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

2015/2016 Interventions Mapping Exercise

Mental Health and Psychosocial Support Working Group

February 2016

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Introduction

The Inter-Agency Standing Committee (IASC), a global humanitarian body devoted to the improvement of humanitarian coordination, established a Task Force on Mental Health and Psychosocial Support (MHPSS) in emergency settings in 2005, 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 implementation in 2010, based on emerging issues and lessons learnt from previous mappings conducted in Jordan, Nepal and Haiti.

Using data and feedback collected by agencies piloting the tool, the IASC Reference Group developed a manual to guide the mapping process. This manual was published in 2013 and is available for download from the Mental Health and Psychosocial Support network, *mhpss.net*. Subsequent mappings were conducted in Jordan in 2010/2011, 2012, 2013 and 2014, with the 2012 and 2013 mappings including Protection elements (specifically Gender-Based Violence and Child Protection) alongside MHPSS. The 2014 mapping however, excluded this additional information in order to allow a more specific focus on MHPSS activities.

Similar to the 2014 4Ws exercise, the 2015/2016 mapping specifically focuses on MHPSS interventions, collecting information on the broad range of mental health and psychosocial support activities provided to all beneficiary groups in Jordan. The list of MHPSS activities 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 list was slightly modified over the years to capture additional inputs suggested by the Jordan Mental Health and Psychosocial Working Group.

This mapping took place during a time of turmoil within the Eastern Mediterranean Region, with ongoing conflict in several areas including Syria, Iraq and Yemen. Now approaching its sixth year, the

Syrian conflict has forced well over 4.7 million of the country's citizens to take refuge in neighboring countries. To date, it is estimated that over 639,704 displaced Syrians reside in Jordan,[1] while government sources estimate an even higher number.[2] Exposure to violence, loss and displacement, in 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 November 2015 to January 2016. The estimated data collection timeframe was initially two weeks; however, the deadline was extended twice 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 2015/2016 MHPSS mapping are to:

1. Compile an updated profile of MHPSS programs and services in Jordan for girls, boys, women and men;
2. Facilitate an understanding 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.

[1] UNHCR Syria Regional Refugee Response: Inter-Agency Information Sharing Portal.
[2] The Hashemite Kingdom of Jordan, Department of Statistics (DOS).

The 4Ws Mapping Process

International Medical Corps contracted a technical consultant to carry out the data collection, analysis and write up of the final report. Additional IMC staff members supported the facilitation of this mapping exercise.

The 4Ws tool was attached to an information 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 2014 4Ws mapping report and aggregate sheet.

The team made initial contact with a total of 53 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. The package was also sent to other sub-sectoral Working Groups to share with their members. Organizations were offered the option of self-completing the survey, or receiving support by a member of the team through phone or face to face interview. Follow-up emails and phone calls were made over a five week period to collect the complete information for the mapping. Forty-six out of 53 organizations listed in the database completed the survey, with the deadline extended to accommodate late submission requests. Two organizations replied as having no activities that matched the assessment components at this time, and the remaining five organizations did not submit the mapping or 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 focused on MHPSS activities and sub-activities, and the additional features recommended following the 2013 mapping exercise were kept (for example, a drop down list of governorates, and a specified list of target groups disaggregated by age, gender and nationality linked to specific codes to facilitate data entry). Feedback provided during the 2014 4Ws workshop indicated that the tool was relatively easy to use, 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 sheet, 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 February 2016 for the MHPSS working group members, to disseminate preliminary mapping findings, consider implications of the emerging data and generate recommendations (See Annex 4 for summary). Various discussions were held, and recommendations were incorporated in the final report.

Findings

Who and What

The 2015/2016 mapping encompassed a cohort of 46 organizations that collectively deliver MHPSS services, programs and activities for communities across the Kingdom. A list of contributing organizations and their contact information is found in Annex 1. The mapping captured approximately 780 MHPSS interventions provided by agencies to citizens and displaced populations living in various governorates. Their profile was diverse, with organizations varying in their scale of operations, type of services they deliver, and locations which they serve.

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

Table 1: Organizations and focus of activities

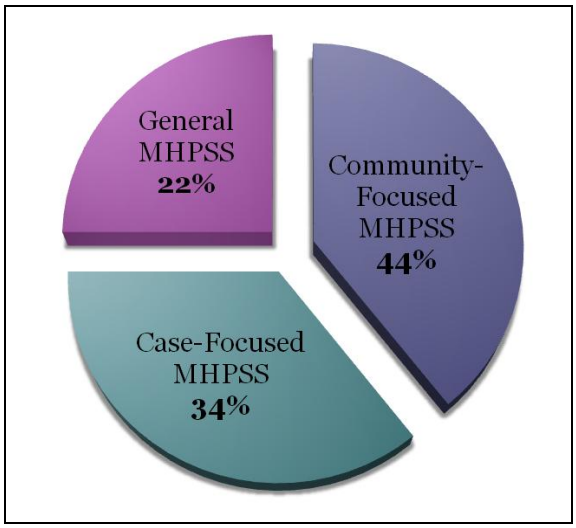
Name of organization	Community-Focused MHPSS	Case-Focused MHPSS	General MHPSS
Action Against Hunger (ACF)	√	√	
Agency for Technical Cooperation and Development (ACTED)	√	√	
Al Kitab Wa Sunna	√		√
Al Takaful	√	√	√
ARDD-Legal Aid	√		
Bayt Al Kol	√		
Bayt Al Liqa for Special Needs	√	√	√
Bright Future for Mental Health	√	√	√
CARE International/ Jordan	√	√	√
Caritas Jordan	√	√	√
Center for Victims of Torture (CVT)	√	√	√

Danish Red Cross	√	√	√
Danish Refugee Council Jordan (DRC)	√	√	
Finn Church Aid (FCA)	√		
International Catholic Migration Commission (ICMC)	√		
International Medical Corps (IMC)	√	√	√
International Relief and Development (IRD)	√	√	
International Rescue Committee (IRC)	√	√	
INTERSOS	√	√	√
Islamic Charity Society Center (ICSC)	√		
Jesuit Refugee Service (JRS)	√	√	√
Jordan Red Crescent (JRC)	√	√	√
Jordan River Foundation (JRF)	√		√
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)	√	√	
Medecins Sans Frontiers France (MSF-F)	√	√	
Mercy Corps	√		√
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)	√	√	√
Our Step Association	√		√
Palliative Care & Pain Management Clinic	√	√	
Syrian American Medical Society (SAMS)		√	√
Save the Children International (SCI)	√		
Save the Children Jordan (SC-J)		√	
Terre des Hommes – Lausanne (Tdh- L)	√	√	√
Un Ponte Per (UPP)	√	√	
Vento di Terra	√	√	√
War Child UK	√	√	
World Health Organization (WHO)	√	√	√
World Vision International (WV-I)	√		

**including Dar Al Wifaq, Child Care Center/Hashmi 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 area of focus

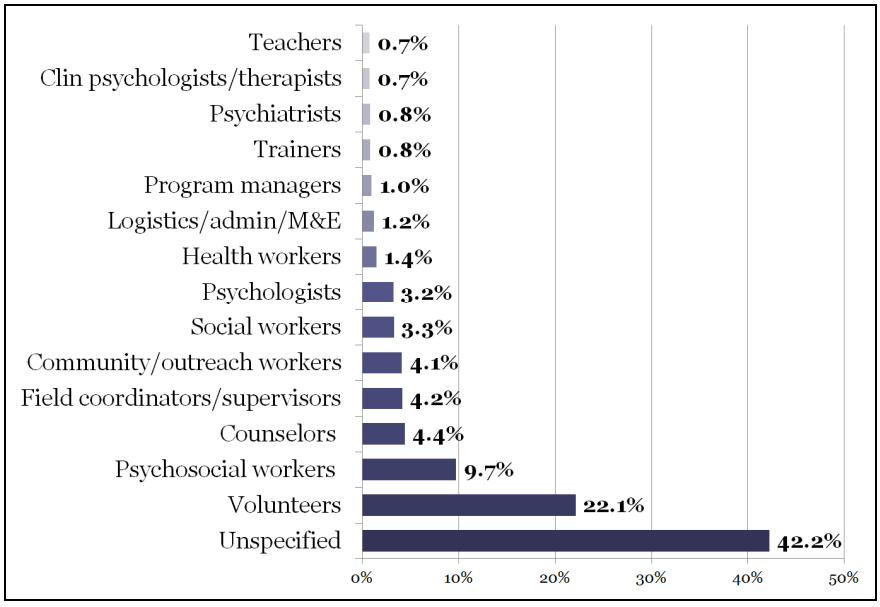


Results demonstrate that 44% of the reported interventions are "community-focused" activities such as information dissemination, community mobilization, safe spaces, psychological support in education and the inclusion of social/psychological considerations in other sectors. Moreover, 34% of activities represent "case-focused" interventions, encompassing psychosocial work, psychological interventions, and clinical management of mental disorders by specialized and non-specialized health care providers. About 22% of activities are "general activities to support MHPSS," and include work related to assessments, training/supervision and research.

Human resources for MHPSS

Figure 2 provides information on the amount and scope of human resources dedicated to mental health and psychosocial support. Findings reveal that at least 1,240 staff members and volunteers are currently providing MHPSS services, with an average of 24 workers per agency. As many agencies only stated job descriptions without specifying the number of staff, the MHPSS workforce is expected to be even higher. Also, at least 80 workers were reported under activities that are not yet implemented. This figure was not included in the estimation in order provide a clearer picture of human resources currently on the ground.

Figure 2: Percentage and type of human resources reported



Most human resources were unspecified at approximately 42%, while volunteers composed the largest group listed at 22%. Psychosocial workers followed at around 10% including case managers, animators and other personnel. Health workers (i.e. nurses, doctors, physiotherapists, pharmacists and occupational therapists) were reported at 1.4%. While counselors and psychologists obtained a percentage of 4.4% and 3.2% respectively, the least reported job categories were psychiatrists, clinical psychologists/psychotherapists and teachers, with about 0.7% for each profile. Human resources also included logistics/administrative officers, assistants, monitoring and evaluation staff and translators.

Funding sources for MHPSS

Figure 3: List of reported donors for MHPSS activities

ACT Alliance; Alianza Por la Solidaridad (APS); German Federal Ministry for Economic Development Cooperation (BMZ); Boeing; Bureau of Population, Refugees and Migration (BPRM)- US DOS; Caritas Austria/ Canada/ Denmark/ Germany; CDB; Center for Disease Control (CDC); Canadian International Development Agency (CIDA); Canadian Lutheran World Relief (CLWR); Catholic Relief Services (CRS); Department of Foreign Affairs, Trade and Development Canada (DFATD); Department for International Development (DFID)- UK-AID; Dutch Government; European Commission (ECHO); European Union (EU); GE; International Medical Corps Taiwan; Italian Cooperation; Japan Platform (JPF); Ministry of Foreign Affairs (MOFA) Canada; No Lost Generation; Private funding; Qatari Charity Center; Self-Funding; Swiss Government; Tavola Valdese- Italian Office for International Aid Program; UN Women; UNESCO; UNFPA; UNHCR; UNICEF; UN Voluntary Fund for Victims of Torture (UNVFVT).

While some participants identified funding sources for their MHPSS activities and programs, others did not provide any information in this regard. Reported funding sources range from governmental donors, to self-funding and private donations. Figure 3 below captures the list of reported donors.

MHPSS partners

Several organizations declared partnerships for implementing their MHPSS services and activities, encompassing donors and other MHPSS actors. Additional partners were also mentioned, including cultural centers, public institutions, local community-based centers, schools and other facilities.

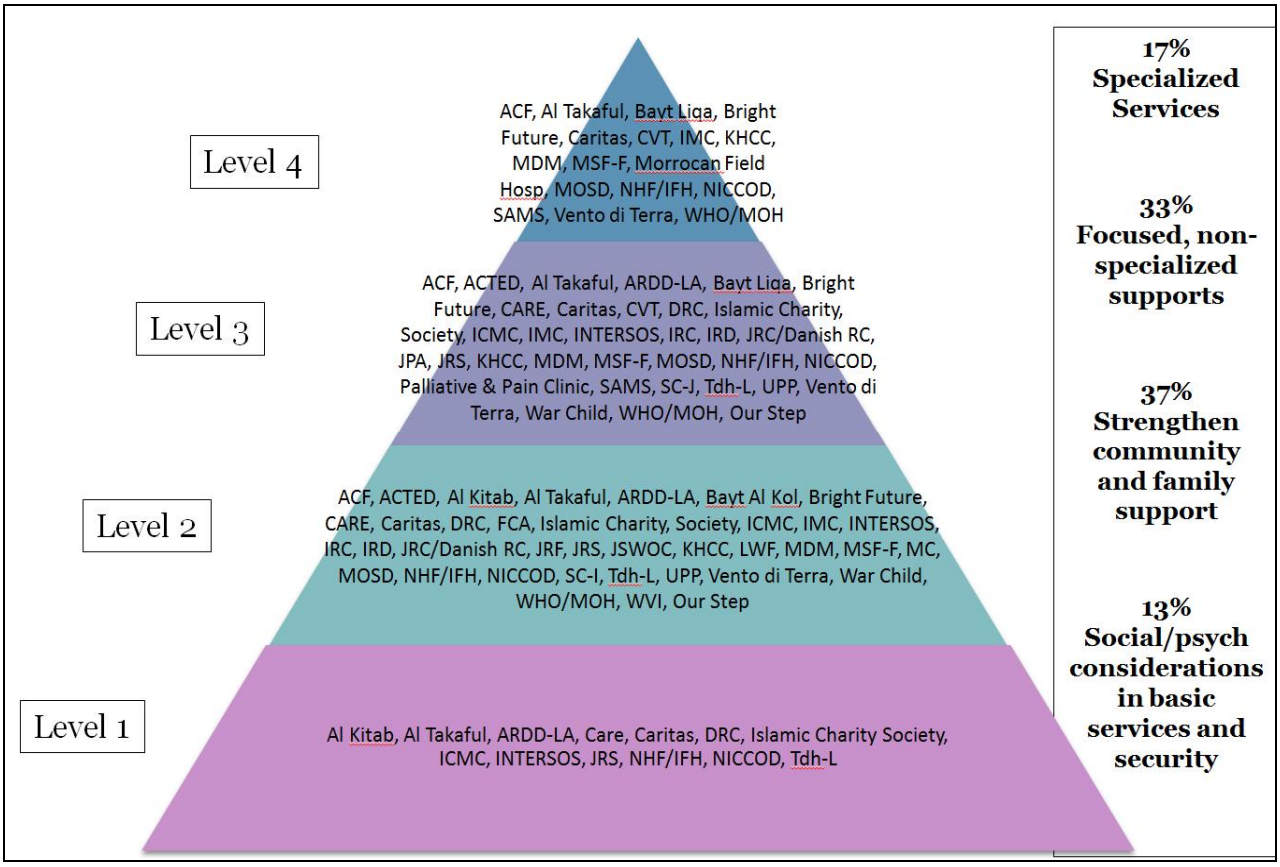
Figure 4: Additional partners reported by MHPSS

Ministry of Culture (Princess Salma Center); Ministry of Education (including 36 schools); Oxfam; Goethe Institute; Jordanian Health Aid Society (JHAS); Jordan Hashemite Charity Organization (JHCO); Jordanian Association for Human Development; Jordanian Women's Union (JWU); Jordanian Relief Organization; Our Step Association; Jordan Hashemite Fund for Human Development (JOHUD); Prince Talal Society; Princess Haya Center; Al Turra Society; Afaq Jordan for Development and Training; Jarasya Charity Association for Women; Hikaya Center for Civil Society Development; Family Guidance Center; Al-Yarmouk Camp; Fatema Alzahra' Park; Bayan Center; Sanabel Alata' Society; Um Khashab Society; Reyad Al Janneh Society; Faiha' Club; Sawe'ed Society; Ayadena Society; Nahleh Society; Al Safsafah Society; Haya Cultural Park; Messenger of Peace; Al Mohafatha; Al Hadareyeh Village; Ebeen Youth Sports Club; Shams Al Amal; Abu Nsair Sports Club; Al Mugayer Association; Child Disability Society; Sama Sarhan Association; Tawasol; Zahr Alroman; Northern Mazar Youth Club; Nashama Al Khaer Association.

IASC intervention pyramid

Figure 5 displays the 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.

Figure 5: Concentration of activities and organizations on the IASC MHPSS intervention pyramid



The majority of activities surveyed (37%) fell under Level 2 of the intervention pyramid 'strengthening community and family support'. This represented a minimal decrease of 1-2% from the 2014 and 2013 mappings, but a significant decline of 18% when compared to 2012. A comparison of the relative concentrations of Levels 1-4 on the intervention pyramid is found in Table 2 and Figure 6 below, including data from the past 5 mapping exercises.

