WHO IS DOING WHAT, WHERE AND WHEN (4Ws) IN MENTAL HEALTH & PSYCHOSOCIAL SUPPORT IN JORDAN

Service Mapping Exercise

October 2021

This mapping was developed & funded with support of Bureau of Population, Refugees, Migration (PRM)

International Medical Corps

This 4Ws MHPSS mapping was completed by International Medical Corps with coordination and contribution of MHPSS group members

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INTRODUCTION

The purpose of the tool is to provide a clear picture of who is doing what, where and when.

The Inter-Agency Standing Committee (IASC), a global humanitarian body devoted to the improvement of humanitarian coordination, established an IASC Mental Health and Psychosocial Support (MHPSS) Reference Group (RG) in 2007, to support and advocate for the use of and adherence to IASC guidelines on MHPSS in emergencies.[1] Its members consist of UN agencies, the International Federation of Red Cross and Red Crescent Societies, as well as a large consortium of NGOs such as the International Council of Voluntary Agencies and Interaction.

Furthering its work, the IASC MHPSS RG 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 provide a clear picture of who is doing what, where and 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.

> "The purpose of the tool is to provide a clear picture of who is doing what, where and when."

WHO and International Medical Corps (IMC) first piloted the tool in Jordan in 2009 in cooperation with UNICEF. A refined tool was applied for the second mapping in 2010, based on emerging issues and lessons learnt from previous mappings conducted in Jordan, Nepal, and Haiti. Subsequent mappings were conducted in Jordan in 2010/2011, 2012, 2013,2014, and 2017. After 2018 the working group members agreed to use the online 4Ws at the mhpss.net website, but many agencies failed to update their data, making data analysis and drawing inferences very difficult.

Using the data and feedback collected by agencies that piloted the tool, the IASC RG developed a manual for conducting 4Ws mappings. This manual was published in 2013 and is available for download from the Mental Health & Psychosocial Support Network, mhpss.net.

TIME FRAME

MHPSS 4Ws mapping took place between the months of July and September 2021.The estimated data collection timeframe was initially around one month, but due to changing the data collection methodology (using an online version through Google Documents instead of the previous Excel sheet) and allowing for further inputs from agencies, the timeframe was extended for another month.

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

OBJECTIVES

The overarching aims of the service mapping exercise center around enhancing coordination and collaboration, creating referral systems for all involved agencies, improving the transparency and legitimacy of 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 responding to the needs. Moreover, it can be used to identify gaps in service provision, geographic and target group coverage, human resources and technical expertise. In addition, participating organizations can use the 4Ws mapping to plan for their programming and funding appeals.

The specific objectives of the 2021 MHPSS mapping are to:

1. Provide an overall picture of the size and nature of MHPSS response in Jordan;
2. Identify gaps in MHPSS response to enable a coordinated action;
3. Enable referral by making information available on who is where, until when and doing what;
4. Improve transparency and legitimacy of MHPSS through structured documentation;
5. Improve the possibility of reviewing patterns of practice and drawing lessons for future practices.

THE 4Ws MAPPING PROCESS

IMC, on behalf of MHPSS members, has discussed the need for the updated information and analysis of MHPSS working group. And therefore, it was agreed to assign a consultant to carry out MHPSS mapping. In consultation with members, the consultant started with adapting the previous versions of the English and Arabic 4Ws tool before they were utilized. These versions were validated during the 2013 mapping exercise and used over the following mapping exercises.

At the beginning, the 4Ws tool was attached to an information package and sent via email to all agencies in MHPSS coordination group's mailing list. The package consisted of brief introductory on launching the activity, where all members were invited to be part of the mapping. The email contained the following documents:

- English and Arabic introduction on the 4Ws;
- English and Arabic version of an Excel sheet, that contained of:1) capture information on 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;
- The recent 4Ws report and aggregated sheet which was produced in 2017.

After receiving feedback from few agencies, the tool was evaluated for accuracy. However, due to the large inconsistencies in the answers, the questions from the previous version were re-organized to portray the specific type of activities and target groups in each governorate. Next, the tool was converted into an on-line survey using Google Forms instead of Excel for ease of reference.

Following the survey, a piloting team was created and were requested to fill out the required information, which was provided by IMC staff. The latter were requested to fill each survey separately. After receiving their feedbacks, another modification was applied accordingly. Another pilot trial was performed and led to the final version of the survey.

All MHPSS member agencies were contacted again during the monthly MHPSS working group meeting, where they were updated on using the new data collection method. At the end of the meeting, a follow up email was sent containing the URL link for the new version of the 4Ws.

In the beginning, the response rate was low due to not having the updated contact list, which was the result of many different reasons, mainly; the high turnover rate among MHPSS contact persons coupled with the fact that some agencies were new for the exercise and didn't feel that they are familiar with the tool. Therefore, snowball sampling technique was used; starting with the agencies who attended regularly MHPSS sub working group monthly meeting until reaching most of the agencies who provided MHPSS services. (36) organizations out of (45) completed the provision of the information. Three responses were omitted due to duplication and submitting empty questionnaires. Eventually, 33 responses were accepted, which is about (73.3 %) response rate.

DATA COLLECTION TOOL

Unlike the previous years, an online version of the tool, using Google Forms, was used. This version allowed an easier and more organized data collection method, in comparison to the previous years when Excel was used. It also required less time and effort according to the pilot team members.

Each organization's response was automatically saved on Google Drive. As soon as the data collection phase was finalized, all responses were downloaded and saved into an Excel sheet, where it was evaluated for accuracy. Certain organizations were contacted to verify some of their entered data.

Following the cleaning of all data, two versions of the Excel sheet were prepared; one version was disseminated with the final report to all MHPSS working group members. It contained a re-organized format of all agencies' data which was more readable, clearer, and most importantly, was able to provide an answer to the question: Who is Where doing What until When. This sheet can be accessed through MHPSS.net. As for the second version, it was kept in its raw form for data analysis purposes. The below are the findings on the four questions of the exercise:

1

WHO IS DOING WHAT?

These results indicate a shift in focus of participating agencies from community-focused activities to case-focused and general support activities.

The 2021 mapping encompassed a cohort of 33 organizations that collectively deliver MHPSS services, programs, and activities for communities across the Kingdom of Jordan. 93.3% (n=31) of these organization participate actively in a coordination mechanism. Of the total, 42.4% (n=14) are members of MHPSS working group and other working groups, 27.3% (n=9) are members of MHPSS working group only, while 24.2% (n=8) are not a member in MHPSS group although they are providing the same services.

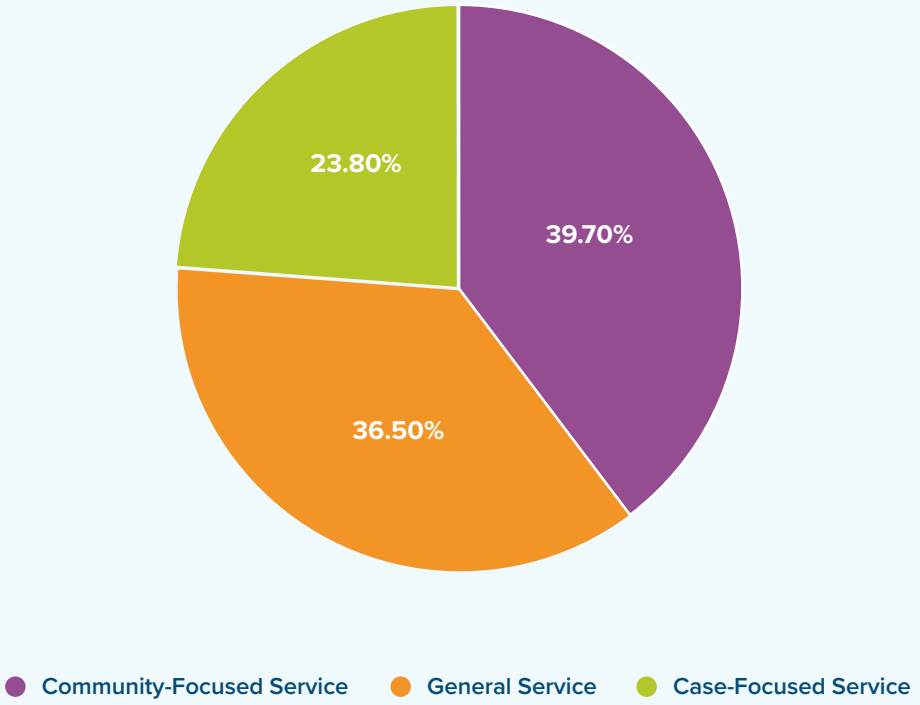
A functioning referral mechanism is essential for coordination among actors. Of the participating organizations, 81.8% (n=27) have a referral mechanism in place, 85.2% of which uses the Inter-Agency Referral Form. While 14.8% (n=4) reported using their own forms. In addition; regarding the referral mechanism; 38.8% reported using emails; 25.4% using phone, 22.1% using paper-based mechanism (hard copy); and 5.9% reported using other mechanisms.

GENERAL MHPSS SERVICES' CATEGORIES

Regarding the concentration of services, as per the three major categories of activities in the 4Ws mapping as shown in Figure 1.1, among all organizations who provide MHPSS services in Jordan, 39.7% provide community-based services, such as information dissemination, community mobilization, safe spaces, psychosocial support in education and the inclusion of psychosocial considerations in other sectors. 36.5% provide case-management services, encompassing psychosocial support, psychological interventions, in addition to clinical management of mental health conditions by specialized and non-specialized providers. Furthermore, only 23.8% provide general services and these activities include work that is related to assessments, training/supervision and research. These results indicate a shift in focus of participating agencies from community-focused activities to case-focused and general support activities, unlike the 2017 mapping; in which 60% of activities focused on community, 28% of activities were case-focused and 12% of activities were general activities supporting MHPSS services.

> “These results indicate a shift in focus of participating agencies from community-focused activities to case-focused and general support activities.”

FIGURE 1.1: THE CONCENTRATION OF ACTIVITIES PER FOCUS IN JORDAN



The organizations' profiles were diverse, with a contrast in their scale of operations, as well as the combination and type of services they deliver. Table 1.1 provides a summary for each organization with the type of activity they implement. Note: the table doesn't identify how often or where the organization provides the service.

TABLE 1.1:
ORGANIZATION AND THE FOCWUS OF ACTIVITY

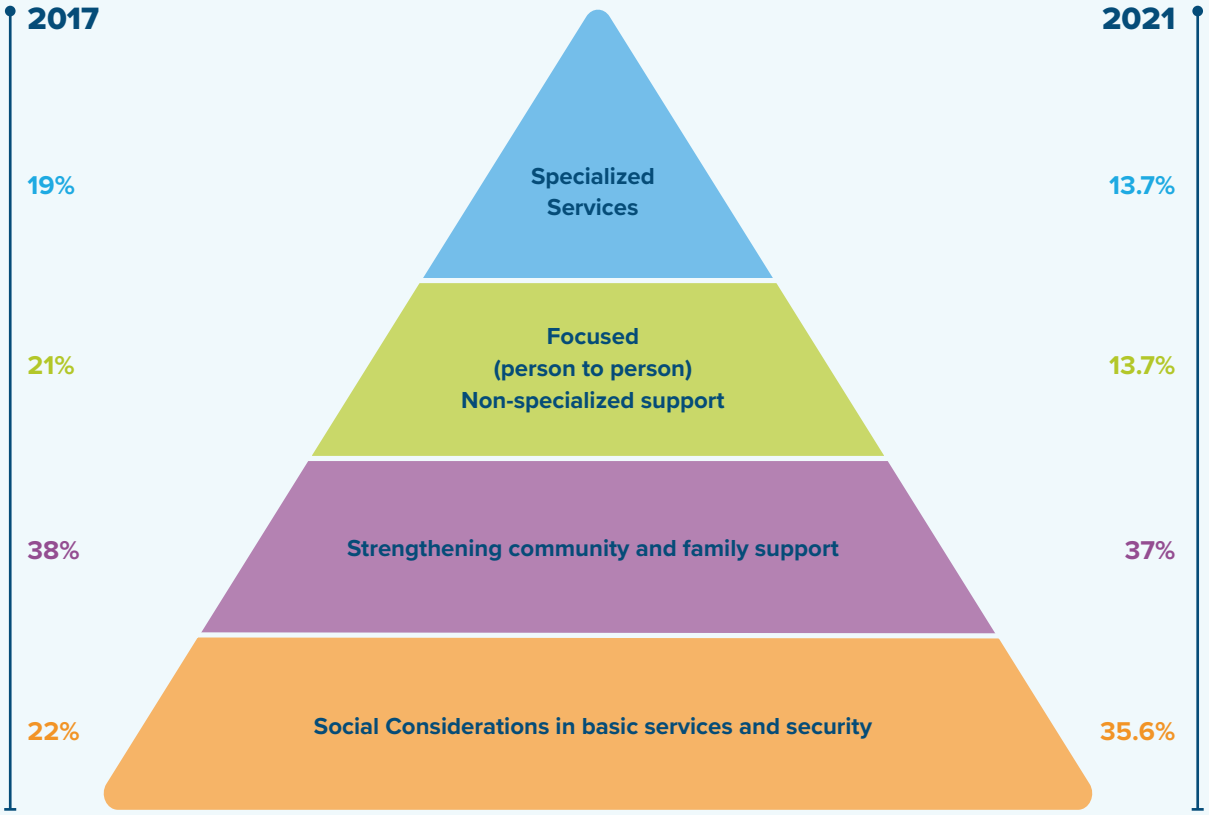
ORGANIZATION NAME	COMMUNITY-FOCUSED MHPSS	CASE-FOCUSED MHPSS	GENERAL MHPSS
ActionAid Arab region	✓	✓	✓
Al-Hussein Society /Jordan Centre for Training and Inclusion	✓	✓	
Arab Renaissance for Democracy and Development	✓		✓
Arabic Medical Relief (AMR)	✓	✓	✓
Blumont	✓	✓	✓
CARE International -Jordan	✓	✓	✓
Caritas Jordan	✓	✓	✓
Danish Refugee Council (DRC)		✓	✓
GIZ	✓		✓
Humanity & Inclusion	✓	✓	
International Labour Organization (ILO)	✓	✓	✓
Institute for Family Health King Hussein Foundation, (IFH/KHF)	✓	✓	✓
International Catholic Migration Commission (ICMC)	✓	✓	
International Committee of Red Cross (ICRC)	✓	✓	✓
International Medical Corps	✓	✓	✓
International Orthodox Christian Charities (IOCC)	✓	✓	
International Rescue Committee (IRC)	✓	✓	

ORGANIZATION NAME	COMMUNITY-FOCUSED MHPSS	CASE-FOCUSED MHPSS	GENERAL MHPSS
INTERSOS	✓	✓	✓
Japan International Cooperation Agency (JICA)	✓	✓	✓
Jesuit Refugee Service (JRS)	✓	✓	
Jordan Red Crescent	✓		
Jordan River Foundation (JRF)	✓	✓	✓
Lutheran World Federation (LWF)	✓	✓	✓
MEDAIR	✓	✓	✓
Our Step (خطوتنا)	✓	✓	✓
Questscope	✓	✓	✓
SAMS	✓	✓	✓
Save the Children Jordan (SCJ)	✓	✓	✓
TDH	✓	✓	✓
The Centre for Victims of Torture (CVT)	✓	✓	✓
The Islamic Charity Centre Society (ICCS)	✓	✓	
War Child Holland/ WCH	✓	✓	✓
Ministry of Health (MoH) & World Health Organization (WHO)	✓	✓	✓

ACTIVITIES AND LAYERS OF SUPPORT

Humanitarian emergencies can cause significant emotional distress and contribute to the developing mental health conditions that affect people in many ways. It is key for MHPSS service providers to meet the different needs of affected persons. To this end, IASC developed a layered model of services that is known as the IASC Pyramid of MHPSS Interventions. According to this pyramid, there are four levels of services; **Level 1** – social considerations, basic services and security, ii) **Level 2** – community and family support, iii) **Level 3** – focused, non-specialized support, iv) **Level 4** – specialized services. Services under **level 3** include all MHPSS services that are provided by non-specialized professionals. The fourth and final level of the pyramid focused on services that are delivered by specialized professionals. FIGURE 1.2 shows the concentration of reported activities regarding the IASC MHPSS Intervention Pyramid.

FIGURE 1.2: THE PROPORTION OF ACTIVITIES REGARDING THE IASC INTERVENTION PYRAMID BETWEEN 2017 AND 2021 MAPPING



Most activities surveyed (37%) fell under **Level 2** of the pyramid "strengthening community and family support". Which is (1%) less than the total services that were provided in 2017.

Level 1 "social considerations in basic services and security" accounted for (35.6%) of the reported activity, with a significant increase from (22%) in 2017.

Level 3 activities "focused; person to person; non-specialized support" accounted for (13.7%) of total activities and it declined by around (7%) from 2017 mapping.

Finally, **Level 4** activities "specialized services" were the least provided services; similar to previous mapping activities, however, this year it amounted to (13.7%) of all reported activities, which is a significant drop in comparison to (19%) in 2017 mapping.

Overall, the result of the 4Ws displays unequal distribution of the services across the pyramid, which matches the results of previous years. Moreover, it reveals a decline in the concentration of the third and fourth level services.

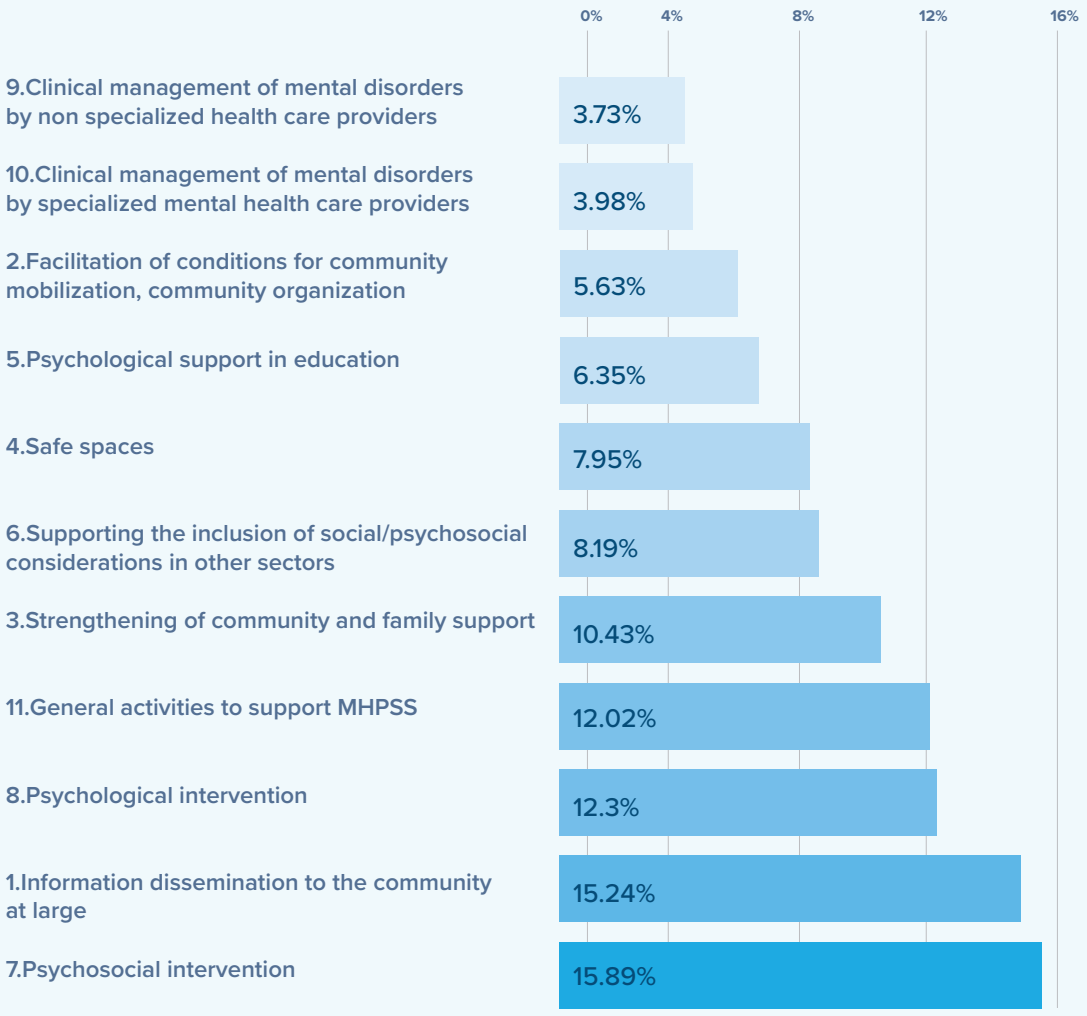
TABLE 1.2 shows the changes in concentration of activities across the pyramid levels over the years.

TABLE 1.2: ACTIVITIES' CONCENTRATION CHANGE OVER YEARS

IASC INTERVENTION PYRAMID LEVEL	2012	2013	2014	2017	2021
Level 4	5%	3%	12%	19%	13.7%
Level 3	15%	41%	31%	21%	13.7%
Level 2	55%	39%	38%	38%	37%
Level 1	25	17%	19%	22%	19%

The following FIGURE 1.3 illustrates the distribution of activities. The results portray a difference between the current mapping and the 2017 mapping. The category of "strengthening of community and family support" consists of the most provided activities in 2017 with more than 20%, this proportion decreased to almost half with 10.4% in 2021 mapping. On the other hand, the current mapping reveals an increase in the case-specific activities; clinical management of mental disorders by specialized mental health care providers increased from 2% in 2017 to almost 4%, while the clinical management by non-specialized remains at roughly 4%.

