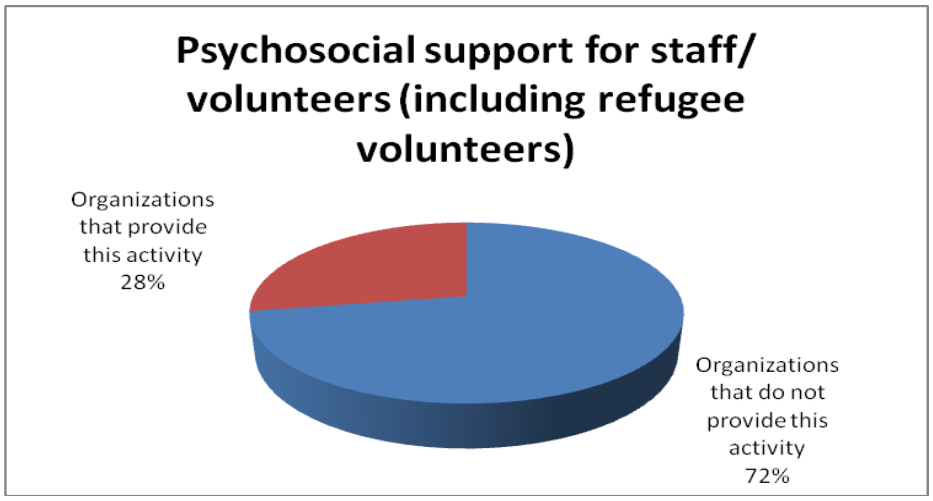


Analysis of Selected Activities

Activity code (11.4): Psychosocial support for staff/volunteers (including refugee volunteers)

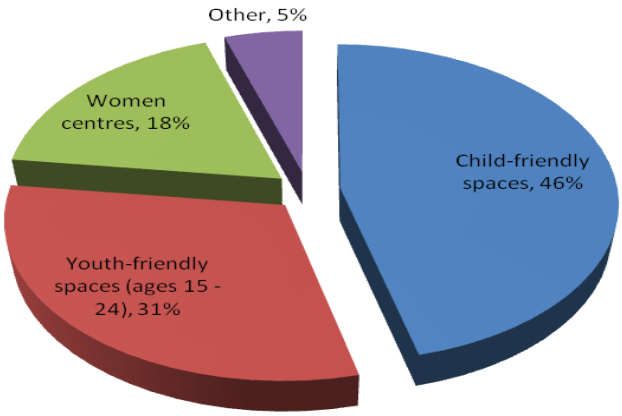
Psychosocial support for staff/volunteers is provided by 28% of the surveyed organizations. The large majority, 34 organizations (72%), do not provide this service. Working with populations exposed to humanitarian crises may cause some distress for humanitarian staff/volunteers; this is especially true for MHPSS service providers. Agencies should ensure that the psychosocial wellbeing of their staff and volunteers is maintained and enhanced through access to self-care and stress management activities, in addition to peer and/or professional support when needed.

Figure 5: Availability of psychosocial support for staff/volunteers per organization



Activity code (4.1-4.4): Safe spaces including child friendly spaces, youth friendly spaces and women centers

Figure 6: Availability of child friendly spaces, youth friendly spaces, women centers and other safe spaces per organization



A total of 16 organizations (approximately 34%) provide safe spaces. The majority (46%) are child friendly spaces followed by youth friendly spaces (31%). These spaces provide a safe and secure environment to key beneficiary groups, and contribute to supporting stability and resilience within an often unstable humanitarian environment. One example of 'other safe spaces'

included spaces available during summer camp for Cancer patients.

Activity code (7.2): Case management, referrals, and linking vulnerable individuals/families to resources (e.g. health services, cash assistance, community resources, etc.)

Figure 7: Availability of case management, referrals and linking beneficiaries to resources per organization

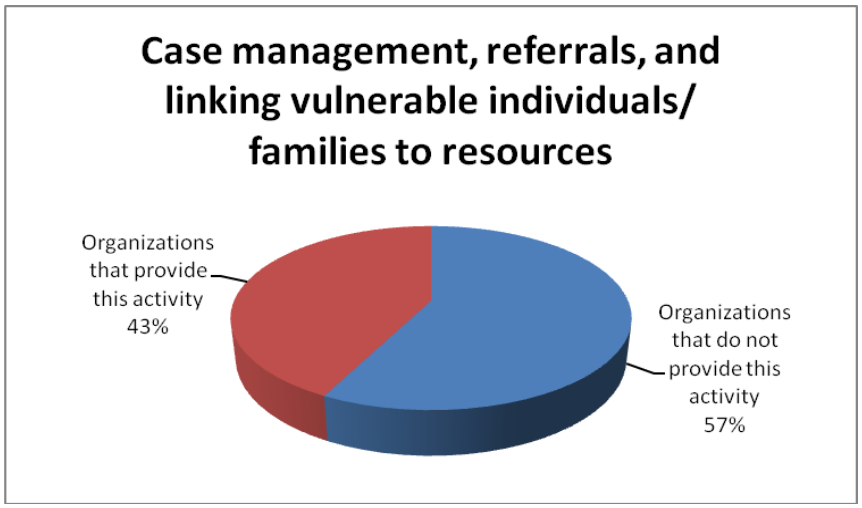


Figure 7 above depicts that 43% of the total organizations (20 organizations) provide case management services, referrals and linking vulnerable beneficiaries to resources. This reflects a good level of coordination/communication among partners about available services and resources.

Activity code (8.4): Interventions for alcohol/substance use problems & Activity code (8.5): Interventions for developmental disorders/intellectual disabilities

Previous reports[2] have indicated a gap in specific interventions to address developmental disorders and intellectual disabilities. Discussions among the MHPSS working group members also suggested a need for a better understanding of available services for alcohol and drug use problems. The significance of the latter issue arises as the use of alcohol/drugs may sometimes be adopted by beneficiaries as a coping strategy after experiencing distress. Such specialized services are considered Level 4 activities on the IASC intervention pyramid.

Figures 8 and 9 below indicate percentages of the provision of these services considering the total number of organizations, as well as the organizations operating at Level 4. Specifically, interventions for alcohol/substance use problems are provided by four Level 4 organizations (31%), while

[2] Help Age International and Handicap International, Hidden Victims of the Syria crisis: disabled, injured and older refugees, May 2014.

interventions for developmental disorders/intellectual disabilities are delivered by three Level 4 organizations (23%). This suggests that further attention needs to be placed in order to meet the specific needs of beneficiaries with developmental disorders/intellectual disabilities, and beneficiaries with alcohol/substance use problems, including the provision of information about the nature and availability of existing services to address these problems.

Figure 8: Availability of interventions for alcohol/substance us problems per organization

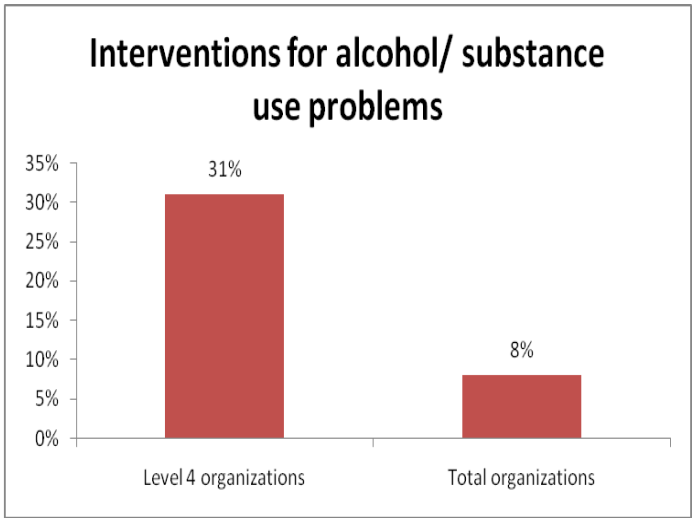
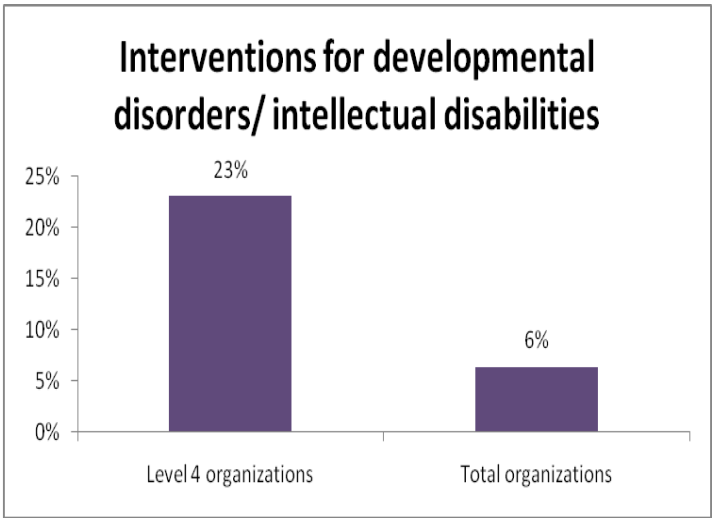


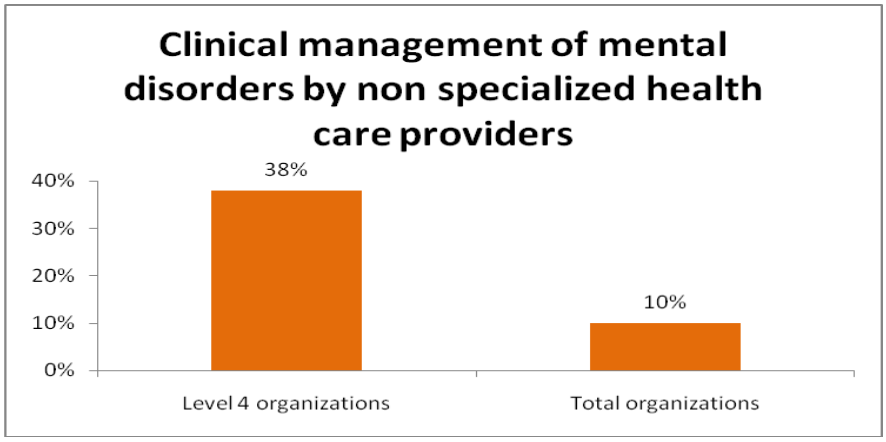
Figure 9: Availability of interventions for developmental disorders/intellectual disabilities per organization



Activity code (9): Clinical management of mental disorders by non-specialized health care providers

A general comparison of activities reveals that services to address the 'clinical management of mental disorders by non-specialized health care providers' account for only 4% of the total activities. A further analysis of the activity across organizations shows that 38% of organizations operating at Level 4 reported providing this service (10% of the total organizations).

Figure 10: Availability of clinical management of mental disorders by non-specialized health care providers per organization

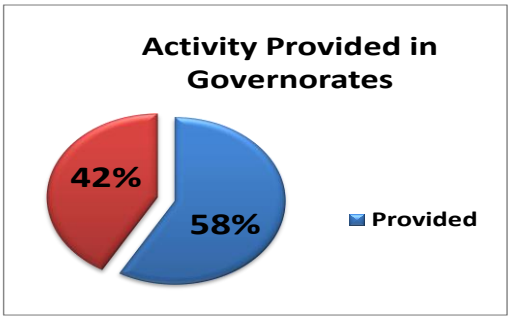


While the activity is provided by 5 organizations, coverage of service provision is relatively widespread as shown in figure 11 below. However, greater service representation is needed in the governorates of Jarash, Ajloun, Ma'an, Tafileh and Aqaba.