Level 3 activities 'focused (person-to-person) non specialized supports' accounted for 33% of the total interventions on the pyramid, corresponding to slight decrease from 2014, a decrease of 8% from 2013, but an increase of 18% when compared to 2012.

Level 1 activities 'social considerations in basic services and security' amounted to 13% of activities on the pyramid, having decreased by 6% from 2014, 4% from 2013, and 12% compared to 2012.

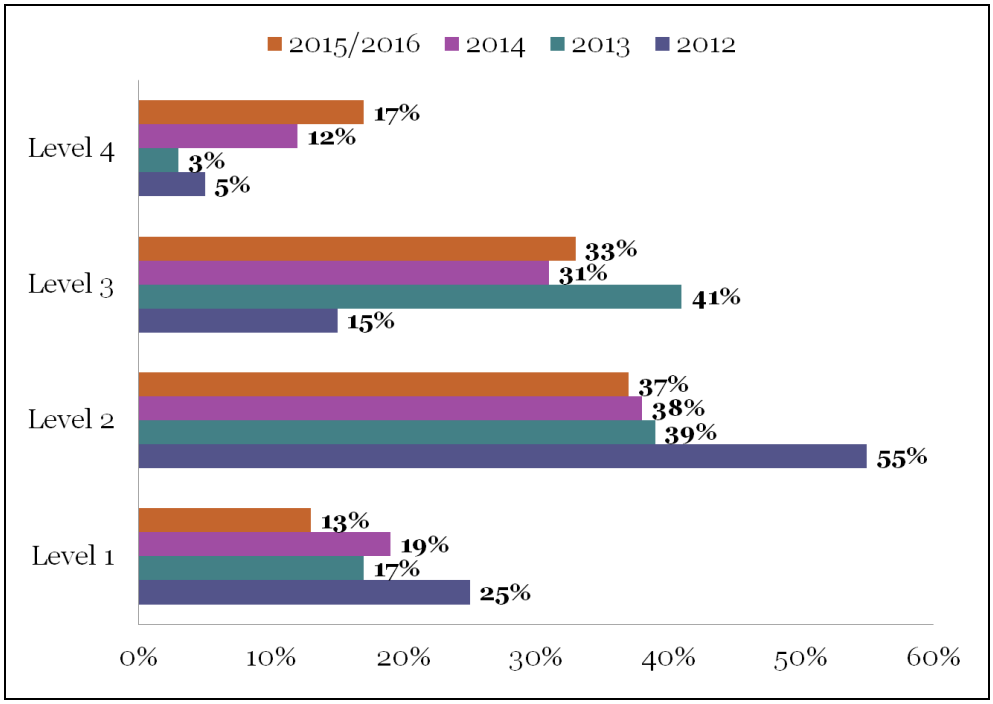
The last 3 years have witnessed an increase in Level 4 'specialized services', from 3% in 2013, to 12% in 2014, and finally to 17% in the 2015/2016 mapping. This is reflected by an increase in agencies operating at level 4, currently at 18 organizations, compared to a total of 13 organizations in 2014 and 7 organizations in 2013.

Table 2: Concentration per level on IASC MHPSS intervention pyramid (2009-2015/2016)

Pyramid Level	2009	2010/ 2011	2012	2013	2014	2015/ 2016
Level 4	14%	12%	5%	3%	12%	17%
Level 3	21%	35%	15%	41%	31%	33%
Level 2	65%	48%	55%	39%	38%	37%
Level 1	0%	5%	25%	17%	19%	13%

It is essential to note that any increase or decrease in percentage of a particular Level indicates a change that is relative to the proportion of other Levels on the intervention pyramid. This does not necessarily mean that activities within each Level follow the same pattern. A more detailed breakdown of activities per selected Levels will follow to provide a closer look.

Figure 6: Concentration per level on IASC MHPSS intervention pyramid (2012-2015/2016)

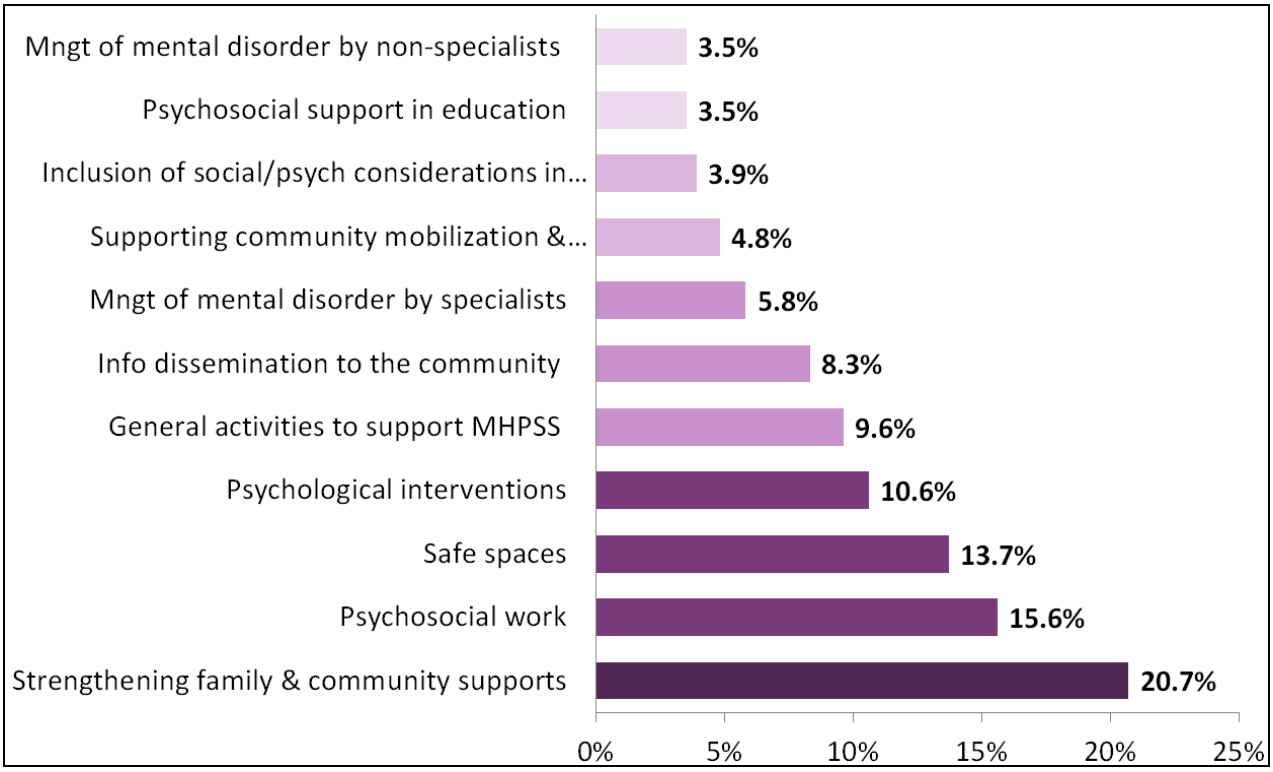


Concentration of services by activity type

Figure 7 below displays the concentration of activity categories per code (in total 11 main activity codes). The most frequently reported activities include 'strengthening of community and family supports' (activity 3) at 20.7%, followed by 'psychosocial work' (activity 7) with 15.6% and 'safe spaces' (activity 4) at 13.7%. These are the same top 3 activities captured by the 2014 mapping. Also similar to the 2014 mapping, the most under-represented services were 'clinical management of mental disorders by non-specialized health care providers' (activity 9) at 3.5%, and 'psychological support in education' (activity 5) at 3.5%, with a noted decrease of the 'inclusion of social/psychological considerations in basic services' (activity 6) from 5.9% in 2014 to 3.5% in this year's mapping.

While 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); on the other hand, it is recommended that lower level activities retain a higher comparative frequency, which means that findings captured through this mapping suggest that level 1 activities should be comparatively higher (for example, facilitation of conditions for community mobilization and organization, supporting the inclusion of social/psychological considerations in other sectors).

Figure 7: Concentration of activities per code



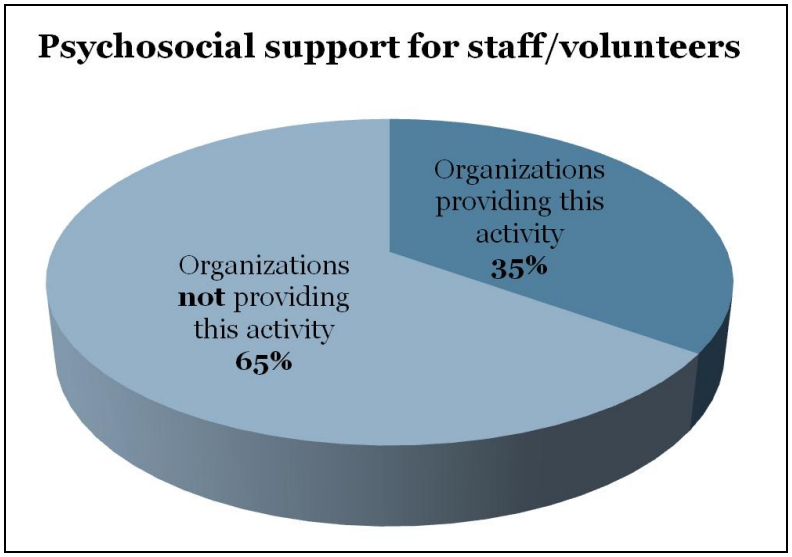
Analysis of Selected Activities

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

Psychosocial support for staff/volunteers is provided by 35% of the surveyed organizations. This is an increase of 7% from the 2014 mapping. However, the large majority, 30 organizations (65%), 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 8: Availability of psychosocial support for staff/volunteers per organization

Organizations reporting this service	
1.	Bayt al Liqa
2.	Bright Future
3.	CARE International/ Jordan
4.	Caritas Jordan
5.	Center for Victims of Torture
6.	INTERSOS
7.	Jesuit Refugee Service
8.	Jordan Red Crescent
9.	Jordan River Foundation
10.	Al Kitab Wal Sunnah
11.	Mercy Coprs
12.	Noor Al Hussein Foundation
13.	Syrian American Medical Society
14.	Al Takaful
15.	Terre des homes- Lausanne
16.	Vento di Terra

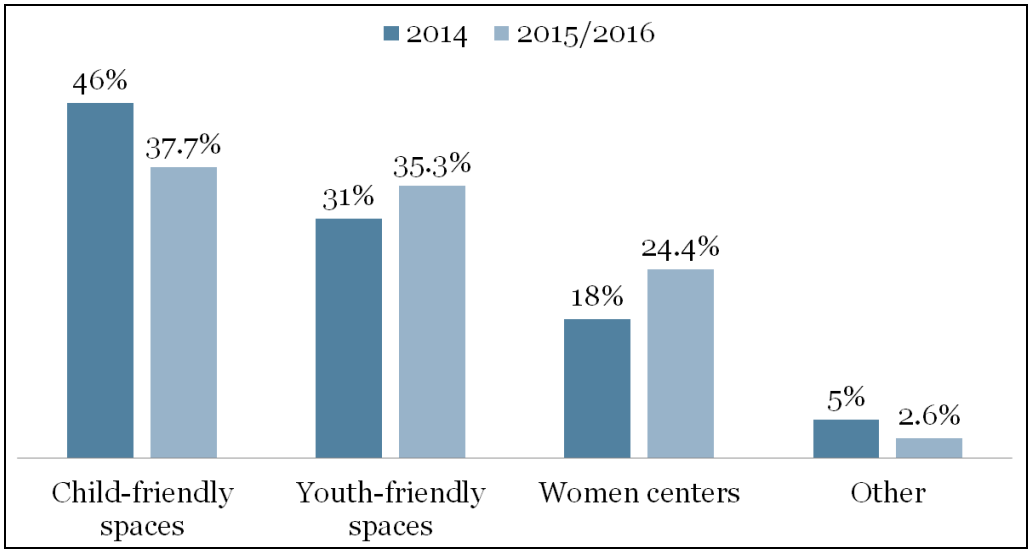


Activity code (4.1-4.4): Safe spaces including child friendly spaces, youth friendly spaces and women centers

A total of 22 organizations (approximately 48%) provide safe spaces. This is an increase of 14% compared to the 2014 mapping, where 34% (16 organizations) operated safe spaces. Similar to the 2014 mapping, the majority (37.7%) are child friendly spaces followed by youth friendly spaces (35.3%), and women centers (24.4%). However, as shown in Figure 9 below, there is a more even distribution between child, youth and women spaces in this year's mapping. Very few (a minority) of

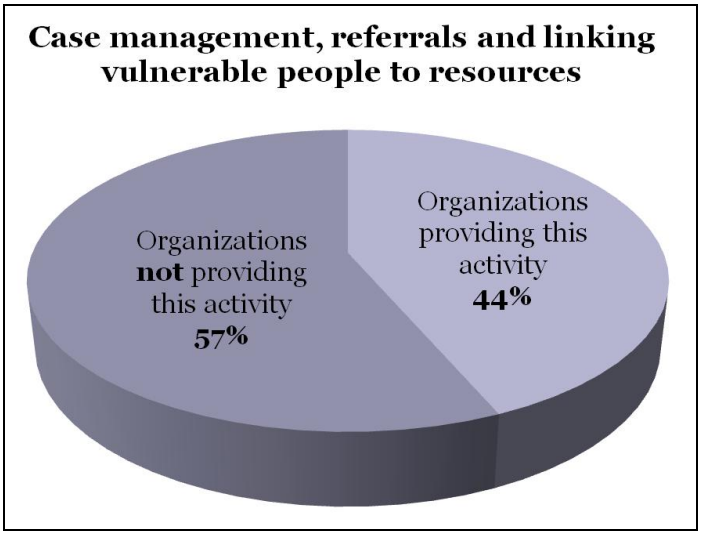
the reported spaces were unclassified under the category 'other'. One example includes services available during summer camp for King Hussein Cancer Center patients. Safe spaces provide a safe and secure environment to key beneficiary groups, and contribute to supporting stability and resilience in unstable humanitarian contexts.

Figure 9: Availability of child friendly spaces, youth friendly spaces, women centers and other safe spaces per organization (2014 and 2015/2016)



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

Figure 10: Availability of case management, referrals and linking beneficiaries to resources per organization

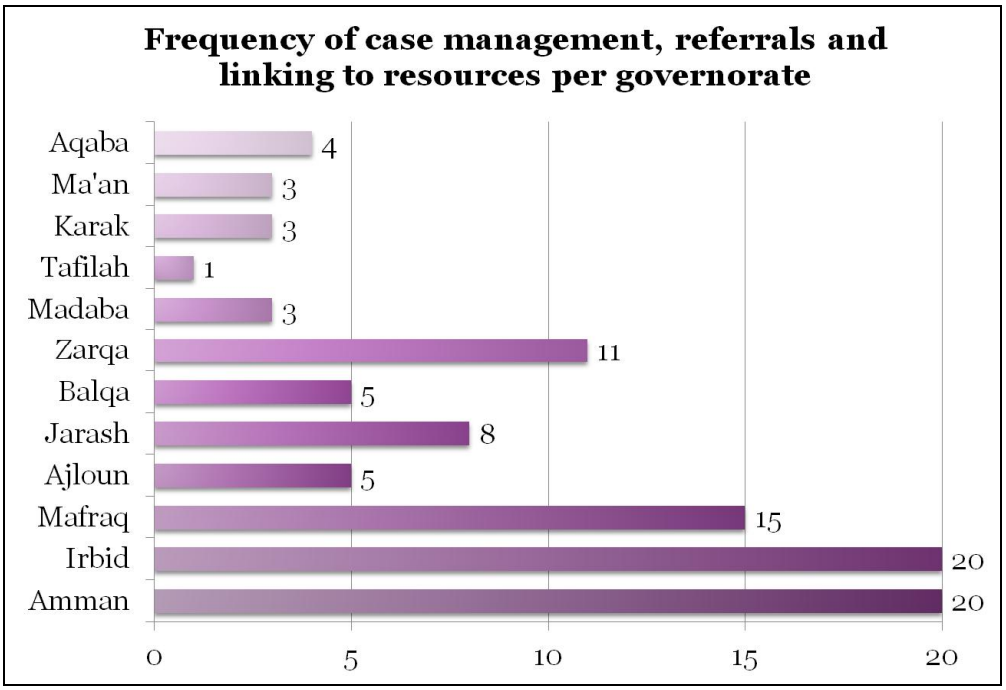


Organisations reporting case management, referrals and linking vulnerable people to resources:

ACTED, ACF, Bayt Al Liwa, Bright Future, Caritas, CVT, IMC, IRD, IRC, INTERSOS, JRS, JRC, MDM, MOSD, NHF/IFH, SC-J, Tdh-L, UPP, Vento di Terra, WC-UK.