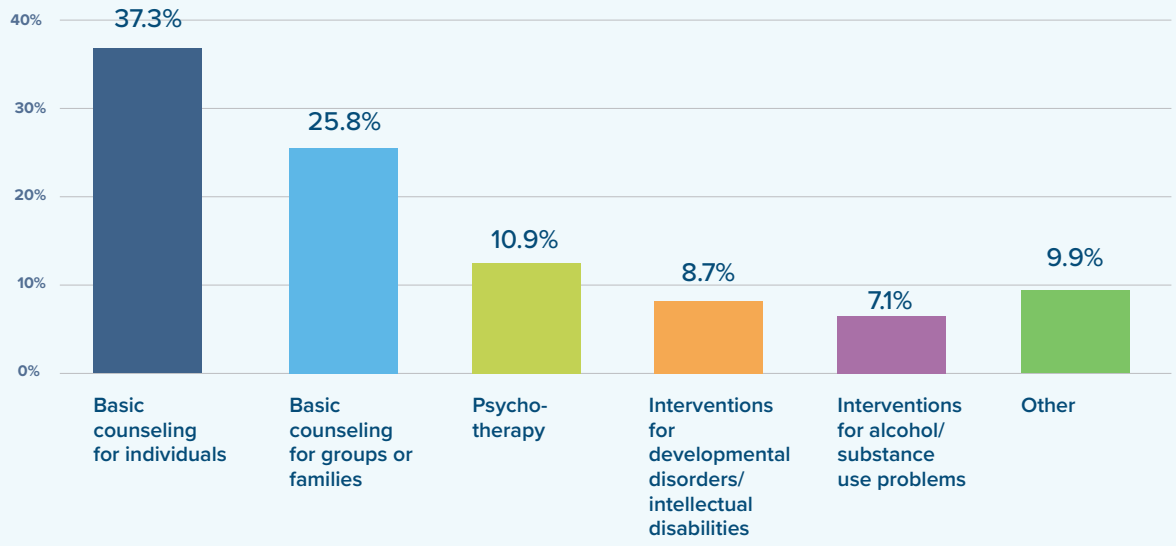
FIGURE 1.3:
ACTIVITIES' DISTRIBUTION



PSYCHOLOGICAL INTERVENTIONS

Psychological interventions make up almost (16%) of all activities in Jordan. Which includes basic counselling for individuals, basic counselling for groups or families, psychotherapy, interventions for alcohol/substance use problems, as well as interventions for developmental disorders/intellectual disabilities. Although, the overall proportion of services for psychological interventions increased in comparison to 2017, interventions for developmental disorders and interventions for alcohol/substance use problems were the least reported.

FIGURE 1.4:
PSYCHOLOGICAL INTERVENTIONS



CLINICAL MANAGEMENT OF MENTAL DISORDERS BY NON-SPECIALIZED HEALTH CARE PROVIDERS (EX: PHC STAFF, POST-SURGERY WARDS)

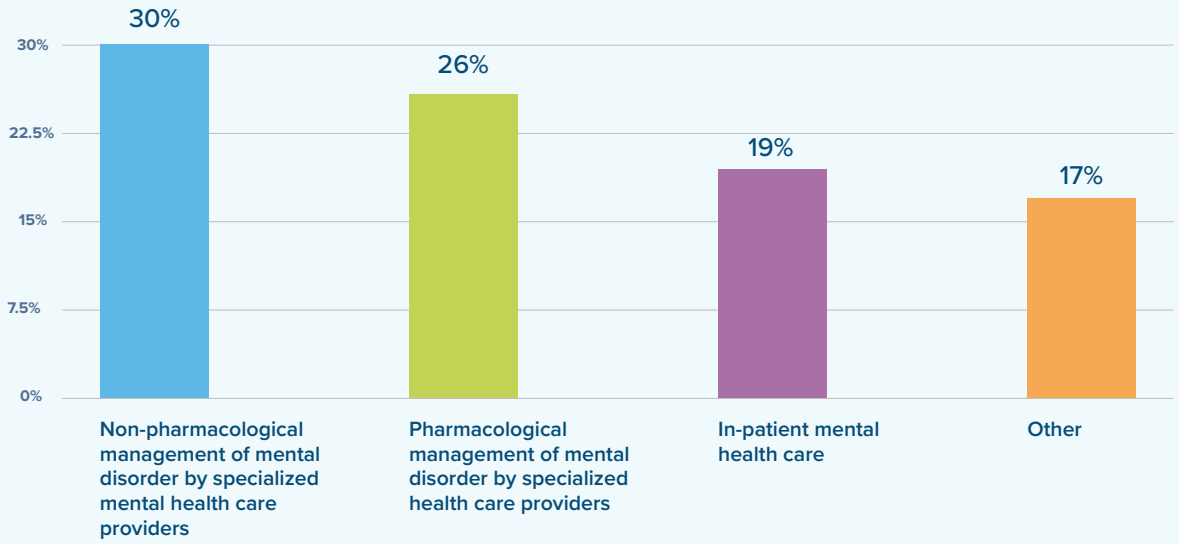
Non-specialized providers refer to the Health Care Providers (HCP) i.e., Primary Health Care (PHC) staff, post-surgery wards, and any other HCP who has been trained with Mental health Gap Action Program (mh-GAP) training. The FIGURE 1.5 showed that agencies who provide the clinical management of mental disorders by non-specialized HCP focus on all its sub-domains, but the overall proportion for this service remains low just like the previous years with 3.7%.

FIGURE 1.5: SUB-ACTIVITIES DISTRIBUTION OF THE CLINICAL MANAGEMENT OF MENTAL DISORDERS BY NON-SPECIALIZED

CLINICAL MANAGEMENT OF MENTAL DISORDERS BY SPECIALIZED HEALTH CARE PROVIDERS (E.G., PHC STAFF, POST-SURGERY WARDS)

Clinical management for mental disorders by specialized mental HCP is considered an essential part of the case-focused interventions. Specialized HCP refer to psychiatrist, psychologist, and psychiatric nurses working at PHC/ general health facilities/ mental health facilities. The current mapping revealed that agencies are giving more focus to the non-pharmacological and pharmacological intervention, and less focus to the in-patient mental health care, as shown in Figure 1.6.

FIGURE 1.6: SUB-ACTIVITIES DISTRIBUTION OF THE CLINICAL MANAGEMENT OF MENTAL DISORDERS BY SPECIALIZED



2

WHAT AND WHERE?

The following section provides specific information about MHPSS services that are provided per governorat

The following section provides specific information about MHPSS services that are provided per governorate. The number of organizations and their activities differ in each governorate; therefore, the type of activity and its concentration differ also. FIGURES 2.1 and 2.2 show the differences in geographic distribution of activities per governorate between 2017 and 2021 mapping. TABLE 2.1 illustrated the concentration of activities per governorate.

FIGURE 2.1: THE GEOGRAPHIC DISTRIBUTION OF ACTIVITIES PER GOVERNORATE IN 2021

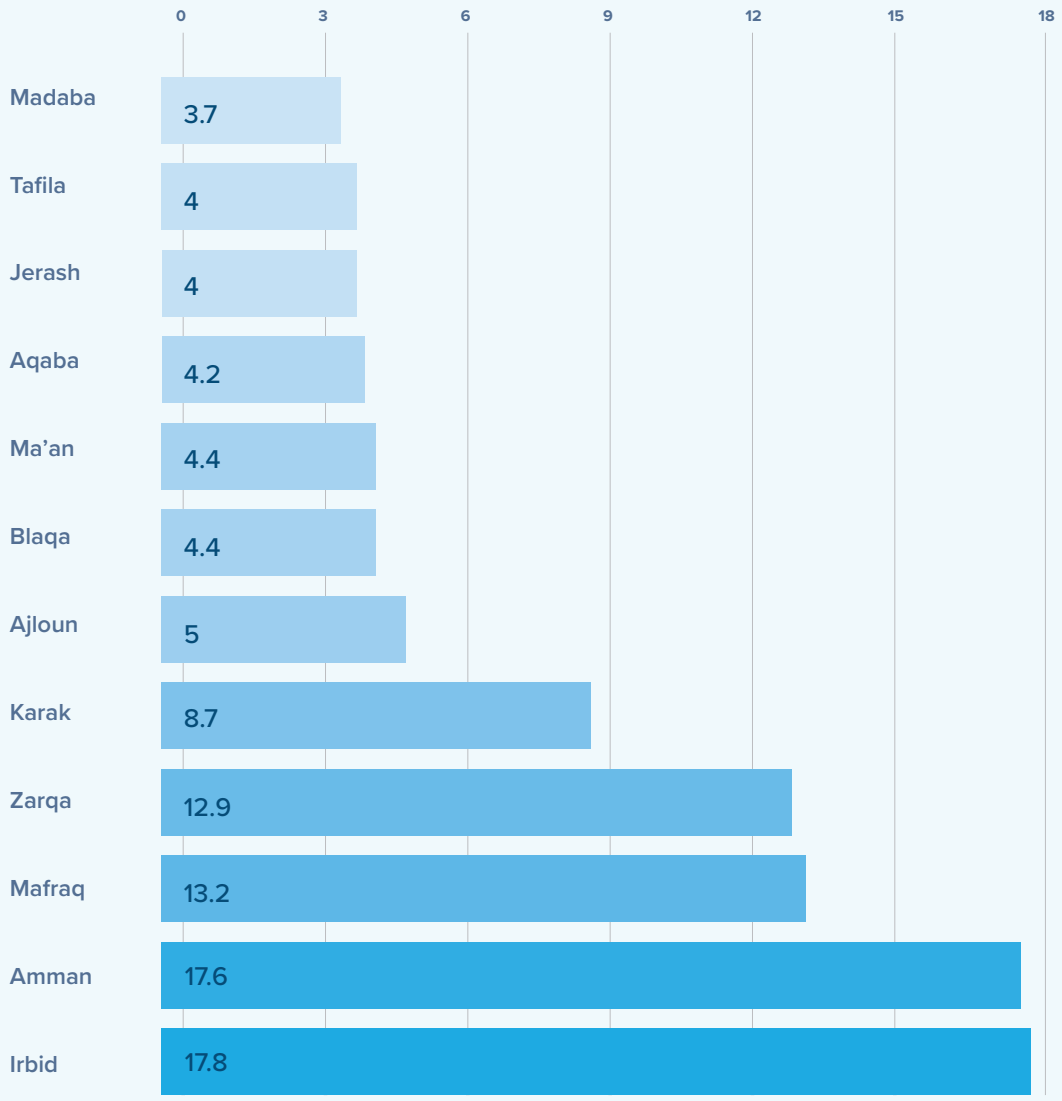


FIGURE 2.2: THE GEOGRAPHIC DISTRIBUTION OF ACTIVITIES PER GOVERNORATE IN 2017

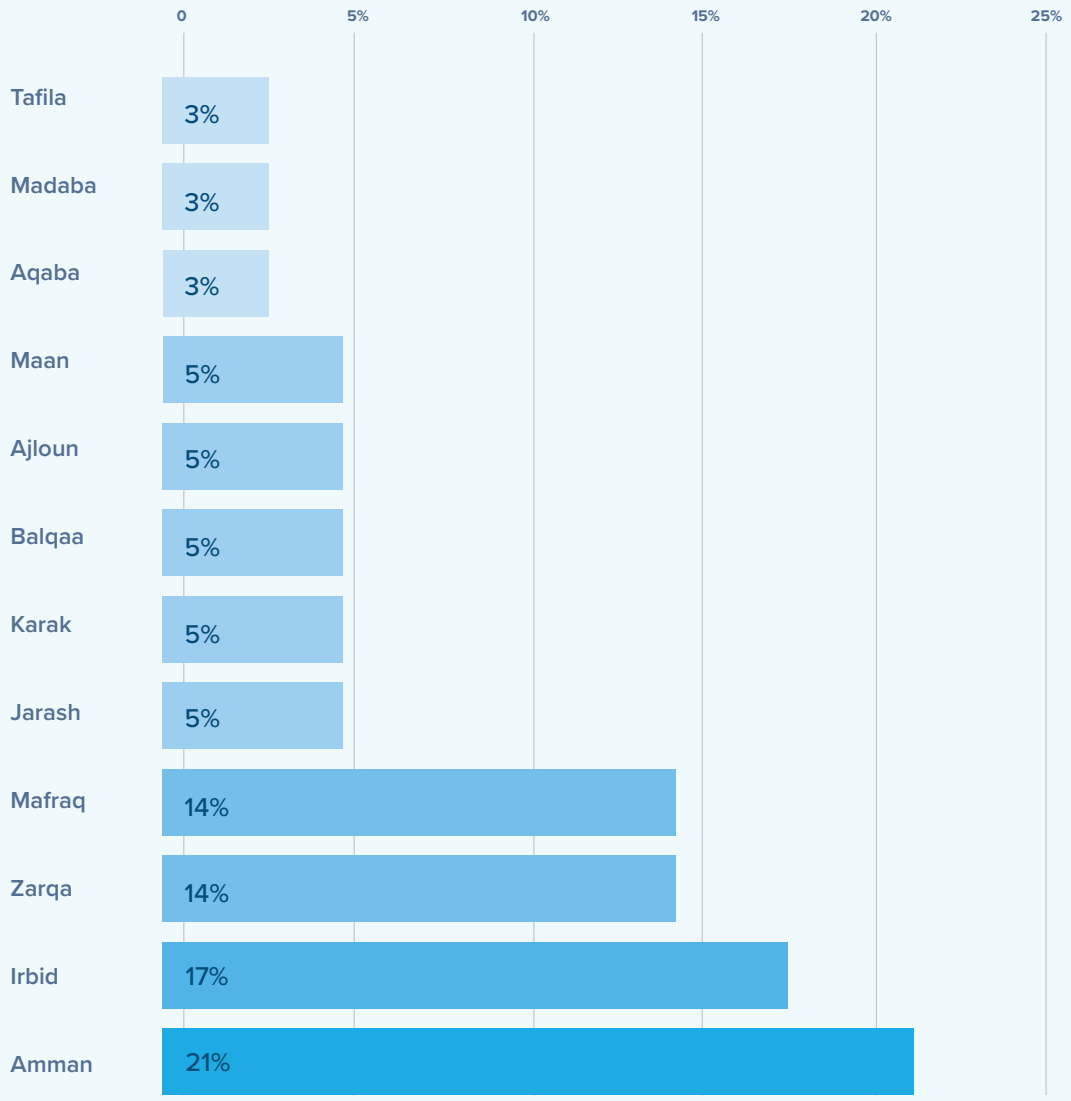


TABLE 2.1:
THE CONCENTRATION OF ACTIVITIES PER FOCUS PER GOVERNORATE

GOVERNORATE	COMMUNITY-FOCUSED MHPSS	CASE-FOCUSED MHPSS	GENERAL MHPSS
Amman (n=27)	39.1% (n=25)	34.4% (n=22)	26.6% (n=17)
rbid (n=23)	40.4% (n=21)	34.6% (n=18)	25% (n=13)
Mafraq (n=19)	42.1% (n=16)	28.9% (n=11)	28.9% (n=11)
Ajloun (n=8)	35.7% (n=5)	35.7% (n=5)	28.6% (n=4)
Jerash (n=7)	41.7% (n=5)	33.3% (n=4)	25% (n=3)
Balqa (n=7)	38.5% (n=5)	30.8% (n=4)	30.8% (n=4)
Zarqa (n=17)	35.9% (n=14)	38.5% (n=15)	25.6% (n=10)
Madaba (n=6)	41.7% (n=5)	33.3% (n=4)	25% (n=3)
Tafila (n=6)	38.5% (n=5)	30.8% (n=4)	30.8% (n=4)
Karak (n=12)	42.3% (n=11)	30.8% (n=8)	26.9% (n=7)
Ma'an (n=6)	38.5% (n=5)	38.5% (n=5)	23.1% (n=3)
Aqaba (n=5)	41.7% (n=5)	33.3% (n=4)	25% (n=3)
Overall country	39.7%	36.5%	23.8%

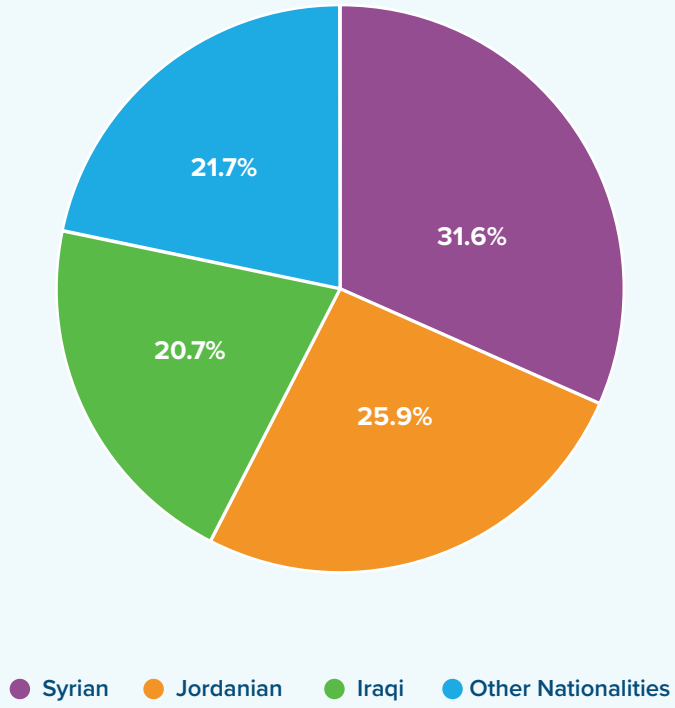
*N= NUMBER OF ORGANIZATIONS WHO PROVIDE THE SERVICE

PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER; AGE IN JORDAN

The following section provides an overview of the profile of MHPSS target beneficiaries by nationality, age and gender in Jordan. These figures will be further specified for each governorate in **Annex 3.**

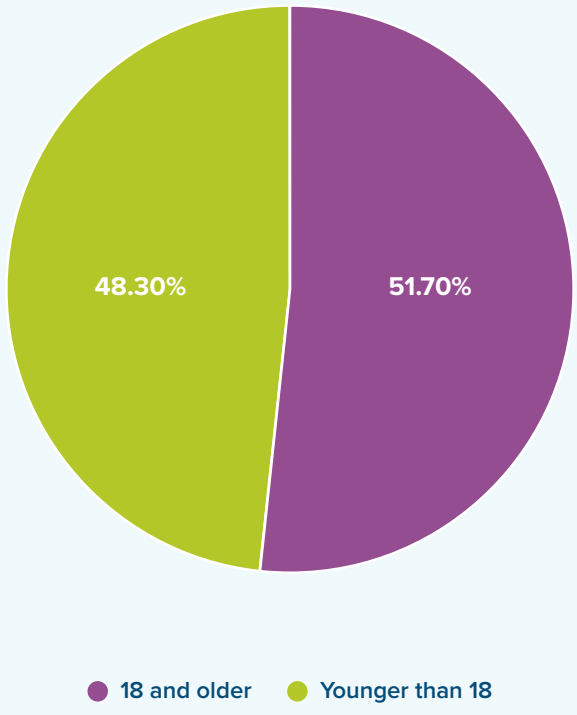
The below FIGURE 2.3 shows the profile of MHPSS target beneficiaries per nationality in Jordan as a whole. The results portrayed some changes in the targeted beneficiaries, compared to 2017, with Syrians still being the most targeted group for MHPSS services in Jordan with 31.6%. On the other hand, more focus is being given to the other nationalities with 21.7%, in comparison to 16% in 2017. Note: other nationalities according to the UNHCR reports include Yemeni, Somali, and Sudanese. This figure will be further analyzed in the following sections, which will provide in-depth information about the target groups per nationality per governorate.

FIGURE 2.3: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN JORDAN



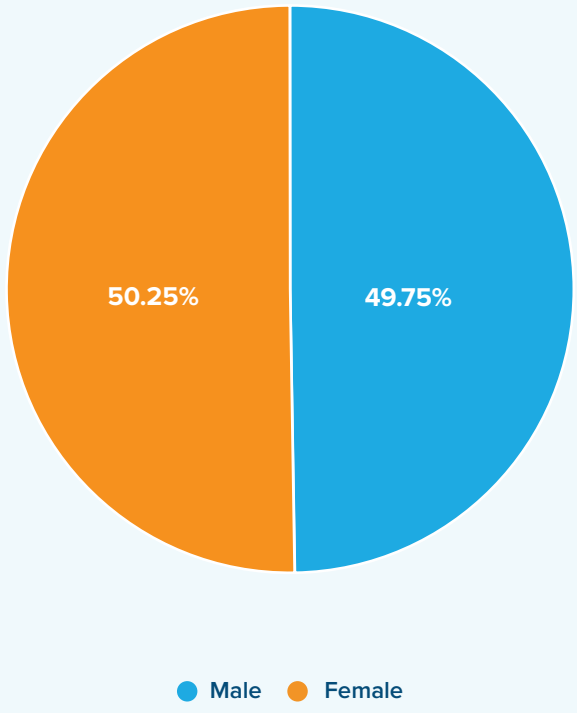
Regarding the distribution of activities by age as shown in FIGURE 2.4, the largest age group targeted by MHPSS services is for ages 18 and over, representing 51.7% of the serviced population, while beneficiaries who are younger than 18 years, represent 48.3% of the targeted population. These results differ from the previous (2017) mapping, where young people under 18 were the major target group with 50.9%.