Figure 11: Availability of clinical management of mental disorders by non-specialized health care providers per governorate

Activity available in governorates
Amman
Irbid
Mafraq
Zarqa
Balqa
Madaba
Karak

Activity not available in governorates
Jarash
Ajloun
Ma'an
Tafileh
Aqaba



Profile of MHPSS target beneficiaries by age, gender and nationality

This section explores the profile of MHPSS target beneficiaries based on age, gender and nationality disaggregation, and helps reveal whether specific target groups are either under-represented or over-represented as target beneficiaries of MHPSS services.

By Nationality

Figure 12: Reported target population nationalities

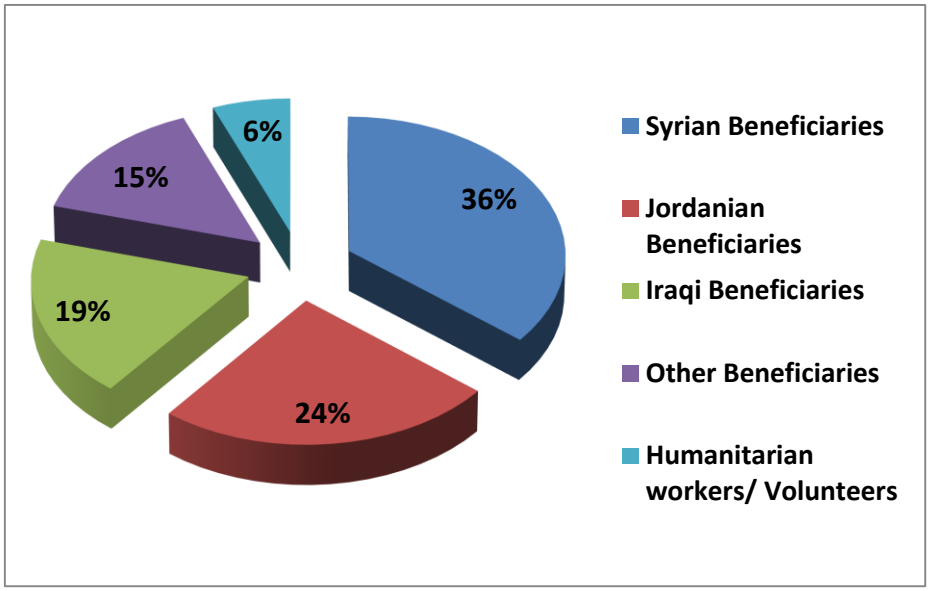
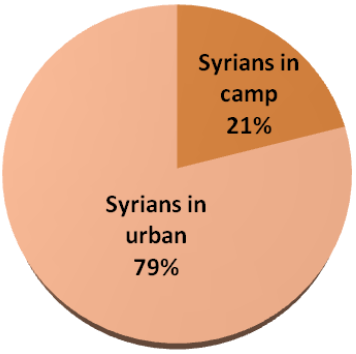


Figure 12 shows the distribution of beneficiaries by nationality targeted for MHPSS services in 2014. According to UNHCR estimates[3], as of June 2014, the total population of concern registered in Jordan is 638,383 persons, including 605,157 Syrians, 28,809 Iraqi refugees and 4,417 refugees of other nationalities. As in the 2013 mapping, Syrians still represent the largest demographic group targeted by MHPSS actors, representing 36% of the target population. At 25%, Jordanian beneficiaries represented the second highest target group, followed by Iraqis with 19%. However, the significant variation in this years' data indicates that more Iraqis are targeted this year compared to 2013 by at least 9%.

[3] UNHCR Jordan Overview as of June 2014.

Moreover, the vast majority of targeted Syrians (79%) reside in non-camp settings, which is consistent with the estimated 75% to 25% ratio of Syrian refugees concentration in host communities and camp settings respectively[4].

Figure 13: Syrian beneficiaries targeted camp vs. non-camp (percentages)

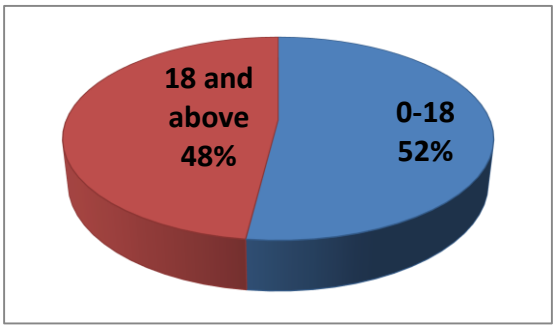


By Age

The largest age group of beneficiaries targeted by MHPSS services is between 0 to 18 years, representing 52% of the serviced population. This is followed by beneficiaries with the ages of 18 and over, representing 48% of the serviced population, which shows an approximately equal targeting among the two age groups.

Having almost half of the target population as children and adolescents under the age of 18 indicates that MHPSS services appear to focus well on early interventions. This is expected to support the early detection and management of MHPSS problems, which in turn often leads to better health and psychosocial outcomes for beneficiaries.

Figure 14: Beneficiaries by age (percentages)

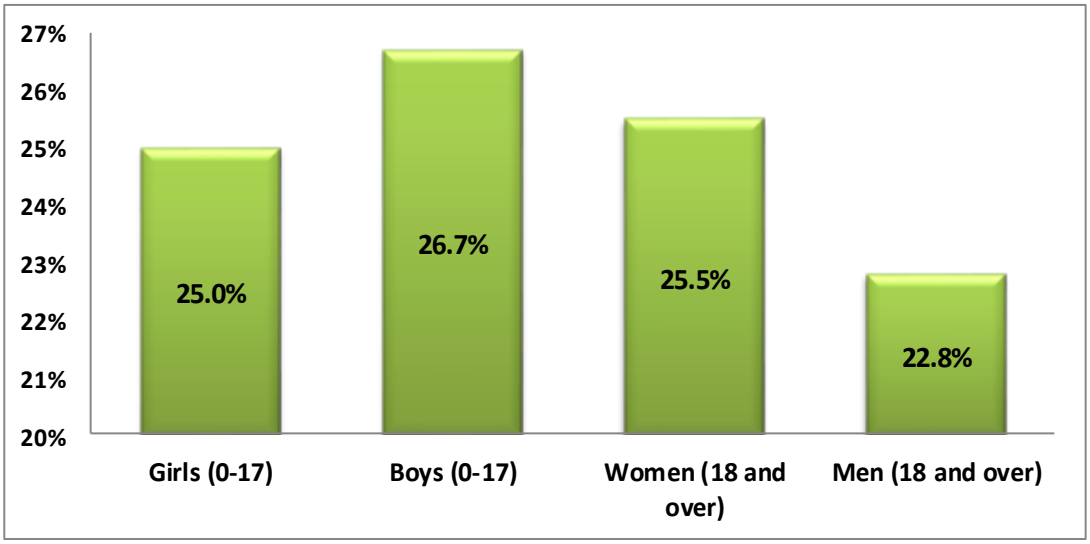


[4] 2014 Syria Regional Response Plan- Jordan.

By Age and Gender

Females (25.5% women, 25 % girls) represent 50.5% of the targeted population, while males represent the remaining 49.5% (22.8% men, 26.7% boys). Data reveals that boys are targeted by approximately 4% more services than men, while girls and women are almost equally targeted. Women are targeted by 2.7% more services than men, while boys are targeted by 1.7% more services than girls. Overall, the figures indicate a relatively similar distribution of the four age and gender groups as beneficiaries targeted by MHPSS services.

Figure 15: Gender distribution of beneficiaries targeted by MHPSS services



Similarly, when comparing individual activities, data reveals that all age and gender groups are similarly targeted across activities as demonstrated in Figure 16 and Figure 17.

Figure 16: Distribution of activities by age and gender

	Activity	Girls	Boys	Women	Men
1	Information dissemination to the community	7%	7%	8%	8%
2	Facilitation conditions for community mobilization, organization and ownership	4%	4%	5%	5%
3	Strengthening of community & family support	19%	20%	21%	20%
4	Safe spaces	20%	19%	18%	16%
5	Psychological support in education	2%	2%	2%	2%
6	Support inclusion of social/psychological considerations in other sector	3%	3%	3%	3%
7	Psychosocial interventions	13%	14%	11%	11%

8	Psychological interventions	15%	16%	15%	16%
9	Clinical management of mental disorders by non-specialized health care providers	5%	2%	4%	5%
10	Clinical management of mental disorders by specialized health care providers	7%	7%	6%	7%
11	General activities to support MHPSS	5%	6%	6%	6%

Figure 17: Distribution of activities for girls and boys

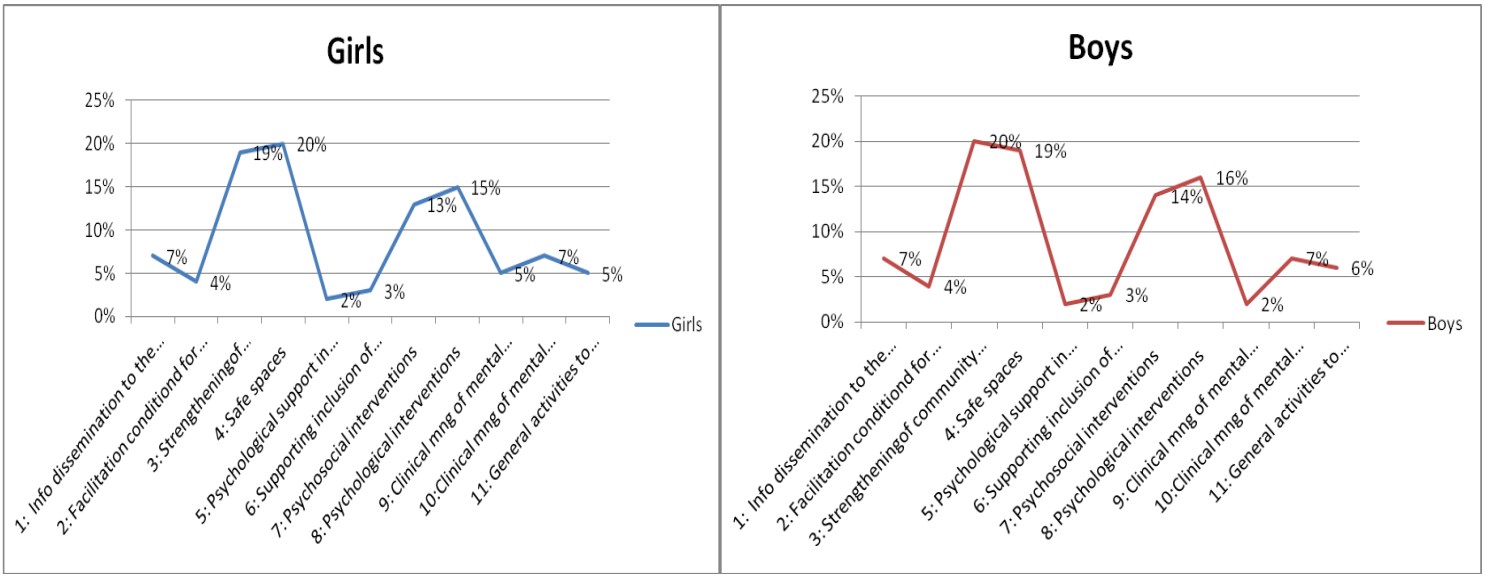
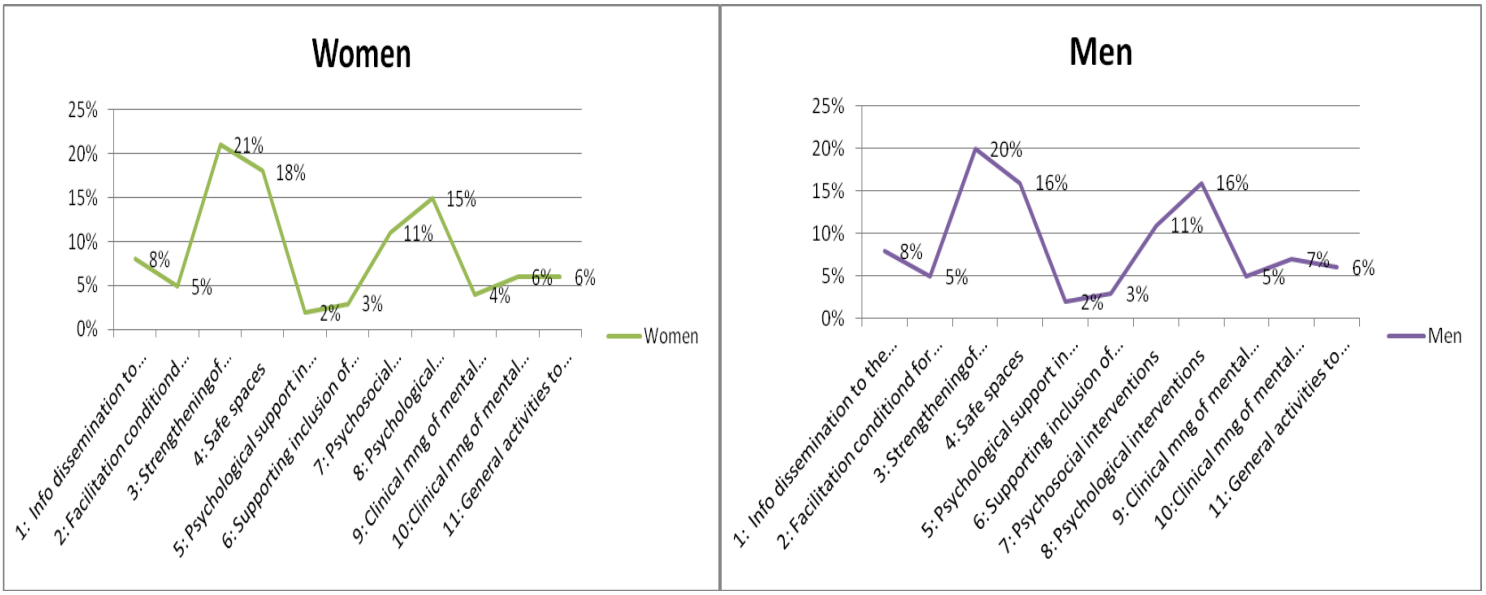