Figure 10 above depicts that 44% of the total organizations (20 organizations) provide 'case management services, referrals and linking vulnerable beneficiaries to resources'. Moreover, this service is being provided in all governorates, which may help promote a good level of collaboration among partners, and an increased ability to meet the needs of vulnerable beneficiaries requiring referral to specific services or resources. Figure 11 below clarifies the distribution of case management activities across the governorates, with the highest frequency reported in Amman, Irbid, Mafraq and Zarqa respectively, while the lowest stated in Tafilah.

Figure 11: Availability of case management, referrals and linking beneficiaries to resources per organization



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

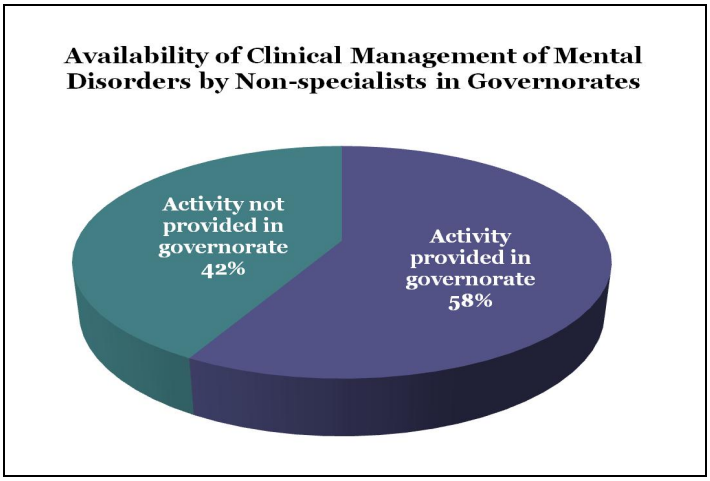
A general comparison of activities reveals that services to address the 'clinical management of mental disorders by non-specialized health care providers' account for only 3.5% of the total activities. This is a slight decrease in proportion from last year's mapping at 4%.

While the activity is provided by only 4 organizations, geographical coverage of service provision is relatively widespread as shown in Figure 12 below, reaching the governorates of Amman, Irbid, Mafraq, Zarqa, Balqa, Madaba and Karak. However, the extent of the coverage at these services is unknown, and previous reports have highlighted a need for sustainable mental health care at general

and primary health services.[3] In particular, the National Mental health Policy outlines a shortage of specialized mental health care professionals, and advocates for the integration of mental health in primary health care, in line with global recommendations. Moreover, availability of this service is lacking in the governorates of Jarash, Ajloun, Ma'an, Tafileh and Aqaba.

Figure 12: Availability of clinical management of mental disorders by non-specialized health care providers in governorates

Activity available in governorates	Activity not available in governorates
Amman	Jarash
Irbid	Ajloun
Mafraq	Ma'an
Zarqa	Tafileh
Balqa	Aqaba
Madaba	
Karak	



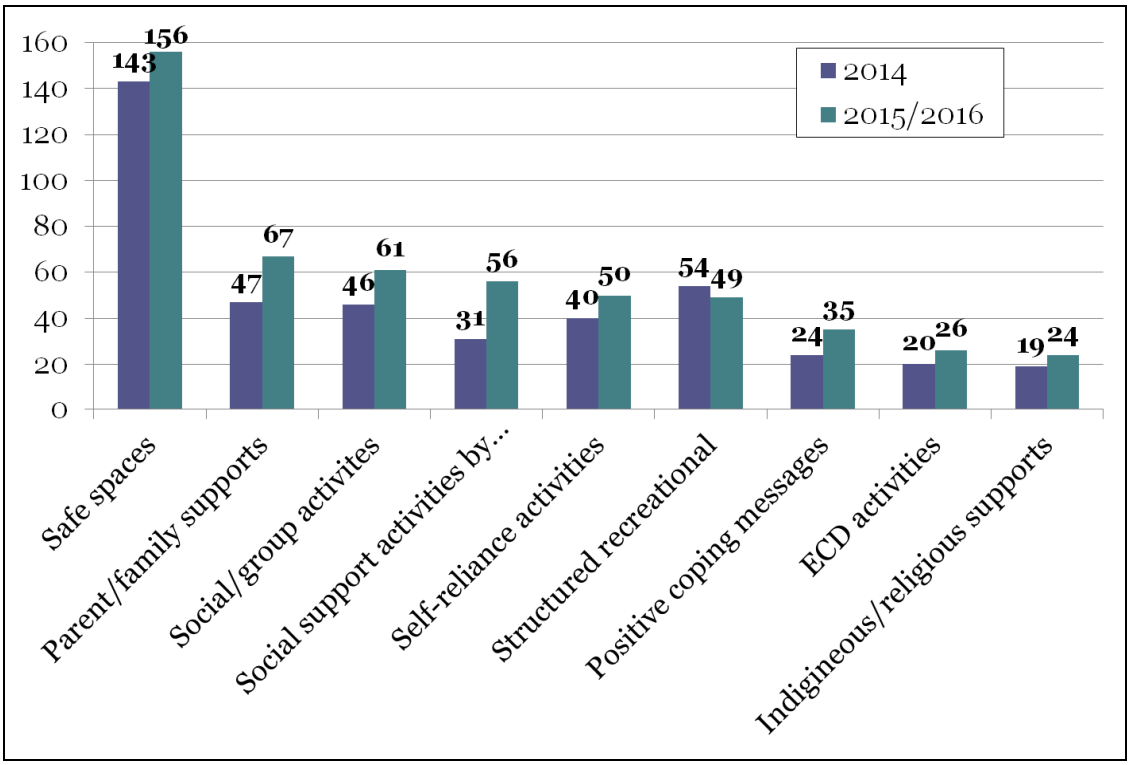
Level 2 activities: Strengthening family and community supports

The concentration of Level 2 activities in the 2015/2016 mapping was juxtaposed with findings from last year's exercise (Figure 13). Data shows some similarities, with safe spaces representing the most common Level 2 activity in both years, followed by strengthening parenting and family supports. Structured social and group activities held the third highest frequency in 2015/2016, while the service least reported for both years was the facilitation of indigenous, religious and spiritual supports.

[3] National Mental Health Policy- Ministry of Health, January 2011; and Secondary Data Review for 3RP- Health Sector.

Furthermore, results reveal that all Level 2 activities have shown some increase in the 2015/2016 mapping, with the exception of structured recreational activities which have slightly decreased from 2014. Accordingly, despite Level 2 has demonstrated a slight overall decrease in *proportion* on the intervention pyramid (i.e. when considered with the concentrations of Levels 1, 3 and 4), a consideration of individual sub-activities has shown an increase from last year.

Figure 13: Frequencies of reported Level 2 activities in the 2014 and 2015/2016 mappings



Level 4 activities: Specialized services provided by trained professionals

This mapping illustrates that 17% of reported activities are specialized services that fall under Level 4 of the intervention pyramid. The IASC Guidelines for Mental Health and Psychosocial Support define Level 4 activities as "additional support required for a small percentage of the population whose suffering, despite the supports (at other levels of the pyramid), is intolerable and who may have significant difficulties in basic daily functioning. This support may include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing services."[4]

[4] Inter-agency Standing Committee (IASC): Guidelines for Mental Health and Psychosocial Support in Emergency Settings, 2007.

Seventeen organizations reported providing Level 4 activities. Figure 14 shows activity distribution, with the majority (approximately 30%) including non-pharmacological management of mental disorders by specialists, followed by 25.5% formal psychotherapy, 22.3% pharmacological management of mental disorders by specialists, 17% pharmacological management of mental disorders by non-specialists, and 5.3% interventions for developmental disorder/intellectual disabilities.

Figure 14: Distribution of activities at level 4 (specialized services)

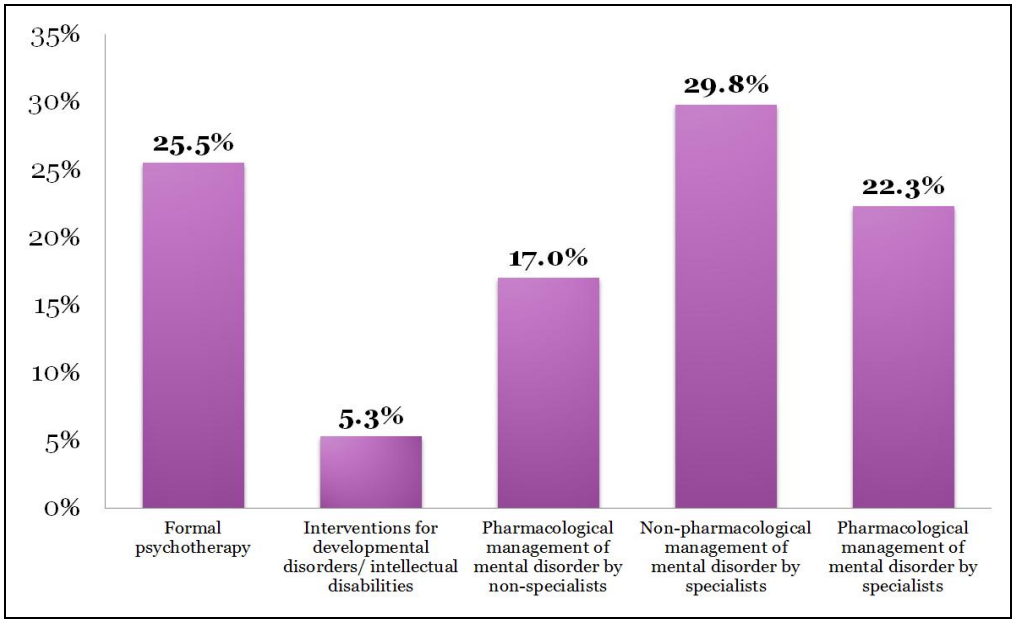
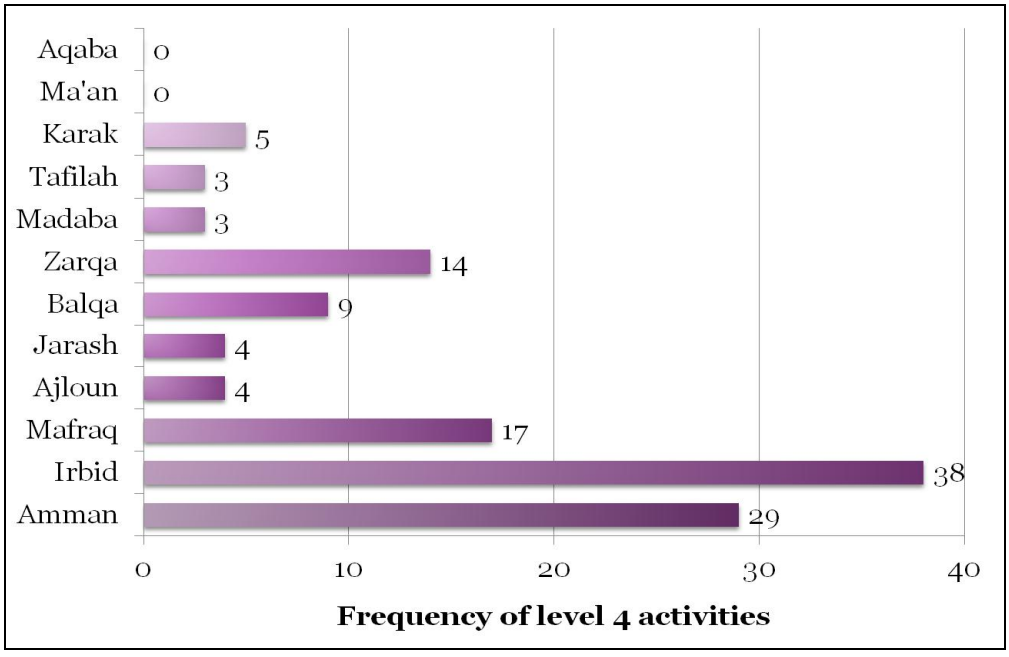


Figure 15: Frequency of Level 4 activities per governorate



As illustrated in the graph above (Figure 15), the highest concentration of specialized services was observed in Irbid (30%), followed by Amman (23%), Zarqa (11%), Mafraq (13%) and Balqa (7%). In this year's mapping, Irbid accounted for most Level 4 services, compared to Amman in 2014. Level 4 activities seem to be limited in all other governorates, with none reported in Ma'an and Aqaba this year. This could imply that further efforts are needed to capture any specialized services provided by governmental and local organizations in these governorates, to ensure that data collected on these areas is as comprehensive as possible.

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

Previous reports[5] 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 substance use problems. The significance of the latter issue arises as the use of alcohol or drugs may sometimes be adopted by beneficiaries as a maladaptive coping strategy. Such specialized services are considered Level 4 activities on the IASC intervention pyramid when provided by qualified and trained professionals.

Figure 16: Reported interventions for developmental disorders/intellectual disabilities per organization

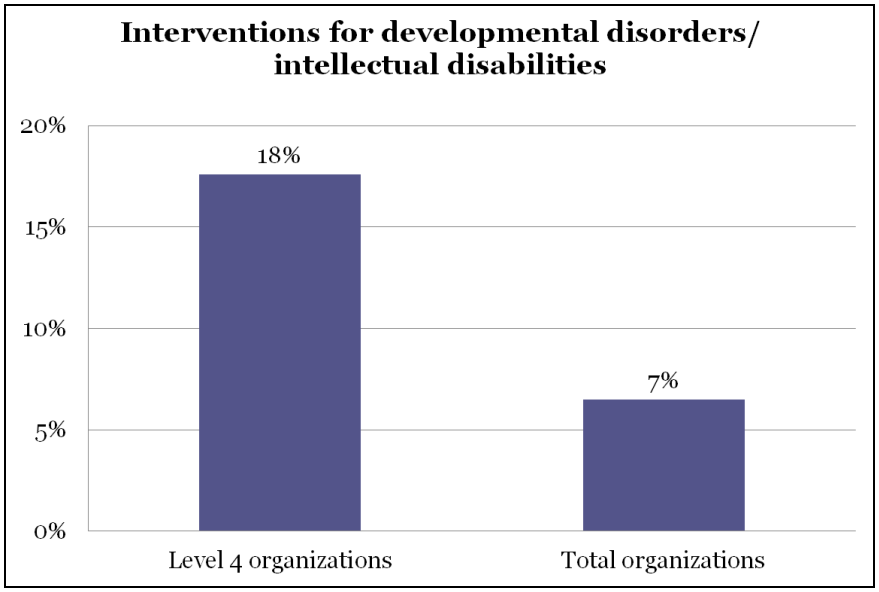


Figure 16 above demonstrates the percentages of reported services for developmental disorders and/or intellectual disabilities, considering the total number of organizations, as well as the organizations operating at Level 4. Specifically, these interventions are delivered by three Level 4

[5] National Mental Health Policy, Ministry of Health, January 2011; Help Age International and Handicap International, Hidden Victims of the Syria crisis: disabled, injured and older refugees, May 2014.

organizations (17.6% – or 6.5% of the total number of organizations). These agencies include Bayt Al Liqa, International Medical Corps, and Noor Al Hussein Foundation.

Of interest, no interventions for alcohol/substance use problems were reported in this year's mapping. This is likely due to halted programs by some organizations which had reported this activity last year, affirming that further effort should be placed to ensure that Ministry of Health and NGO services for alcohol/substance use are captured in future mappings. This will also support MHPSS actors in the provision of relevant information to beneficiaries with a need for these services.

Profile of MHPSS target beneficiaries by nationality, age and gender

This section explores the profile of target beneficiaries for MHPSS activities based on nationality, age and gender disaggregation; and is meant to help reveal whether specific target groups are either under-represented or over-represented as target beneficiaries of MHPSS services.