FIGURE 2.4: MHPSS PROFILE TARGET BENEFICIARIES BY AGE IN JORDAN



Examining the distribution of MHPSS activities per gender, it was found that there is almost equal distribution, with males representing 50.25% and females with 49.75% of the serviced population. As shown in FIGURE 2.5.

FIGURE 2.5: MHPSS PROFILE TARGET BENEFICIARIES BY GENDER IN JORDAN



In the case of referring to the humanitarian workers as a target group, 32.9% of all functioning agencies in Jordan reported having specific MHPSS activities to target them.

MHPSS WORKFORCE

Few organizations reported the total number and specialization of staff who provide MHPSS services, thus, making the analysis of MHPSS workforce very difficult. On one hand, some organizations stated that they provided staff members with one-time, ongoing and/or periodic trainings related to MHPSS topics, while others asserted that no additional trainings were 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, parenting skills and protection principles.

FIGURE 2.6 shows the roles of MHPSS service providers. It was observed that most providers were volunteers, followed by case managers, while the more specialized providers (according to the academic/ professional background, i.e., psychiatrist, psychologist, psychiatric nurses) were the least represented of MHPSS service providers.

FIGURE 2.6:
MHPSS SERVICE PROVIDERS IN JORDAN

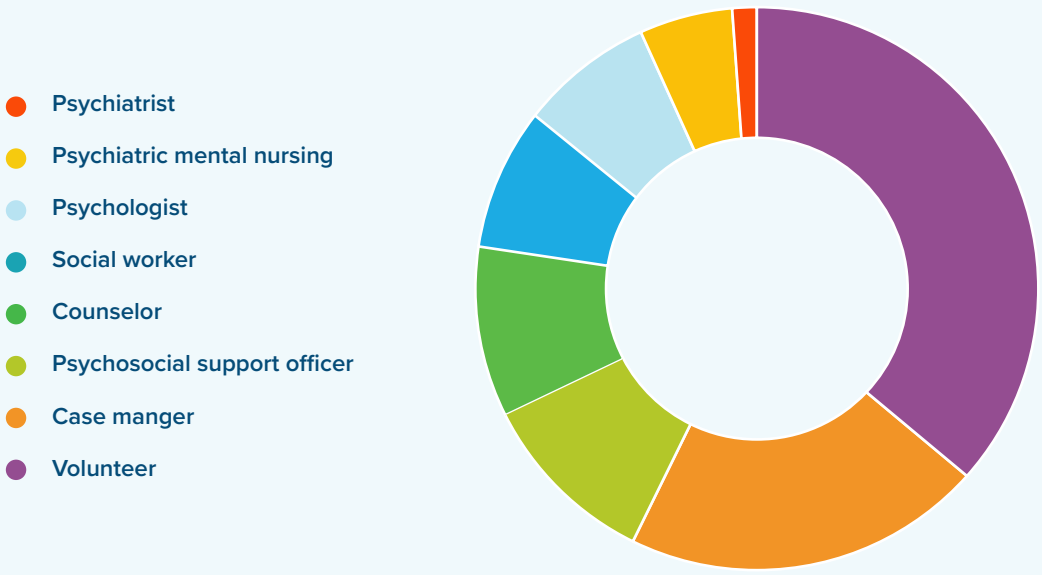
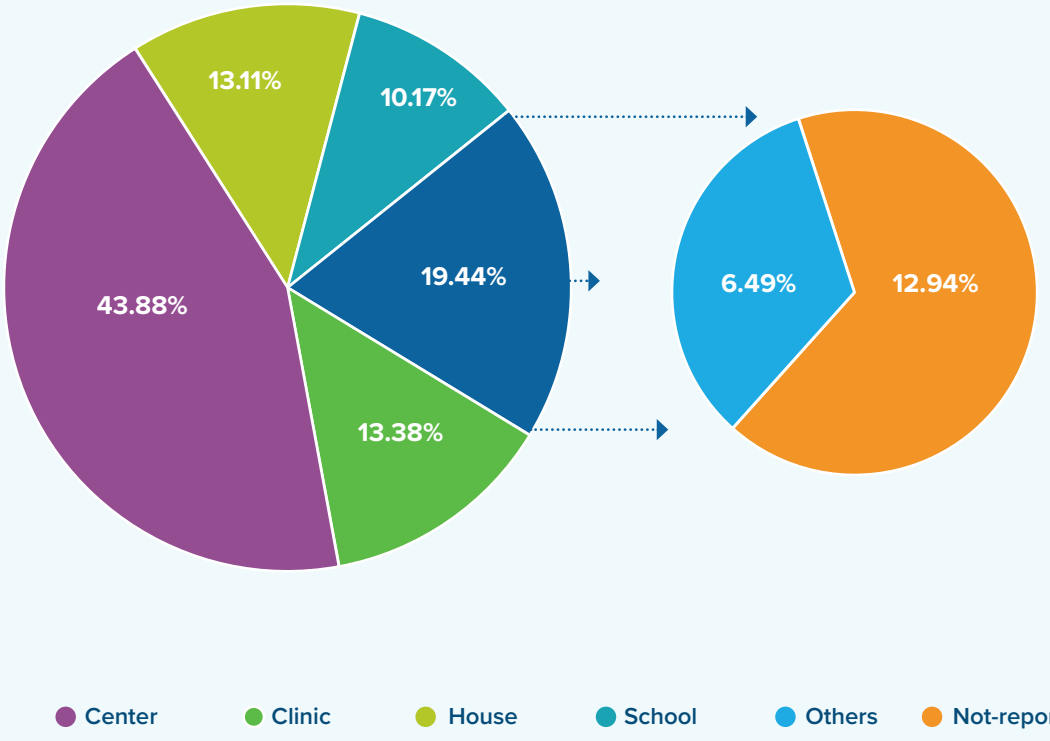


FIGURE 2.7: THE SETTINGS WHERE MHPSS SERVICES ARE PROVIDED AT IN JORDAN



3

WHEN

Little focus is given to the in-patient mental disorder

In mapping MHPSS services, the 4Ws tool also sought to identify until when will these activities be carried out to help in designing new proposals and funding requests. The actual starting and finishing dates for MHPSS services in each governorate varied widely. Thus, to give a clearer picture about the activity cycle; the participants were asked to report their activities' status and funding cycle. The following FIGURES 3.1 and 3.2 show the activities' status and frequencies of funding in Jordan, followed by FIGURE 3.3 to specify the funding cycle per governorate

FIGURE 3.1:
MHPSS ACTIVITIES' STATUS

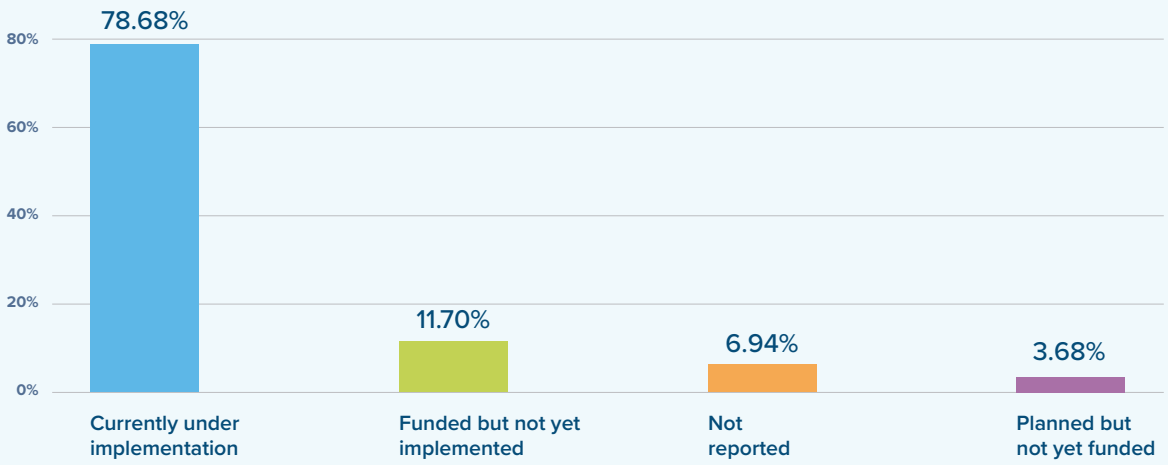
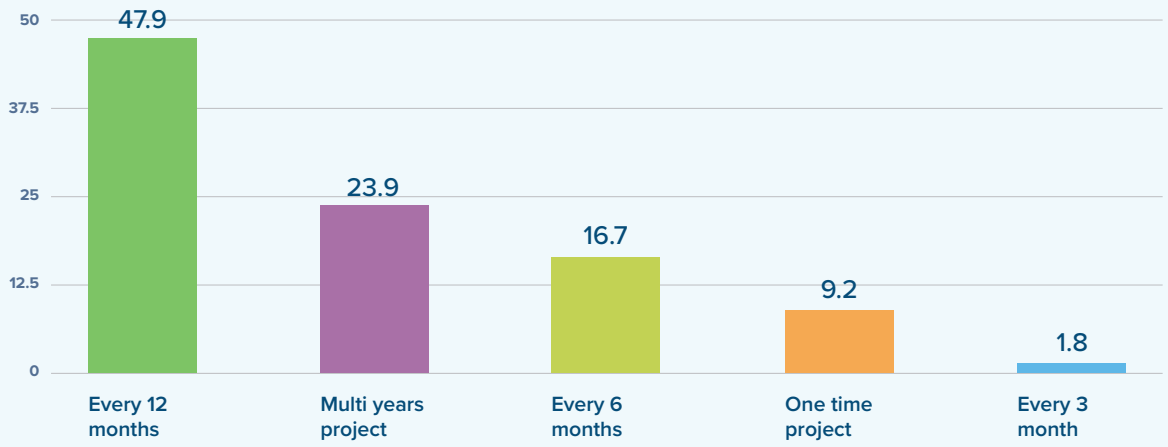


FIGURE 3.2:
MHPSS FUNDING CYCLE IN JORDAN (N=33)



The previous figures showed that the highest percentage (78.6%) goes for the activities that are currently under implementation, while the least percentage goes for the planned but not yet funded with 3.7%. This might indicate an ambiguity related to upcoming MHPSS projects and activities.

In addition, FIGURE 3.2 shows the length of funding cycle for the reported activities in Jordan. It indicates that most activities (47.9%) were funded throughout 12 months, followed by multi-years' projects with 23.9%, which is consistent to what has been found in the 2014 mapping activity. Also, there is less focus on the short period projects as manifested by the small percentages for 3- and 6-months' projects funding.

FIGURE 3.3:
ACTIVITIES' STATUS PER GOVERNORATES

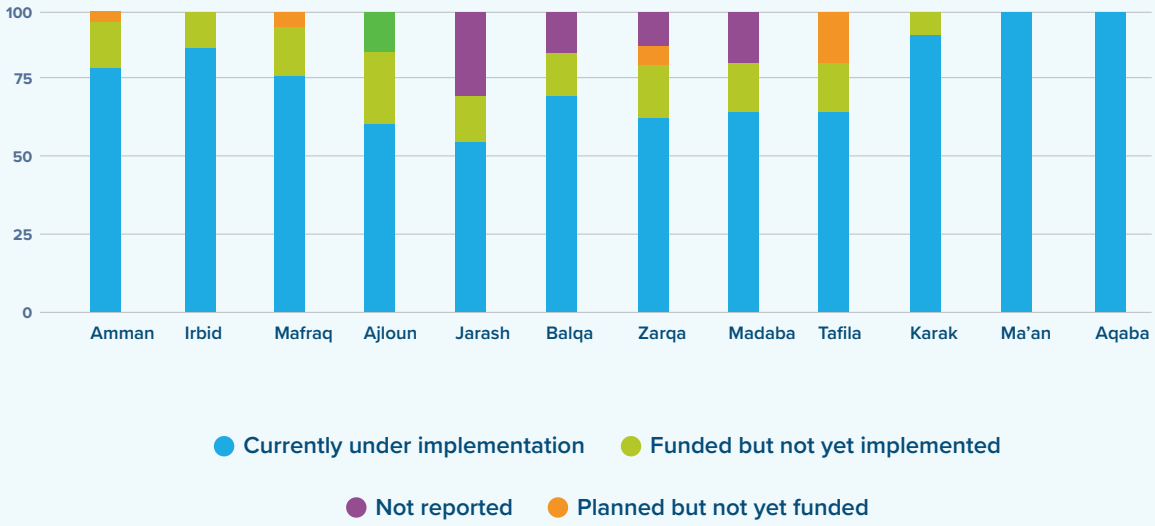


FIGURE 3.1:
THE FUNDING CYCLE FOR MHPSS ACTIVITIES PER GOVERNORATE (N=33)

GOVERNORATES	EVERY 3 MONTHS	EVERY 6 MONTHS	EVERY 12 MONTHS	MULTI YEARS PROJECT	ONE TIME PROJECT
Amman	4.2%	8.3%	33.3%	37.5%	16.7%
Irbid	8.7%	13%	34.8%	30.4%	13%
Mafraq	0%	11.8%	47.1%	17.6%	17.6%
Ajloun	0%	14.3%	57.1%	14.3%	14.3%
Jerash	0%	20%	60%	20%	0%
Balqa	0%	16.7%	66.7%	16.7%	0%
Zarqa	0%	13.3%	40%	33.3%	13.3%
Madaba	0%	40%	40%	20%	0%
Tafila	0%	16.7%	50%	16.7%	16.7%
Karak	9.1%	9.1%	36.4%	27.3%	18.2%
Ma'an	0%	16.7%	50%	33.3%	0%
Aqaba	0%	20%	60%	20%	0%

Most respondents reported the source of donation, and the following is the list of donors in Jordan for MHPSS services. However, many organizations didn't report the amount of funding per cycle, which made analyzing the annual amount of funding per activity or per governorate not possible.

Note: The arrangement of donors did not reflect the amount of funding neither the importance

Bureau of Population, Refugees, and Migration (BPRM), ACID, ADA, Italian Agency For Development Cooperation (AICS), Federal Ministry of Economic Cooperation and Development (BMZ), Bernard van Leer Foundation (BvLF), Caritas, Danish International Development Agency (DANIDA-E), European Civil Protection and Humanitarian Operations (ECHO), Japan International Cooperation Agency (JICA), King Frederik, Music Aid, NL, Schooner foundation and interaction, Swiss Agency for Development and Cooperation (SDC), The Higher Council of the Rights of Persons with Disabilities, UN women Rutgers, United Nations High Commissioner for Refugees (UNHCR), United Nations International Children's Emergency Fund (UNICEF), United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), United States Department of Labour (US DOL).

OTHER MHPSS SERVICES' PROVIDERS IN JORDAN

Several organizations decided not to participate in the mapping activity. For example, the Ministry of Social Development (MoSD) did not participate due to the short period of the activity and due to long-expected bureaucratic process needed to obtain approvals. It is worth mentioning that MoSD plays a major role in providing MHPSS services through its countrywide offices. These offices include, but are not limited to:

- Juvenile care centers
- 27 care centers for people with disability

Through these offices, the ministry, according to their previous reported data, provides three major types of activities:

Activity 3: Strengthening of community and family support, by performing the following sub-activities:

- Strengthening of parenting/family support;
- Facilitation of community support to vulnerable persons;
- Structured social activities (example: group activities);
- Early childhood development (ECD) activities;
- Facilitation of conditions for indigenous traditional, spiritual, or religious support;
- Self-reliance activities (income-generating activities, life skills, literacy classes, etc.).

Activity 7: Psychosocial intervention, by performing the following sub-activity:

- Case management, referrals and linking vulnerable individuals/families to resources (example: health services, cash assistance, community resources, etc.).

Activity 8: Psychological intervention, by performing the following sub-activities:

- Basic counselling for individuals;
- Basic counselling for groups or families;
- Psychotherapy.

DISCUSSION

The current mapping activity showed a re-distribution in the proportions of provided services across the levels of the IASC intervention pyramid in comparison to the previous years' mapping. The current mapping showed a significant decline in the third and fourth levels of IASC intervention pyramid. Regarding the third level which "the focuses (person to person) on non-specialized care", the percentage declined from 21% in 2017 mapping to 13.7% in the current mapping. This level consists of the psychosocial interventions and clinical management of mental disorders by non-specialized health care providers. Although the percentage of psychosocial interventions was high when compared to other activities with about 15%, the clinical management of mental disorders was very low with 3.7%. Therefore, to enhance the person-to-person level, the agencies need to plan and implement further activities related to clinical management of mental disorders.

Regarding the fourth level, which focuses on specialized services, the percentage declined from 19% in 2017 mapping to 13.7%. This level consists of psychological interventions and clinical management of mental disorders by specialized mental health care providers. According to the current mapping result, psychological interventions shape 12.3% of all activities in Jordan. Further analysis for this activity revealed that most of its' sub-activities cover the individual (37.3%) and group counselling (25.8%). On the other hand, less attention is given to the developmental disorders and substance/alcohol use problems with only 10.9% and 7.1% respectively. The analysis is indicating the need to plan and implement further activities to cover the health needs of individuals with developmental disorders or substance/alcohol use problems.

Managing mental disorders by specialized health care providers shape only 3.9% of all running activities in Jordan. Although this percentage increased from 2% in 2017 mapping, it is still low. Through examining the sub-activities that lay under this domain, the results showed most of the activities cover the pharmacological and non-pharmacological management of mental disorders with 30% and 26% respectively. In addition, little focus is given to the in-patient mental disorder with 19%. The results are consistent with the average numbers of psychiatrists, mental health nurses and psychologists that have been reported in the current mapping. Consequently, there is a need to give more attention to these types of activities, such as increasing the number of specialized (psychiatrist, psychiatric nurses and psychologist) HCP and implementing further in-patient mental health services.

> "little focus is given to the in-patient mental disorder."

Jordan is considered to be in the stabilization phase of the humanitarian emergency that has been reflected by the overall stability of the second level of the IASC intervention pyramid, which was 37% in 2017 mapping and 36% in 2012 mapping. The second level, strengthening community and family support through activating social networks, communal traditional support, and supportive child-friendly spaces, consists of information dissemination, strengthening of community and family support and safe spaces. Although information dissemination percentage increased from 11% to 15.4%, strengthening of community and family support declined from 29% in 2017 mapping to 10.4% in 2021 mapping. This decline can be explained when taking into consideration the precautionary measures of COVID-19 pandemic; the government forced a quarantine and social distancing measures that inhibited people from gathering in the recent two years. Finally, the safe spaces percentage remains stable with roughly reaching 8%.

Social consideration in basic services and security represents the first level of the IASC intervention pyramid and it shapes 35.6% of all pyramid's levels. This percentage witnessed a significant increase in comparison to 2017 mapping (22%). This level consists of facilitation of conditions for community mobilization, supporting the inclusion of social/psychosocial considerations in other sectors for example: nutrition, health, hygiene, and some elements of information dissemination in particular; mass campaigns (tv or radio... etc.). Supporting the inclusion of social/psychosocial considerations in other sectors witnessed a jump; with 8% in 2021 mapping in comparison to 4% in 2017 mapping. This jump can be explained by the economical strains that people face since the start of the COVID-19 pandemic, which caused a strain on the health, nutrition, hygiene services ever since.

MHPSS profile by beneficiaries' nationality witnessed a change between 2017 mapping and the current 2021 mapping. The Syrian population remains the most targeted group with 31.6%. However, the percentage of targeted group from the other nationalities increased from 16% to 21.7%. This percentage has increased due the fact of Jordan receiving more refugees from other countries such as Yemen, due to the Yemeni civil war, Somalia and Sudan. The highest percentages of other nationalities as a target group were found in the southern governorates; Karak, Ma'an, and Aqaba. while the percentage of MHPSS targeted Iraqi population remain almost stable with 20%.

Despite the increased attention towards the importance of taking care of the humanitarian workers themselves; only (39.5%) of all agencies have specific MHPSS activities for staff care. Humanitarian workers deal with a wide variety of humanitarian crisis, which could result in psychological distress affecting their wellbeing and their services' quality. Caring for them by designing a specific MHPSS services is considered essential for sustaining the mental health and psychosocial workforce, thus, this percentage needs to be addressed and further activities must be tailored to all workers in the humanitarian field.

The current mapping aimed to get specific indicators from each governorate to help in analyzing the gaps and closing it. In general, the current mapping reveals a re-distribution of activities per governorate; more attention was given to the southern governorates, and less attention to the northern and middle governorates (Amman, Irbid, Ajloun, Jerash, Mafraq, Balqa, Zarqa and Madaba) when compared to the previous mapping activity. Amman has the highest concentration of MHPSS services with 109 different activities, which makes up 17.6% (previously was 21%) of the total distribution. This percentage is consistent with the refugees' ratio according to the UNHCR reports. On the other hand, most of the organizations started to provide more MHPSS services in the southern governorates (Tafila, Karak, Ma'an, and Aqaba), where 21.3% (previously was 16%) of all MHPSS services are being provided.