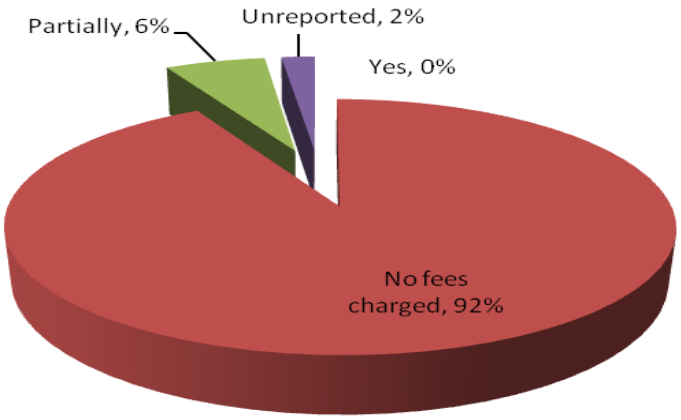
Figure 18: Distribution of activities for women and men



Cost of MHPSS Service Provision

Similar to previous years, the majority of MHPSS services (92%) are provided free of charge by organizations to all population groups. A small number of organizations reported charging partial or minimal fees for their services.

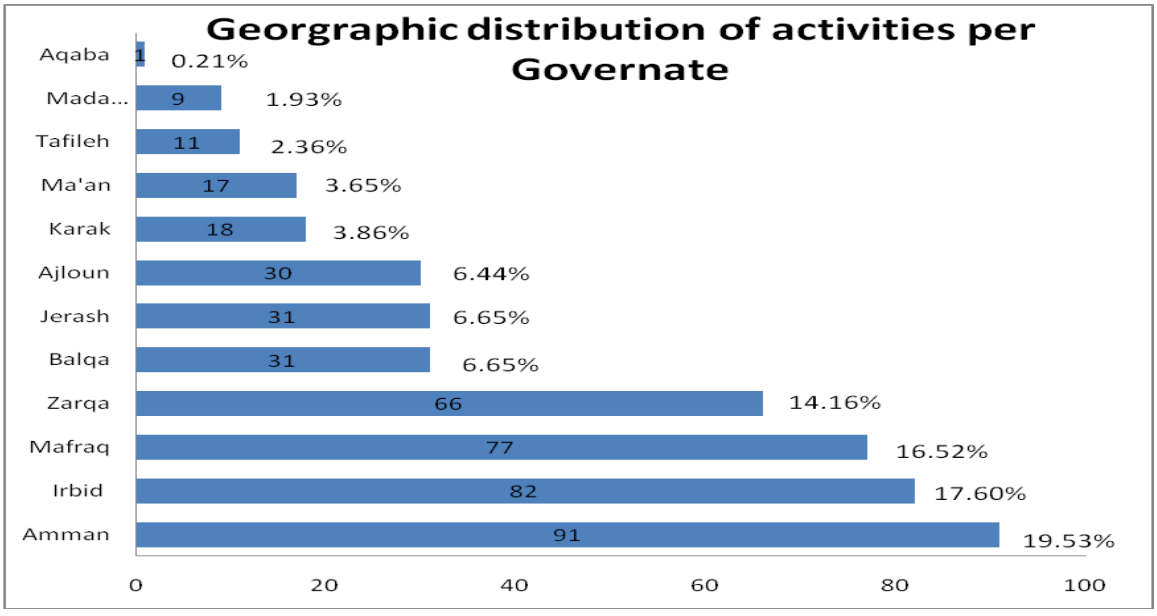
Figure 19: Cost of MHPSS service provision



Where

The following section provides an overview of the frequency and distribution of MHPSS services across governorates, with a more detailed geographic distribution by district/neighborhood for Amman, Irbid and Mafraq governorates.

Figure 20: Geographic distribution of activities per governorate (percentages)



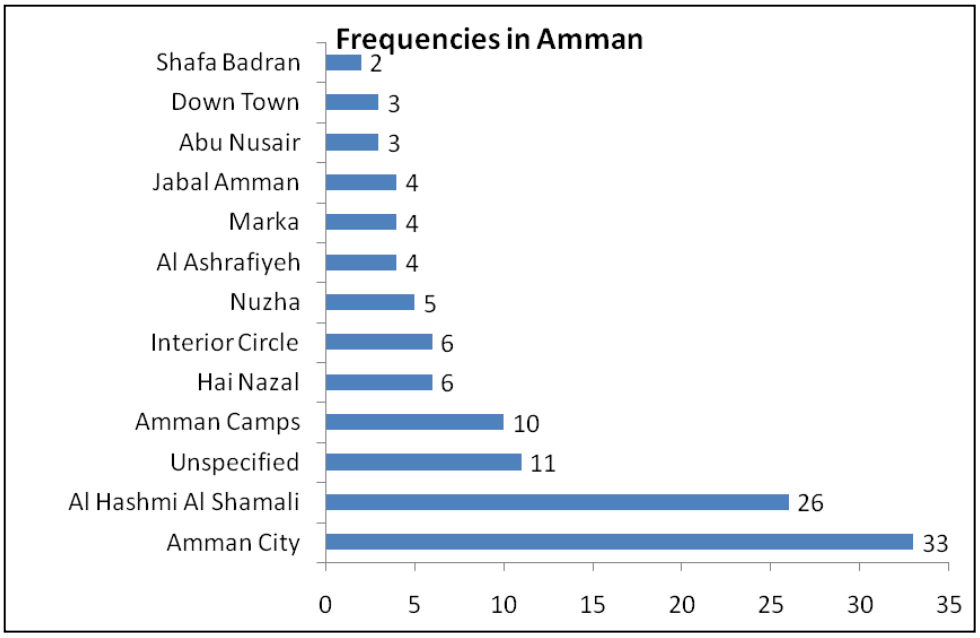
Similar to the previous year's mapping, the 2014 mapping evidenced continuous concentration of activities in Amman and the Northern areas of the country mirroring the proportion of Syrian refugees in these areas, with the largest percentage of MHPSS activities concentrated in the three governorates of Amman (19.5%), Irbid (17.6%) and Mafraq (16.5%), followed by the Central governorate of Zarqa at 14.2%. The Southern governorates of Aqaba, Tafileh, Ma'an and Karak, in addition to the Central governorate of Madaba, had the least concentration of MHPSS activities, with the lowest being in Aqaba.

Notably, the frequency of services in Ajloun has increased compared to the 2013 mapping (from 1 to 30). Similarly, Al Tafileh witnessed an increase in frequency of activities (from 1 to 11), with Jerash increasing from 2 to 31. On the other hand, activity frequency in Aqaba showed a decrease in 2014 (from 13 to 1). While initial analysis seems to indicate that the governorates of Amman, Irbid and Mafraq are well supported, further analysis is needed to understand the distribution of services within these governorates.

Distribution of Services in Amman

The breakdown of activities per neighborhood in Amman is shown below in Figure 21. The numbers of reported activities have dropped slightly since the 2013 mapping. As with previous mappings, the highest concentration of activities is located in Al Hashemi Al Shamali. As many respondents did not provide specific information related to service area, it was difficult to determine whether specific areas in Amman were under reached

Figure 21: Activity frequencies per neighborhood in Amman



Distribution of Services in Irbid and Mafraq

Within the governorate of Irbid, the large majority of services (65%) are based in the districts of Ramtha and Irbid City. As in the 2013 mapping, Mafraq remains the third most supported region. Most of the services seem to be well distributed between Za'atari camp and Mafraq city. The frequency of activities in Za'atari camp decreased compared to the 2013 mapping (from 68 to 32), amounting to a decrease of 48% to 41% of the total activities in Mafraq.