By Nationality

Figure 17: Reported target population nationalities

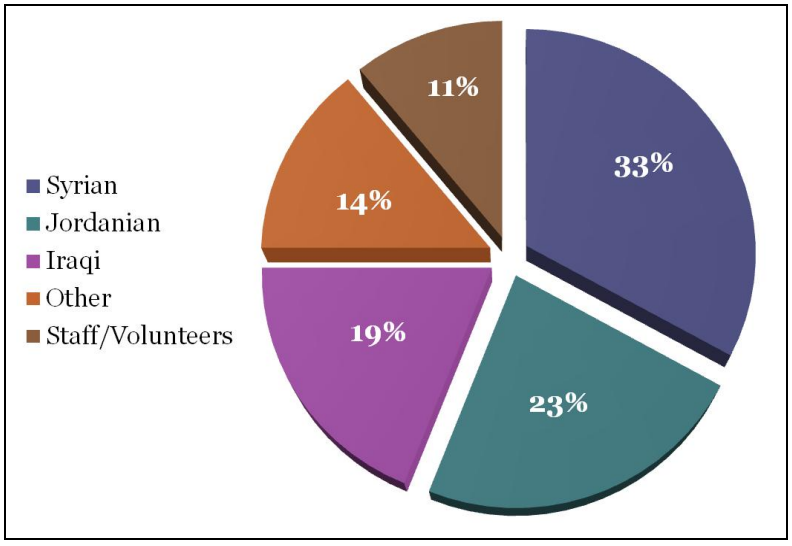
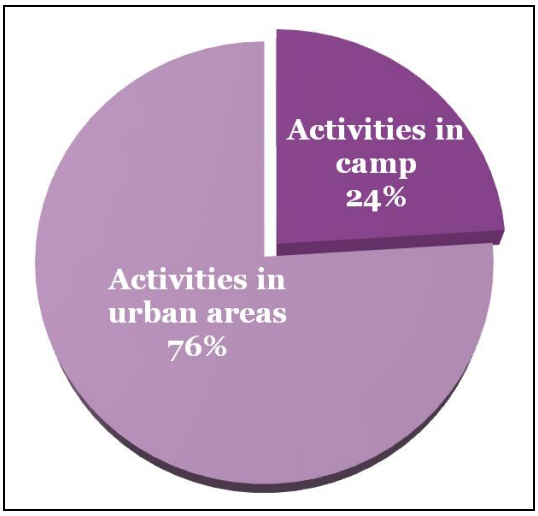


Figure 17 shows the distribution of beneficiaries by nationality targeted for MHPSS services in 2015/2016. According to UNHCR estimates[6], as of January 2016, the total population of concern registered in Jordan is 684,795 persons, including 639,704 Syrian refugees and 32,800 Iraqi refugees. Akin to the 2014 mapping, Syrians are the largest demographic group targeted by MHPSS actors, representing 33% of the reported population. At 23%, Jordanian beneficiaries represent the second largest group, followed by Iraqis at 19%. The category 'other' includes Sudanese, Somalis, Yemenis and Palestinians. Furthermore, findings identify an increased targeting of staff and/or volunteers, at 11% this year compared to 6% in 2014.

[6] UNHCR Jordan Country Operations Profile/ Overview: Statistical Snapshot.

A closer look at the targeted Syrian refugee population (Figure 18) illustrates that the vast majority (76%) reside in non-camp settings, while the remaining 24% reside in camps. This is consistent with the estimated 75% to 25% ratio of Syrian refugee concentrations in host communities and camp settings respectively.[7]

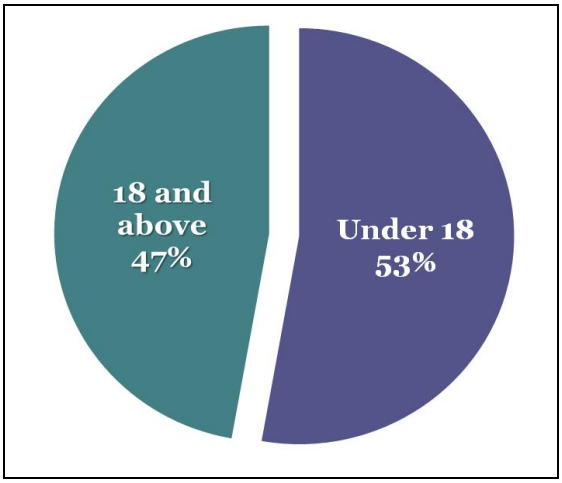
Figure 18: Syrian beneficiaries targeted camp vs. non-camp (percentages)



By Age

Figure 19 illustrates the distribution of activities based on the age of beneficiaries. The largest age group targeted by MHPSS services is between 0 to 18 years, representing 52.8% of the serviced population, while beneficiaries with the ages of 18 and over, represent 47.2% of the targeted population. This shows an approximately equal targeting among the two age groups. It is important to adequately target children and adolescents with MHPSS interventions, in order to support the prevention, early detection and management of MHPSS problems, which leads to better health and psychosocial outcomes for beneficiaries.

Figure 19: Beneficiaries by age (percentages)

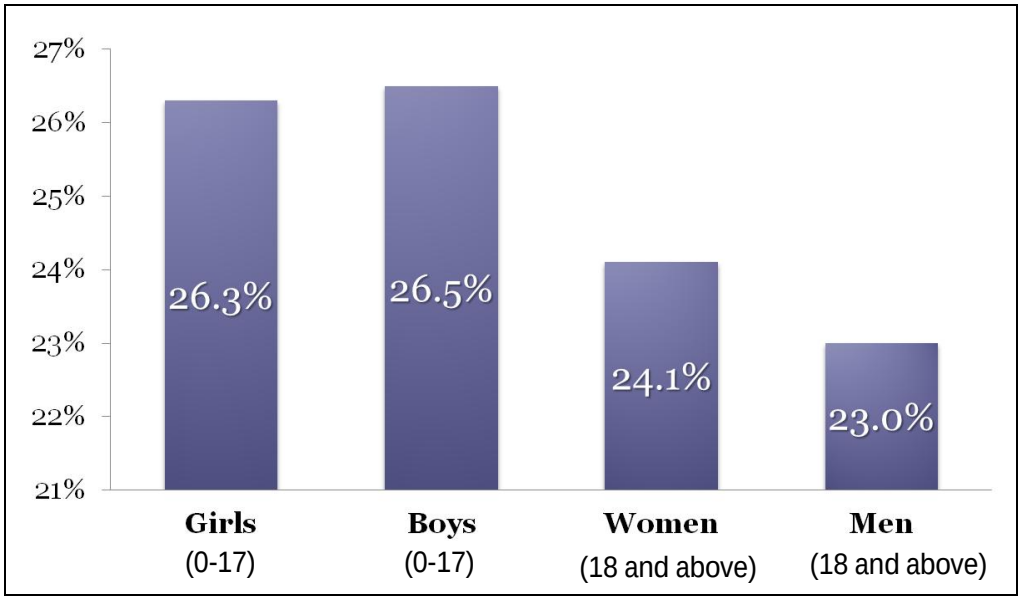


By Age and Gender

Overall, the mapping reveals a relatively similar distribution of the four age/gender groups as beneficiaries targeted by MHPSS services. Females (24.1% women, 26.3 % girls) represent 50.5% of the targeted population, while males represent the remaining 49.5% (23% men, 26.5% boys). Data shows that boys are targeted by approximately 3.5% more services than men, while girls are targeted by 2.2% more services than women. Women are targeted by 1.1% more services than men, while boys and girls are approximately equally targeted. These findings are displayed in a number of figures below (Figure 20, Table 3 and Figure 21).

[7] 2014 Syria Regional Response Plan- Jordan.

Figure 20: Age/gender distribution of beneficiaries targeted by MHPSS services



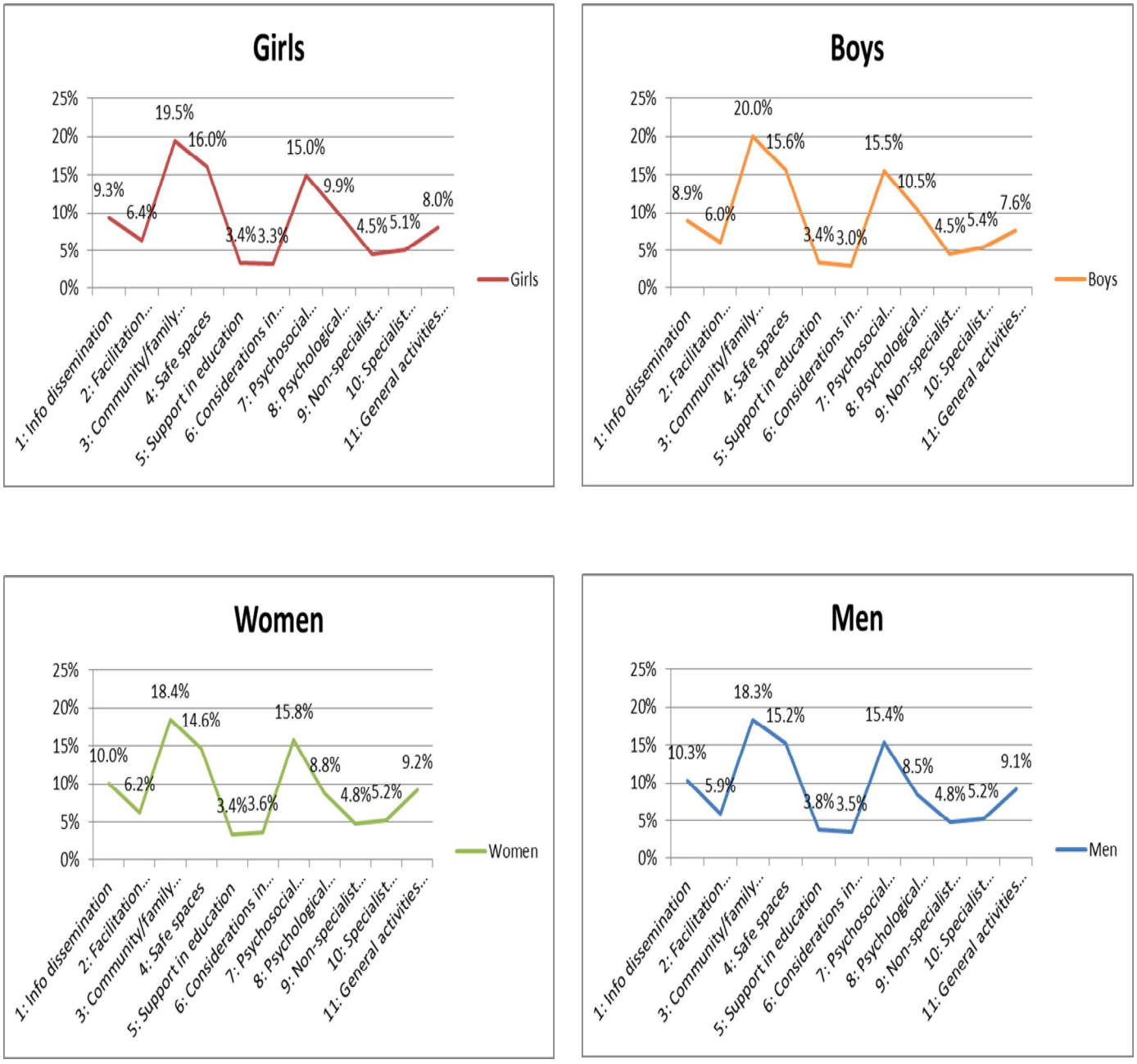
In addition, when comparing individual activities per code across age and gender groups (Activity 1 to 11), data reveals that girls, boys, women and men are fairly similarly targeted by individual MHPSS activities as well.

Table 3: Distribution of activities by age and gender

Activity		Girls	Boys	Women	Men
1	Information dissemination to the community	9.3%	8.9%	10.0%	10.3%
2	Facilitation conditions for community mobilization, organization and ownership	6.4%	6.0%	6.2%	5.9%
3	Strengthening of community & family support	19.5%	20.0%	18.4%	18.3%
4	Safe spaces	16.0%	15.6%	14.6%	15.2%
5	Psychological support in education	3.4%	3.4%	3.4%	3.8%
6	Support inclusion of social/psychological considerations in other sectors	3.3%	3.0%	3.6%	3.5%
7	Psychosocial interventions	15.0%	15.5%	15.8%	15.4%
8	Psychological interventions	9.9%	10.5%	8.8%	8.5%
9	Clinical management of mental disorders by non-specialized health care providers	4.5%	4.5%	4.8%	4.8%

10	Clinical management of mental disorders by specialized health care providers	5.1%	5.4%	5.2%	5.2%
11	General activities to support MHPSS	8.0%	7.6%	9.2%	9.1%

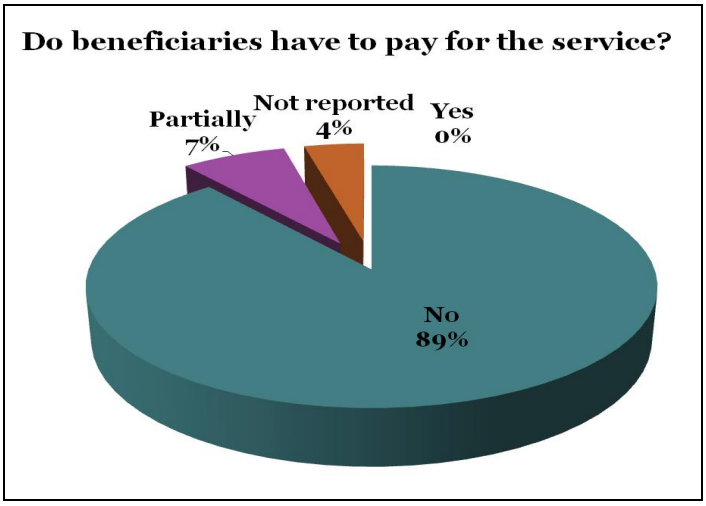
Figure 21: Distribution of activities for girls, boys, women and men



Cost of MHPSS Service Provision

Similar to previous years, the majority of MHPSS services (89%) are provided free of charge by organizations to all target population groups. A small number of organizations reported charging partial or minimal fees for their services.

Figure 22: 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 breakdown by district/neighborhood for Amman, Irbid, Mafraq and Zarqa. While the section addresses geographic distributions of overall activities, specific breakdown for selected activities/sub-activities across governorates has also been mentioned in the previous section.

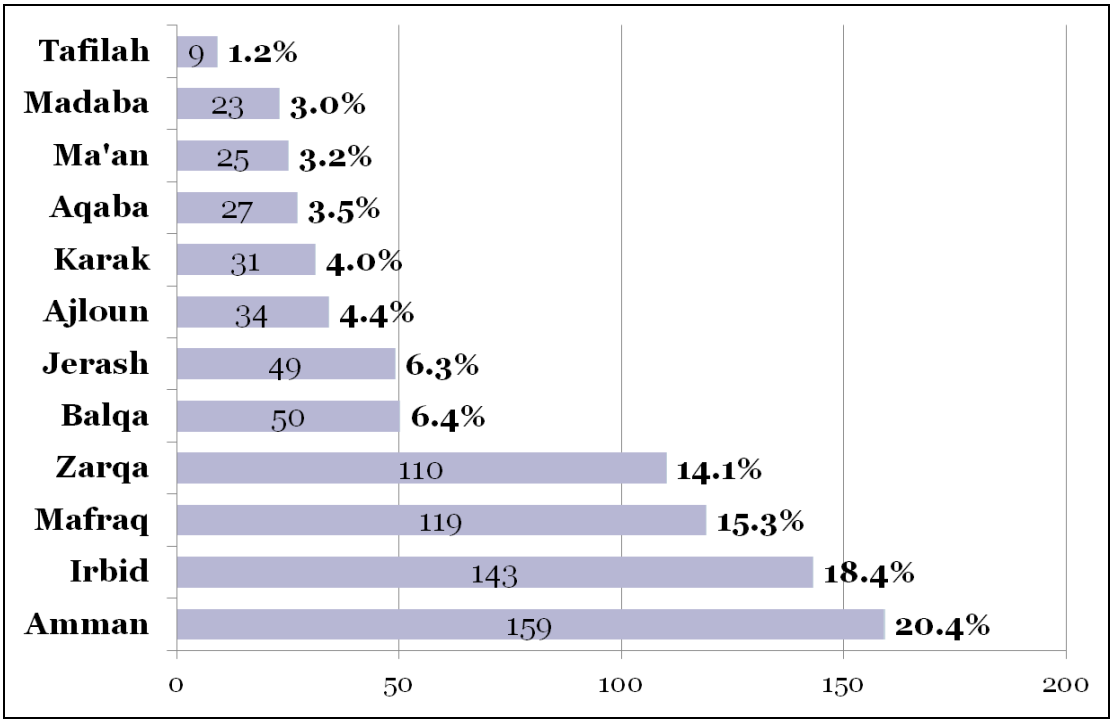
Table 4: Agencies operating MHPSS programs/activities per governorate

Governorate	Organizations
1: Amman	ARDD-Legal Aid, Bright Future, CARE, Caritas, CVT, JRC/Danish RC, DRC, FCA, IMC, IRD, ICSC, JRS, JPA, JRF, KHCC, MDM, MSF-F, MOSD, NHF/IFH, SC-I, Palliative & Pain Clinic, UPP, WVI, WHO/MOH
2: Irbid	ACF, Bright Future, CARE, Caritas, ICMC, FCA, IMC, IRD, IRC, INTERSOS, ICSC, Kitab Wa Sunna, MDM, MSF-F, MC, MOSD, NHF/IFH, SAMS, SC-I, Takaful, Tdh-L, UPP, WVI, WHO/MOH

3: Mafraq	ACTED, ARDD-Legal Aid, Bright Future, CARE, Caritas, ICMC, FCA, IMC, IRD, IRC, ICSC, JSWOC, LWF, MDM, MC, Moroccan Field Hospital, NHF/IFH, NICCOD, SC-I, SC-J, Tdh-L, Vento di Terra, WCUK, WVI, WHO/MOH
4: Ajloun	JRC/Danish RC, ICMC, IMC, IRD, ICSC, MC, NHF/IFH
5: Jarash	JRC/Danish RC, ICMC, IMC, ICSC, MC, NHF/IFH, Tdh-L
6: Balqa	ARDD-Legal Aid, Caritas, ICMC, IMC, IRD, ICSC, MC, NHF/IFH
7: Zarqa	ARDD-Legal Aid, Bayt Al Kol, CARE, Caritas, CVT, ICMC, FCA, IMC, IRD, ICSC, MC, MOSD, NHF/IFH, NICCOD, Our Step, SC-I, SC-J, Tdh-L, UPP, WVI, WHO/MOH
8: Madaba	Bayt al Liqa, Caritas, ICMC, NHF/IFH
9: Tafilah	IMC, ICSC
10: Karak	Caritas, DRC, IMC, INTERSOS, ICSC, SC-I
11: Ma'an	DRC, IRD, INTERSOS, ICSC, MOSD, UPP, WHO/MOH
12: Aqaba	ARDD-Legal Aid, JRC/Danish RC, IRD, ICSC, JRF

An analysis of services per activity code across geographic area was carried out, highlighting frequency and percentage of activities in each governorate (Figure 23 below). Similar to the previous year's mapping, the 2015/2016 findings illustrate a continued concentration of activities in the Northern and Central areas of the Kingdom, mirroring the larger proportion of Syrian refugees (and Jordanian host population) in these areas. The highest percentage of MHPSS activities is concentrated in the four governorates of Amman (20.4%), Irbid (18.4%), Mafraq (15.3%) and Zarqa (14.1%). The Southern governorates of Aqaba, Tafilah and Ma'an, in addition to the Central governorate of Madaba, showed the least concentration of activities, with the lowest being in Tafilah at 1.2%.