COVID-19 AND MHPSS

The COVID-19 pandemic is a major threat to physical and mental health and to individuals and societies to a level that evoked attention towards urgent and priority interventions. Hardships associated with socioeconomic effects, fear of the virus and its spread and other related concerns have an unquestionable impact on the mental health of the population. Many agencies responded to the international calls to address these needs through committing to public safety measures and precautions to combat the spread of COVID-19. The public health authority response in Jordan, to combat the outbreak of COVID-19, has also affected the organizations and agencies' abilities to meet their beneficiaries' needs. Therefore, numerous on-line methodologies (telehealth) were created and developed as alternatives to presume their activities and ensure their sustainable plans and interventions. Some agencies reported the activation of teletherapy services both for individuals and groups sessions; utilizing different platforms such as Microsoft teams, Zoom, WhatsApp and traditional phone calls. Moreover, some agencies reported that they will launch a mobile application to facilitate accessing their services.

Teletherapy is a promising approach for the remote people, and many actors stated that they will keep providing these services even after minimizing the social distancing precaution and going back to normal life. Of course, while teletherapy is a great tool during emergencies like COVID-19, it should not permanently replace face-to-face therapy – at least not for everyone.

The limitations of teletherapy are especially recognized when working with children who have been abused, neglected or otherwise traumatized. Generally, children have not yet fully developed the attention and emotional regulation skills that are needed for effective virtual therapy. In addition, not all households have a computer or smartphone, and among those that do, not all have reliable (or any) internet connection. Older adults are not familiar with technology, which can make the telehealth seeking confusing and intimidating. Finally, the quality of these activities needs further analysis.

CHALLENGES

TOOL-SPECIFIC CHALLENGES AND LIMITATIONS

Based on lessons learned from past mapping exercises, the project team made some improvements to some elements of the 4Ws tool. Collecting the data using the on-line format was chosen to replace to the traditional format of data collection, as it allows to collect MHPSS services' data per governorate instead of collecting it collectively. At the same time; Excel was used for the organizations who face technical difficulties in receiving and opening external URL. Therefore, to ensure unified answers by all organizations, many checks and follow ups were made.

Not all agencies submitted information regarding the source of funding for MHPSS programs. This could be a result of data confidentiality or the un-familiarity of the MHPSS's focal point who fill the 4Ws with the specific details of budget per activity and per governorate. Moreover, the project team recommends to design specific sections to collect data regarding refugees' camps.

Although the generated feedback of the mapping indicated that organizations found it relatively easy to complete the 4Ws tool, there exists a need to ensure a unified understanding of specific terminology used in MHPSS sector. For that the project team suggests conducting a training on the 4Ws tool before collecting the data.

SECTORIAL CHALLENGES AND LIMITATIONS

Key factors affecting the sustainability of MHPSS activities are related to policy and program priorities, funding, available infrastructure, governance and management, as well as the local social and economic contexts. The issues impacting the capacity of organizations to deliver appropriate, accessible and reliable services are not new and have been covered extensively in past mappings. These factors include but are not limited to:

COLLABORATION AND REFERRAL MECHANISM

Typically, the degree to which organizations currently share information is often based on informal networks. Although this issue existed in most of the previous mapping activities, the level of difficulty increased in the current 2021 mapping. Since 2017, MHPSS working group members agreed to update their 4Ws annually using the mhpss.net. Unfortunately, most of the organizations failed to do so, due to the frequent changes in MHPSS focal points and the un-familiarity with the website that resulted in huge gaps in the dataset and an outdated contact list.

Previous mappings consistently identified multiple task forces, working groups and forums which served as coordination mechanisms, facilitated dialogue along with referrals between sectors and partners including governmental bodies, NGOs, CBOs and other stakeholders. Unfortunately, attending MHPSS meetings was not a regular activity for many agencies. The lack of commitment and contradicting working agendas carried by organization are carrying on, lead to a deficiency of coordination or slowed down the participation in communication cycles.

Regarding the referral mechanism, as the result showed most of the active agencies have a referral mechanism and most of them are using the unified inter-agency referral form developed by MHPSS and Child Protection/SGBV working groups. Therefore, the disseminating of the updated organizations' basic information and their MHPSS activity list should reflect positively on the level of the referral and coordination mechanism.

KNOWLEDGE TRANSFER CHALLENGES

Staff changes and other situations requiring the transfer of duties and information between agency members presented challenges for the 4Ws project team; there is a high staff turnover and knowledge limitation to some new staff about the 4Ws process.

Situations that arise from trained staff members leaving without proper handover led to loss in functionality and expertise. To ensure effective knowledge transfer, it is recommended that organizations have a standardized process for transferring 4Ws knowledge and expertise held by experienced personnel for incoming staff.

STAFF AND TRAINING

The diverse profile of reporting agencies was reflected in the number of staff employed to deliver services. But as reported in previous sections, most of the governorates have few specialized (psychiatrists, psychiatric nurse, and psychologist) staff members allocated to them. In addition, most of the organizations didn't report the qualifications and training courses of their MHPSS providers.

Moreover, with few exceptions, various organizations involved volunteers in delivering MHPSS services. For some, it was not always viable or appropriate to use volunteers in the delivery of services and programs. Others commented during the interview that the cost of supporting and supervising volunteers sometimes outweighs the benefits.

The ability of MHPSS system to successfully deliver services and achieve positive outcomes depends highly on trained and qualified workforce. There is an apparent need for increased human resources for mental health care delivery, including the need to manage human resources in a cost-effective manner.

RECOMMENDATIONS

The mapping of MHPSS services provides an overview of the relatively extensive coverage of multi-layered MHPSS services throughout Jordan. Therefore, the collected data allows for recommendations to be made for future program planning. The recommendations below were discussed and agreed upon by active members of MHPSS working group, in a workshop where the key findings of the 4Ws mapping were provided. Key recommendations by members of the group are as follows:

- Mapping showed clear consideration of MHPSS interventions in general, however, there is still a need for additional awareness activities to highlight the importance of MHPSS considerations across sectors. It is essential on Level 1 of the IASC intervention pyramid: "social consideration in basic services and security" to be continually integrated within various sectors, to ensure multi- sectorial MHPSS sensitive programming.

- Level two activities are fundamental to supporting the prevention and promotion of mental health and psychosocial wellbeing for children, youth, families, and communities. Mapping showed that level two on the pyramid is still around the same level of services provided in comparison of the recent mapping exercise, there is a need to maintain the provision of level two services and to integrate them with other types of services and sectors such as community centers, schools and education in general, to ensure multi-sectorial MHPSS integrated programming.

- Mapping showed a decline in services provided on level three on the IASC intervention pyramid in comparison with previous years, where it used to be 21% in 2017 as appose to 13.7% at present. This drop of level three services "focused, non-specialized support" need to be taken into consideration. A solution to this issue would be to increase the percentage of integration of MHPSS services with the health services, clinical management of mental disorders by community health facilities/ PHC staff. Another solution would be by considering psychosocial interventions as part of the clinical management of patients at the level of primary health care.

- Mapping showed a decline in MHPSS services on the IASC intervention pyramid "specialized care" from 19% in 2017 to reach 13.7% at present, despite increasing the psychological needs due to COVID-19 pandemic. This outcome needs to be considered in the planning for future programs to maintain the level of accessibility to specialized mental health and psychosocial services (management of mental health disorders by specialized staff). The developmental disorders are still not getting attention it requires, and the same can be said about alcohol/substance use problems.

- The geographical distribution for activities still shows there is more attention given to the north, middle areas of Jordan in terms of provision of MHPSS services, which is due to the distribution of the refugees in general. Furthermore, many of MHPSS are provided for everyone, including all nationalities of refugees and the host population. The low number of services provided in the southern governorates need to be addressed, as well as the issue of finding a balance between the camps and urban areas based on the needs and the distribution of people in need.

- In terms of funding, the results showed a high percentage of funding streams don't consider long term sustainability of services. It's important to advocate with donors

to look into long term implementation for better outcomes and improving the mental health systems to absorb the increasing needs.

- Mapping shows that high percentage of MHPSS services by non-specialized volunteers. It's always recommended to invest in local capacities of service providers and create a monitoring environment to make sure standards are being followed and avoid doing any harm.
- Many agencies showed great efforts; Some increased the capacity to address the increase in needs, many tried to maintain MHPSS services, and others shifted to online/ remote service modalities. A few of the new interventions will be practiced still as they contribute to better access to mental health services for the population. This process can be enhanced and improved to accommodate different groups. And it should be noted that the staff performing online support requires special training and supervision.
- Mapping showed that few agencies are providing support such as, staff care for the mental health and psychosocial staff providing the services. It's recommended to view staff care in a broader manner and to understand that it requires attention from management and Human Resources department, where they need to take the lead and plan for it as a cross cutting issue in all programs.
- Mapping showed low number of local participations of local MHPSS service providers in MHPSS working group. It's highly important to try to engage local agencies, involve them in training for coordination and referrals, as well as provide them with needed materials.

International Medical Corps

This 4Ws MHPSS mapping was completed by International Medical Corps with coordination and contribution of MHPSS members

ANNEX 1. THE LIST OF MHPSS ACTIVITIES RECOMMENDED BY THE IASC REFERENCE GROUP[15]

	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 row 5 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 row 5 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 support
			3.3	Facilitation of community support to vulnerable persons
			3.4	Structured social activities (e.g., group activities)

15. IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2012). Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes. Geneva.

	ACTIVITY CODE	ACTIVITY / INTERVENTION	SUB-ACTIVITY CODE	SUB-ACTIVITIES (EXAMPLES OR DETAILS OF ACTIVITIES)
Community-Focused MHPSS	**3**	Strengthening of community and family support	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 row 5 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 row 5 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 row 5 of MHPSS Services Info sheet)

	ACTIVITY CODE	ACTIVITY / INTERVENTION	SUB-ACTIVITY CODE	SUB-ACTIVITIES (EXAMPLES OR DETAILS OF ACTIVITIES)
Community-Focused MHPSS	**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 programing (provide details and specify sector in row 5 of MHPSS Services Info sheet)
			6.2	Other (describe in row 5 of MHPSS Services Info sheet)
Case-focused MHPSS	**7**	Psychosocial intervention	7.1	Psychological First Aid (PFA)
			7.2	Psychological First Aid (PFA)
			7.3	Other (describe in row 5 of MHPSS Services Info sheet)
	8	Psychological intervention	8.1	Basic counseling for individuals (specify type in row 5 of MHPSS Services Info sheet)
			8.2	Basic counseling for groups or families (specify type in row 5 of MHPSS Services Info sheet)
			8.3	Psychotherapy (specify type in row 5 of MHPSS Services Info sheet)
			8.4	Interventions for alcohol/ substance use problems (specify type in row 5 of MHPSS Services Info sheet)
			8.4	Psychosocial support to teachers/other personnel at schools/learning places
			8.5	Interventions for developmental disorders/intellectual disabilities (provide details and specify type in row 5 of MHPSS Services Info sheet)
			8.6	Other (describe in row 5 of MHPSS Services Info sheet)

	ACTIVITY CODE	ACTIVITY / INTERVENTION	SUB-ACTIVITY CODE	SUB-ACTIVITIES (EXAMPLES OR DETAILS OF ACTIVITIES)
Case-focused MHPSS	**9**	Clinical management of mental disorders by non-specialized health care providers (e.g., PHC staff, post-surgery wards)	9.1	Non-pharmacological management of mental disorder by non-specialized health care providers (where possible specify type using categories 7 and 8)
			9.2	Pharmacological management of mental disorder by non-specialized health care providers
			9.3	Action by community workers to identify and refer people with mental disorders and to follow up on them to ensure adherence to clinical treatment
			9.4	Other (describe in row 5 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 disorders by specialized mental health care providers (where possible specify type using categories 7 and 8)
			10.2	Pharmacological management of mental disorders by specialized health care providers
			10.3	In-patient mental health care
			10.4	Other (describe in row 5 of MHPSS Services Info sheet)
General MHPSS	**11**	General activities to support MHPSS	11.1	Situation analyses/assessment (provide details and specify type in row 5 of the MHPSS Services Info sheet)
			11.2	Structured training
			11.3	Technical or clinical supervision
			11.4	research
			11.5	other (describe in row 5 of MHPSS Services info sheet)

ANNEX 2. A LIST OF CONTRIBUTING ORGANIZATIONS AND THEIR CONTACT INFORMATION

NAME OF ORGANIZATION (FULL NAME & ACRONYM)	ADDRESS OF ORGANIZATION	NAME OF THE FOCAL POINT AT THE ORGAN-IZATION	PHONE NUMBER OF FOCAL POINT	EMAIL ADDRESS OF FOCAL POINT
ILO International Labour Organisation	Al-Umawyeen St Street South Abdoun P.O.Box 83120 111183 Amman- Jordan	Alaa Alnasser	T: (6) 5925778: Ext: 333 M: (79) 9786714	alnasser@ilo.org
Arab Renaissance for Democracy and Development	ZUHARE MALHAS ST	Souzan Mohareb	775777077	somohareb@ardd-legalaid.org
Lutheran World Federation (LWF)	Dsdsd	Oroba Nofan Shawaqfeh	795300167	oruba.shawaqfeh@lutheranworld.org
International Orthodox Christian Charities (IOCC)	Sweifieh, Princess Thaghrid St. Building No.16, 3rd Floor	Meg McManus	79 002 4288	mmcmanus@iocc.org
Action Against Hunger	Amman Jordan	Noor Amawi	799215186	mhpsshod@jo-actionagainsthunger.org
International Catholic Migration Commission (ICMC)	Irbid - Mafraq - Amman	Rami Alkhalil	795447217	alkhalil@icmc.net
War Child Holland (WCH)	Jordan/ Amman- St. Mamdouh Al-Sarairah	Mohammad Al-Adam	795262235	mohammad.aladam@warchild.nl
ActionAid Arab region	Amman - Weibdeh office SSC in Zarqa	Zain Silawe	782917519	zainsilawe@gmail.com
Questscope	Amman Jordan Weibdeh /Zaatari District 4	Haneen Alfayoumi/ Ahmad Abu Nimreh	799193643/ 798517971	h.fayoumi@questscope.org/nimreh@questscope.org
CARE International-Jordan	Amman-Jordan	Lina AL Darras	791220668	lina.aldarras@care.org
Jordan River Foundation (JRF)	7th Circle, Amman, Jordan	Adel Bondokji	796884547	a.bondokji@jrf.org.jo

NAME OF ORGANIZATION (FULL NAME & ACRONYM)	ADDRESS OF ORGANIZATION	NAME OF THE FOCAL POINT AT THE ORGANIZATION	PHONE NUMBER OF FOCAL POINT	EMAIL ADDRESS OF FOCAL POINT
Blumont	Building# 162 (Balsan tower) | Floor 7 | Mecca Street |	Mohammad Obadiallah	795132514	mobaidallah
Humanity & Inclusion	Amman	Bashayer Othman	782150133	b.othman@hi.org
The Islamic Charity Centre Society (ICCS)	Amman-Abdali	Fawaz Mazrawi	795054944	f.mazrawi@islamicc.org
SAMS	3 floor, Taras Al-madina blodg. (#195) Al-Madina Al-Monawara St. Amman	Aroub Alnemrat	770688820	alnmerat@sams-usa.net
Danish Refugee Council (DRC)	4 Mohammad Al-Jamaan Street, Wadi Saqra, Amman, Jordan	Muna Rawhi	782143433	muna.mohd@drc.ngo
AL-Hussein Society / Jordan Center for Training and Inclusion	Amman -Hay Alrwabi -Alredaneh Street- B# 11	Annie M. Medzhagobian	79 660 008	Execdirector@ahsrehab.org
TDH	Dina Center 2, Sulayman Al-Nabulsi Street, Al-Abdali, Amman in front of Audi Bank, 3rd floor	Dalia Ajweh	796303576	dalia.ajweh@tdh.ch
INTERSOS	Jordan / Amman - Shemsani Area - Al-Sharif Naser Ben Jamil - Building 12- Third Floor - INTERSOS Office	Abdallah Sabah	772457879	pss.counsellor.jordan@intersos.org
Institute for Family Health king Hussein Foundation, IFH/KHF	Jubiha , Baana Street	AREEJ SEMREEN	798812594	a.sumreen@ifh.org.jo
Jordan Red Crescent	Amman	Khaled AL-Shouara	777008971	khaled.shoura@jnrcs.org
International Rescue Committee (IRC)	Khalil Dabbas St., Rabyah, Amman	Leila Zghoul	787510152	leila.zghoul@rescue.org
The Center for Victims of Torture (CVT)	Amman	Moath Assfour	795639 016	masfoor@cvt.org

NAME OF ORGANIZATION (FULL NAME & ACRONYM)	ADDRESS OF ORGANIZATION	NAME OF THE FOCAL POINT AT THE ORGAN-IZATION	PHONE NUMBER OF FOCAL POINT	EMAIL ADDRESS OF FOCAL POINT
Jesuit Refugee Service - JRS	Amman	Rasha Dmour	790311387	Rasha.aldmour@jrs.net
Save the Children Jordan (SCJ)	180 Mecca St. Um Al Summaq- Amman, Jordan	Israa Abujamous	799477628	Israa.abujamouse@savethechildren.org
MEDAIR	Paris St., No 20, Al Sweifieh, Amman	Temporary (Ameera Amin) Lama Al-Shurafa	790039131	amira.ameen@medair.org
International Medical Corps - Jordan	Amman, Shmisani	Ahmad Alshibi	797462142	aalshibi@internationamedicalcorps.org
Caritas Jordan	Downtown-Bisharat Center	Lana Snobar	775444525	lanas@caritasjordan.org.jo
International Committee of Red Cross (ICRC)	21, Princess Sumaya Bint Alhassan Street, Al Rawanwaq District, Wadi Alseer, P.O. Box 9058-11191 Amman Jordan	Christine Clavier	778403928	cclavier@icrc.org
our Steps (خطوتنا)	Zarqa-Rusifah- Prince Hashem district	Amerah Ali ALjamal	797922056	ourstep_2010@hotmail.com
Arabic medical relief (AMR)	Za'atri camp	Samer aljarah	790128351	s.aljarah@amr.org.jo
Japan International Cooperation Agency (JICA)	5th circle, Emmar Tower, 196 zahran street (6th circle), Amman	Risa Ichishi	795706893	ichishi.risa2@jica.go.jp
World Health Organization (WHO) & Ministry of Health (MOH)	Interior Circle- Amman	Hadeel Alfar	(6) 5100655/ EXT. 64019	alfarh@who.int
GIZ	19 Ma'rouf Al Rusafi St., Shmisani- Amman	Christina-Maria Kraus	797129568	Christina-maria. Kraus@
The Jordanian Women's Union Association	Mafraq-Khalidieyah	Fasal Alsbehat	787373190	fasel.alsbehat@gmail.com

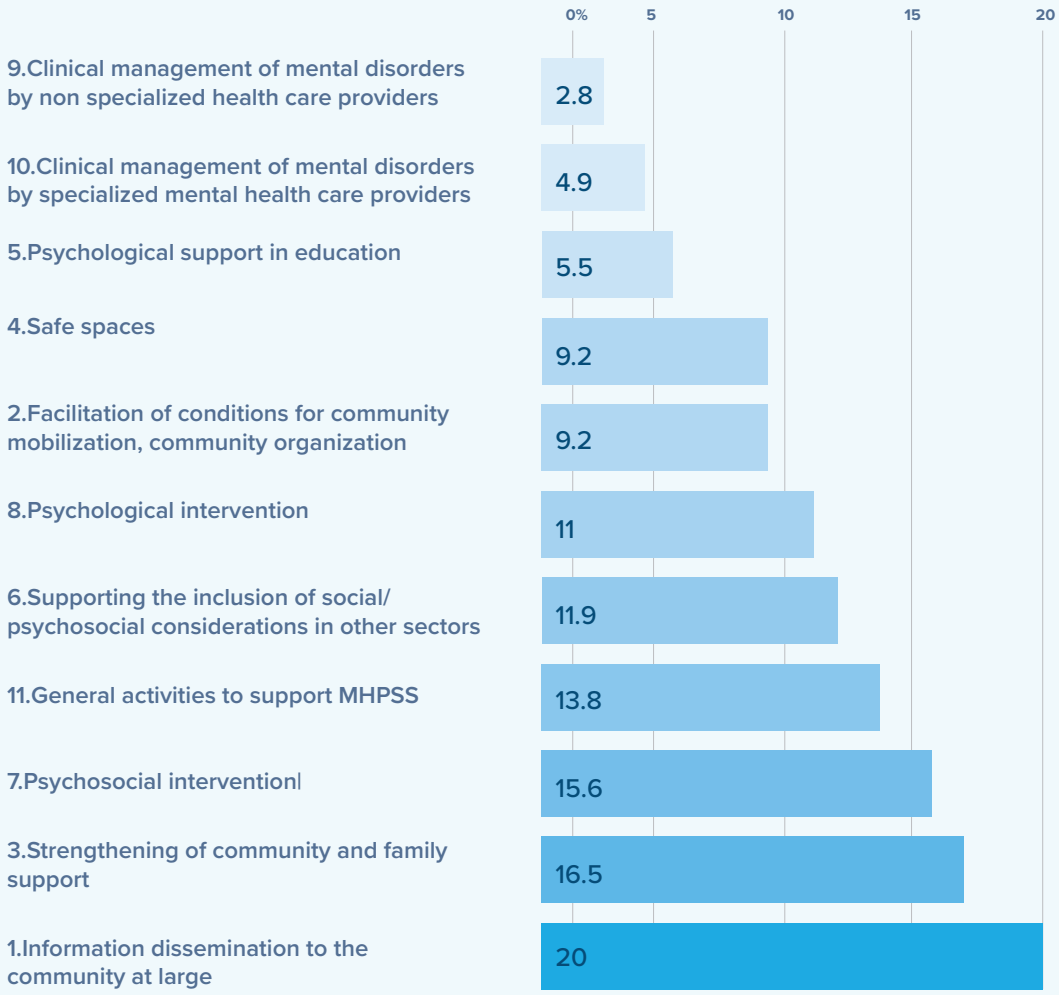
ANNEX 3. WHAT AND WHERE PER GOVERNORATE

1. AMMAN

1.1. ACTIVITY DISTRIBUTION

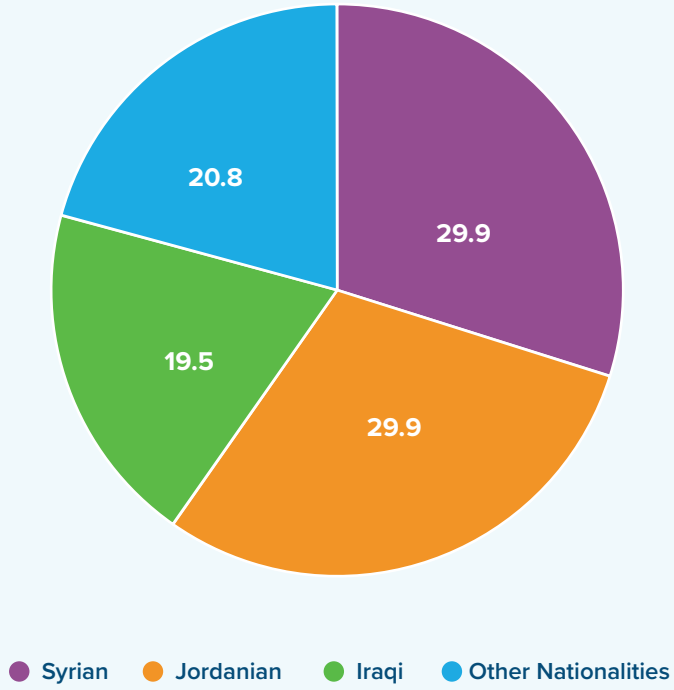
Most of the organizations 78.8% (n=26) provide MHPSS services in the capital of Jordan. About 109 MHPSS interventions are being provided in Amman alone. Ranging from Activity 1 “Information dissemination to the community at large”, to Activity 11 “General activities to support MHPSS”. The distribution of these activities is presented in FIGURE 1.1.