Figure 22: Activity frequencies per neighborhood in Irbid

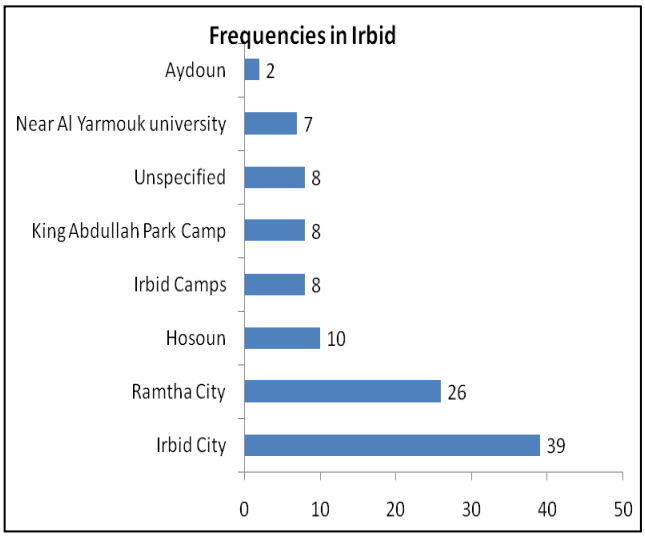


Figure 23: Activity frequencies per neighborhood in Mafraq

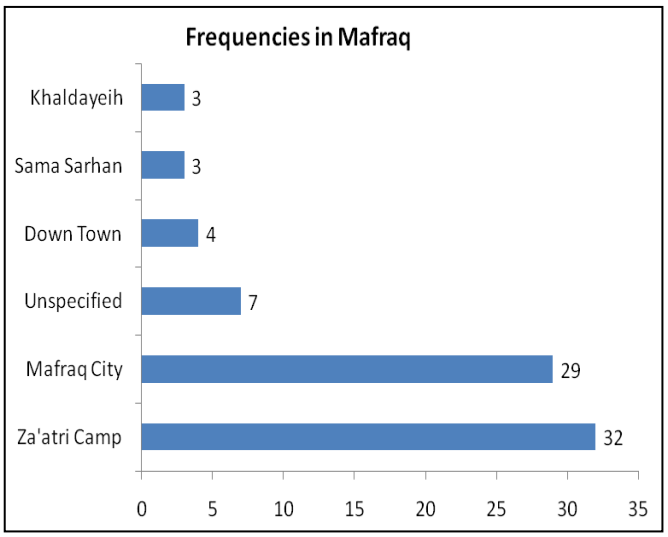


Figure 24 below provides a comparison of activities in all governorates by the target population serviced. Both the Jordanian and Syrian populations are served in each governorate, with varying percentages between the governorates. MHPSS service in Irbid and Mafraq, for example, target a majority Syrian population, while services in Amman and Zarqa target a majority Jordanian population.

Figure 24: Concentration of activities and population per governorate

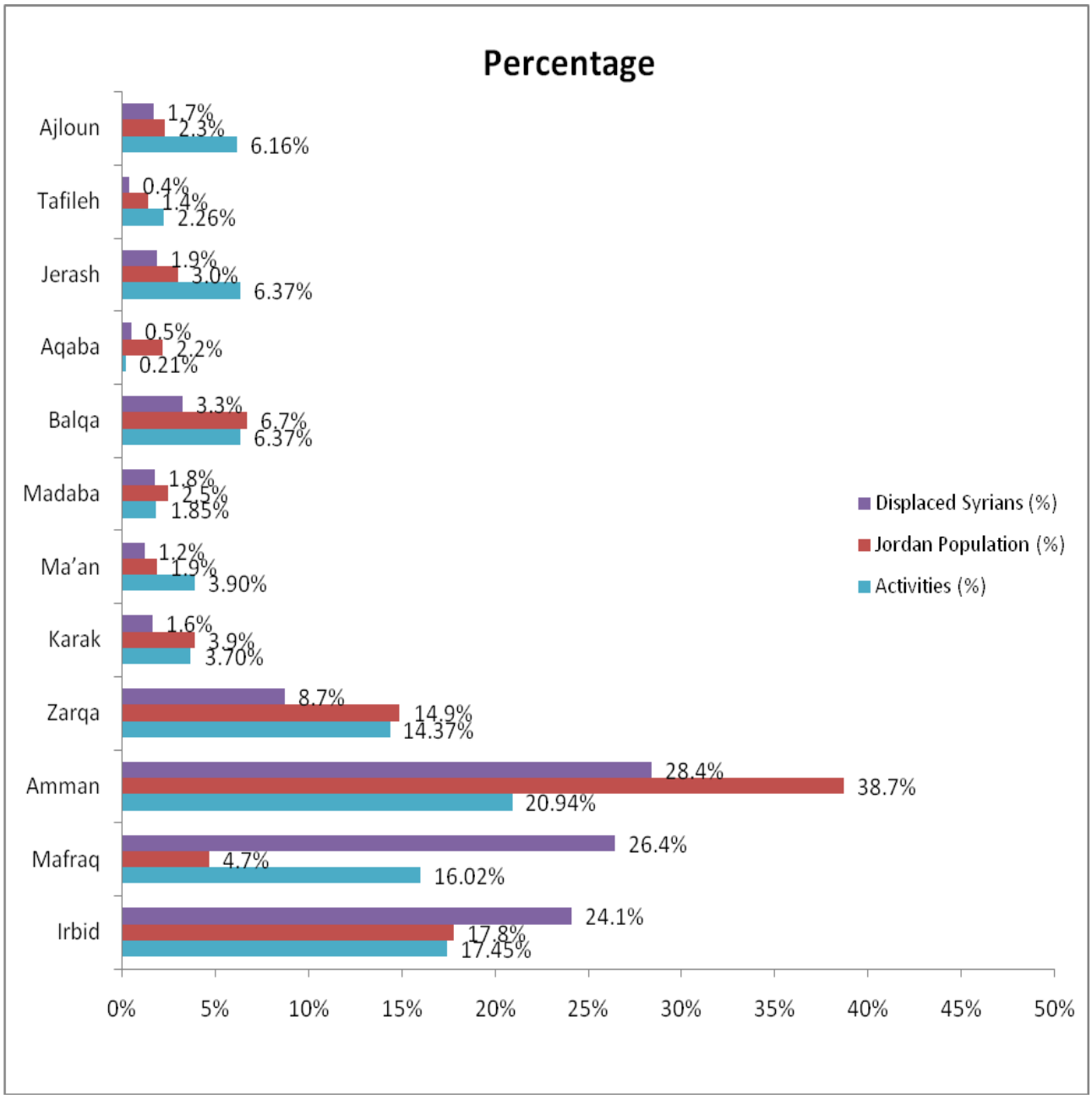
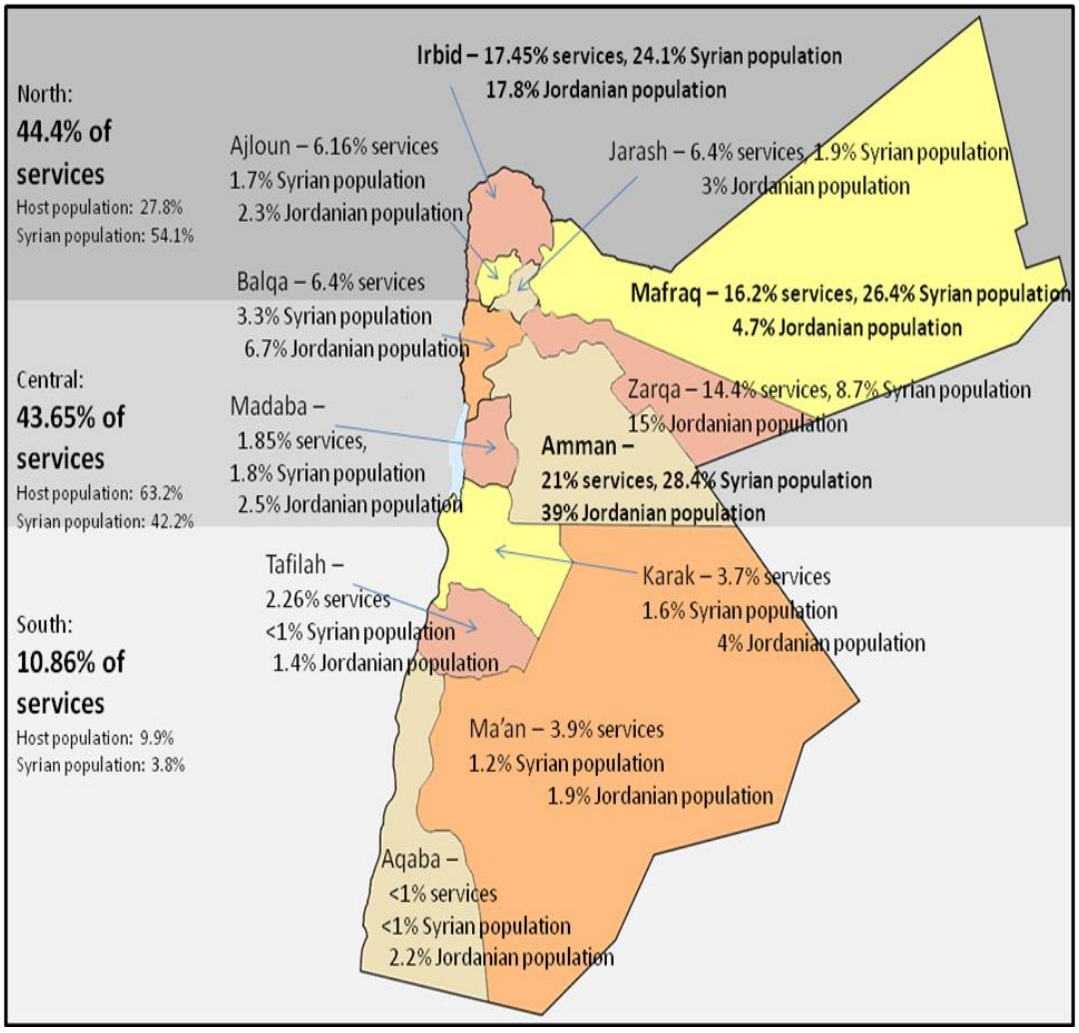


Figure 25: Density map of services per governorate and population



The map indicates the concentration of activities in percentages per governorate, as well as the corresponding population percentages. The geographic divisions were mapped out to delineate the Northern areas (Irbid, Mafraq, Ajloun and Jarash), the Central areas (Amman, Zarqa, Madaba and Balqa), and the Southern areas (Aqaba, Ma'an, Tafileh and Karak). The country map indicates that 44.4% of MHPSS services are located in the Northern governorates and 43.65% are located in Central governorates. The South is served by 10.86% of services.