Figure 23: Geographic distribution of activities per governorate (percentages)



Notably, the percentage of services in Ajloun has decreased compared to the 2014 mapping (from 6.4% to 4.4%). Similarly, Tafilah witnessed a decreased proportion of activities (from 2.4% to 1.2%). On the other hand, concentration of activities in Aqaba has increased in 2015/2016 (from 0.2% to 3.5%), in addition to the governorate of Madaba (from 1.9 to 3%). Despite few roving teams were reported within governorates, no roving teams were reported across governorates this year. While initial geographic analysis indicates that Amman, Irbid, Mafraq and Zarqa are the most supported locations, further analysis is provided to understand the distribution of services within these governorates.

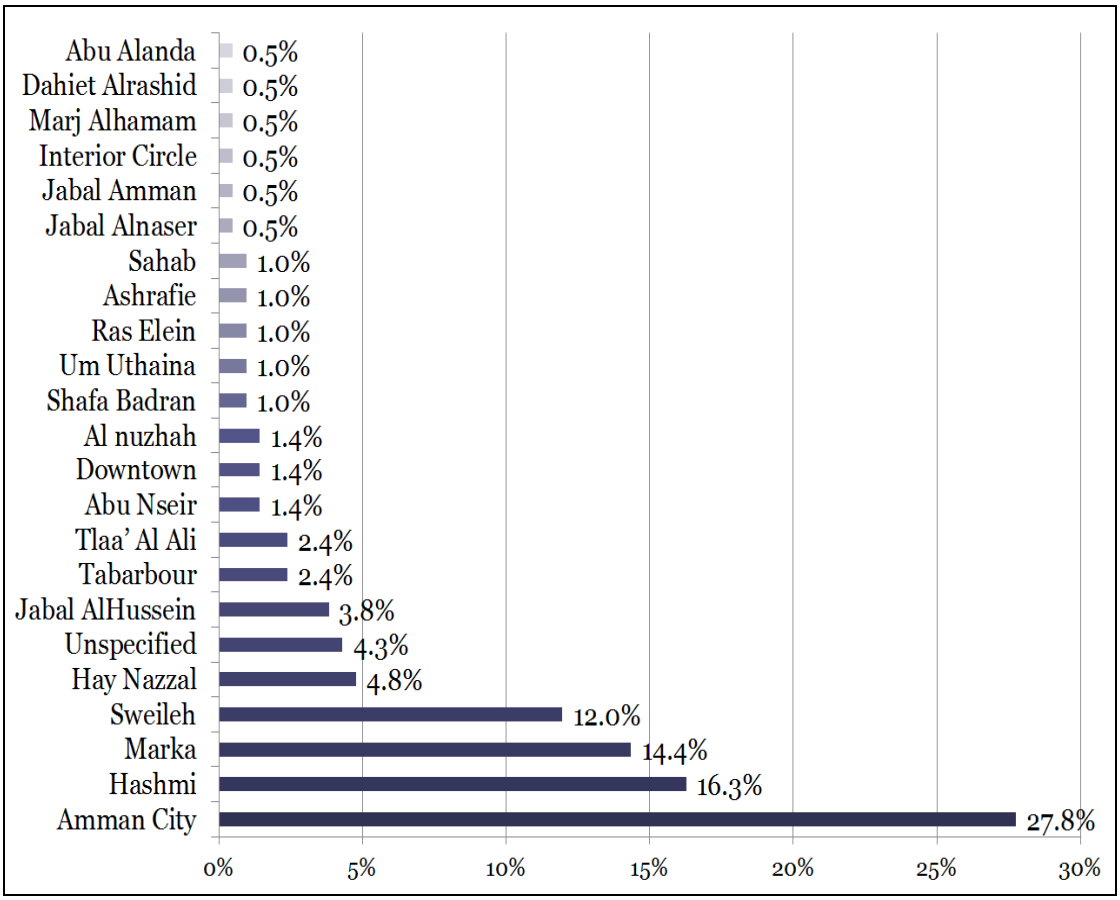
Distribution of Services in Amman

The breakdown of activities per area/neighborhood in Amman is shown below in Figure 24. As with previous mappings, the highest concentration of activities is located in Al Hashmi area, amounting to approximately 16%. However, a large increase was reported in Marka, with the percentage of reported services in this area increasing from 3.4% in 2014 to 14.4% in 2015/2016. This was followed by a good concentration of activities in Sweileh at 12%.

As many respondents did not provide specific information related to service area, or only specified "Amman City" in general, it was difficult to determine whether particular regions in Amman governorate were under-reached. However, a general review of the data does suggest an uneven

distribution of activities across the governorate, with a large proportion of interventions concentrated in Hashmi, Marka and Sweileh.

Figure 24: Activity frequencies per area in Amman governorate



Distribution of Services in Irbid, Mafraq and Zarqa

Figure 25 below outlines the distribution of activities per area in Irbid governorate. Similar to the 2014 findings, the majority of services within the governorate were reported in Irbid City at 17.6%. The second highest concentration (9.4%) is based in Ramtha. This is followed by Kharja (8.6%), Cyber City camp (8.2%), King Abdullah Park camp (7.4%) and Al Hoson (6.6%). In contrast, the lowest activity concentration in Irbid was found in Sahel Al Horan at 0.4% and Tayeh at 1.6%. Similar to inputs for Amman governorate, many of the organizations surveyed did not report a specific area within Irbid City itself.

Figure 25: Activity frequencies per area in Irbid governorate

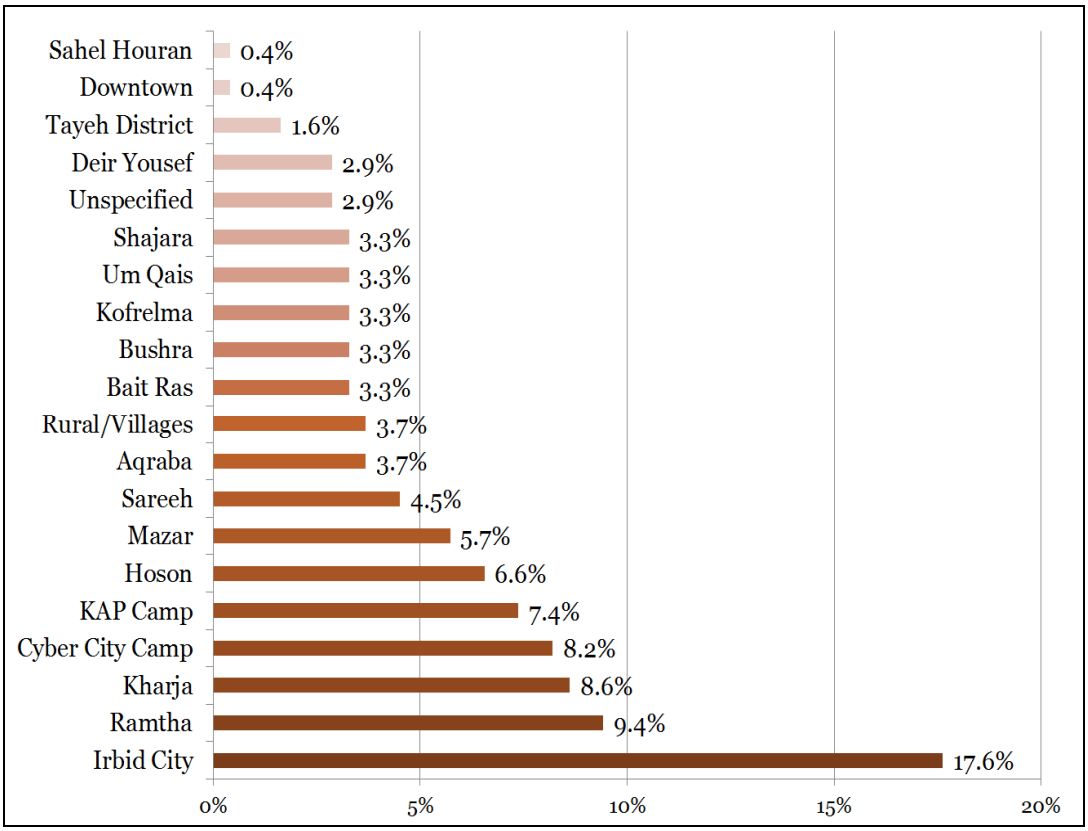


Figure 26: Activity frequencies per area in Mafraq governorate

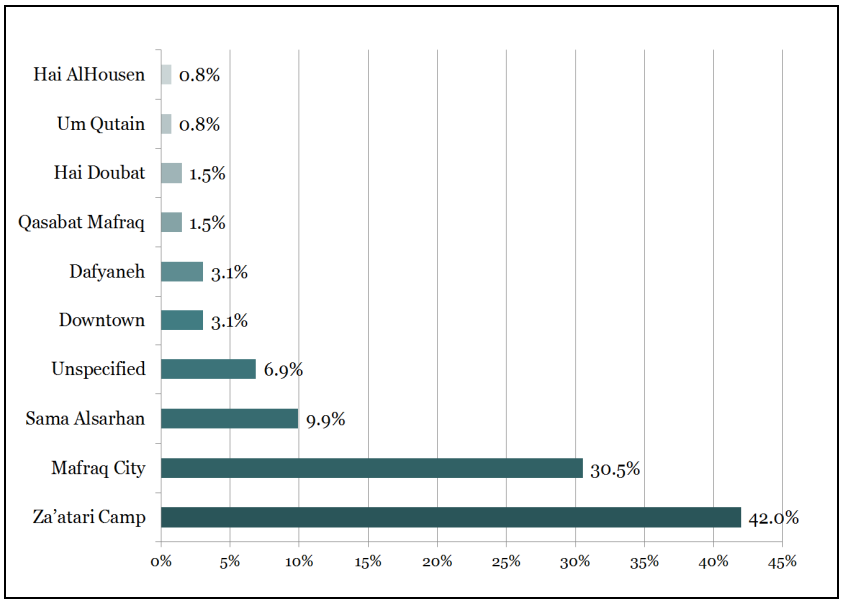
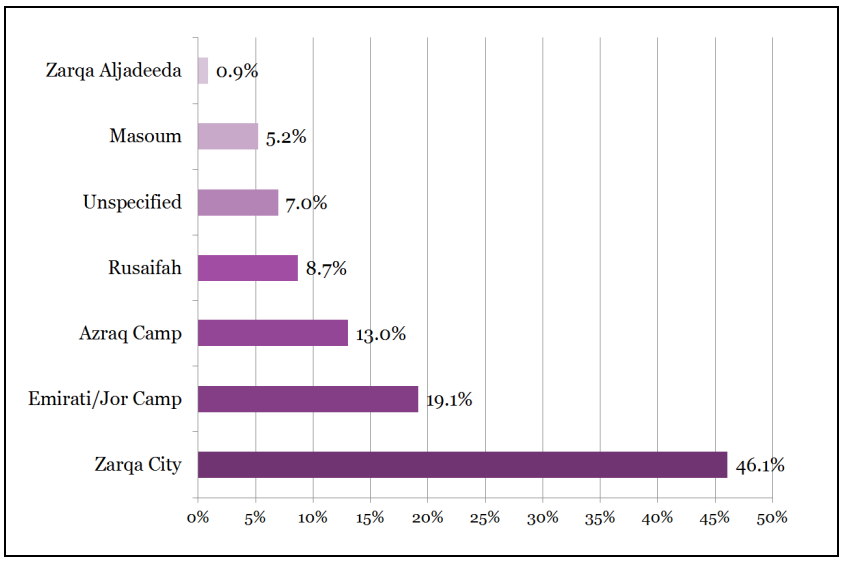


Figure 26 reflects the distribution of mental health and psychosocial support services in Mafraq. Results show similarity to the 2014 mapping, where the majority of activities are being delivered in Za'atari camp (42%) followed by Mafraq City at 30.5%. Of interest is the notable increase of services reported at Sama Al Sarhan, with activity concentration growing from 3.8% in 2014 to 9.9% in 2015/2016.

Figure 27: Activity frequencies per area in Zarqa governorate



The mapping also included a breakdown of activities per area in Zarqa governorate (Figure 27). Data reveals a majority concentration of MHPSS activities in Zarqa City at approximately 46%, followed by the Emirati Jordanian Camp with about 19%, and Al Azraq camp with 13%. Activities in Rusaifah were reported at 8.7%. However, 7% of the reported interventions did not specify a particular area, and in general, less detail was entered by responders about neighborhoods in Zarqa compared to the three previously-mentioned governorates.