FIGURE 1.1:
ACTIVITIES' DISTRIBUTION IN AMMAN (N=26)



The previous figure entails that the most reported activities are "information dissemination to the community as large" with about 20%. This activity has three main sub-activities which are Information, Education & Communication (IEC) materials on the current situation, relief efforts or available services, messages on positive coping and mass campaigns (events, tv, radio, etc.). The least two activities are clinical management of mental disorders by non-specialized health care providers (i.e., PHC staff, post-surgery wards, and any other HCP who has been trained with mh-GAP training) and clinical management of mental disorders by specialized mental health care providers (i.e., psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities) with a percentage of 4.9% and 2.8% respectively. Both activities are categorized as case-focused activities, which indicates that there is a need to increase the amount of these activities by boosting the number of health centers that provide MHPSS services by either general health care providers or specialized ones.

FIGURE 1.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN AMMAN (N=26)



1.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

The previous figure shows how the most targeted groups by MHPSS services in Amman are Syrians and Jordanians with an equal percentage of 29.9%. The results are similar to the ones of the previous mapping (2017), which showed that Syrian people were the most targeted group in all of Jordan, and not only in Amman.

Moreover, MHPSS services target more males than females in Amman, the percentage of targeted males is 54.8%, while the percentage of targeted females is 45.2% in all activities. Considering the activities distribution by age; the largest age group targeted by MHPSS services is of those who are younger than 18, representing 52.2% of the serviced population, while beneficiaries who are 18 and above, represent 47.8% of the targeted population.

In reference to the humanitarian workers being considered as a target group, 38.5% of all operating agencies in Amman provide them with specific MHPSS services, while the majority of 53.8% didn't provide such services, and 7.7% didn't report back regarding this aspect.

1.3. SPECIFIC INFORMATION

Among all participating organization who provide MHPSS services in Amman, 48% reported that they provide their services along with partners i.e., CBOs or governmental institution, while 52% reported that they provide MHPSS services on their own. Moreover, among all reported activities, 80.8% are currently being implemented, 15.4% are funded but not yet implemented, and 3.8% are planned but not yet funded.

TABLE 1.3: MHPSS STAFF IN AMMAN (N=26)r

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	14	.54 (1.6)
Psychiatric mental nursing	10	.38 (1.8)
Psychologist	32	1.3 (2.9)
Social worker	44	1.7 (2.7)
Counselor	51	2 (3.2)
Psychosocial support officer	29	1.1 (1.7)
Case manger	47	1.8 (3.1)
Volunteer	63	2.4 (3.7)

The majority of organizations, 51.6%, reported that they carry out their activities inside centers, 12.9% inside clinics, 6.5% inside beneficiaries' houses and 6.5% inside schools. At the same time, 22.6% reported that they perform their activities in other settings, for examples; in other CBOs' centers, provide remote services, factories, and at the Higher Council for the Rights of Persons with Disabilities' building.

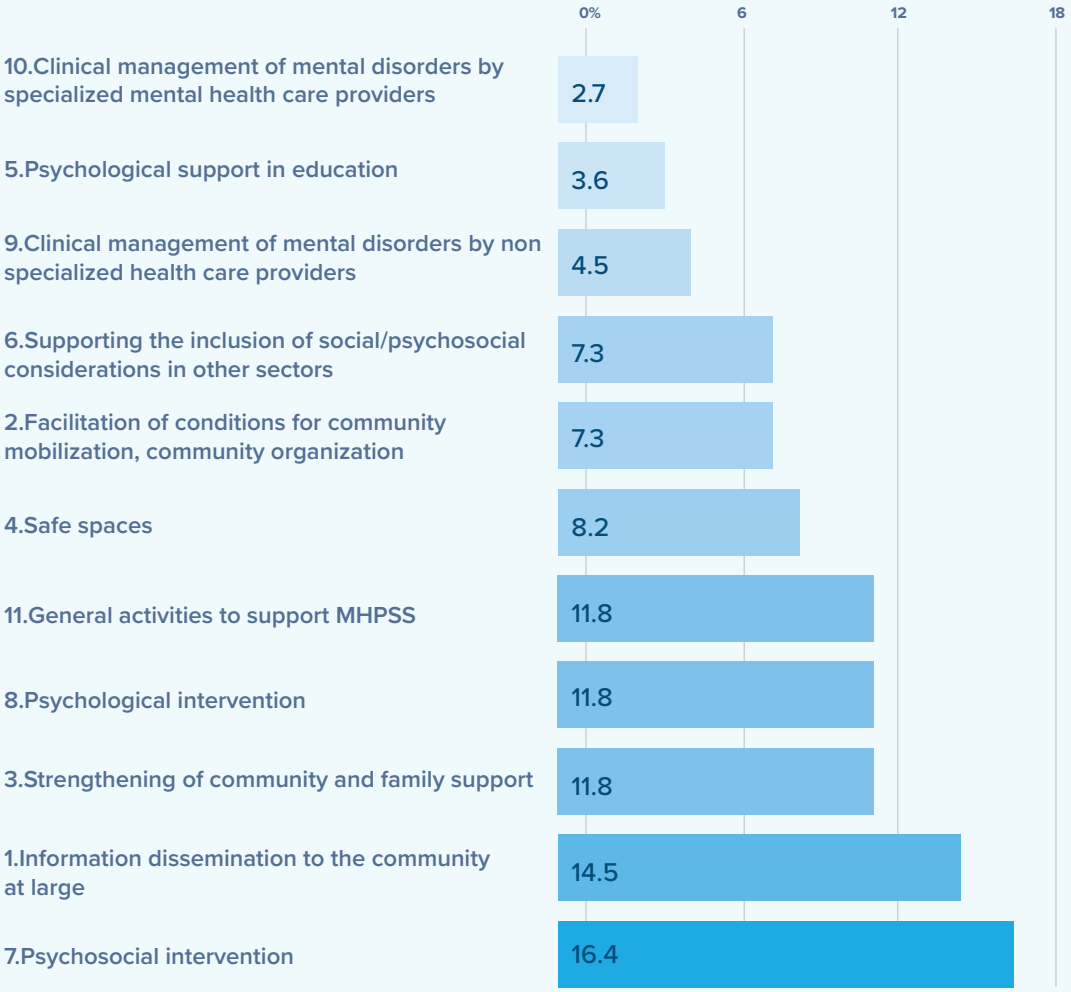
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

2. IRBID

2.1. ACTIVITY DISTRIBUTION IN IRBID

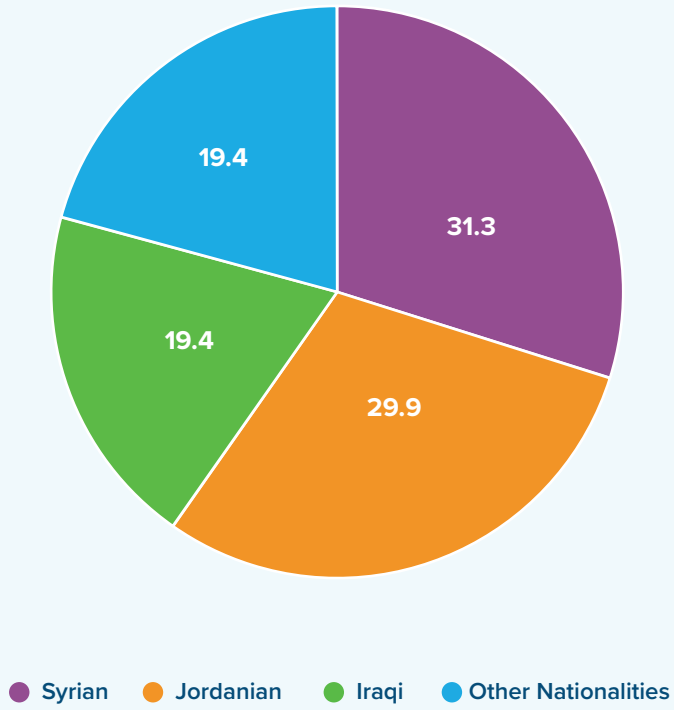
Among all participating organizations, 70% (n=23) provide MHPSS services in Irbid in the form of 110 general activities, which ranges from activity 1 “Information dissemination to the community at large”, to activity 11 “General activities to support MHPSS”.
The distribution of these activities is presented in FIGURE 2.1.

FIGURE 2.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN IRBID (N=23)



The previous figure shows how the psychosocial interventions were the most provided type of activities in Irbid, according to the organizations' self-report, with about 16.4%. This activity consists of two main sub-activities; 1) Psychological First Aid (PFA) 2) case management, referrals and linking vulnerable individuals/families to resources. The least provided activity was the clinical management of mental disorders by specialized health care providers with only (2.7%), this percentage is almost similar to what has been found in Amman. Moreover, psychological support in education, which consists of psychosocial support to teachers and children, accounted for only 3.6% of all activities. This can be explained when taken into mind the nation-wide quarantine that was forced as a governmental measure to manage the COVID-19 pandemic.

FIGURE 2.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN IRBID



2.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

The previous figure showed that Syrian are the most targeted group in Irbid with 31.3%, a percentage that is higher than what has been found in Amman which was 29.9%, followed by Jordanian with 29.9%. where Iraqi and all other nationalities (Yemani, Sumali, and Sudaneses) were equally targeted with 19.9% by all MHPSS services.

By examining the proportion of MHPSS services that target beneficiaries based on gender and age, the result reveals that males were targeted more than females in Irbid with 53.8% of MHPSS services are targeting males, and 46.2% target females. In addition, people who are younger than 18 years represented 51.1% of all serviced population, while the percentage of people who are 18 years and above reached 48.9%.

In reference to the humanitarian workers being considered as a target group, 40.9% of all operating agencies in Irbid provide specific MHPSS services to them, while the majority of organizations, 59.1%, didn't perform such services.

2.3. SPECIFIC INFORMATION

Among all participating organizations who provide MHPSS services in Irbid, 43.5% reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 56.5% reported that they provide MHPSS services on their own. Moreover, among all reported activities, 87% are currently under implementation and 13% are being funded but not yet implemented.

Regarding MHPSS activities' providers, the following table specifies the numbers and means:

TABLE 2.3: MHPSS STAFF IN IRBID (N=23)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.04 (.21)
Psychiatric mental nursing	1	.04(.21)
Psychologist	3	.04(.21)
Social worker	6	.26(.69)
Counselor	13	.26(.69)
Psychosocial support officer	5	.26(.69)
Case manger	24	1.1(1.8)
Volunteer	30	1.3(2.5)

The previous table shows how there is a lack of specialized MHPSS personnel, which is reflected by the few numbers of psychiatrist, psychiatric mental nurses and psychologist. This result explains the low percentage of clinical management of mental disorders by specialized care providers that has been found in this governorate. Moreover, some organizations reported that they have other job titles like; MHPSS focal point; MHPSS project coordinator; non-specialist facilitator and clinical coordinator.

In reference to the specific location of where the activities are performed; most organizations, with a percentage of 57.7%, reported that they carry out their activities inside centers, 15.4% inside clinics, 3.8% inside beneficiaries' houses and 3.8% inside schools. At the same time, 19.3% of organizations reported that they perform their activities in other settings, for examples; in other CBOs' centers, factories and some reported that they rent a place if it was required.

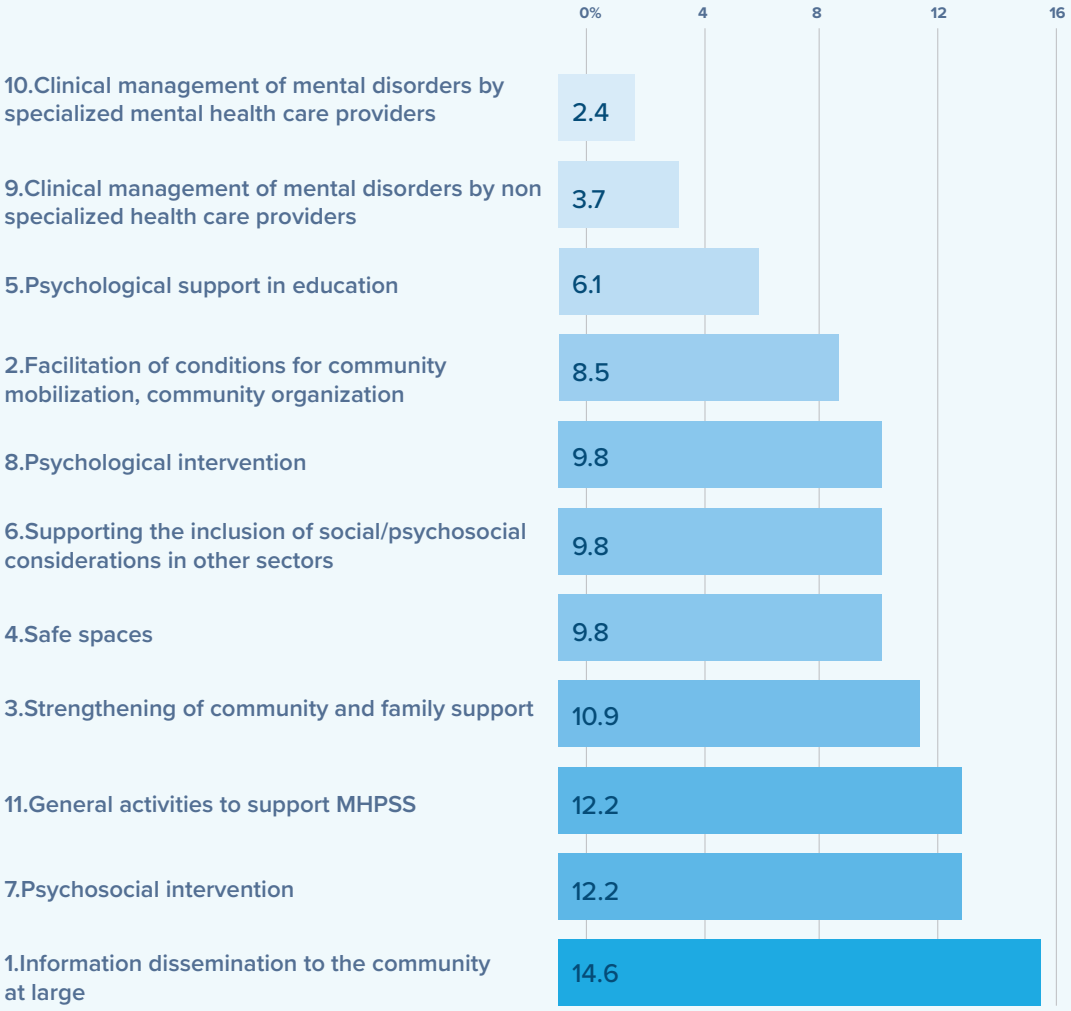
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

3. MAFRAQ

3.1. ACTIVITY DISTRIBUTION IN MAFRAQ

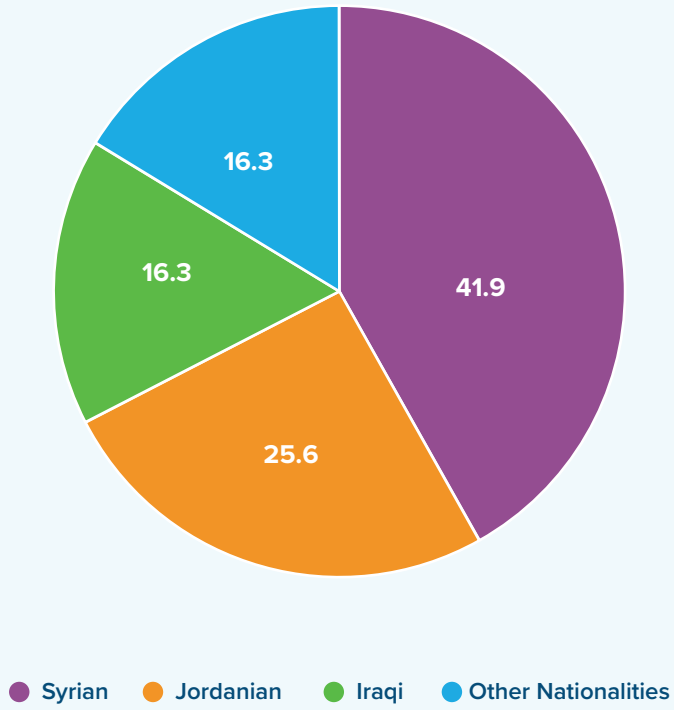
Among all participating organizations, 57.6% (n=19) provide MHPSS services in Mafraq in the form of 82 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 3.1.

FIGURE 3.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN MAFRAQ (N=19)



The previous figure shows how the most provided activities are “information dissemination to the general” with a percentage of 14.6%. followed by the psychosocial intervention and general activities to support MHPSS services with a percentage of 12.2% for each. The least provided activities are the clinical management of mental disorders by specialized health care provider and clinical management of mental disorders by non-specialized health care providers with 2.4% and (3.7%); respectively, this result is similar to what has been found in other cities.

FIGURE 3.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN MAFRAQ (N=19)



3.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

By examining the previous figure, it is evident that the most targeted group based on nationality is Syrians with a percentage of 41.9%, followed by Jordanians with 25.6%. Moreover, 47.4% of all acting organizations in Mafraq reported that they provide MHPSS services inside Za'tari camp.

Regarding the activities distribution by age and gender; the result shows how the males' percentage reached 51.2% and the females one reached 48.7% in all serviced population. In addition; 51.4% of MHPSS services are targeted towered people who are younger than 18, and (48.6%) for people who are 18 and above.

In reference to the humanitarian workers being considered as a target group, 26.3% of all operating agencies in Mafraq provide specific MHPSS services to them, while the majority of organizations, 68.4% didn't perform such services, and (5.3%) didn't report back this information.

3.3. SPECIFIC INFORMATION

Among all participating organizations who provide MHPSS services in Mafraq, 52.6% reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 42.4% reported that they provide MHPSS services on their own. Moreover, among all reported activities, 78.9% are currently under implementation, 15.8% are being funded but not yet implemented, and 5.3% being planned but not yet funded.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 3.3: MHPSS STAFF IN MAFRAQ (N=19)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	4	.21 (.71)
Psychiatric mental nursing	2	.11(.46)
Psychologist	4	.11(.46)
Social worker	13	.68(1.8)
Counselor	11	.58(1.3)
Psychosocial support officer	5	.26(.73)
Case manger	23	1.3(3.5)
Volunteer	4	.11(.46)

Moreover, some organizations reported that they have other job titles like delegator, psychosocial focal point and clinical coordinator.