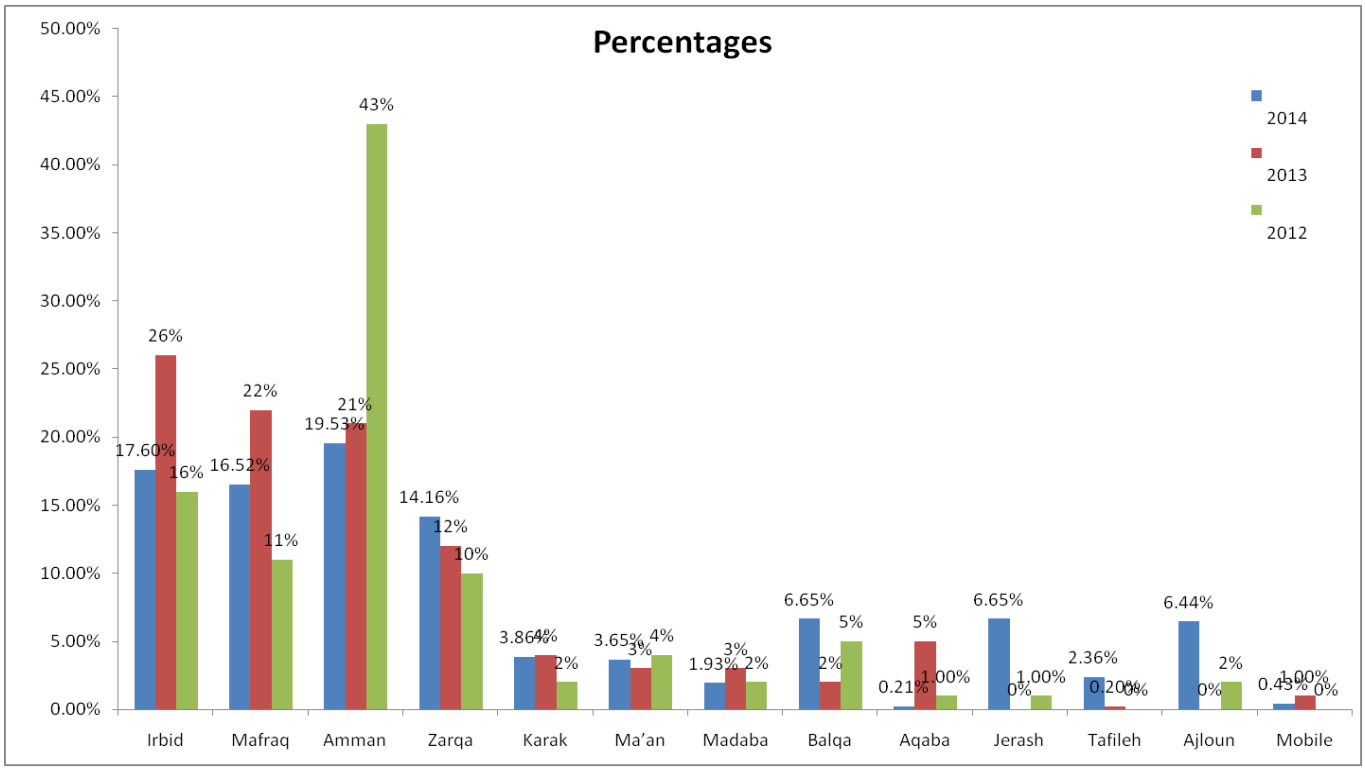
Table 3 on the following page shows the concentration of activities per governorate, the size of the general population in each governorate, and activity concentration per 100,000 of the general population. The percentages of displaced Syrians are also listed per governorate.

Table 3: Activities per governorate and population

Governorate	Concentration of activities (freq)	Jordanian Population (#)	Jordanian Population (%)	Per 100,000 Jordanians (freq)	Displaced Syrians (#)	Displaced Syrians (%)	Per 100,000 Syrians (freq)
Amman	**91**	2,473,400	39%	3.67	167,898	28%	54.19
Irbid	**82**	1,137,100	17.80%	7.21	142,473	24%	57.55
Mafraq	**77**	300,300	4.70%	25.64	156,256	26%	49.27
Zarqa	**66**	951,800	15%	6.93	51,767	9%	127.49
Balqa	**31**	428,000	7%	7.24	19,326	3.20%	160.4
Jarash	**31**	191,700	3%	16.17	11,168	1.90%	277.57
Ajloun	**30**	146,900	2%	20.42	10,094	1.70%	297.2
Karak	**18**	249,100	4%	7.22	9,638	2%	186.76
Ma'an	**17**	121,400	2%	14	7,158	1%	237.5
Tafileh	**11**	89,400	1%	12.3	2,491	0.40%	441.6
Madaba	**9**	159,700	2%	5.63	10,431	1.70%	86.28
Aqaba	**1**	139,200	2%	0.71	2,959	0.50%	33.8

**Note: Numbers of displaced Syrians were estimated using UNHCR data as of August 2014. Numbers of Jordanians were estimated using Department of Statistics data as of August 2014.*

Figure 26: Activities per governorate from the 2012, 2013, and 2014 mappings

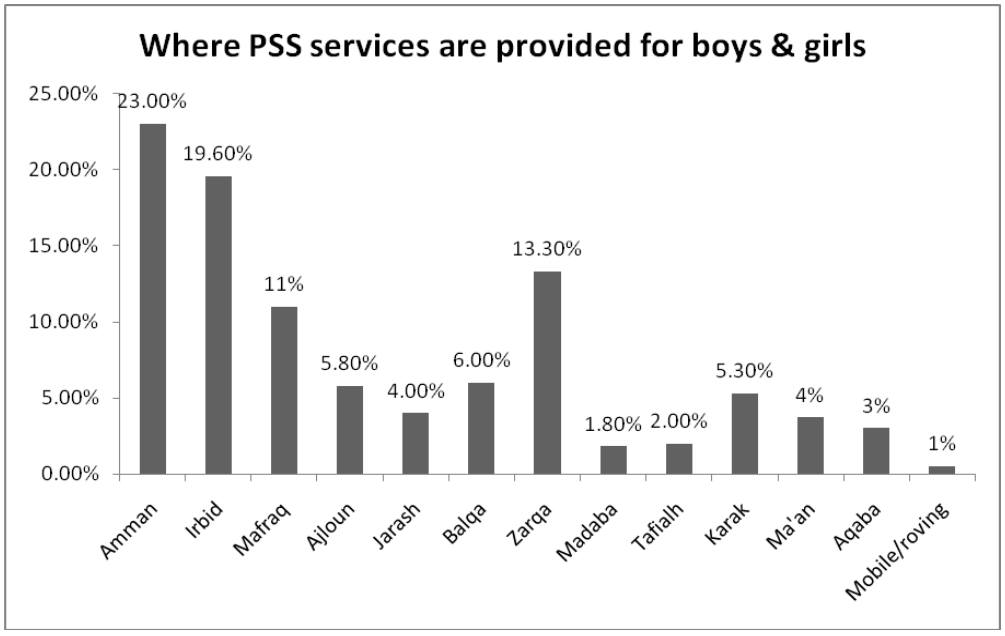


In general, there has been a wider distribution of MHPSS services across governorates over the years. At 19.5% of the total activities, Amman still remains the governorate with the highest concentration of MHPSS activities in 2014. However, data also indicates that the governorate has witnessed an incremental decrease in levels of service provisions since 2012.

At 17.6%, Irbid had the second highest concentration of activities, followed by Mafraq with 16.5%. Compared to the 2013 mapping, both evidenced a decrease in reported activities by 8% and 6% respectively.

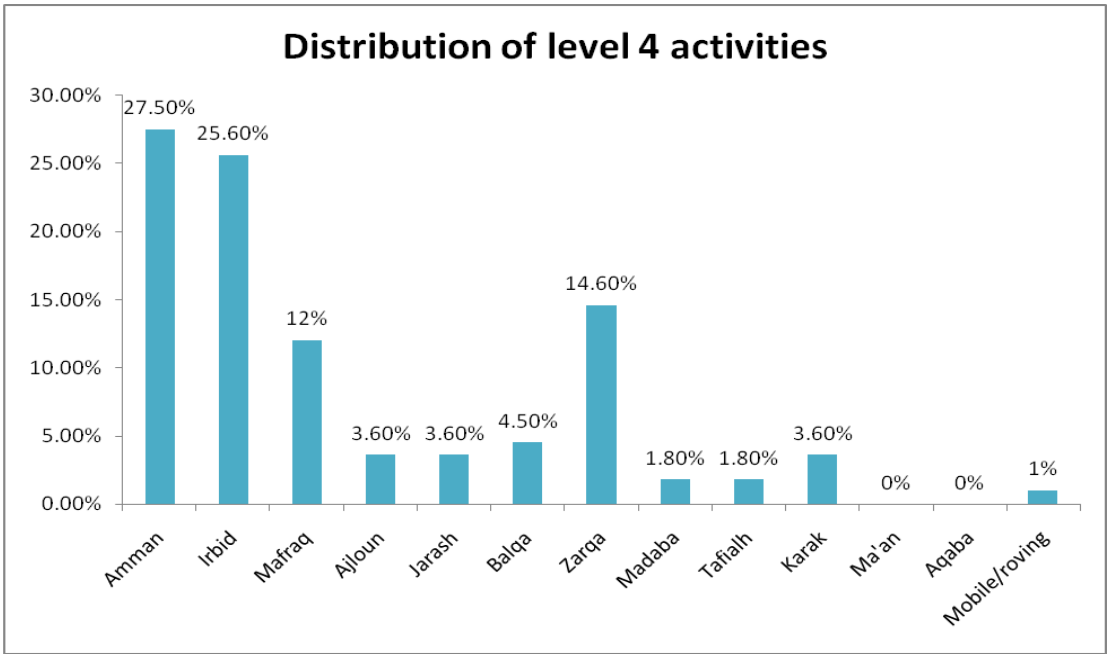
Other governorates, namely Ajloun, Jarash and Tafileh, have registered an increase in MHPSS activities, mirroring an increasingly larger number of displaced Syrians residing in their communities since the 2012 and 2013 mappings.

Figure 28: Psychosocial Support Services provided to boys and girls (below 18 years)



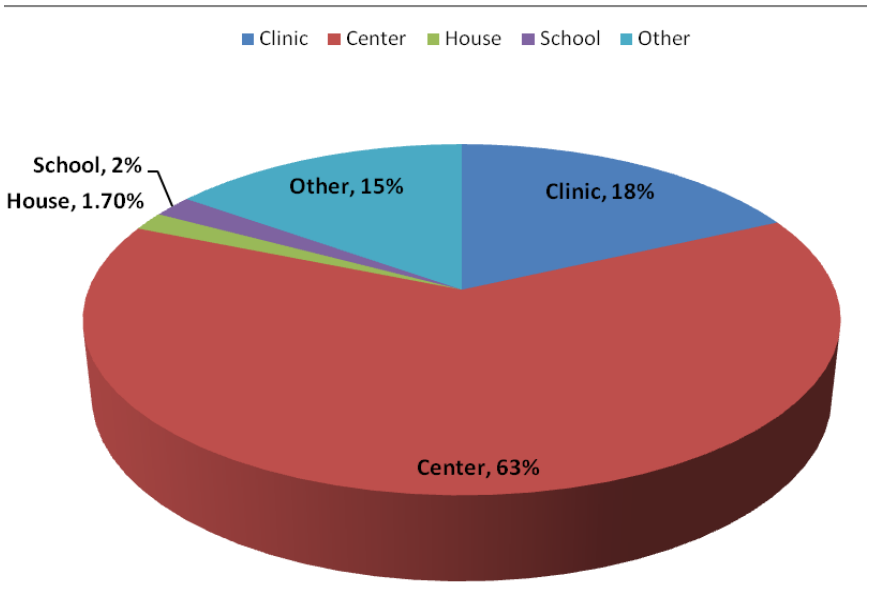
The above figure depicts concentration of community-based and non-specialized psychosocial services targeting boys and girls. Amman takes the lead with about 23% of the total activities, followed by Irbid (19.6%) and Zarqa (13.3%). Madaba, Tafileh and Aqaba were among the governorates with the lowest percentages of psychosocial services targeting boys and girls.

Figure 29: Distribution of Level 4 activities



Thirteen organizations are providing Level 4 activities. The highest concentration of Level 4 specialized services was observed in Amman (27.5%), followed by Irbid (25.6%), Zarqa (14.6%) and Mafraq (12%). Level 4 activities seem to be limited in all other governorates.

Figure 27: Setting where MHPSS services are provided



MHPSS services are provided in a wide range of settings to accommodate different levels of care, and the varying needs of MHPSS beneficiaries. The majority of services (63%) are offered at centers, while 18% are offered at specialized clinics. Only 1.7% of services are provided through home visits, while 2% of MHPSS services are provided in schools. As the 4Ws mapping only includes information from MHPSS service providers, further information is needed from Education Sector partners to determine if additional MHPSS services are provided in schools beyond what was captured through this exercise.

When

In mapping MHPSS services, the 4Ws tool also sought to identify the sources of funding for organizations' programs, services and activities. Diverse funding sources were indicated, including various donors and multiple funding cycles including recurrent funding, fixed funding, and one-off grants.