Figure 28: Concentration of activities and targeted population per governorate

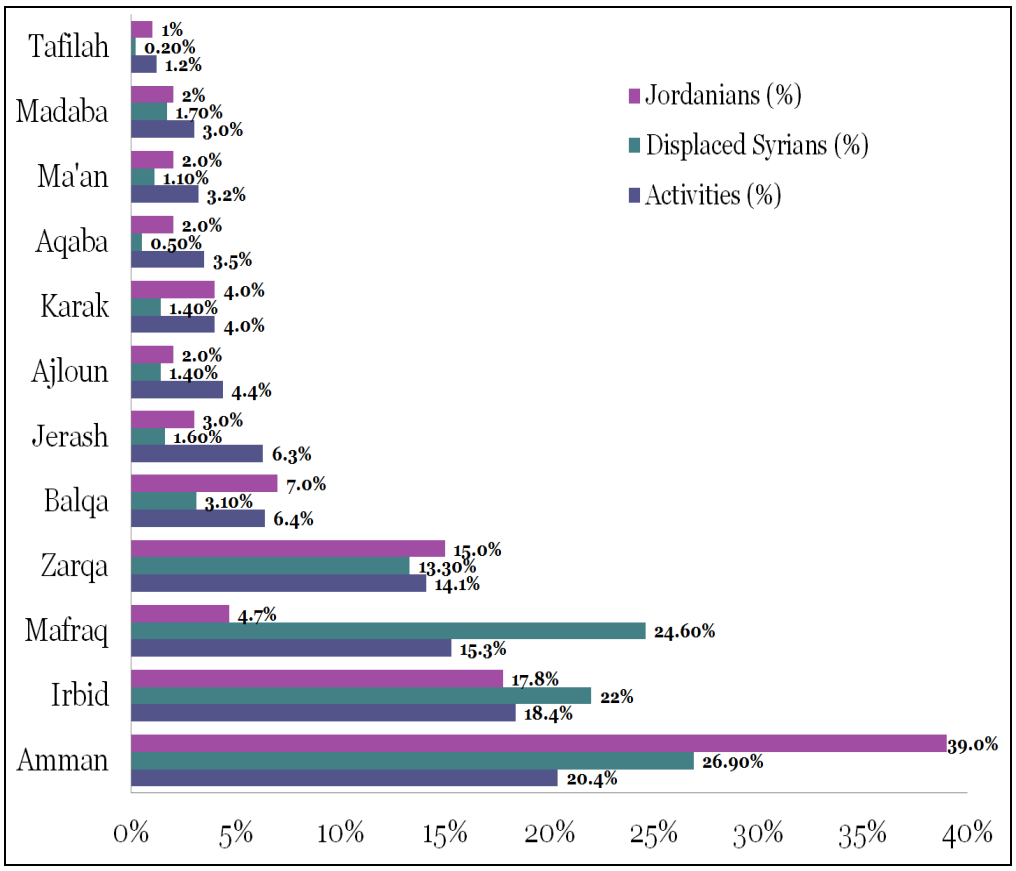
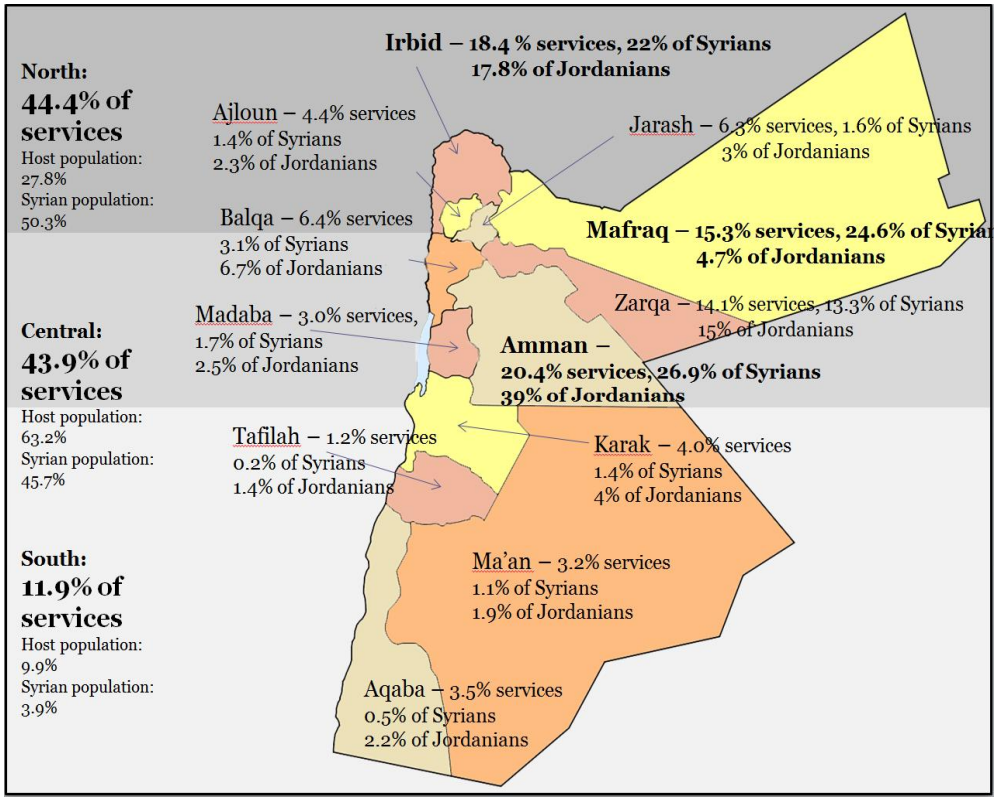


Figure 28 (above) provides a comparison of activities in the twelve governorates while considering the target population served (specifically Jordanians and Syrian refugees). Results demonstrate that both the Jordanian and Syrian populations are targeted by mental health and psychosocial support activities in each governorate, with varying percentages between them. For example, MHPSS services in Irbid and Mafraq, target a majority Syrian population, while services in Amman and Zarqa target a majority Jordanian population.

Additional information about the geographic distribution of MHPSS activities in relation to the actual respective populations present in each governorate is illustrated below. The map (Figure 29) highlights the concentration of activities in percentages per governorate, as well as the corresponding population percentages.

Geographic divisions were mapped out to delineate the Northern region (Irbid, Mafraq, Ajloun and Jarash), the Central region (Amman, Zarqa, Madaba and Balqa), and the Southern region (Aqaba, Ma'an, Tafileh and Karak). The country map indicates that 44.4% of MHPSS services are located in the Northern governorates, while 43.9% are concentrated in the Central areas. The South is served by only 11.9% of services. This pattern of activity distribution by region is very similar to findings from the 2014 mapping.

Figure 29: Density map of services per governorate and population



**Note: the total population of Syrian refugees displayed on the map amounts to 97.8%, as 2.2% are dispersed and not located in one specific governorate. For the purpose of this figure, this was equally adjusted for the northern, central and southern regions.*

Table 4 (shown on the following page) conveys the concentration of activities per governorate, the size of the host and Syrian refugee population in each governorate, and the activity concentration per 100,000 of each respective population.

Table 4: 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	159	2,473,400	39%	6.43	171,122	26.9%	92.92
Irbid	143	1,137,100	17.80%	12.58	139,647	22%	102.4
Mafraq	119	300,300	4.70%	39.63	156,102	24.6%	76.23
Zarqa	110	951,800	15%	11.56	84,489	13.3%	130.19
Balqa	50	428,000	7%	11.68	19,852	3.1%	251.86
Jarash	49	191,700	3%	25.56	10,269	1.6%	477.16
Ajloun	34	146,900	2%	23.14	8,779	1.4%	387.29
Karak	31	249,100	4%	12.44	8,676	1.4%	357.31
Aqaba	27	139,200	2%	19.40	3,154	0.5%	856.06
Ma'an	25	121,400	2%	20.59	7,187	1.1%	347.85
Madaba	23	159,700	2%	14.40	10,735	1.7%	214.25
Tafilah	9	89,400	1%	10.07	1,571	0.2%	572.88

**Note: Numbers of displaced Syrians represent registered refugees as per UNHCR data as of February 2016. Numbers of Jordanians as per Jordan Department of Statistics data (August 2014).*

Data from the 2013, 2014 and current 2015/2016 mapping was juxtaposed to portray the geographical distribution of activities per governorate over the past 3 mapping exercises. Figure 30 below suggests that, in general, there has been a wider reach of MHPSS services across governorates over the years, as well as a slightly more even distribution between the various locations.

At 20.4%, Amman remains the governorate with the highest concentration of MHPSS activities in this year's mapping, mirroring this finding over the last 3 years. Similarly, at 18.4%, Irbid had the second highest concentration of activities, followed by Mafraq governorate at 15.3%. The percentage of activities for these latter two governorates is somewhat similar to the 2014 mapping, with a 0.8% increase of reported activities in Irbid, and a 1.2% decrease of activities reported in Mafraq. Again, it should be emphasized that these figures represent *proportional* estimations relative to the collective amount of activities reported in all governorates, as opposed to independent changes in frequencies for each governorate.

As previously mentioned, the governorate of Aqaba demonstrated an increase of reported services from last year (0.2% to 3.5%). On the other hand, some governorates registered a proportional decrease of MHPSS activities, including Ajloun and Tafilah by 2% and 1.2% respectively.

Figure 30: Activities per governorate from the 2013, 2014 and 2015/2016 mappings

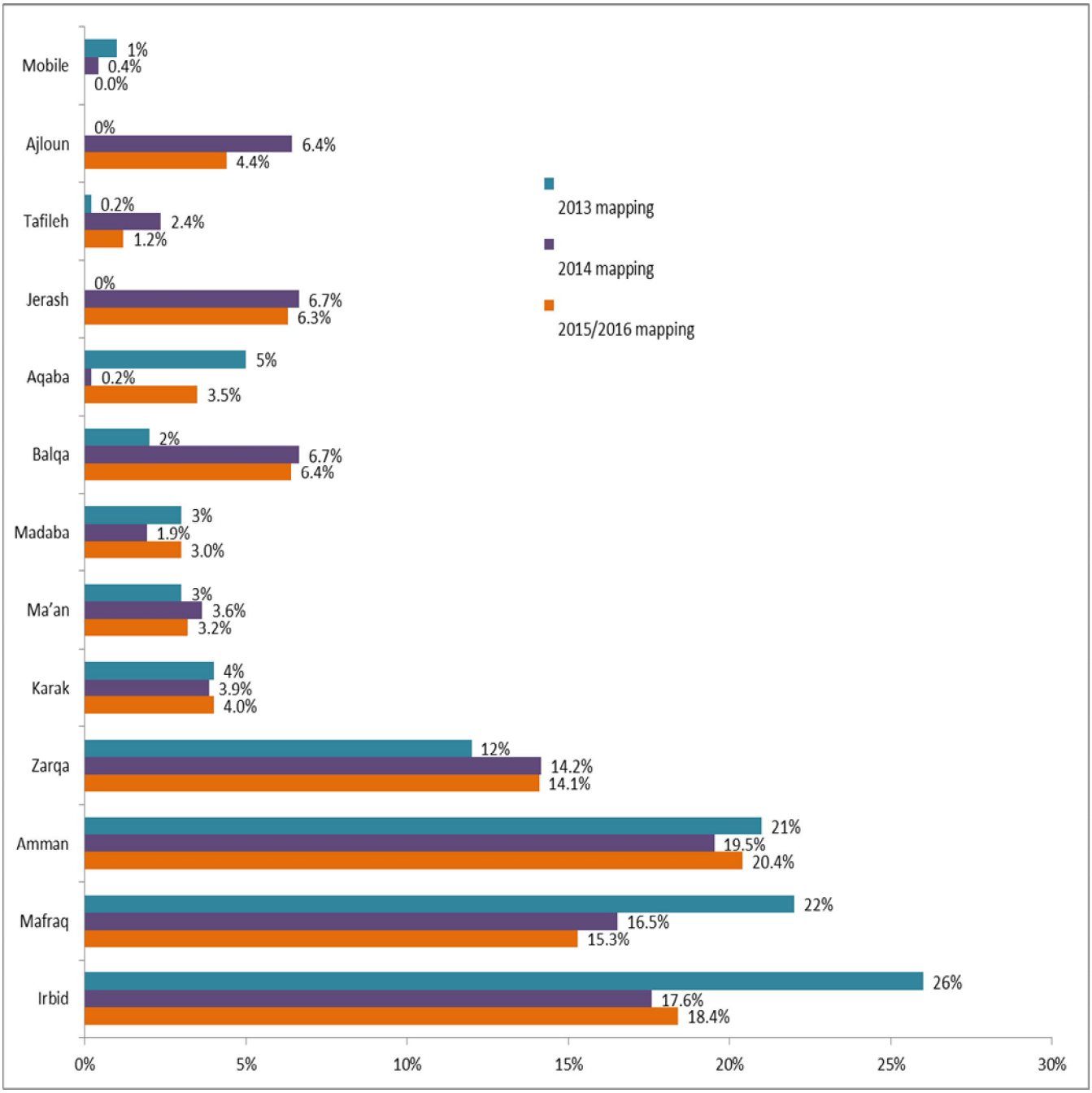


Figure 31: Percentage of activities per Syrian refugee camp

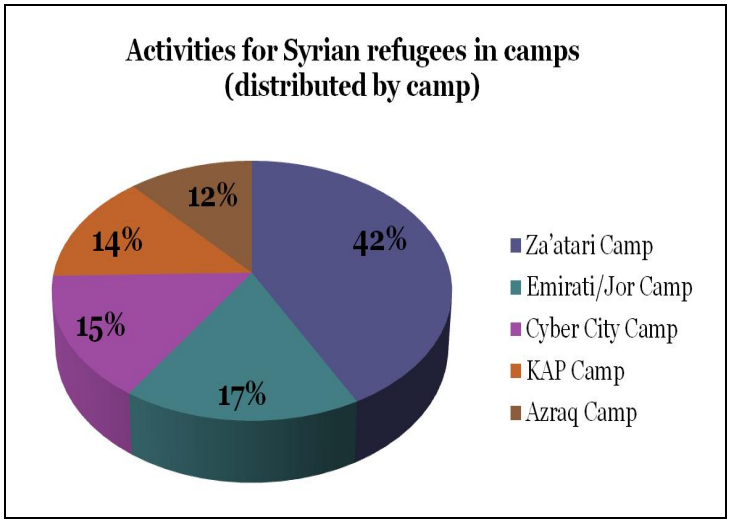
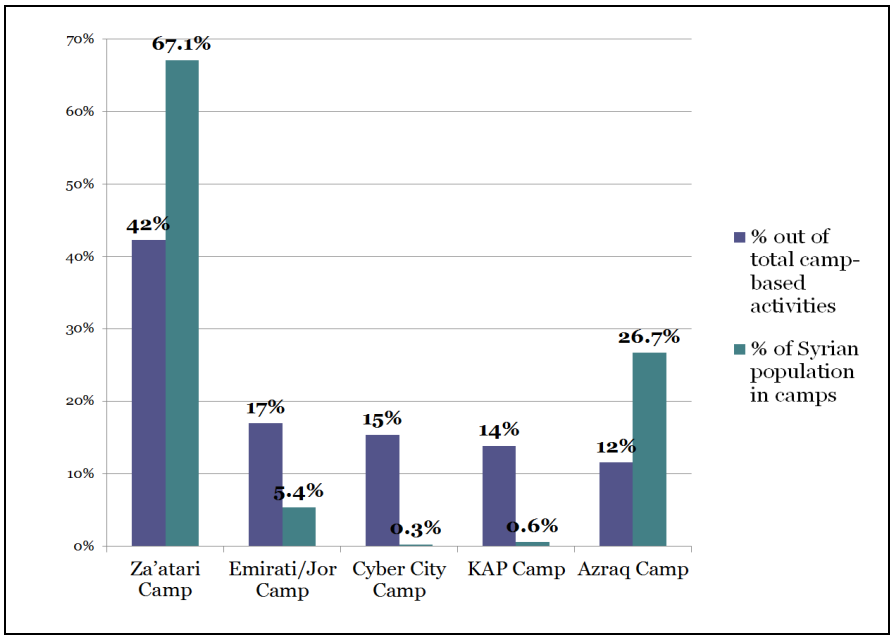


Figure 31 depicts the distribution of mental health and psychosocial support activities taking place at Syrian refugee camps in Jordan. The majority of camp-based activities are present in Za'atari camp (Mafraq governorate) at 42%. This is followed by 17% in the Emirati Jordanian camp (Zarqa governorate), 15% at Cyber City camp in Irbid governorate and 14% at King Abdullah Park camp, also in Irbid. The lowest concentration of MHPSS activities among Syrian refugee camps was reported in Azraq at 12% (Zarqa governorate).

The proportion of activities in each camp was compared to the recorded population of Syrian refugees (Figure 32). Overall, MHPSS activity distribution does not appear to be adequately proportional to corresponding refugee populations in the camps. In particular, Cyber City and KAP have a very low relative concentration of refugees (0.3% and 0.6% respectively) when compared to MHPSS activities reported in these camps, with 15% and 14% respectively. On the other hand, Al Azraq holds 26.7% of the Syrian refugees residing in camps, while being targeted by only 12% of MHPSS activities.

Figure 32: Camp-based activities compared to Syrian refugee population

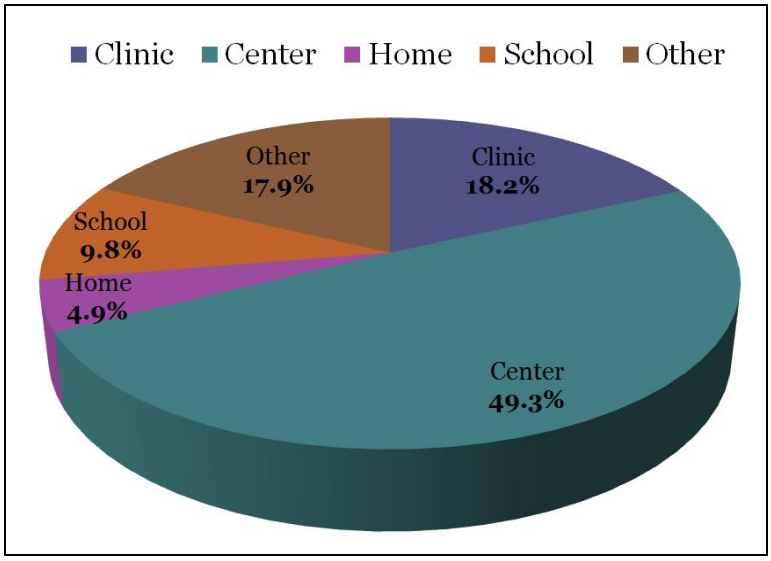


**Note: Figures for population of Syrian refugees in camps were extracted from UNHCR's Syrian Refugee Response Portal (as of 17 Feb 2016), and UNHCR Irbid Field Office Factsheet (as of May-June 2015).*

Provision of MHPSS activities in various settings

MHPSS services are provided in a wide range of settings to accommodate the different levels of care delivered, and the varying needs of beneficiaries. In general, the 2015/2016 mapping reflects a wider distribution of services across settings when compared to the 2014 mapping. The majority of MHPSS services (49.3%) are still offered at centers this year; however, this is a decrease from the 63% of center-based services reported in 2014. Moreover, 18.2% of MHPSS services are offered at specialized clinics, about 9.8% are provided in school settings, while only 4.9% of activities and interventions are provided through home visits. Nonetheless, in comparison to the 2014 mapping, this represents an increase of 7.8% and 3.2% for school- and home-based services respectively.