In reference to the specific location of where the activities are performed; most organizations, with a percentage of 65%, reported that they carry out their activities inside centers, 10% inside clinics, 5% inside beneficiaries' houses, and 10% didn't report back any location. At the same time, 10% reported that they perform their activities in other settings, for examples, in other CBOs' centers.

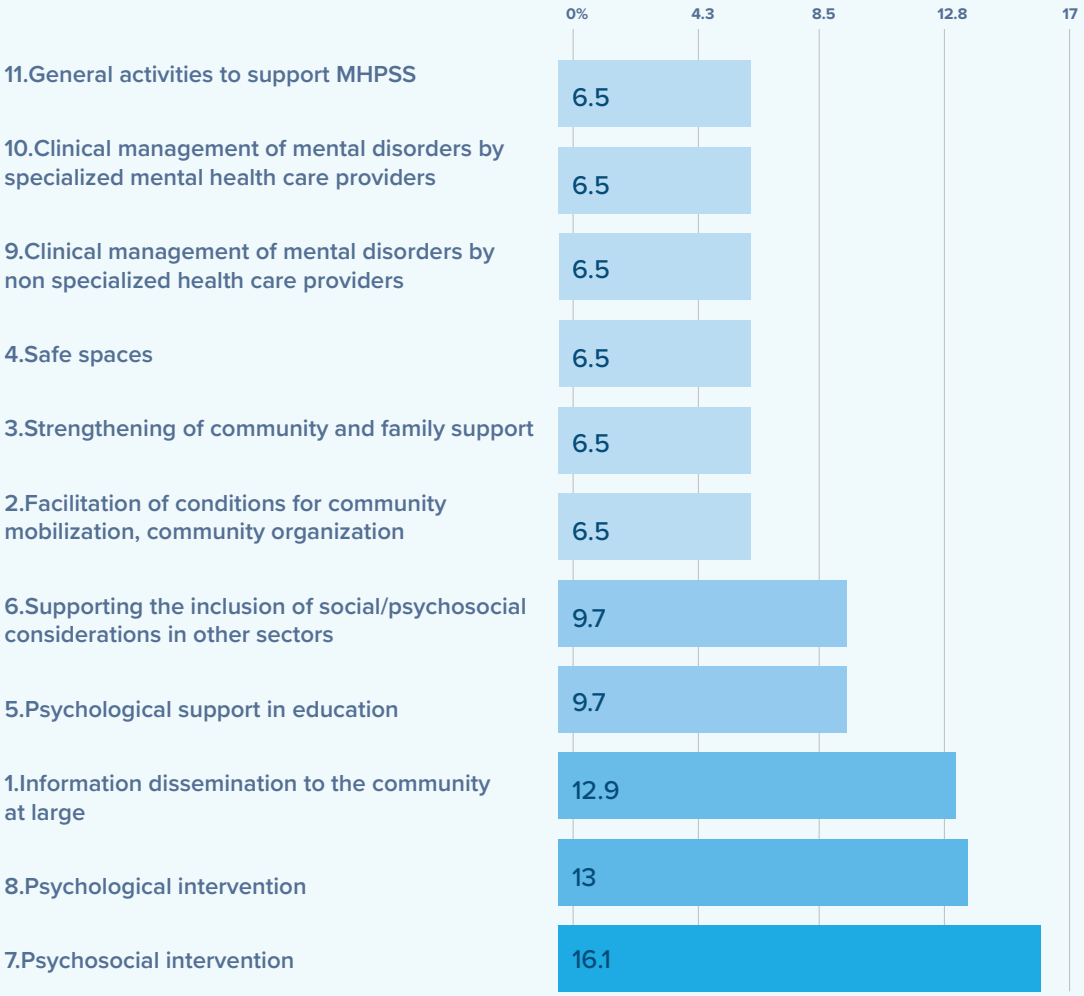
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

4. AJLOUN

4.1. ACTIVITY DISTRIBUTION IN AJLOUN

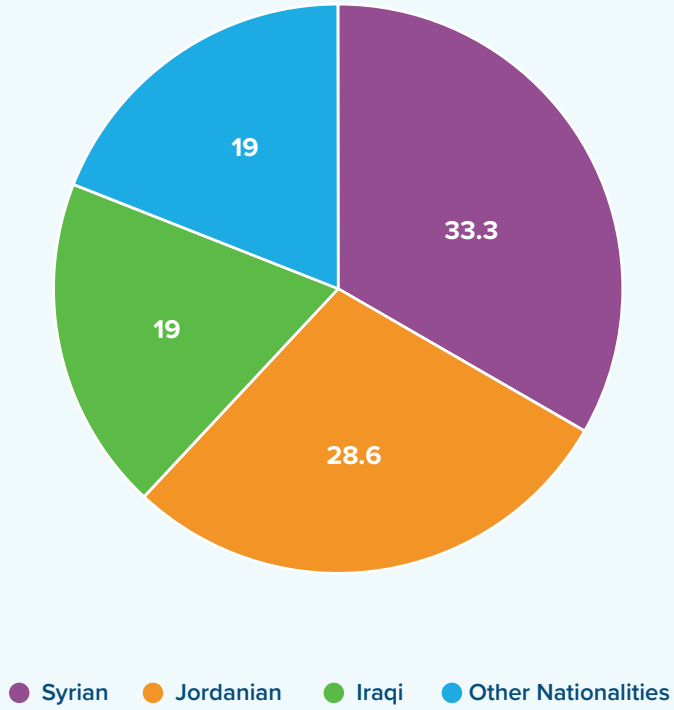
Among all participating organizations, 24.2% (n=8) provide MHPSS services in Ajloun in the form of 31 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 4.1.

FIGURE 4.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN AJLOUN (N=8)



The previous figure shows that information dissemination to the general, psychosocial interventions are the most provided activities' type in Ajloun, with a percentage of 16.1%. There seems to be an almost equal distribution for all the other types of activities. It is important to interpret this result in the light of the low number of acting agencies there.

FIGURE 4.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN AJLOUN (N=8)



4.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

By examining figure 4.2, the result shows how the most targeted group according to nationality is Syrians with 33.3%, followed by Jordanians with a percentage of 28.6%.

Regarding the frequencies of MHPSS services that target beneficiaries by gender and age, the result revealed that males were targeted more than females in Ajloun; with 53.8% of MHPSS services targeted towered males, and 46.2% targeted towered females. On the other hand, there was an equal distribution of MHPSS activities by age for both groups who are “18 years and above” and those who are “younger than 18”.

In reference to the humanitarian workers being considered as a target group, the majority of agencies, with a percentage of 85.7%, didn't provide any specific MHPSS activities to them, and 14.3% didn't report back this information.

4.3. SPECIFIC INFORMATION

Among all participating organization, who provide MHPSS services in Ajloun, 37.5% reported that they provide these services with other partners i.e., CBO or governmental institutions, while 62.5% reported that they provide MHPSS services on their own. Moreover, among all reported activities, 62.5% are currently under implementation, 25% are being funded but not yet implemented and 12.5% being planned but not yet funded.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 4.3: MHPSS STAFF IN AJLOUN (N=8)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	4	.5 (1.1)
Psychiatric mental nursing	0	0
Psychologist	1	.13(.35)
Social worker	1	.13(.35)
Counselor	4	.58(1.3)
Psychosocial support officer	0	0
Case manger	5	.5(1.1)
Volunteer	7	.87(1.8)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator and mental health focal point.

In reference to the specific location of where the activities are performed; the majority of organizations, with a percentage of 33.3% reported that they carry out their activities inside centers, 11.1% inside clinics, beneficiaries' houses, and schools separately, while 22.2% didn't report back where they perform their activities. At the same time, 11.1% reported that they perform their activities in other settings, for examples; in other CBOs' centers.

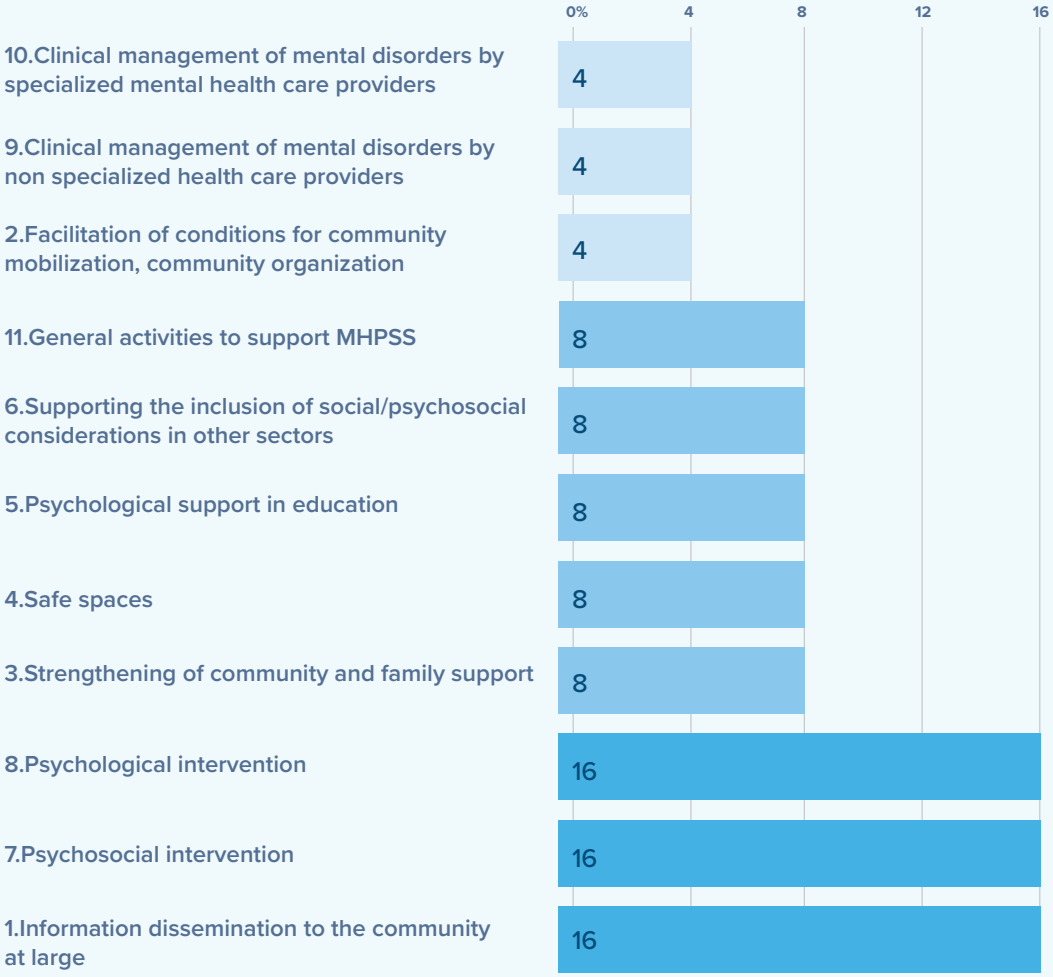
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

5. JERASH

5.1 MHPSS ACTIVITY DISTRIBUTION IN JERASH

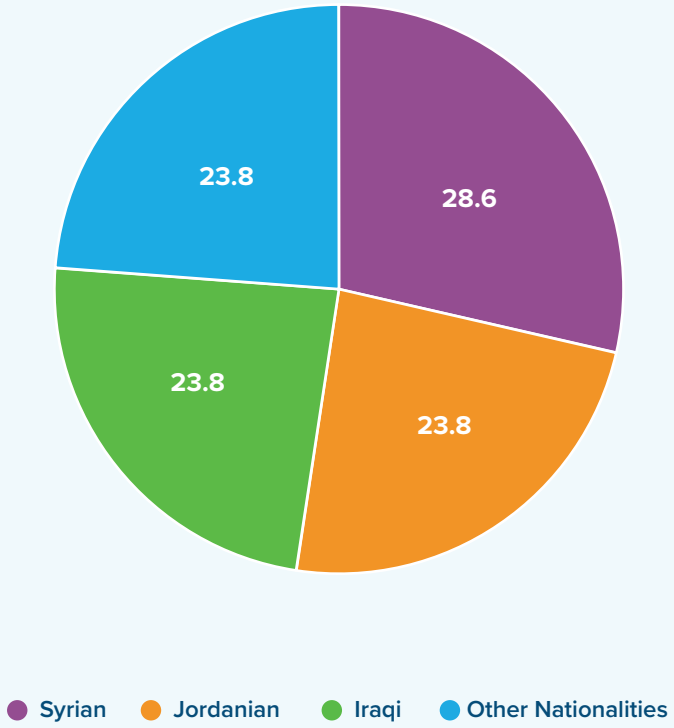
Among all participating organizations, 21.7% (n=7) provide MHPSS services in Jerash, in the form of 25 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 5.1.

FIGURE 5.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN JERASH (N=7)



The previous figure shows how the information dissemination to the general, psychosocial interventions, and psychological interventions are the most provided activities type in Mafraq with a percentage of 16% for each. The least provided activities are clinical management of mental disorders by either a general health care provider or specialist with a percentage of 4% for each, which is similar to what has been found in Amman, and most of the other activities are sharing about equal percentages.

FIGURE 5.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN JERASH (N=7)



5.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

The previous figure shows how Syrians were the most targeted nationality with a percentage of 28.6%, followed by all other nationalities (Jordanians, Iraqis, others) with 23.8% for each.

In reference to the humanitarian workers being considered as a target group, unprecedentedly, no agency reported provide any specific MHPSS services to them.

Finally, in regards to the activity distribution by gender and age, there were equal proportions of MHPSS services, with 50%, that targeted each category (male vs. female) and (younger than 18 vs. 18 and above).

5.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Jerash; 37.5 % reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 62.5% reported that they provide MHPSS services on their own. Moreover, among all reported activities, 57.1% are currently under implementation, 14.3% are being funded but not yet implemented, and 28.6% of the organization didn't report back their activity status.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 5.3: MHPSS STAFF IN JERASH (N=7)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.14 (.38)
Psychiatric mental nursing	0	0
Psychologist	1	.14 (.38)
Social worker	0	0
Counselor	0	0
Psychosocial support officer	0	0
Case manger	3	.43 (.79)
Volunteer	10	1.4 (3.8)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator and mental health focal point.

In reference to the specific location of where the activities are performed; the majority of organizations, with a percentage of 33.3%, reported that they carry out their activities inside centers, 11.1% inside the clinics, beneficiaries' houses, and schools for each. while 22.25 didn't report back where they are carrying out their activities. On the other hand, 11.1% reported that they perform their activities in other settings, for examples, in other CBOs' centers.

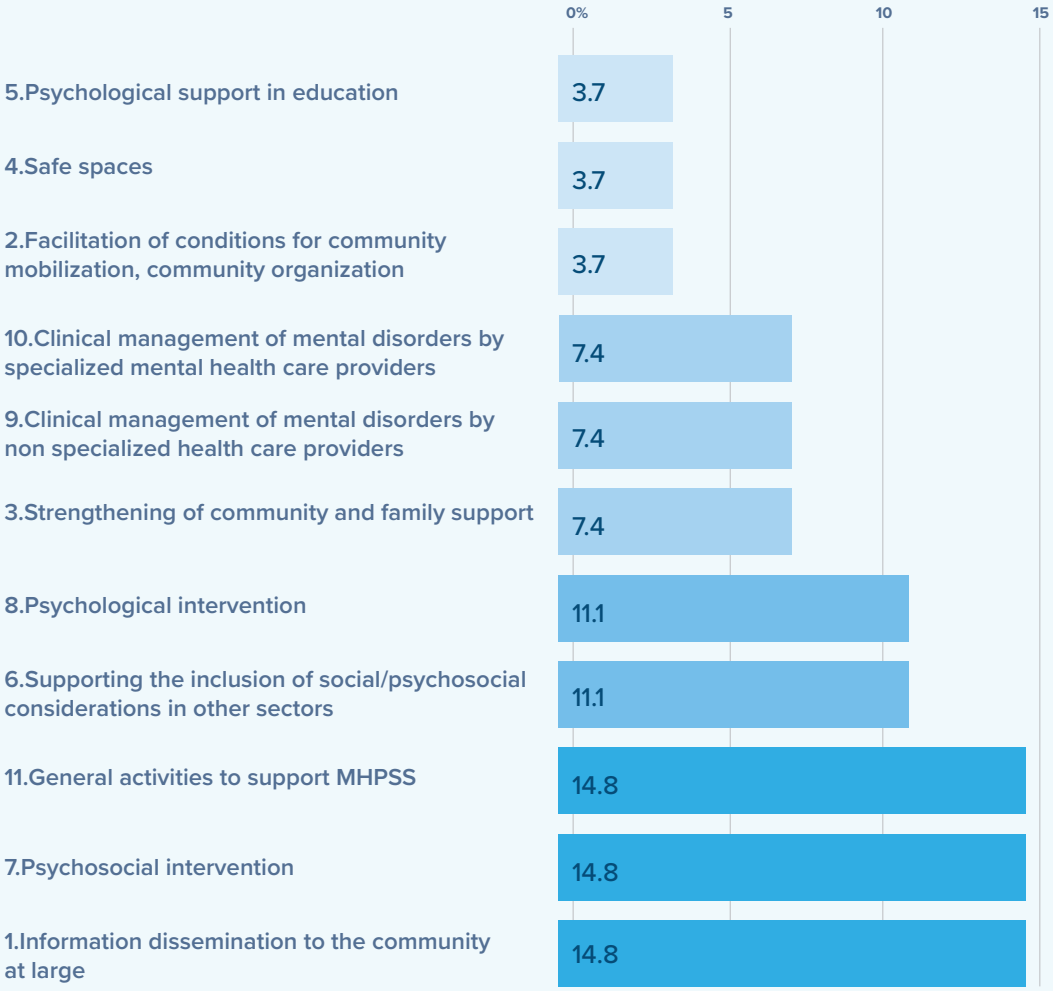
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

6. BALQA

6.1 ACTIVITY DISTRIBUTION IN BALQA

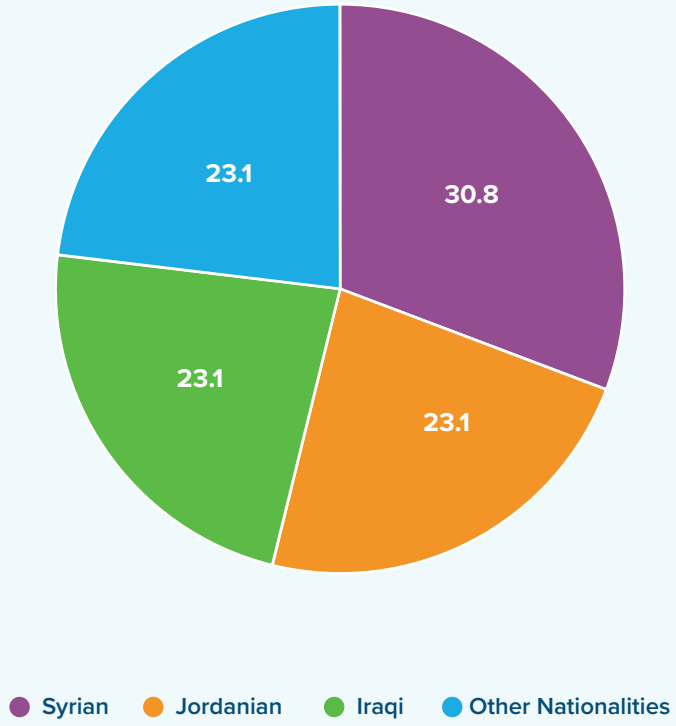
Among all participating organizations, 21.3% (n=7) provide MHPSS services in Balqa in the form of 27 general activities; ranging from activity 1 “Information dissemination to the community at large”, to activity 11 “General activities to support MHPSS”. The distribution of these activities is presented in FIGURE 6.1.

FIGURE 6.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN BALQA (N=7)



According to the previous figure, the result shows that information dissemination, psychosocial intervention, and the general activities to support MHPSS services were the most frequently reported activities with a percentage of 14.8% for each. This result is similar to what has been found in Mafraq. On the other hand, “facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general”, “Safe spaces”, and “Psychological support in education” were the least reported activities with a percentage of 3.7% for each. These low percentages can be explained when taken into mind the nation-wide quarantine that was forced as a governmental measure to manage the COVID-19 pandemic.

FIGURE 5.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN JERASH (N=7)



6.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

By analyzing MHPSS profile in Balqa; according to the previous figure; the results show that Syrians were the most targeted group by MHPSS services with a percentage of 30.8%, followed by all other nationalities (Jordanians, Iraqis, and other nationalities) with 23.1%.

By examining the frequencies of MHPSS services that target beneficiaries by gender and age, the results reveal that males were targeted more than females in Balqa; with 55.6% of MHPSS services targeting males and 44.4% targeting females. On the other hand, there was an equal distribution of MHPSS activities by age for both groups who are “18 years and above” and those who are “younger than 18”.

In reference to the humanitarian workers being considered as a target group, 38.5% of all operating organizations in Balqa provide specific MHPSS services to them, while 33.3% didn't perform such services, and 16.7% didn't report back this information.

6.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Balqa; (42.9%) reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 57.1% reported that they provide MHPSS services on their own. Moreover, among all reported activities, the majority, with s percentage of 71.4%, are currently under implementation, 14.3% are being funded but not yet implemented, and 14.3% didn't report back their activity status.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 6.3: MHPSS STAFF IN BALQA (N=7)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.14 (.38)
Psychiatric mental nursing	0	0
Psychologist	2	.29(.84)
Social worker	1	.14 (.38)
Counselor	1	.14 (.38)
Psychosocial support officer	0	0
Case manger	3	.43(.79)
Volunteer	15	2.1(3.9)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator, clinical coordinator, mental health focal point and technical advisor.