Figure 30: Status of implementation of activities

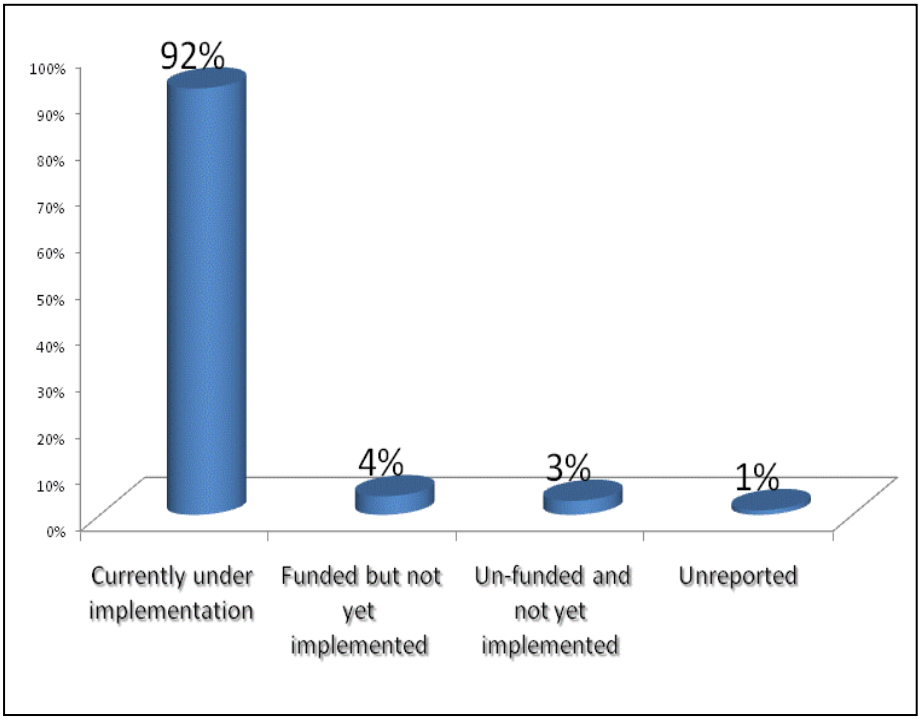


Figure 30 shows the breakdown of activities as related to their status of implementation. Respondents indicated that the majority (92%) of their activities are "currently under implementation".

Figure 31: Funding cycle per activity

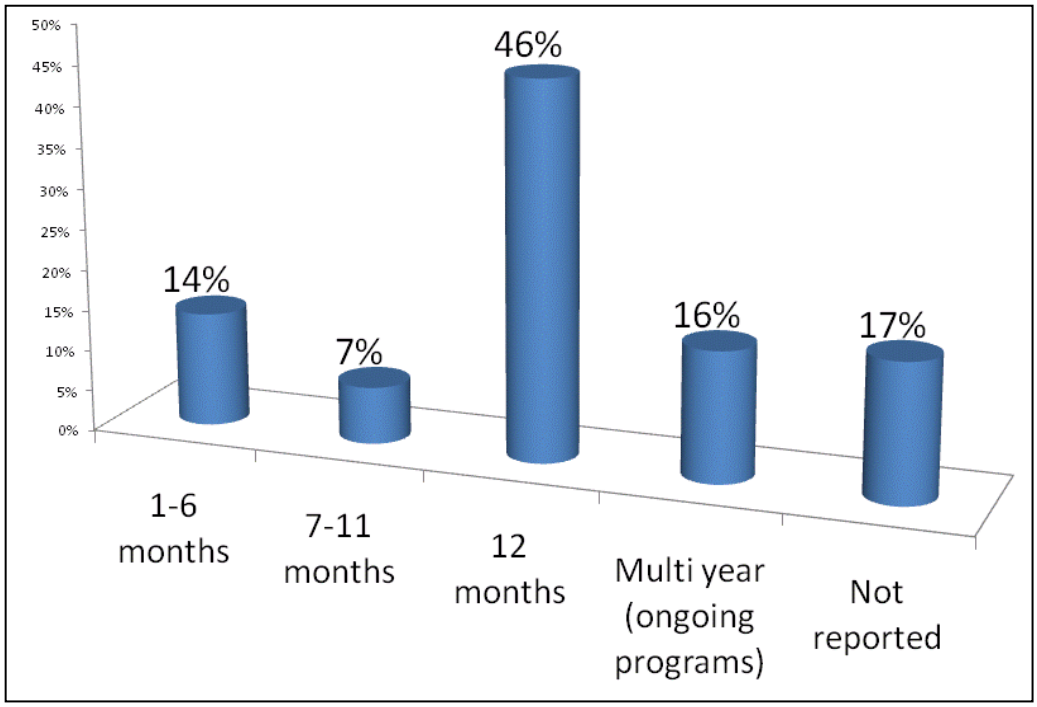


Figure 31 shows the length of funding (or funding cycles) for activities reported. Results indicate that the majority of funding cycles (46%) were in the '1 year or more' category. These results evidence a marked change from the 2013 mapping, in which the majority of funding, approximately 52%, was in the shortest cycle of one to six months. Longer funding cycles are desirable for MHPSS actors as they enable more efficient planning towards service provision, sustainability and continuity of care.

Discussion

Service Coverage and Distribution

The 2014 mapping indicated variances in the distribution of services across the levels of the IASC intervention pyramid as compared to the previous year's mapping. Data evidenced an increase of services at Level 4 (case-focused specialized services) from 3% in 2013 to 12% in 2014. Level 3 activities (focused non-specialized supports) witnessed a notable decrease compared to the 2013 mapping, from 41% to 31%), which could be partially due to the exclusion of Child Protection and SGBV data for this year's mapping, as these areas included numerous focused services targeting specific population groups (e.g. survivors of gender-based violence, children with specific protection concerns). Activities at Level 2 and Level 1 were approximately the same between 2013 and 2014.

Similar to the 2012 and 2013 mappings, data reveals a lower proportion of Level 1 activities compared to what is recommended by IASC intervention pyramid. This has been previously anecdotally accounted for through the substantial provision of Level 1 services by the Government of Jordan and local communities, with the support of international partners (i.e. security, shelter, food, etc.). However, as the Syrian crises continues to be a protracted concern, the resources and natural supports available in Jordan are become increasingly burdened[5]. Moreover, this mapping reveals very limited activities targeting the integration of social/psychological considerations in other sectors, which remains a seeming area of action for the MHPSS sub-sector. This is especially important to ensure sufficient focus on preventative and protective measures and activities.

This year's mapping shows that Syrians are the major targeted beneficiary population. To date, the influx of Syrians arriving to Jordan has not halted, and is placing considerable burden on local host communities and their basic health, social and economic services. To address this situation, the Ministry of Planning and International Cooperation (MOPIC) has required aid agencies to include 30% Jordanian beneficiaries in all projects targeting Syrian refugees. In light of this, it is important that direct support be provided to vulnerable Jordanians in host communities of the Northern governorates of Irbid and Mafraq, to help mitigate the impact of the Syrian crisis in these highly-affected areas. It should be noted that MHPSS activities in the North targeting vulnerable Jordanians are well represented in correlation to local population size.

Overall, the concentration of services in the Central zones were found to be in direct proportion to the Syrian populations residing in host communities but are not entirely matched to the Jordanian population size in the region. Similarly, while overall percentages of services in the North were significantly larger than the Jordanian population, they were less in proportion to the percentage of displaced Syrian population. For example, the governorate of Irbid, reportedly has 24% of the Syrian population, but only 17.45% of total services. Also, Mafraq has 26% of the Syrian population with 16% of services. These findings by no means infer that services in both of these governorates are insufficient in meeting the needs of the Syrians residing there. Further scrutiny is needed to determine whether an increase in service provision is indeed required.

While the South shows the highest correlation of services to both Jordanian and Syrian populations, it remains the most under-served area with 10.86% of the total services. The data shows that new programs have been initiated in Tafileh, Ajloun and Jarash, areas where few activities were reported in the 2013 mapping. This suggests that MHPSS coverage has increased to encompass new areas and previously underserved communities.

[5] Jordan National Resilience Plan 2014-2016.

Challenges

Tool-specific challenges and limitations

Based on lessons learned from past mapping exercises, the project team made some improvements to some elements of the 4Ws tool. The team initially explored the options of transferring data from Excel to Access and using VBA programming to add pop-up boxes to the current Excel sheet. However, a decision was made to maintain the Excel sheet as to keep the process as close as possible to previous years.

Feedback consequent to the mapping indicated that the organizations found it relatively easy to complete the 4Ws tool. The codified data points for activity and sub-activity were simpler to complete compared to last year where MHPSS and Protection codes were integrated. Furthermore, this years' mapping included specific coding in order to produce more precise information on target group categories, specifically adding age and gender disaggregation, which was regarded as helpful by the respondents.

As with the previous mappings, there is a need to ensure a unified understanding of specific language used in the MHPSS sector. Anecdotal evidence indicates a possible inclination for different agencies to define their MHPSS services in different ways, leading to inconsistencies in some reported activities.

While the majority of organizations reporting the funding sources per activity and location, many did not submit funding amounts. This may be due to the fact that the person filling in the 4Ws tool was not aware of funding allocations at their organization. Moreover, some respondents said that they lacked sufficient time to collect funding amounts. Due to these shortcomings, this year's mapping was not able to provide a detailed assessment on the scale and scope of current interventions as related to funding amounts in order to disseminate useful data for regional funding opportunities.

Despite these challenges, the final aggregate data spreadsheet was relatively easy to cross-tabulate for analysis. The sorted and collated data was extracted through filter and sort commands, and use to create products such as service directories.

Sectoral challenges and limitations

Key factors affecting the sustainability of the MHPSS activities are related to policy and program priorities, funding, available infrastructure, governance and management, and the local social and economic contexts. The issues impacting the capacity of organizations to deliver appropriate,

accessible and reliable services and program are not new and have been covered extensively in past mappings. These factors include but are not limited to:

Collaboration and referral mechanisms

Typically, the degree to which organizations currently share information is often based on informal networks. Many smaller organizations rely heavily on established informal communications networks and do not have processes to facilitate formal information sharing. While informal networks can be highly effective, the movement of information is hampered when there is a change in focal point or activities provided.

Previous mappings consistently identified multiple task forces, working groups and forums which served as coordination mechanisms and facilitated dialogue and referrals between sectors and partners including governmental bodies, NGOs, CBOs and other stakeholders. These alliances seek to address system improvement and service delivery for beneficiaries accessing MHPSS services. The entities establish linkages and promote coordination critical to an effective continuum of care. Their efforts exist on a scale ranging from institution-based programmatic partnerships, to formal operational agreements, to ad hoc collaborating on short-term issues.

The majority of organizations indicated that where feasible, they participated in the networks and forums that are relevant to their agency and target group. A variety of mechanisms were reported, for example, Finn Church aid participates in MHPSS/GBV working group and Youth Task force in Za'atari camp, while Al Kitab Al Sunna coordinates with other CBOs in Ramtha through informal networks. Previous mappings indicated that many agencies reported significant resource limitations (staff and funding), leading to a stretch in their capacity to participate in coordination activities outside their regular programming. These challenges remain relevant during this year's mapping, as mentioned during discussions and partner consultations, as coordination demands continues to place significant demands on already overstretched time.

The majority of partners reported referral mechanisms in place, both formal (e.g. case management teams) and informal, and all partners expressed interest in continuing the use of the interagency referral form developed by the MHPSS and Child Protection/SGBV working groups.

