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

2017 Interventions Mapping Exercise

Mental Health & Psychosocial Support Working Group

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International Medical Corps
الهيئة الطبية الدولية

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1. INTRODUCTION

The Jordan Context

The Syrian conflict, which is now approaching its seventh year, has forced well over 5.2 million of the country's citizens to take refuge in neighboring countries. To date, it is estimated that over 654,582 displaced Syrians reside in Jordan[1], while according to official 2015 census it is estimated that Syrian refugees in Jordan exceed 1.2 million[2]. Due to its positioning and security within the region, Jordan has also become host to refugees and migrants from surrounding countries such as Iraq, and Yemen, and occupied Palestinian territories. Exposure to violence, loss and displacement, as well as pre-existing mental health conditions, have various implications on the MHPSS sub-sector and services in Jordan.

To respond to the needs of refugees in Jordan, many INGO, NGO, UN agencies and CBOs have established operations in Jordan, making it the country with the highest number of NGOs in the MENA region. To ensure effective coordination between the various actors the MHPSS working group was established in Amman. The working group co-lead by IMC and WHO meet on a monthly basis to discuss a number of issues including, service updates, contextual factors, and best practices in MHPSS service provision. As part of the working group an annual mapping exercise is conducted to document active MHPSS service providers, and to highlight potential gaps in service delivery.

History and Background of the IASC 4Ws MHPSS Tool and Use in Jordan:

The IASC Global Reference Group and the World Health Organization (WHO) developed a "4Ws" tool (Who, What, When, Where) to map MHPSS services in emergencies. The purpose of the tool is to gain a clearer picture of who is doing what, where and until when. Unlike other "3Ws" mapping tools often used across sectors, this tool also provides a comprehensive overview of the size and nature of an emergency response with respect to MHPSS. WHO and International Medical Corps (IMC) first piloted the tool in Jordan in 2009 in cooperation with UNICEF. A refined tool was applied for the second implementation in 2010, based on emerging issues and lessons learnt from previous mappings conducted in Jordan, Nepal and Haiti.

Using data and feedback collected by agencies piloting the tool, the IASC Reference Group developed a manual to guide the mapping process. This manual was published in 2013 and is available for download from the Mental Health and Psychosocial Support innovation network[3]. Subsequent mappings were conducted in Jordan in 2010/2011, 2012, 2013 and 2014, with the 2012 and 2013 mappings including Protection elements (specifically Gender-Based Violence and Child Protection), alongside MHPSS. The 2014 mapping however, excluded this additional information in order to allow a more specific focus on MHPSS activities.

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[1] UNHCR Inter-Agency Information Sharing Portal
http://data.unhcr.org/syrianrefugees/country.php?id=107 (Accessed October 19th 2017)

[2] Department of Statistics; General Census Results 2015
http://www.dos.gov.jo/dos_home_e/main/population/census2015/index.htm (Accessed October 19th 2017)

[3] Available online at http://www.mhinnovation.net/sites/default/files/downloads/resource/iasc%204ws%20manual.pdf

The 2017 4Ws Mapping in Jordan

Similar to the 2014 4Ws exercise, the 2017 mapping specifically focuses on the broad range of MHPSS interventions and activities provided to all beneficiary groups in Jordan. The MHPSS activity categories as recommended by the IASC Reference Group, include; community-focused MHPSS, case-focused MHPSS, and general support for MHPSS, the activity categories is provided in Annex 1. This list was slightly modified over the years to capture additional inputs suggested by the Jordan Mental Health and Psychosocial Working Group.