In reference to the specific location on where the activities are performed; the majority of organizations, with a percentage of 36.4%, reported that they carry out their activities inside centers, 27.3% inside clinics, 9.1% inside beneficiaries' houses and 9.1% inside schools. At the same time, 9.1% reported that they perform their activities in other settings.

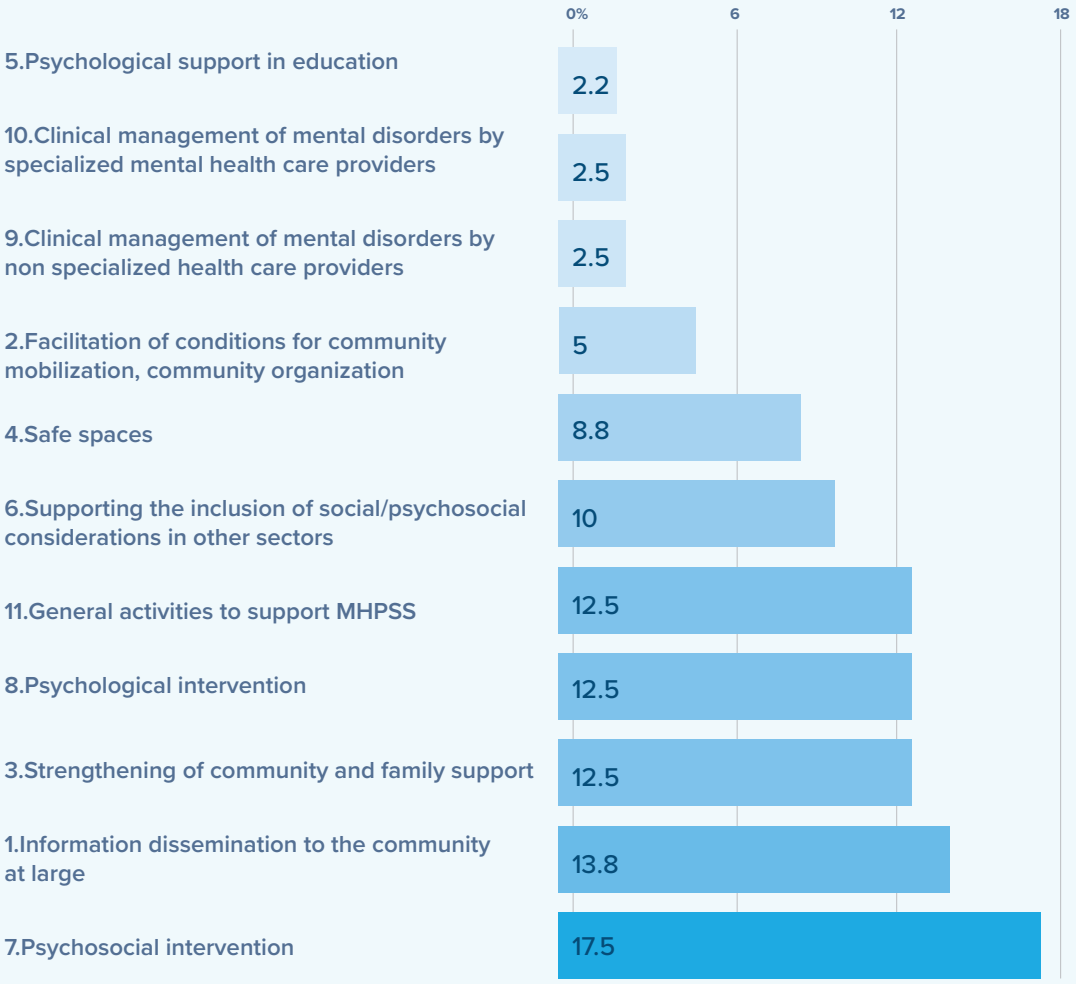
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

7. ZARQA

7.1 ACTIVITY DISTRIBUTION IN ZARQA

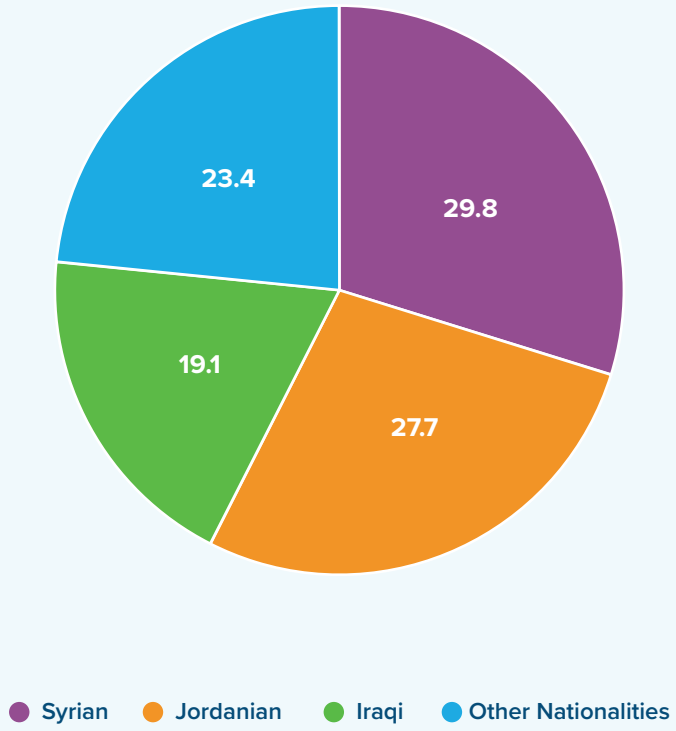
Among all participating organizations, 51.5% (n=17) provide MHPSS services in Zarqa in the form of 80 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 7.1

FIGURE 7.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN ZARQA (N=17)



According to the previous figure, "psychosocial interventions" were the most reported activities with a percentage of 17.5%, followed by "information dissemination to the general" with 13.8%. The least reported activities were "psychological support in education", "clinical management of mental disorders by non-specialized HCP" and "clinical management for mental disorders by specialized HCP" with 2.5% for each. Zarqa profile indicates a high variability in the percentages of activities, which calls for an urgent action to close these gaps.

FIGURE 7.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN ZARQA (N=17)



7.2. PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER AND AGE

The figure shows that the most targeted group by nationality in Zarqa were Syrians with (29.8%), followed by Jordanians with (27.7%). In addition, 9.1% (n=3) of all organizations who provide MHPSS services in Zarqa reported that they provide MHPSS services inside Azraq camp, while 70.6 (n=12) reported that they don't provide any MHPSS services there, and 6.1% (n=2) didn't report back this information.

Regarding the distribution of MHPSS services by gender, males were targeted more, with a percentage of 53.8%, than females with 46.2% in all MHPSS services. Also, people who are 18 years and above were targeted the most, with a percentage of 51.7%, in all MHPSS services, while the percentage of people who are less than 18 was 48.3%. The reason behind such results is that some agencies reported that they provide MHPSS services inside factories, where the demographics of workers consist mostly of men who are above 18 years.

In reference to the humanitarian workers being considered as a target group, 29.4% of all operating agencies in Zarqa provide specific MHPSS services to them, while the majority, with a percentage of 58.8%, didn't provide such services, and 11.8% didn't report back this information.

7.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Zarqa; 41.2% reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 58.8% reported that they provide MHPSS services on their own. Moreover, among all reported activities, the majority, with a percentage of 64.7%, are currently under implementation, 17.6% are being funded but not yet implemented, 5.9% being planned but not yet funded and 11.8% didn't report back their activity status.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 7.3: MHPSS STAFF IN ZARQA (N=17)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	3	.18 (.73)
Psychiatric mental nursing	1	.06(.24)
Psychologist	3	.18(.53)
Social worker	1	.06 (.24)
Counselor	0	0
Psychosocial support officer	10	.59 (1.38)
Case manger	19	1.1(2.5)
Volunteer	11	.65(1.4)

Moreover, some organizations reported that they have other job titles like; psychosocial activity facilitator, clinical coordinator, mental health focal point, delegator, senior mental health officer and technical advisor.

In reference to the specific location of where the activities are performed; the majority of organizations, with a percentage of 40%, reported that they carry out their activities inside centers, 15% inside clinics, 5% inside schools, while 25% didn't report back where they perform their activities. On the other hand, 15% reported that they provide their activities in other settings, for examples, in other CBOs' centers and factories.

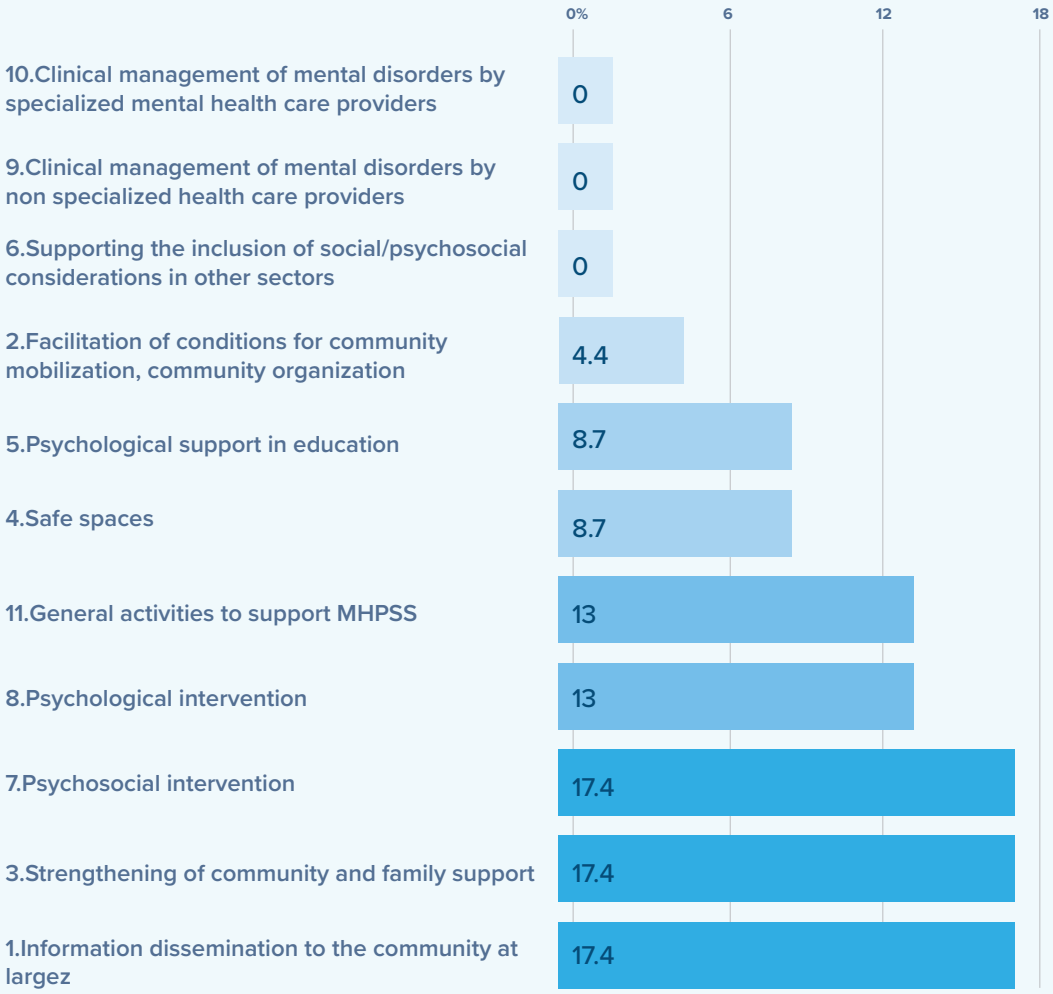
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

8. MADABA

8.1 ACTIVITY DISTRIBUTION IN MADABA

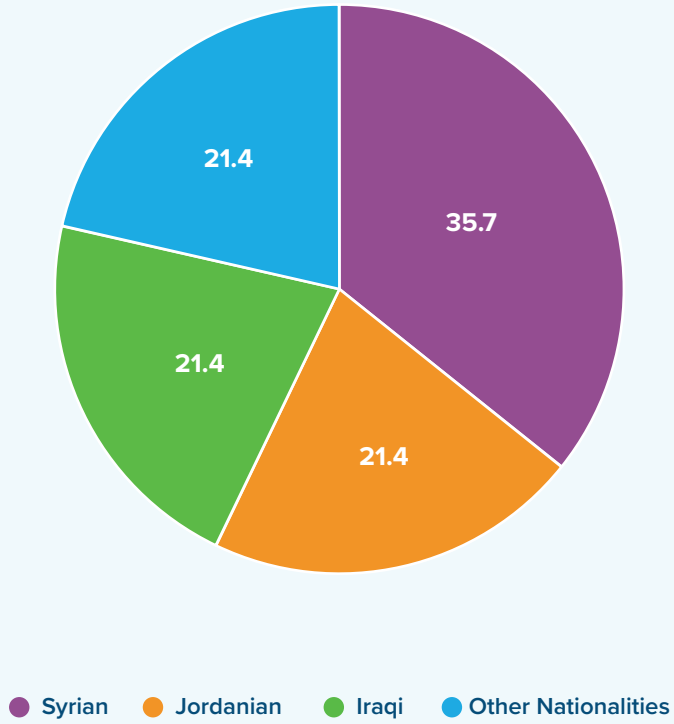
Among all participating organizations, 18.2% (n=6) provide MHPSS services in Madaba in the form of 23 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 8.1.

FIGURE 8.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN MADABA (N=6)



The previous figure shows that the most reported activities were "information dissemination", "strengthening of community and family support", and "psychosocial intervention" with 17.4% for each. There were no activities reported under the title of "clinical management of mental disorders by non-specialized or specialized HCP" and "supporting the inclusion of social/psychosocial considerations in other sectors". This outcome is considered very critical and requires urgent intervention to fill this gap.

FIGURE 8.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN MADABA (N=6)



8.2 PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER, AGE

The previous figure show that the most targeted group by nationality in Madaba were Syrians, with a percentage 35.7%, followed by all other nationalities (Jordanians, Iraqis, and others) with an equal percentage of 21.4%. Moreover, regarding the activity distribution by gender and age, there were equal proportions of MHPSS services, with a percentage of 50% that targeted each category (male vs. female) and (younger than 18 vs. 18 and above).

In reference to the humanitarian workers being considered as a target group, 50% of all operating agencies in Madaba provide specific MHPSS services to them, while the 33.3% didn't perform such services and 16.7% didn't report back this information.

8.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Madaba; 33.3% reported that they provide these services with other partners i.e., CBOs or governmental institutions, while 66.6% reported that they provide MHPSS services on their own. Moreover, among all reported activities, the majority, with a percentage of 66.7% are currently under implementation, 16.7% are being funded but not yet implemented, and 16.7% didn't report back their activity status.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 8.3: MHPSS STAFF IN TAFILA (N=6)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	0	0
Psychiatric mental nursing	0	0
Psychologist	0	0
Social worker	0	0
Counselor	0	0
Psychosocial support officer	1	.17 (.41)
Case manger	1	.17 (.41)
Volunteer	10	1.6 (4.1)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator and delegators.

In reference to the specific location of where the activities are performed; most organizations, with a percentage of 22.2% reported that they carry out their activities inside centers and beneficiaries' houses separately, 11.1% inside clinics, 11.1% inside schools, while 33.3% didn't report back where they perform their activities.

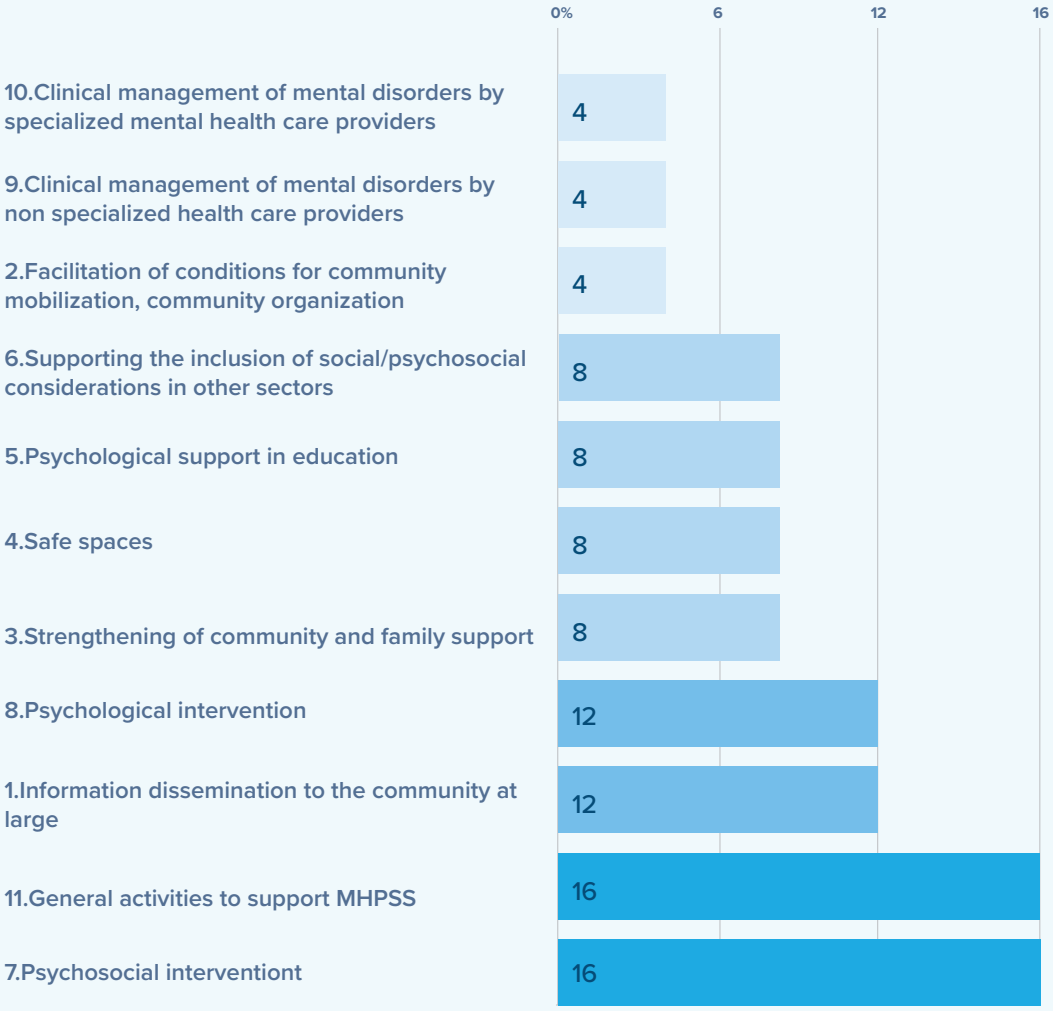
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

9. TAFILA

9.1 ACTIVITY DISTRIBUTION IN TAFILA

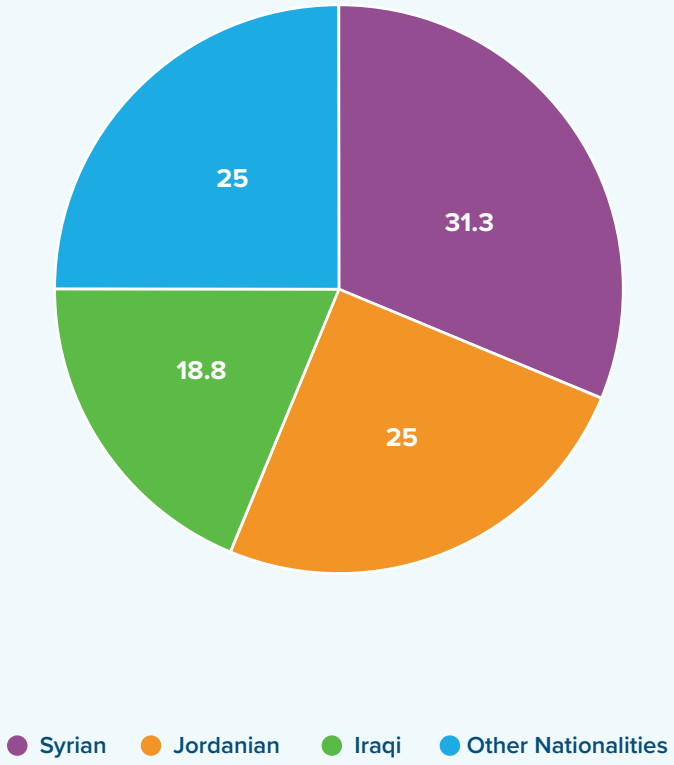
Among all participating organizations, 18.2% (n=6) provide MHPSS services in Tafila in the form of 25 general activities; ranging from activity 1 “Information dissemination to the community at large”, to activity 11 “General activities to support MHPSS”. The distribution of these activities is presented in FIGURE 9.1.

FIGURE 9.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN TAFILA (N=6)



The previous figure shows that the most reported activities were “psychosocial interventions” and “general activities to support MHPSS services” with a percentage of 16% for each. The least reported activities were “Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general” and “Clinical management of mental disorders by non-specialized or specialized HCP” with a percentage of 4% for each. Other activities had almost equal portions.