Knowledge transfer challenges

Staff changes and other situations requiring the transfer of duties and information between agency members presented challenges for the 4Ws project team. The team noticed that due to perceptible

staff turnover, new staff members in certain organizations spoken to, had limited knowledge of the 4Ws process and as such needed to be updated.

Situations where staff members are trained for a specific function without effective hand-over leads to lost functionality and expertise. To ensure effective knowledge transfer, it is recommended that organizations have a standardized process for transferring 4Ws knowledge and expertise held by experienced personnel for incoming staff.

Staff and training

The diverse profile of reporting agencies was reflected in the number of staff employed to deliver services. The number of staff employed for MHPSS services ranged from one person employed full-time to more than 50 staff. Most agencies employed an average of ten staff per governorate with several employing no more than five staff. All of organizations had staff members who had received ongoing and periodic training in MHPSS topics.

In informal discussions with agencies, many organizations commented on the adverse impact of high staff turnover in the sector and unavailability of qualified workforce. The ability of the MHPSS system to successfully deliver services and achieve positive outcomes depends on a trained and qualified work force. There is an apparent need for increased human resources for mental health care delivery, including the need to manage human resources in a cost effective manner.

With few exceptions, many involved volunteers in services delivered by various organizations. For some, it was not always viable or appropriate to use volunteers in the delivery of services and programs. Others commented that the cost of supporting and supervising volunteers sometimes outweighs the benefits, noting that volunteer turnover was high.

Recommendations

The 2014 mapping evidenced an increased focus on Level 4 services as compared to previous years. This demonstrates the need for adopting supported guidelines and clear referrals for the increased transition to more specialized mental health care services, including the delivery of services to persons with specific needs, including people with developmental disorders/intellectual disabilities, and people with alcohol and substance use problems. Additionally, Level 4 services require more specialized training and supervision, which should be reflected in agency activities. The mapping also revealed limited management of mental disorders by non-specialized health professionals (e.g. PHC general health staff).

In concordance, it is recommended to ensure that essential Level 1 and Level 2 activities continue to be adequately implemented. This includes the integration of social/psychological considerations in other sectors through the IASC MHPSS Guidelines, and the provision of family and community support, including support to parents/caregivers of children, adolescents and adults with MHPSS problems.

The mapping determined that most services are provided in either centers or clinics, with limited provision of services at homes and schools. As such, there is a need to ensure that effective outreach and community-based MHPSS interventions are in place, reaching homes and schools. Although services are being provided in some rural and/or remote locations, MHPSS providers should take into consideration that a large number of beneficiaries may still have to travel significant distances to access services. In this regard, increased provision of mobile services as a method of service delivery will greatly enhance access to services by vulnerable populations. Moreover, although MHPSS services are more widespread across governorates in 2014, there is still a need to ensure adequate coverage in the Southern governorates.

This year's mapping revealed that women, girls, boys and men are approximately equality targeted by MHPSS actors, showing similar patterns across the 11 activity categories. It is recommended to juxtapose these findings with further information about the actual consumption of MHPSS service by the difference age and gender groups.

Annex 1: List of agencies that contributed to the mapping

Name of organization	Address of organization	Name of the focal point	Phone number of focal point	Email address of focal point
ActionAid Arab regional initiative	30 Alidreesi ST Al shesiani	Hanaa Mcdady	790211912	HANAA.MCDADY@ACTIONAID.ORG
Al Kitab Wa Sunna	Down Town/ Ramtha/ Jordan	Ahmad Saggar	788015165	saggggar@yahoo.com
Altkaful	Ramtha- southern bus station	Abdul Majeed Zou'bi	797661312	altkaful.healthcenter@yahoo.com
ARDD-Legal Aid	amman, Jordan	Dr. Lina Darras	077-8400548	ldarras@ardd-legalaid.org
Bright Future for Mental Health	Amman - Jabal Al Hussain, Tabarieh Street, building 88	Faizaeh Abu Jadow / Executive director Musa'ada Abu Mahfouz / Director	0788290299 0787366194	musada_1970@yahoo.com
CARE International/ Jordan	Jabal AL nuzha, behind Estiklal mall, building NO. 19 Amman 11195, P.O. Box: 950793	Sawsan Sa'adeh, Saba Jadallah Rania Al-Sabbagh	0776731870, 0779967771 0779967774	Sawsan.Mohammed@jo.care.org Duaa.AlDaraweesh@jo.care.org
Caritas Jordan	Amman- Jabal Amman, Al Rainbow Street	Lana Snobar	796320982	counseling@caritas.jo
DRC: Danish Refugee Council-Jordan	11 Ibn Seedah Street P.O. Box 940289 Amman 11194 Jordan	Jennifer Gulbrandson	789111208	jennifer.gulbrandson@drc-jordan.org
Fida International	P.O.Box 1581, Amman 11821, Tla al Ali	Katja Köykkä	65519389	office@fd-jordan.org
Finn Church Aid (FCA)	Ali Sedo Al Kurdi St. No 41, Al Swifia.	Soraja Nasser El-Dine	779118888	soraja.nassereldine@kua.fi
Handicap International (HI)	4, Moqadeesho St, Um Uthaina, Amman	Gwenola Le Blanc, Gihanes		psy.ta.jd@hi-emergency.org
The International Catholic Migration Commission (ICMC)	Faisal Al Thane Street- Hai El Doubat Al-Mafraq, Jordan	Benedetta Balmaverde	0795712526	balmaverde@icmc.net
International Medical Corps (IMC)	Global Investment House, 9 Abd Alhamid Sharaf St. , Al Shmaisani, Amman	Ahmad Bawa'neh	798516131	abawaneh@internationalmedicalcorps.org
INTERSOS	Ahmed Urabi Street n.20, Shmeisani, Amman	Marcello Rossoni	0796614738	jordan@intersos.org
Islamic Charity Society Center (ICSC)	Amman- Abdali	Fawaz Al Mazrawai	795054944	fawaz1960@hotmail.com
Jesuit Refugee Service (JRS)	The Jesuit Centre, 43 Sh. Al Razi, Jebel Hussein, Amman, Jordan	Bernard Arputhasamy	0791304844	jordan.director@jrs.net
Jordan Red Crescent	Almisdar, Amman, Jordan	Razan Obeid/	795577117	razan_obeid@hotmail.com /

Danish / Italian Red Cross	Amman	Despina Constandinides	796040544	Decon@rodekors.dk
Jordanian Psychological Association (JPA)	Amman- Dahiet Al Rashhed, Zagholi Street- Building 11	Dr Samir Abu Moghli	795132771	menamog@hotmail.com
Jordanian Society for Widow and Orphan Care	Mafraq Opposite Engineers Union	Foza Musa Malatis	796685924	**
King Hussein Cancer Center (KHCC)	Amman, 201 queen rania al Abdullah St	Dr. Bassam Kamal	777415581	bkamal@khcc.jo
Lutheran World Federation (LWF) Jordan	Mitharri Street #2A, Um-As-Summaq, Amman, Jordan	Wejdan Jarrah	798898316	psy.jor@lwfdws.org
Medecins du Monde - MDM	Jabal Al-Weibdeh Ba'ounya Street, Building No14, 3rd floor Amman, Jordan	Valentina Di Grazia	079 70 49 506	coord.mh.jordan@medecinsdumonde.net
Ministry of Health (MoH)	Amman- Jordan	Dr Basheer Al Qaseer	799050216	b.alqaseer@hotmail.com
MoSD: Al Hussein Social Institute/Amman	Ashrafiyeh: Amman	Nziha Al Shatrat	06 5679327	NA
MoSD: Child Care Center/Hashemi Shamali	Hahshemi Ash Shamali, Amman	Imad As Suhaibeh	0775400964 06/ 5059176	NA
MoSD: Child Care Center/Shafa Badran/Amman	Shafa Badran: Opposite Health Care Center	Ashraf Khatatbeh	0775400977 06/ 5231408	NA
MoSD: Dar Al Hanan Girls Care Center/Irbid	Irbid	Sawsan Hadad	0798518278 02 7404359	NA
MoSD: Dar Al Wifaq	Marka: Urban Development	Dr. Zain Al Abbadi	0775400991 06/4899935	NA
MoSD: Girls Care Center/Rusaifeh	Rusaifeh: Near Rusaifeh Police/Station	Raghda Al Azzeh	0775400972 05 3743667	NA
MoSD: Girls Education and Rehabilitation Center/Amman	Amman: Um Uthaina, Opposite the Ministry of Transport	Suhad Mubaydeen	0775400965 06 5537083	NA
MoSD: Juvenile Education and Rehabilitation Center/Amman	Tareq area, Near General Army Command	Jamal Al Amlah	0775400978 06 5051904	NA
MoSD: Juvenile Education and Rehabilitation Center/Irbid	Irbid: Hai At Twal	Aiman Al Labpon	0775400973 02 7258612	NA
MoSD: Juvenile Education and Rehabilitation Center/Ma'an	As Sateh: Ma'an	Rakad Hilalat	0775400989 03 2133872	NA
MoSD: Juvenile Education Center/Rusaifeh	Rusaifeh: Near Rusaifeh Police Department	Mohammed Al Khawaldeh	0775400970 05 3750782	NA
Moroccan medical-surgical field hospital	Za'atari camp, district 3	Zakaria KHADIR	0.777038608	lakhaderzakaria@yahoo,fr

Nippon International Cooperation for Community Development (NICCOD)	P.O. Box 927177, Amman, 11190 Jordan Ahmad Urabi Street, Bldg #46, Rm #3, Amman	Mr. Yu KUBO Ms. Sari NISHIDA	795864948 797601095	kubo@kyoto-nicco.org nishida@kyoto-nicco.org
Noor Al Hussein Foudation, Institute for Family Health	Sweileh, near the Educational Development School al hashemi al shamali next to abdullah azzam mosque	Dr. Manal Tahtamouni Monda Qunash	065344190 Ext: 8 06/4908310	dr.tahtamouni@ifh-jo.org m.qunash@ifh-jo.org
Palliative Care & Pain Management Clinic	Al Madinah Al Mwnawarah Street, building # 273	Safa'a Al Thaher	795677001	safa_yara@yahoo.com
Qatar Red Crescent (QRC)	Al Zata'ri Camp, district 5, near MSF	Rasha Sawaf	795931045	rashasawaf@hotmail.com
Save the Children International	St 62 Abdul Hamid Badees St. Shmeisani - Amman - Jordan	Naima Chohan	775778851	naima.chohan@savethehcildren.org
Save the Children-Jordan	Jabal Al-Nuzha	Kareem Makkawi	077-5464970	Kmakkawi@savethechildren.org.jo
Terre des hommes - Lausanne	Al-Ilammiyat Al-Arabiyat st. Jabal Lweibdeh, in front of the Ministry of Education. Building #10, 2nd floor	Delegate: Anne Laure Baulieu	Office: 06.46.55.717 Mob: 079.70.28.174	Anb@tdh.ch
The Center for Victims of Torture (CVT)	Amman Center: Raed Building, Al-Bat-Haa' Street, Naifa District, North Hashmi, Amman - P.O. Box 231706 Amman - 11123 Jordan; Zarqa Center: Samer Alrefa'ay Street, Youth Center Association, Building No. (38). Zarqa -Jordan	Simone van der Kaaden	079 5645815	svdkaaden@cvt.org
UPP	Jabal Webdeh - Kulliat AlShareia, building n. 46, 2nd floor	Roberta Businaro	079-5347085	roberta.businaro@unponteper.it
War Child UK	Amman	Hadeel Abedo	796078226	hadeela@warchild.org.uk
World Health Organization (WHO)	Amman/ interior circle	Zein Ayoub	779855001	ayoubz@jor.emro.who.int