Figure 33: Setting where MHPSS services are provided



As the 4Ws mapping only includes information from MHPSS service providers through the MHPSS Working Group, further information is needed from Education Sector partners to identify additional MHPSS services provided in schools beyond what was captured through this exercise. Finally, the category 'other' has increased from to 1.5% in 2014 to 17.9% in 2015/2016. This 16.4% increase is most likely linked to the 14% increase in organizations providing safe spaces this year, with most responders reporting 'safe spaces' or 'community' under this category.

When

In mapping MHPSS services, the 4Ws tool also sought to identify the sources of funding for organizational programs, services and activities. Diverse funding sources were indicated (previously mentioned), with multiple cycles including recurrent funding, fixed funding, and one-off grants.

Figure 34: Status of implementation of activities

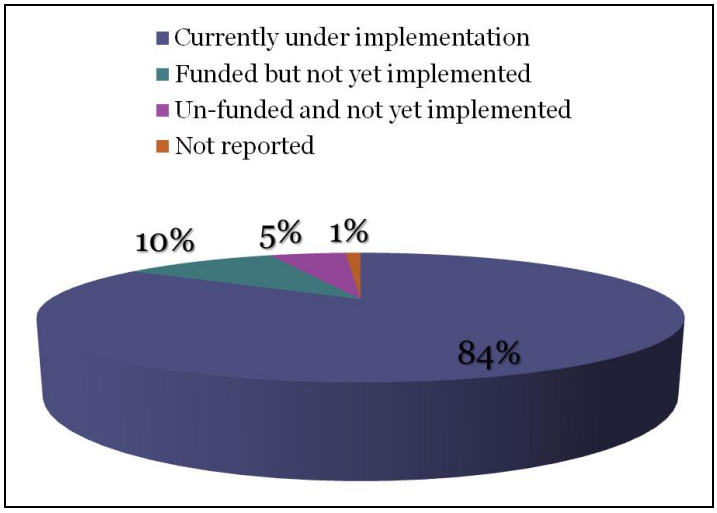
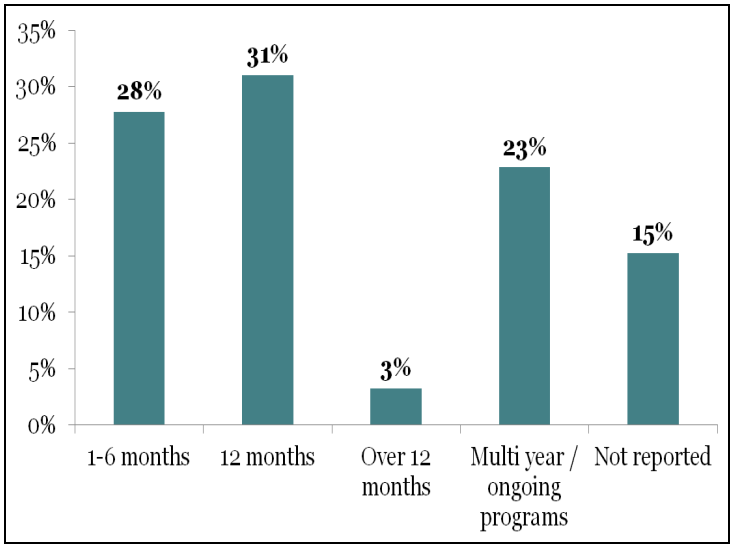


Figure 34 shows the breakdown of activities as related to their status of implementation. Respondents indicated that the majority (84%) of their activities are 'currently under implementation'; while 10% are 'funded but not yet implemented', and 5% are 'un-funded and not yet implemented'. For activities reported as 'un-funded and not yet implemented', some participants noted that project proposals are awaiting donor approval.

Figure 35 shows the length of funding (or funding cycles) for reported activities. Findings indicate that the majority of funding cycles (31%) fall in the '12 months' category, which was also listed as the highest category in the previous year at 46%. However, results evidenced a marked change from the 2014 mapping, where projects under the '1-6 month' category increased from 14% to 28%. The category 'multi-year/ongoing' also witnessed an increase from 16% to 23% in this year's mapping. These longer funding cycles enable more planning towards longer-term service provision that allows better sustainability and continuity of care.

Figure 35: Funding cycle per activity



Discussion

Service Coverage and Distribution

Type of Activities

This year's mapping shows some changes in the distribution of MHPSS services across the IASC pyramid levels when compared to the 2014 exercise. Data indicates a 5% increase in proportion of Level 4 (specialized services), reflecting work carried out by 18 organizations. On the other hand, the concentration of Level 2 (community and family supports) and Level 3 (focused non-specialized supports) activities is similar to the previous year, with a slight increase at Level 2, and a slight decrease witnessed at Level 3. While Level 2 still accounts for the majority of activities reported by the MHPSS sub-sector, it seems to have been stabilizing in proportion on the intervention pyramid over the last 3 years to an average of 38% of services.

Similar to the 2013 and 2014 mappings, data reveals a lower proportion of Level 1 activities compared to what is recommended by IASC intervention pyramid. While there is 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.), very limited activities are reported to target the inclusion of social/psychological considerations in other sectors, which is especially important to enhance preventative and protective measures that promote MHPSS wellbeing.

As this remains an area for increased action by the sub-sector, suggestions include delivering orientations/sensitization on key MHPSS issues (e.g. IASC Guidelines principles; MHPSS Do's and Don'ts), in addition to the increased facilitation of conditions for community-led mobilization and organization. Another possibility is to conduct routine screenings/ brief evaluation of key MHPSS-related issues in basic services and security, to generate recommendations or suggestions for augmenting or maintaining MHPSS wellbeing. Moreover, the Working Group is currently preparing a 1-2 day basic training package to be delivered to various target trainees. This could be helpful towards increasing activities at Level 1, should the package also be delivered to humanitarian workers in basic services and security.

Despite findings evidenced an increased proportion of Level 4 on the intervention pyramid; nonetheless, the most reported activities by MHPSS actors remain to fall under Levels 2 and 3, including strengthening family and community support, psychosocial work and safe spaces. This is in line with IASC recommendations, indicating a higher need for non-specialized services by a larger proportion of beneficiaries. However, there is still a limited availability of the management of MHPSS problems by non-specialized health care workers, despite global mental health recommendations on

the importance of this intervention as a bridge on the continuum between community activities and specialized services[8]. This is especially true for the governorates of Jarash, Ajloun, Ma'an, Tafileh and Aqaba, where this activity is generally unavailable.

Furthermore, the breakdown of specialized services points to the limited availability of interventions for developmental disorders and intellectual disabilities. This has been a constant gap carried over from previous 4Ws mappings, field observations as well as findings by other relevant reports[9]. In addition, no interventions for alcohol and substance use were reported in this year's exercise. It is unclear whether this input was simply missed, or if it is due to halted programs/activities by organizations delivering specialized services.

This suggests that future mappings should strive to capture more comprehensive data from governmental entities. For instance, the Ministry of Health is still being mapped through its partners; consequently, data on particular specialized services (e.g. interventions for substance use; inpatient care) is not entered as these services have not been part of organizational programs with MOH at the time of the mapping. A more comprehensive inclusion of such activities is recommended to generate further clarity on the full scope of specialized services. Nonetheless, the findings do indeed provide a picture of the services being delivered by our collective agencies.

Similarly, data is also low for psychological support in education at 3.5%. However, this is most likely due to the limited representation of such activities in the mapping. As the 4Ws exercise is completed by the Mental Health and Psychosocial Support Working Group members, services delivered by agencies that are not part of this group might not be captured. Future mappings should strive for greater inclusion of such activities through ensuring input from the Ministry of Social Education and additional education actors.

Activity code 11 is related to general activities to support MHPSS, including the provision of psychosocial support for staff and volunteers. 'Staff care' refers to "individual practices and institutional responses to stress among humanitarian workers, aiming to promote the wellbeing, create a supportive environment and enhance productivity"[10]. Managing stress enables the organization to fulfill its field objectives, protect the wellbeing of individual staff, teams and beneficiaries, as well as increase safety and security.

[8] WHO Mental Health Gap Action Programme (mhGAP).
[9] National Mental Health Policy, Ministry of Health, January 2011; 3RP Secondary Data Review- Health Sector 2014; Help Age and Handicap International, Hidden Victims of the Syria crisis: disabled, injured and older refugees, May 2014.
[10] Definition of self-care is adapted from InterAction (2008) and People In Aid (2009).

Despite its importance, results reveal that the majority (65%) of MHPSS agencies do not provide this service. It is highly recommended that more organizations are committed to supporting staff wellbeing either directly through access to self-care and stress management activities, peer and professional support, or through facilitating access to this care by external entities. It is also recommended that the MHPSS training package being prepared by the Working Group includes some basic information about self-care.

Target Populations

A wide range of populations are targeted by MHPSS activities, including Jordanians as well as Syrian, Iraqi, Palestinian, Yemeni, Somali and Sudani refugees. The mapping shows that Syrian refugees represent the majority of the target beneficiaries. To date, the influx of Syrians arriving into Jordan continues, placing considerable burden on local host communities and basic health, social and economic services, a challenge that led the Ministry of Planning and International Cooperation (MOPIC) to apply a requirement of at least 30% service provision to Jordanians. This is meant to help mitigate the impact of refugee influx, and to ensure the Jordanian population is also properly supported.

Most activities targeting Syrian refugees are located in urban areas, while almost one quarter of the interventions are directed towards Syrians in camps, which is consistent with population estimations in urban areas and camps.[11] As expected, the refugee camp predominantly targeted by MHPSS activities is the largest, Al Za'atari, of 79,648[12] registered Syrian refugees located in Mafraq governorate. A closer look at the distribution of services across camps suggests that the proportion of activities may not always correspond to the estimated population in the respective camp. For example, activity proportions seem to be relatively higher than population proportions in the smaller camps (e.g. Emirati Jordanian camp, Cyber City and King Abdullah Park), while being lower than population proportions in Zarqa governorate's Azraq camp. One recommendation from this mapping is to further explore whether there is a need for additional MHPSS services in Azraq camp.

An analysis of activities disaggregated by age and gender groups reveals very similar distribution of activities targeting girls, boys, men and women. Akin to last year's mapping, girls and boys are targeted by a slightly higher frequency of activities than woman and men (about 2-3.5% higher), with girls and boys receiving more community/family supports and psychological interventions, while women and men receiving more general activities to support MHPSS. These differences are very minimal however, and overall, it appears that MHPSS activities are similarly supporting girls, boys, women and men.

[11] UNHCR Information Sharing Portal, Syrian Refugee Response.
[12] UNHCR Information Sharing Portal, Syrian Refugee Response.

Geographic Areas

Overall, the concentration of services in the Northern and Central zones was found to be similar, with slightly more activities targeting the Northern governorates. As expected, the governorates with the highest presence of Syrian refugee populations; Amman, Irbid, Mafraq and Zarqa, represent the areas most serviced by MHPSS interventions. While the Southern governorates and the Central governorate of Madaba are the least targeted areas by MHPSS activities.

In the Central zones, activities are relatively proportional to the Syrian refugee populations residing in host communities, but are lower than the percentage of the Jordanian population in these areas. In contrast, while overall percentages of services in the North were significantly larger than the corresponding Jordanian population, they were less in proportion to the percentage of displaced Syrians. For example, the governorate of Mafraq hosts an estimated 24.6% of the Syrian refugee population, yet only 15.3% of total MHPSS services. In the South, activities appear to match to the percentage of Jordanians, yet are notably higher than the proportion of Syrian refugees in this area.

However, despite the Southern zone exhibits a fair concentration of MHPSS services compared to both the Jordanian and Syrian refugee populations (as both are relatively low in these governorates), it remains to be the most under-served area with only 11.9% of the total interventions. Data suggests that new programs have been initiated in Aqaba with a 3.3% increase in activities, while it appears that services in Tafilah have decreased, with very few agencies operating in the governorate.

It is difficult to infer definite conclusions about geographic coverage without obtaining additional data, including observations from actors in the field. Further localized assessment is essential to provide a more comprehensive evaluation of service provision in specific geographic areas, including whether or not the MHPSS needs of populations in these areas are being met. Similarly, a general review of activity concentrations across districts/neighborhoods suggests some uneven distribution in certain governorates (e.g. in Amman). Hence, a comparison with population densities and pockets of refugees within governorates will also help further our understanding of geographic coverage and needs.

Challenges

Tool-specific challenges and limitations

Feedback following the mapping exercise indicated that responders found it generally easy to complete the 4Ws tool. The codified data points for activity, sub-activity and target groups were simple to complete, and the tool has become relatively familiar to most agencies. Few suggested

modifications/additions are summarized in Annex 4 (overview of the 2015/2016 4Ws mapping workshop).

Nevertheless, some challenges and limitations did emerge, as the input entered was sometimes inconsistent between different organizations, or sometimes even within the same organizational entry, possibly as different staff members may have been completing the information for different activities. Moreover, there is still a need to ensure a more unified use of specific terminology among MHPSS actors. Anecdotal observations suggest that different agencies tend to define their provided MHPSS services in various ways, leading to inconsistencies in some reported activities. It may be useful to hold an orientation for the focal points responsible for completing the 4Ws data in future mappings. Further, additional drop-down options can be added to the tool to increase standardization of the information provided; for example, outlining fixed municipalities/districts, human resource categories, broad training topics, as well as other possible options.

While the majority of organizations reported information on funding sources and cycles, most did not submit funding amounts. Accordingly, the mapping was unable to provide more detailed information on the scale of funding for mental health and psychosocial support activities. The lack of input in this regard is possibly due to the unavailability of this information for persons filling out the 4Ws tool, or the lack of time/ability to identify funding specific to the reported activities. Despite these challenges, the findings provided a good amount of information on funding sources and cycles.

Sectoral challenges and limitations

Key factors affecting the sustainability of MHPSS activities are related to policy and program priorities, funding, available infrastructure, governance/management, and the local social and economic contexts. This also includes the widespread stigma and lack of awareness on mental health and psychosocial issues. Factors impacting the capacity of organizations to deliver appropriate, accessible and reliable services have been highlighted in previous mappings. They include but are not limited to:

Collaboration and referral mechanisms

The majority of organizations confirmed participation in regular coordination mechanisms whenever possible. A variety of groups/networks were reported in the capital Amman, the governorates and in camps. These include MHPSS, Health, Nutrition, Protection, Child Protection, Gender-Based Violence, Education, Advocacy, Non-Food Items, Food, Shelter, Age and Disability, Gender Focal Point Network, Youth Task Force, Winterization Task Force, Informal Tented Settlements Task Force, Community Service/Mobilization, Basic Needs, Family Protection Department meetings, Jordan Palliative Care network, referral networks, operational/field meetings, and other informal networks.

The majority of partners reported having referral mechanisms in place; both formal and informal (e.g. case management teams, standard or internal referral forms, standard operating procedures, official letters, phone calls, email, focal points). Also, most partners expressed interest in maintaining the use of the standard interagency referral form, developed by the MHPSS and CP/SGBV working groups. This is important as good referral and communication channels allow the sharing of useful information and promote more effective work within and among sectors, especially as coordination needs continue to place significant demands on often overstretched human and financial resources.

Knowledge transfer challenges

Changes in staff/focal points within contributing agencies presented some challenges during the 4Ws mapping process, similar to previous years. Some organizations were not represented by a consistent focal point at the MHPSS Working Group, while newly-appointed staff members at other agencies had limited knowledge of the 4Ws tool and process. A recurrent challenge is the limited availably of updated contact information as focal points continue to change. As such, it is recommended that agencies ensure regular attendance and participation in the Working Group, maintenance of updated contact information, in addition to conducting a proper hand-over to new focal points.

Staff and training

The diversity of reported MHPSS services was reflected in the number and profile of human resources dedicated to deliver these activities. This ranged from one full-time staff member in some organizations, to over 100 staff and volunteers in others. Collectively, MHPSS actors retain a minimum of 1240 staff members and volunteers, with an average of 24 workers per agency. It should be noted that the MHPSS workforce is expected to be higher in practice, as several agencies only stated job descriptions without specifying a particular number of staff. Also, only projects listed as 'currently under implementation' were included in this estimation.