FIGURE 9.2.: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN TAFILA (N=6)



9.2 PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER, AGE

The previous figure shows that the most targeted group by nationality is Syrians, with a percentage of 31.3%, followed by Jordanians and other nationalities, with a percentage of 25%, while Iraqis were targeted by 18.8% in all activities.

By examining the frequencies of MHPSS services that target beneficiaries by gender and age, the results reveal that females were targeted more, with a percentage of 55.6%, than males, with a percentage of 44.4% in Tafila. This outcome calls for a need to provide more males with services. On the other hand, there was an equal distribution of MHPSS services by age for both groups who are "18 years and above" and those who are "younger than 18".

In reference to the humanitarian workers being considered as a target group, 33.3% of all operating agencies in Tafila provide specific MHPSS services to them, while the majority, with a percentage of 50%, didn't perform such services and 16.7% didn't report back this information.

9.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Tafila; 50% reported that they provide these services with other partners i.e., CBOs or governmental institutions. Moreover, among all reported activities, the majority, with a percentage of 83.3% are currently under implementation, 16.7% are being planned but not yet funded.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 9.3: MHPSS STAFF IN TAFILA (N=6)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.17 (.48)
Psychiatric mental nursing	0	0
Psychologist	4	.67 (1.2)
Social worker	0	0
Counselor	3	.51 (1.2)
Psychosocial support officer	0	0
Case manger	4	.67 (1.2)
Volunteer	10	1.6 (4.1)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator and mental health focal point.

In reference to the specific location on where the activities are performed; most organizations, with a percentage of 42.9%, reported that they carry out their activities inside centers, 14.3% inside clinics, beneficiaries' houses and schools. At the same time, 14.3% reported that they perform their activities in other settings, for examples, in other CBOs' centers.

Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

10. KARAK

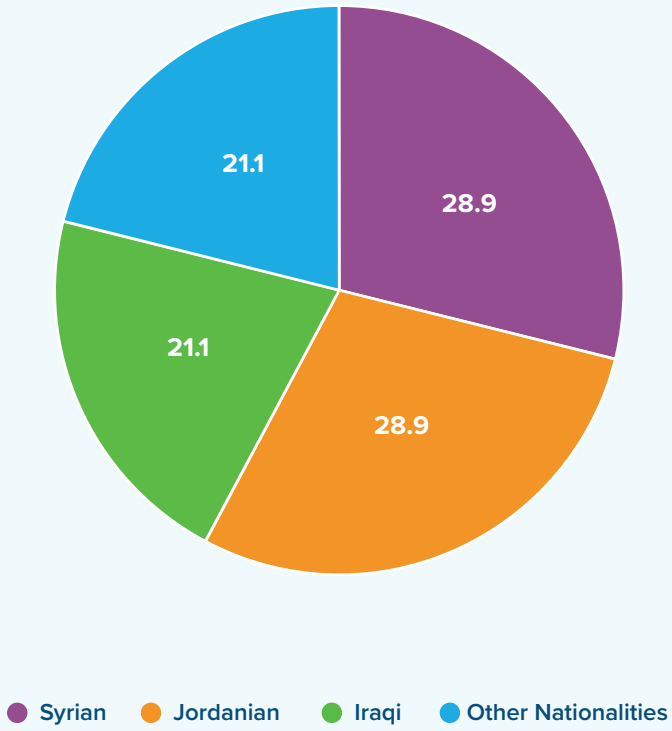
10.1 ACTIVITY DISTRIBUTION IN KARAK

Among all participating organizations, 18.2% (n=6) provide MHPSS services in Karak in the form of 54 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 10.1

FIGURE 10.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN KARAK (N=6)

The previous figure shows that the most reported activity in Karak was “information dissemination”, with a percentage of 16.7%, followed by “psychosocial interventions” with a percentage of 14.8%. The least reported activities were the “clinical management of mental disorders by non-specialized or specialized HCP”, with a percentage of 1.9%, for each activity, which is consistent to what has been found in most of the other governorates.

FIGURE 10.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN KARAK (N=6)



10.2 PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER, AGE

The previous figure shows that the most targeted group by nationalities were Syrians and Jordanians, with a percentage pf 28.9% for each group, followed by Iraqi and other nationalities with a percentage of 21.1%.

By examining the frequencies of MHPSS services that target beneficiaries by gender and age, the result reveals that males were targeted more, with a percentage of 52.4%, than females, with a percentage of 47.6%, in Karak. This outcome calls call for a need to provide more females with MHPSS services. On the other hand, there was an equal distribution of MHPSS activities by age for both groups who are "18 years and above" and those who are "younger than 18".

In reference to the humanitarian workers being considered as a target group, 33.3% of all operating agencies in Karak provide specific MHPSS services to them, while the majority, with a percentage of 66.7%, didn't perform such services.

10.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Karak; 50% reported that they provide these services with other partners i.e., CBOs or governmental institutions. Moreover, among all reported activities, the majority, with a percentage of 91.7%, were currently under implementation, and 8.3 % were funded but not yet implemented.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 10.3: MHPSS STAFF IN KARAK (N=6)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.08 (.29)
Psychiatric mental nursing	0	0
Psychologist	2	.17 (.39)
Social worker	7	.58 (1.1)
Counselor	3	.25 (.62)
Psychosocial support officer	5	.42 (.9)
Case manger	10	.83 (1.3)
Volunteer	18	1.5 (2.9)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator and mental health focal point.

In reference to the specific location on where the activities are performed; most organizations, with a percentage of 57.1%, reported that they carry out their activities inside centers, 14.3% inside clinics, 7.1% inside beneficiaries' houses and 7.1% inside schools. At the same time, 7.1% reported that they perform their activities in other settings, for examples, in other CBOs' centers. In addition, 7.1% didn't report back where they perform their activities.

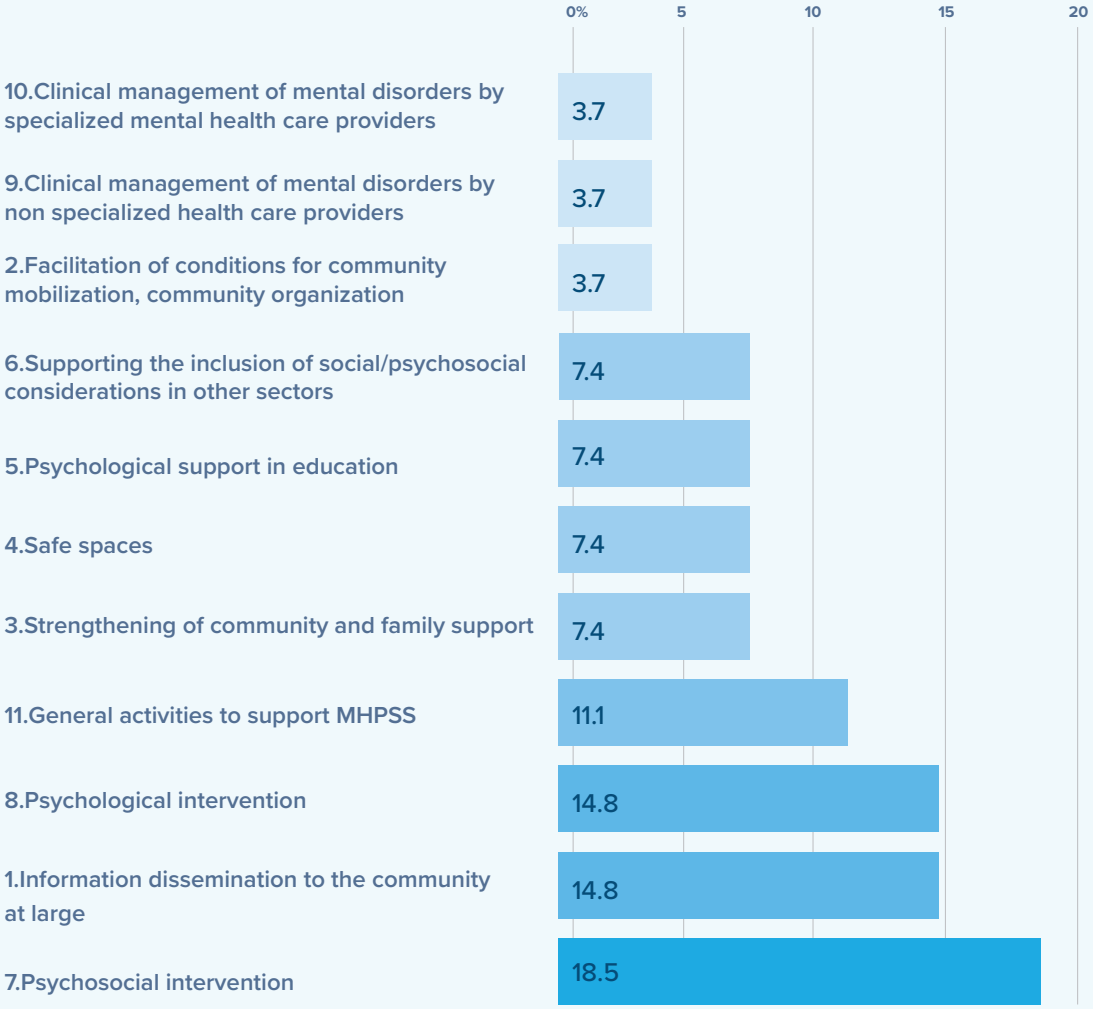
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

11. MA'AN

11.1 ACTIVITY DISTRIBUTION IN MA'AN

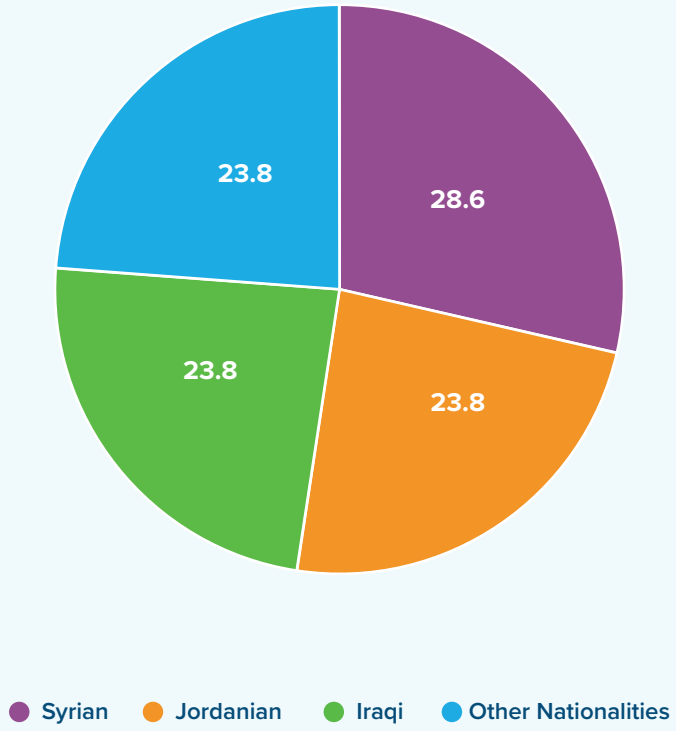
Among all participating organizations, 18.2% (n=6) provide MHPSS services in Ma'an in the form of 27 general activities; ranging from activity 1 "Information dissemination to the community at large", to activity 11 "General activities to support MHPSS". The distribution of these activities is presented in FIGURE 11.1

FIGURE 11.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN MA'AN (N=6)



The previous figure shows that the most reported activities in Ma'an were "psychosocial intervention", with a percentage of 18.5%, followed by "information dissemination to the general" and "psychological intervention" with a percentage of 14.8% for each. The least reported activities were "Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general", and" clinical management of mental disorders by non-specialized and specialized HCP" with a percentage of 3.7% for each.

FIGURE 11.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN MA'AN (N=6)



11.2 PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER, AGE

The figures showed that the most targeted group by nationalities were Syrians, with a percentage of 28.6%, followed by all other nationalities (Jordanians, Iraqis, others) with a percentage of 23.8%.

By examining the frequencies of MHPSS services that target beneficiaries by gender and age, the results reveal that there was an equal distribution of activities according to the gender and age with a percentage of 50% for each sub-category (males vs. females) and (18 and above vs. younger than 18).

In reference to the humanitarian workers being considered as a target group, 33.3% of all operating agencies in Ma'an provide specific MHPSS services to them, while the majority, with a percentage of 66.7% didn't perform such services.

11.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Ma'an; 50% reported that they provide these services with other partners i.e., CBOs or governmental institutions. Moreover; 100% of the reported activities were currently under implementation.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 11.3: MHPSS STAFF IN MA'AN (N=6)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.17 (.41)
Psychiatric mental nursing	0	0
Psychologist	1	.17 (.41)
Social worker	0	0
Counselor	1	.17 (.41)
Psychosocial support officer	5	.83 (1.3)
Case manger	4	.67 (.82)
Volunteer	10	1.7 (4.1)

Moreover, some organizations reported that they have other job titles like; psychosocial activity facilitator.

In reference to the specific location on where the activities are performed; the majority of organizations, with a percentage of 50%, reported that they carry out their activities inside centers, 12.5% inside clinics, houses and schools. on the other hand, 12.5% didn't report back where they perform their activities.

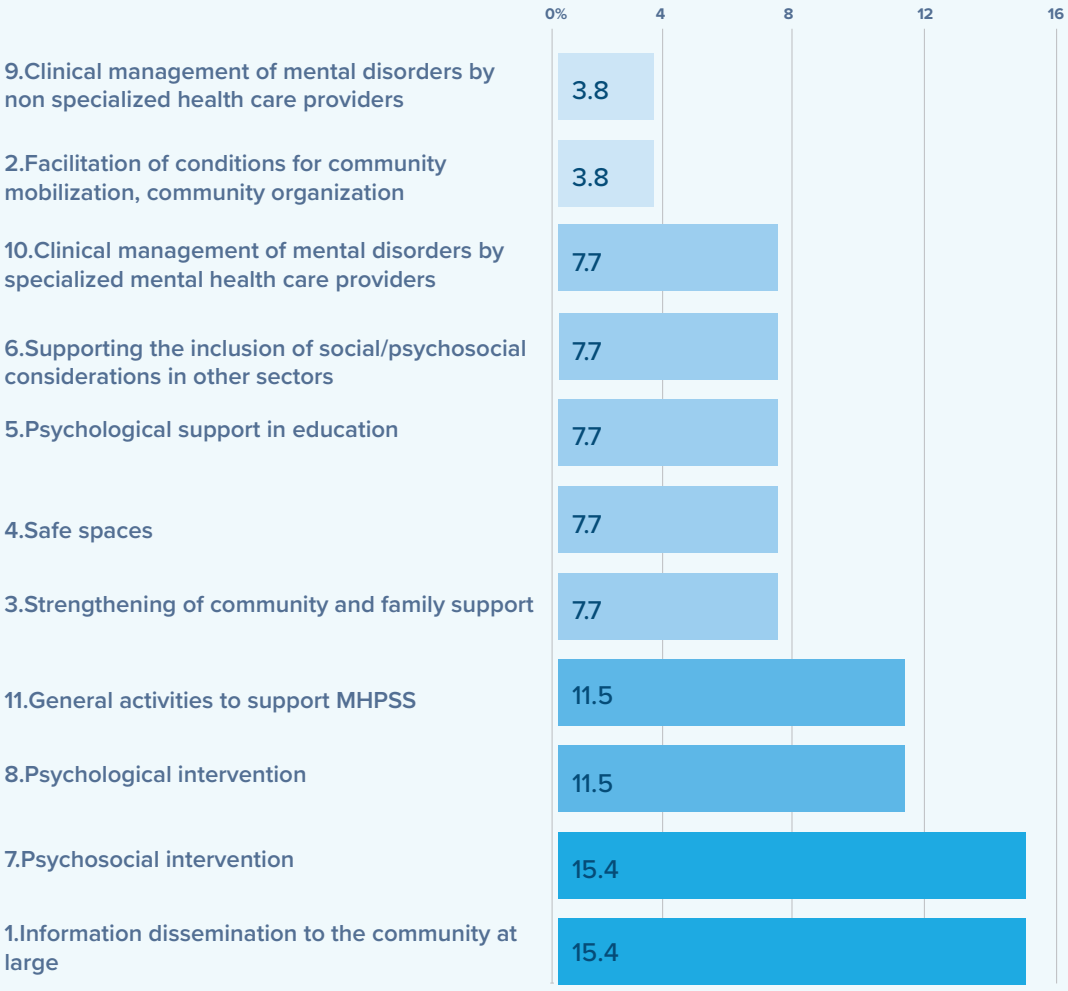
Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

12. AQABA

12.1 ACTIVITY DISTRIBUTION IN AQABA

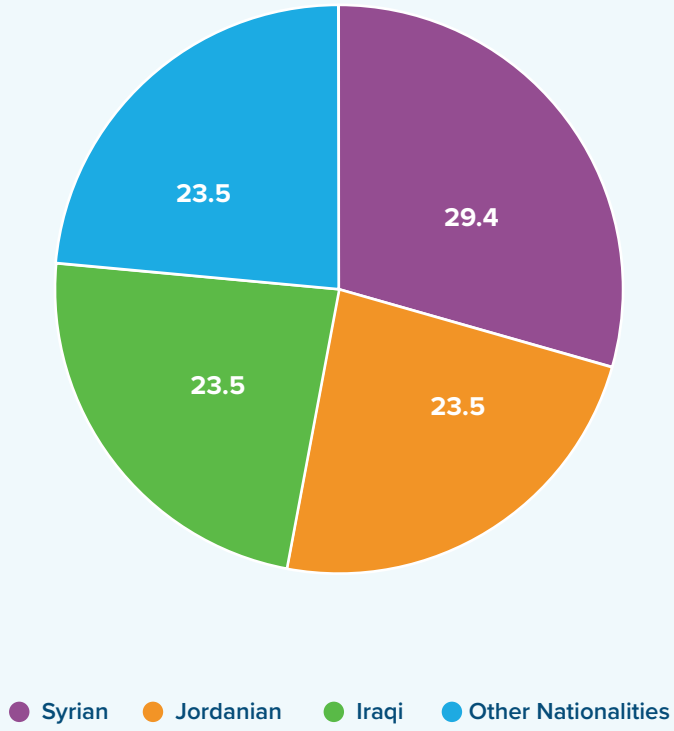
Among all participating organizations, 17.1% (n=5) provide MHPSS services in Aqaba in the form of 26 general activities; ranging from activity 1 “Information dissemination to the community at large”, to activity 11 “General activities to support MHPSS”. The distribution of these activities is presented in FIGURE 12.1

FIGURE 12.1: THE DISTRIBUTION OF MHPSS ACTIVITIES IN AQABA (N=5)



The previous figure shows that the most reported activities in Aqaba were “Psychosocial intervention” and “Information dissemination” with a percentage of 15.4% for each. The least reported activities were “Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general”, and “Clinical management of mental disorders by non-specialized HCP” with a percentage of 3.8% for each, which is consistent to what has been found in other governorates.

FIGURE 12.2: MHPSS PROFILE TARGET BENEFICIARIES BY NATIONALITY IN AQABA (N=5)



12.2 PROFILE OF MHPSS TARGET BENEFICIARIES BY NATIONALITY, GENDER, AGE

The previous figure shows that the most targeted group by nationality was Syrians, with a percentage of 29.4%, followed by Jordanians, Iraqis, and other nationalities with a percentage of 23.5% for each group.

B examining the frequencies of MHPSS services that target beneficiaries by gender and age, the results reveal that there was an equal distribution of activities according to gender and age with a percentage of 50% for each sub-category (males vs. females) and (18 and above vs. younger than 18)

In reference to the humanitarian workers being considered as a target group, 60% of all operating agencies in Aqaba provide specific MHPSS services to them, while 40% didn't perform such services.

12.3. SPECIFIC INFORMATION

Among all participating organizations, who provide MHPSS services in Aqaba; 40% reported that they provide their activities with other partners i.e., CBOs or governmental institutions, while 60% reported that they provide MHPSS services on their own. Moreover; 100% of the reported activities were currently under implementation.

Regarding MHPSS activities' providers, the following table specify the numbers and means:

TABLE 12.3: MHPSS STAFF IN AQABA (N=5)

JOB TITLE	TOTAL NUMBER	MEAN (SD)
Psychiatrist	1	.2 (.45)
Psychiatric mental nursing	0	0
Psychologist	1	.2 (.45)
Social worker	0	0
Counselor	1	.2 (.45)
Psychosocial support officer	0	0
Case manger	3	.6 (.89)
Volunteer	10	2.0 (4.5)

Moreover, some organizations reported that they have other job titles like, psychosocial activity facilitator.

In reference to the specific location on where the activities are performed; most organizations with a percentage of 50% reported that they carry out their activities inside centers, 12.5% inside clinics, 25% inside beneficiaries' houses and 12.5% inside schools.

Finally; 100% of all organizations reported that service recipients don't have to pay for any of the provided services.

PARTNERS/SPONSORS

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International Medical Corps

This 4Ws MHPSS mapping was completed by International Medical Corps with coordination and contribution of MHPSS group members

WHO IS DOING WHAT, WHERE AND WHEN (4WS) IN MENTAL HEALTH & PSYCHOSOCIAL SUPPORT IN JORDAN

Service Mapping Exercise - October 2021

International Medical Corps