Annex 2: List of MHPSS activities and sub-activities

	Activity Code	Activity / Intervention	Sub-Activity Code	Sub-Activities (examples or details of activities)
Community-Focused MHPSS	1	Information dissemination to the community at large	1.1	Information, education & communication (IEC) materials on the current situation, relief efforts or available services
			1.2	Messages on positive coping
			1.3	Mass Campaigns (Events, TV, Radio, etc)
			1.4	Other (describe in column G of MHPSS Services Info sheet)
	2	Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general	2.1	Support for emergency relief that is initiated by the community
			2.2	Support for communal spaces/meetings to discuss, problem-solve and organize community members to respond to the emergency
			2.3	Other (describe in column G of MHPSS Services Info sheet)
	3	Strengthening of community and family support	3.1	Support for social support activities that are initiated by the community
			3.2	Strengthening of parenting/family supports
			3.3	Facilitation of community supports to vulnerable persons
			3.4	Structured social activities (e.g. group activities)
			3.5	Structured recreational or creative activities (do not include activities at child/ youth/ women spaces that are covered in 4.1, 4.2, 4.3)
			3.6	Early childhood development (ECD) activities
			3.7	Facilitation of conditions for indigenous traditional, spiritual or religious supports
			3.8	Self-reliance activities (income-generating activities, life skills, literacy classes, etc)
			3.9	Other (describe in column G of MHPSS Services Info sheet)
	4	Safe spaces	4.1	Child-friendly spaces
			4.2	Youth-friendly spaces (ages 15 - 24)
			4.3	Women centers

			4.4	Other (describe in column G of MHPSS Services Info sheet)
	5	Psychological support in education	5.1	Psychosocial support to teachers/other personnel at schools/learning places
			5.2	Psychosocial support to classes/groups of children at schools/learning places
			5.3	Other (describe in column G of MHPSS Services Info sheet)
	6	Supporting the inclusion of social/psychosocial considerations in other sectors (e.g., protection, health, nutrition, food aid, shelter, site planning, or water and sanitation services)	6.1	Orientation, training or advocacy with aid workers/agencies on including social/psychosocial considerations in programming (provide details and specify sector in column G of MHPSS Services Info sheet)
			6.2	Other (describe in column G of MHPSS Services Info sheet)
Case-focused MHPSS	7	Psychosocial intervention	7.1	Psychological first aid (PFA)
			7.2	Case management, referrals and linking vulnerable individuals/families to resources (e.g. health services, cash assistance, community resources, etc).
			7.3	Other (describe in column G of MHPSS Services Info sheet)
	8	Psychological intervention	8.1	Basic counseling for individuals (specify type in column G of MHPSS Services Info sheet)
			8.2	Basic counseling for groups or families (specify type in column G of MHPSS Services Info sheet)
			8.3	Psychotherapy (specify type in column G of MHPSS Services Info sheet)
			8.4	Interventions for alcohol/substance use problems (specify type in column G of MHPSS Services Info sheet)
			8.5	Interventions for developmental disorders/intellectual disabilities (provide details and specify type in column G of MHPSS Services Info sheet)
			8.6	Other (describe in column G of MHPSS Services Info sheet)
	9	Clinical management of mental disorders by non specialized health care providers (e.g. PHC staff, post-surgery wards)	9.1	Non-pharmacological management of mental disorder by non-specialized health care providers (where possible specify type using categories 7 and 8)
			9.2	Pharmacological management of mental disorder by non-specialized health care providers
			9.3	Action by community workers to identify and refer people with mental disorders and to follow up on them to ensure adherence to clinical treatment
			9.4	Other (describe in column G of MHPSS Services Info sheet)

	10	Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)	10.1	Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type using categories 7 and 8)
			10.2	Pharmacological management of mental disorder by specialized health care providers
			10.3	In-patient mental health care
			10.4	Other (describe in column G of MHPSS Services Info sheet)
General MHPSS	11	General activities to support MHPSS	11.1	Situation analyses/assessment (provide details and specify type in column G of the MHPSS Services Info sheet)
			11.2	Structured Training
			11.3	Technical or clinical supervision
			11.4	Psychosocial support for staff/volunteers (including refugee volunteers)
			11.5	Research
			11.6	Other (describe in column G of MHPSS Services Info sheet)

Annex 3: List of agencies that provide safe spaces

	Name of organization (full name and acronym)	**Address** of organization	Name of the **focal point**	**Phone number** of focal point
1.	Bright Future for Mental Health	Amman - Jabal Al Hussain, Tabarieh Street, building 88	Faizaeh Abu Jadow / Executive director Musa'ada Abu Mahfouz / Director	0788290299 faizeh 0787366194 Musadeh
2.	CARE International/ Jordan	Jabal AL nuzha, behind Estiklal mall, building NO. 19 Amman 11195, P.O. Box: 950793	Sawsan Sa'adeh Saba Jadallah Rania Al-Sabbagh	0776731870 0779967771 0779967774
3.	Caritas Jordan	Amman- Jabal amman, Al Rainbow Street	Lana Snobar	796320982
4.	The International Catholic Migration Commission (ICMC)	Faisal Al Thane Street- Hai El Doubat Al-Mafraq, Jordan	Benedetta Balmaverde	0795712526
5.	International Medical Corps (IMC)	Global Investment House, 9 Abd Alhamid Sharaf St. , Al Shmaisani, Amman	Ahmad Bawa'neh	798516131
6.	INTERSOS	Ahmed Urabi Street n.20, Shmeisani, Amman	Marcello Rossoni	0796614738
7.	Islamic Charity Society Center (ICSC)	Amman- Abdali	Fawaz Al Mazrawai	795054944
8.	Jesuit Refugee Service (JRS)	The Jesuit Centre, 43 Sh. Al Razi, Jebel Hussein, Amman, Jordan	Bernard Arputhasamy	0791304844
9.	Jordan Red Crescent/ Danish and Italian Red Cross	Almisdar, Amman, Jordan	Razan Obeid/ Despina Constandinides	0795577117 /0796040544
10.	King Hussein Cancer Center (KHCC)	Amman, 201 queen rania al Abdullah St	Dr. Bassam Kamal	777415581
11.	Lutheran World Federation (LWF) Jordan	Mitharri Street #2A, Um-As-Summaq, Amman, Jordan	Wejdan Jarrah	798898316

12.	Noor Al Hussein Foudation, Institute for Family Health (NHF/ IFH)	Sweileh, near the Educational Development School al hashemi al shamali next to abdullah azzam mosque	Dr. Manal Tahtamouni Monda Qunash	065344190 Ext: 8 06/4908310
13.	Nippon International Cooperation for Community Development (NICCOD)	P.O. Box 927177, Amman, 11190 Jordan Ahmad Urabi Street, Bldg #46, Rm #3, Amman	Mr. Yu KUBO Ms. Sari NISHIDA	795864948 797601095
14.	Save the Children International (SCI)	St 62 Abdul Hamid Badees St. Shmeisani - Amman - Jordan	Naima Chohan	775778851
15.	Terre des hommes - Lausanne (Tdh-L)	Al-Ilammiyat Al-Arabiyat st. Jabal Lweibdeh, in front of the Ministry of Education. Building #10, 2nd floor	Delegate: Anne Laure Baulieu	Office: 06.46.55.717 Mob: 079.70.28.174
16.	Un ponte per (UPP)	Jabal Webdeh - Kulliat AlShareia, building n. 46, 2nd floor	Roberta Businaro	079-5347085

Annex 4: Summary of the 2014 MHPSS 4Ws Workshop

A workshop was held on 17 September 2014 to present the initial findings of the 2014 MHPSS 4Ws mapping. The workshop was hosted by International Medical Corps (IMC) and the World Health Organization (WHO), and was attended by 20 individuals from 12 organizations. The welcome statement was delivered by the WHO Representative to Jordan after which presentations were made addressing the following: brief on 4Ws history, process and the initial findings of the 2014 mapping. The attendees were subsequently divided into four groups and asked to discuss and present their ideas on the following topics as summarized below.

1. *What needs/gaps/priorities would your group like to highlight?*

- Participants stated the need for capacity building and strengthening of MHPSS staff and service providers in order to address the gaps in MHPSS human resources (e.g. social workers, psychiatrists).

- Participants emphasized the need to foster greater linkages, coordination and referral (including follow-up and feedback) of services between the organizations working in the field.

- The need to develop effective strategies to integrate MHPSS in educational/school settings was also discussed, alongside improving the capacity of the educational system to better implement and increase provision of school-based MHPSS interventions.

- One participant voiced the prevailing lack of awareness in the community of the importance of mental health issues. Also there is a need to promote greater empathy and sensitization from key stakeholders i.e. humanitarian workers, health workers, policy makers, police, educators and governmental authorities to reduce stigma and discrimination of people suffering from mental health and psychosocial problems.

- Participants discussed the need to have more community-based MHPSS services, and to work on developing greater linkages to the community. The need to increase investment in developmental disorder interventions was also mentioned. Discussions highlighted the need to address gaps in services targeted at children with specific needs and the elderly. Another unmet gap is the lack of timely and effective provision of psychiatric care in camps.

2. *What are the main achievements of the MHPSS sub-sector during 2014?*

- MHPSS support is shifting from centers and clinics into communities.

- Evidence of wider coverage and distribution of services.
- The evolvement of the 4Ws tool that is now being used as a vital document aiding in planning, reporting and identifying priorities and needs. The 4W tool is being utilized as evidence-based validated process in MHPSS programming.
- Improved coordination by participating agencies is been achieved, resulting in better quality provision of services.
- The presence of the active working group whose concerted efforts have contributed to ensuring that mental health in psychosocial services is on the policy agenda.
- Guiding documents/guidelines produced by the working group.

3. What are some of the challenges faced by the MHPSS sub-sector?

- Redundancy and/or duplication in efforts across the board.
- Workforce shortage of qualified personnel.
- MHPSS not always regarded as a priority by government bodies and some donors.
- Prevailing negative stigma towards mental health by society at large.
- The need to engage all key stakeholders and ensure equal representation.
- Referrals/protocols and procedural requirements between organizations sometimes lengthy and unclear.

4. What recommendations should be highlighted?

- The need for increased gender-sensitive approaches and greater sensitization of MHPSS issues.
- Provide more specialized training for staff.
- Conduct training needs assessment to identify capacity building needs across MHPSS organizations, including self-care/ stress management.

The following are overarching recommendations based on the workshop discussions:

- MHPSS service providers should work on the development of country wide social inclusion initiatives to decrease the stigma and eliminate discrimination associated with mental health in order to strengthen levels and standards of service delivery.

- MHPSS organizations can leverage their resources and operate more effectively when they collaborate and share information. The development of a well coordinated referral system is vital to improve both the quality and delivery of MHPSS services. An increased focus on fostering partnerships between existing organizations will help strengthen coordination across working groups. Promoting improved coordination mechanisms are vital to ensuring that participating agencies cooperate in the provision of services and that there is little redundancy or duplication in efforts ensuring resources are allocated in a rational manner across various levels of MHPSS care.

- The need for greater representation of key stakeholders and collaboration within existing MHPSS networks, including the consistent attendance and participation in MHPSS activities by agencies.