Many organizations stated provided staff members with one-time, ongoing and/or periodic trainings related to MHPSS topics, while others asserted that no additional training was provided to workers beyond the required educational training/background. Some of the trainings listed include: psychological first aid, early childhood development, case management, psychosocial support skills, parental skills, protection principles, working with persons with disability, peace building, life skills, mental health Gap Action Program, and trainings on particular tools or SOPs.

It was difficult to generate a distribution of training topics provided to staff, as many organizations did not enter any input on this, while other data in this regard was diverse and inconsistent (e.g. some specified only the duration, while others stated "general topics" or "internal training"). In future

mappings, it is recommended to add a drop-down list with specific training categories, or to provide general guidance on completing this section.

Informal discussion with agencies continues to stir up the challenge of staff turnover in the sub-sector, as well as the limited availability of qualified workforce. The ability of MHPSS agencies to deliver quality services and achieve positive outcomes is highly contingent on a trained and qualified work force. The National Mental Health Policy emphasizes a key need for increased and more qualified staff for mental health care delivery.[13]

General Recommendations

As previously mentioned, a general recommendation is to increase implementation of Level 1 activities by MHPSS actors, including the integration of social/psychological considerations in other sectors. Level 2 activities are fundamental to supporting the prevention and promotion of MHPSS wellbeing for children, youth, families and communities, and should continue to be supported in urban areas as well as in rural or remote locations.

The mapping also highlighted a larger proportion of Level 4 services as compared to previous years. One recommendation is to support the adoption of guidelines and clear referral mechanisms to specialized MHPSS services, with links to existing SOPs in relevant sectors. Moreover, adequate training and supervision should be ensured for personnel providing specialized services. This is considered a general recommendation for all staff profiles delivering mental health and psychosocial support.

Overall, the mapping revealed a limited management of mental disorders by non-specialized health workers (e.g. general health/PHC staff), no reported interventions for alcohol and substance use problems, as well as limited psychosocial work in education. It is recommended that future mappings ensure a more comprehensive capturing of governmental services, in particular the Ministry of Health and the Ministry of Education, as their activities are currently being addressed only through partners.

Findings also determined that most MHPSS services are being provided at centers, with a limited delivery of home-based care. Consequently, there is a need to ensure that sufficient outreach networks 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 outreach and mobile services as a method of service delivery will greatly enhance access to services by vulnerable populations.

[13] National Mental Health Policy, Ministry of Health Jordan, 2011-2021.

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
Action Against Hunger (ACF)	Amman, Abdulhameed Badees street	Randa Kuhail	778465143	mhcppm-ir@jo.missions-acf.org
Agency for Technical Cooperation and Development (ACTED)	25, Ahmad Shawqi street, Amman 11194, Jordan	Nicolas Grijelmo Eshraq Mashaqbeh	796948777 798020973	nicolas.grijelmoperez-salado@acted.org eshraq.mashaqbeh@acted.org
Al Kitab Wa Sunna	Ramtha, bank street	Murad Shagran	797413000	moradalbashir@yahoo.com
Al Takaful	Ramtha - Sahel Houran, south bus station	Ahmed Munais	798344030	ahmad.Jor88@yahoo.com
ARDD-Legal Aid	amman, Jordan	Dr. Lina Darras	077-8400548	ldarras@ardd-legalaid.org
Bayt Al Kol	Masoum - Zarqa -Jordan	Ashraf Bdour	00962 777135723 00962 5 3932856	a.bdour@baytalkol.org
Bayt Al Liqa for Special Needs	Madaba - Al Taim	Kiara Georjio	079-5062153	sermigjordan@gmail.org
Bright Future for Mental Health	Amman, interior ceircle, Tabraia Street, building 88	Faiza Abu Jado	788290299	fabujado@yahoo.com
CARE International/ Jordan	Head office -Um Uthaina , Dejlah 27 Amman Jordan	Mariam AlSalahat	797117249	mariam.alsalahat@care.org
Caritas Jordan	Amman-Hashmi	Lana Snobar	775444525	counseling@caritas.jo
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
Danish Refugee Council Jordan (DRC)	Um Ulthaina- Albasrah St. Bldg 14, Amman, Jordan	Karin Rahmberg	780777787	krahmberg.rahmberg@drc-jordan.org

Finn Church Aid (FCA)	20 Al-Kafour st - Um Al-Somaq - Amman,Jordan	Mohammed Bandora	0777-111-872	Mohammed.Bandora@kirkonulkomaanapu.fi
International Catholic Migration Commission (ICMC)	Al Baraka Complex- Prince Mohammad Street Jabal Amman 3rd Circle - Jordan	Osama Al-Muhammad	776171271	almuhammad@icmc.net
International Medical Corps (IMC)	Global Investment House, 9 Abd Alhamid Sharaf St. , Al Shmaisani, Amman	Ahmad Bawa'neh	0798516131	abawaneh@internationalmedicalcorps.org
International Relief and Development (IRD)	4 Medina Al Munawara St | PO Box 3732 | Amman 11821 Jordan , T: 962 6 5563399 | F: 962 6 5563394 | M: 962 797264070	Focal point for PSS - Wejdan Jarrah / Protection Advisor	798898316	w.jarrah@ird-jo.org
International Rescue Committee (IRC)	#12 Al Shareef Nasser Bin Jameel Street, Amman	Manal Fataftah (WPE Manager)	(0) 775100095	manal.fataftah@rescue.org
INTERSOS	Amman - Shmessani	George Theodory	0799379831	cp.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	Matthew R. Stevens	0795188996	jordan.director@jrs.net
Jordan Red Crescent (JRC)/ Danish Red Cross	Almisdar, Amman, Jordan	Razan Obeid	795577117	razan_obeid@hotmail.com
Jordan River Foundation (JRF)	south Marka	Ayham Awabdeh , Dr Muntaha Harasis	777779755, 795785113	a.alawabdeh@jrf.org.jo, m.alharasis@jrf.org.jo
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 (JSWOC)	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	Adel Aldahien	796514542	protection.jor@lwfdws.org
Medecins du Monde (MDM)	Jabal Al-Weibdeh Ba'ounya Street, Building No14, 3rd floor Amman, Jordan	Jose de Vries	079 0921329	coord.mh.jordan@medecinsdumonde.net

Medecins Sans Frontiers France (MSF-F)	Coordination: Al Ajluni Street, Shemesani. POBox 510928 Amman MH project: IRBID	Gemma Dominguez in Amman; Elsa Ganas in Irbid	799035652 Gemma; 0791309251 Elsa	msff-amman-medco@paris.msf.org ; msff-irbid-mhmanager@paris.msf.org
Mercy Corps	Amman- 5th circle	Rana Raji	778498278	rmatahneh@jo.mercycorps.org
Ministry of Health (MoH)				
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. Yasutaka Akimoto Ms. Sari Nishida	795864948 797601095	akimoto@kyoto-nicco.org nishida@kyoto-nicco.org
Noor Al Hussein Foundation, Institute for Family Health (NHF /IFH)	Sweileh, near the Educational Development School al hashemi al shamali next to abdullah azzam mosque	Areej Samreen Dr Said Ratrout	065344190 Ext: 8 06/4908310	areej@ifh-jo.org D.ratrout@ifh-jo.org

Our Step Association				
Palliative Care & Pain Management Clinic	Al Madinah Al Mwnawarah Street, building # 273	Safa'a Al Thaher	795677001	safa_yara@yahoo.com
Syrian American Medical Society (SAMS)	Irbid/ bagdad st.	Laith Odeh	0798070220 / 0788953594	sams.irbid@gmail.com
Save the Children International (SCI)	St 62 Abdul Hamid Badees St. Shmeisani - Amman - Jordan	Sana hiaryi	0 776936440	Sana.AlHyari@savethechildren.org
Save the Children Jordan (SC-J)	83 - Al saad al Ali st. Jabal Al Nuzha	Kareem Makkawi	077-5464970	Kmakkawi@savethechildren.org.jo
Terre des Hommes – Lausanne (Tdh- L)	Jabal El-Weibdeh, Nimir Edwan St., Building 37, 2nd Floor, Amman, Jordan	Celine Lefebvre	Office: 06.46.55.717 Mob: 079.70.28.174	celine.lefebvre@tdh.ch
Un Ponte Per (UPP)	Jabal Alweibdeh - Kullliat Al-Sharia St. 46, 2nd Floor	Ekhlas Al -Khawaldeh	00962 787280811 00962 6 4640227	ekhlas.alkhawaldeh@unponteper.it
Vento di Terra	Jabal-Amman / Al Bohteri st	Mariachiara dellora	96279-065-6133/0799861917	mariachiara.dellora@ventoditerra.org
War Child UK	Amman, Sweefieh	Hadeel Abedo	079/6078226	hadeela@warchild.org.uk
World Health Organization (WHO)	Amman/ interior circle	Dr Cristina Profili		profilim@who.int
World Vision International (WV-I)	Abu Shihab Building, Paris Street, Sweifieh, P.O.Box 941379, Amman 11194, Jordan	Eric Bunnet Kitsa	0778 482439	Eric_Kitsa@wvi.org

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,	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

		post-surgery wards)	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.	Action Against Hunger (ACF)	Amman, Abdulhameed Badees street	Randa Kuhail	778465143
2.	CARE International/ Jordan	Head office -Um Uthaina , Dejlah 27 Amman Jordan	Mariam AlSalahat	797117249
3.	Caritas Jordan	Amman-Hashmi	Lana Snobar	775444525
4.	Danish Refugee Council (DRC)	Um Ulthaina- Albasrah St. Bldg 14, Amman, Jordan	Karin Rahmberg	780777787
5.	International Catholic Migration Commission (ICMC)	Al Baraka Complex- Prince Mohammad Street Jabal Amman 3rd Circle - Jordan	Osama Al-Muhammad	776171271
6.	International Medical Corps (IMC)	Global Investment House, 9 Abd Alhamid Sharaf St. , Al Shmaisani, Amman	Ahmad Bawa'neh	0798516131
7.	Internattional Rescue Committee (IRC)	#12 Al Shareef Nasser Bin Jameel Street, Amman	Manal Fataftah (WPE Manager)	0775100095
8.	INTERSOS	Amman - Shmessani	George Theodory	0799379831
9.	Islamic Charity Society Center (ICSC)	Amman- Abdali	Fawaz Al Mazrawai	0795054944
10.	Jesuit Refugee Service (JRS)	The Jesuit Centre, 43 Sh. Al Razi, Jebel Hussein, Amman, Jordan	Bernard Arputhasamy	0791304844
11.	Jordan Red Crescent/ Danish Red Cross	Almisdar, Amman, Jordan	Razan Obeid/ Despina Constandinides	0795577117 /0796040544
12.	Jordan River Foundation / Queen Rania Center	Amman- Abdali	Fawaz Al Mazrawai	795054944

13.	King Hussein Cancer Center (KHCC)	Amman, 201 queen rania al Abdullah St	Dr. Bassam Kamal	777415581
14.	Lutheran World Federation (LWF) Jordan	Mitharri Street #2A, Um-As-Summaq, Amman, Jordan	Adel Aldahien	796514542
15.	Medecins Sans Frontieres France	Coordination: Al Ajluni Street, Shemesani. POBox 510928 Amman MH project: IRBID	Gemma Dominguez in Amman; Elsa Ganas in Irbid	799035652 Gemma; 0791309251 Elsa
16.	Mercy Corps	Amman- 5th circle	Rana Raji	778498278
17.	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	Areej Samreen Dr Said Ratrout	065344190 Ext: 8 06/4908310
18.	Nippon International Cooperation for Community Development (NICCOD)	P.O. Box 927177, Amman, 11190 Jordan Ahmad Urabi Street, Bldg #46, Rm #3, Amman	Mr. Yasutaka Akimoto Ms. Sari Nishida	795864948 797601095
19.	Terre des hommes - Lausanne (Tdh-L)	Jabal El-Weibdeh, Nimir Edwan St., Building 37, 2nd Floor, Amman, Jordan	Celine Lefebvre	Office: 06.46.55.717 Mob: 079.70.28.174
20.	Un ponte per (UPP)	Jabal Alweibdeh - Kullliat Al-Sharia St. 46, 2nd Floor	Ekhlas Al -Khawaldeh	00962 787280811 00962 6 4640227
21.	War Child UK	Amman, Sweefieh	Hadeel Abedo	079/6078226
22.	World Vision International (WVi)	Abu Shihab Building, Paris Street, Sweifieh, P.O.Box 941379, Amman 11194, Jordan	Eric Bunnet Kitsa	0778 482439

Annex 4: Summary of the 2015/2016 MHPSS 4Ws Workshop

A workshop was held on 17 February 2016 to present the initial findings of the 2015/2016 MHPSS 4Ws mapping. The workshop was hosted by International Medical Corps (IMC), and was attended by 38 participants from 30 organizations. A presentation was delivered on the 4Ws mapping, including a brief history of the tool's implementation in Jordan, a description of the general process, and the initial findings. The attendees were subsequently divided into small groups and requested to discuss and present their feedback on the following topics, as summarized below.

1. Feedback on the 4Ws tool and process:

- As the 4Ws mapping is an exercise completed by the Mental Health and Psychosocial Support Working Group, participants noted that data from agencies working in relevant sectors who are not part of this Working Group may not be captured, for example education actors. The need to ensure a greater representation of these actors, including input from the Ministry of Education was highlighted, in order to provide a better idea of psychosocial work being conducted in education for future mappings.

- A request was made to provide MHPSS focal points (or M&E staff) with a brief orientation on how to complete the 4Ws tool, as there are new focal points who are not familiar with the tool, and this will help unify the manner in which the excel sheet is filled out, and decrease unreported information.

- A discussion was held on the possibility of capturing some aspects about the 'quality' of services. However, it was pointed out that the 4Ws is designed as a self-report exercise with the purpose of mapping activities and not evaluating service quality.

- A general recommendation emerged in regards to future mappings. Participants suggested that the group collectively identifies what type of information MHPSS actors are interested in capturing from the 4Ws exercise *prior* to implementing the activity. In this way, any modifications could be made to the tool prior to implementation, and the analysis could be directed to focus on particular questions relevant to the MHPSS context at the time. This will allow further details to be shared on a particular activity/location depending on the changing needs and situation at the time of the mapping.

- It was noted that capturing target population per month for particular activities (e.g. safe spaces) is a bit difficult; one suggestion was to report target population at the end of the project. However as program durations and details vary, it was stated that capturing target/month allows agencies to unify the measure of targets against a specific timeframe as far as possible. Yet, further guidelines

on how to capture this measure can be outlined, despite the challenge of agencies using different standards to capture their targets/month may continue (i.e. depending on type of activity, different M&E system for each agency, etc.).

- Further efforts should be placed to capture data from local CBOs and community partners providing MHPSS services. This can be supported by agencies working with local partners, by presenting the 4Ws within field/operational coordination networks, links to available/ongoing mappings, etc.

2. *Specific suggestions for inclusion in the 2015/2016 4Ws report:*

- A comparison of the availability of MHPSS activities across camps for Syrian refugees.
- Providing the names of organizations working in each governorate to facilitate planning and collaboration.
- Comparing the percentage of activities in each governorate to the proportion of host/refugee populations.
- Clarifying which specialized services are being provided, and how they are distributed across governorates.
- Providing information about the types of MHPSS trainings being conducted.

3. *Identifying MHPSS needs/challenges/recommendations based on work in the field:*

- Various participants emphasized the need to foster greater linkages, coordination and referrals (including follow-up and feedback) between organizations working in the field, stating that effective referrals are a measure for good coordination of active organizations in the MHPSS sub-sector.
- The limited availability of human resources for MHPSS was once again highlighted in this year's workshop, as well as the limited capacities of front-line workers. Participants stated the need for further capacity building of staff, including mentoring and support for front-line humanitarian workers, and the provision of staff care.
- Some participants suggested that trainings on mental health and psychosocial support should be harmonized. In response, it was mentioned that the MHPSS Working Group is compiling materials for a brief 1-2 day training for humanitarian workers on key MHPSS issues.

- 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.

- Participants raised the issue of stigma facing mental health service users, including the prevailing lack of awareness in the community of the importance of mental health issues. Efforts to improve MHPSS education and awareness through orientations for beneficiaries, workers, educators, decision makers and community members was suggested as a means to reduce stigma and discrimination. Raising awareness on the importance of structured recreational activities was also mentioned.

- One reoccurring challenge mentioned is the limited sustainability of activities after funds are discontinued or finished. Emphasis was placed on building capacity of national institutions through supporting Ministries and local organizations.

- The need for increased activities to integrate social and psychological considerations in basic services and security was highlighted.

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.

- 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 services. An increased focus on fostering partnerships between existing organizations will help strengthen coordination across working groups.

- There should be a higher representation of key stakeholders, in particular local organizations, as well as increased collaboration within existing MHPSS networks.