Overall funding to the Syrian crisis has been comparatively limited based on identified needs. The 2017 Syria regional refugee and resilience (3RP) plan, highlighted the need for funding in the region to ensure Syrian refugees are provided with appropriate services. The funding required as outlined in the 3RP was only funded 49.9%, indicating an extreme deficit in funds available which impacts all sectors and actors. The mapping results for 2017 should be interpreted in light of the reduction of funding which was noted in the 2016-2018 Jordan Response Plan (JRP)[4] for psychosocial activities. Due to funding constraints and a limitation noted by donors in the lack of evaluation data available on psychosocial interventions implemented in Jordan, funding for psychosocial activities was considerably reduced from that of the previous JRP. As such it was anticipated a slight drop in psychosocial activities would be visible, in favor of other sectors in the JRP.

2. TIMEFRAME

The mapping took place between the months of July and September 2017. Initial data collection occurred over a period of 4-weeks in September. The deadline for entering data was initially scheduled to be a 2-week period, however the deadline was extended to accommodate additional inputs by agencies, with some agencies continuing to submit information until mid-September 2017.

3. OBJECTIVES

The specific objectives of the 2017 MHPSS mapping were to:

- ✓ Enhance coordination, collaboration, referral systems & accountability for all involved agencies
- ✓ Identify gaps in service provision, barriers to accessing services, geographic and target group coverage, human resources & technical expertise
- ✓ Provide data on patterns of practice to inform recommendations, agency plans/proposals and lessons learnt for future response
- ✓ Allow participating organizations to plan for their programming, and advocate for recommended services and legislation
- ✓ Improve the transparency & legitimacy of MHPSS services through structured documentation and increase awareness around need for MHPSS services

[4] Available online at https://reliefweb.int/sites/reliefweb.int/files/resources/JRP16_18_Document-final+draft.pdf

4. The 4Ws Mapping Process

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

International Medical Corps contracted a technical consultant to carry out the data collection, analysis and write up of the final report over a three-month period, with support from IMC staff. The 4Ws tool was attached to an information package and sent via email to all agencies in the MHPSS coordination group mailing list. The package consisted of:

- A one-page introduction to the 4Ws exercise;
- An Excel data file with four sheets to: 1) capture information about the organization, 2) capture details of activities; 3) delineate the list of 11 MHPSS activities and corresponding sub-activities 4) capture information on target groups; and
- The 2015/2016 4Ws mapping report and aggregate sheet.

The package was also sent to other sub-sectoral Working Groups to share with their members. Organizations were offered the option of self-completing the survey, or receiving support by a member of the project team through phone or face to face interview. Follow-up emails and phone calls were made over a six-week period to collect the complete information for the mapping. Thirty five out of 50 organizations included in the MHPSS working group mailing list completed the survey, with the initial 2-week deadline extended for an additional two-weeks to accommodate late submission requests. One organization stated that it had discontinued MHPSS activities. Another organization replied saying that it is no longer part of the MHPSS working group. The remaining organizations did not submit the mapping, nor did they respond to email requests and subsequent contact attempts by the project team.

5. Data collection tool

As in previous years, Microsoft Excel was utilized for data collection. The 4Ws tool focused on MHPSS activities and sub-activities, and the additional features recommended following the 2013 mapping exercise were incorporated (for example, a specified list of target groups disaggregated by age, gender and nationality linked to specific codes to facilitate data entry). Feedback provided on previous 4Ws exercises indicated that the tool was relatively easy to use, which was instrumental to ensure the method of data collection remained flexible to allow as many respondents as possible to complete the exercise.

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

6. FINDINGS

6.1. Who is doing What?

The 2017 mapping encompassed a cohort of 35 organizations that collectively deliver MHPSS services, programs and activities for communities across the Kingdom. A list of contributing organizations and their contact information is found in Annex 1. The mapping captured approximately 1253 MHPSS activities provided by agencies to Jordanian citizens and displaced populations living in various governorates.

The profile of activities recorded this year was diverse, with organizations varying in their scale of operations, type of services they deliver, and locations which they serve. Furthermore, there was considerable variation in the length of time organizations have operated on the ground. Some had accrued decades of experience operating in the country, while others had been operating for no more than one to two years. Table 1 lists organizations with the focus of their reported activities.

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

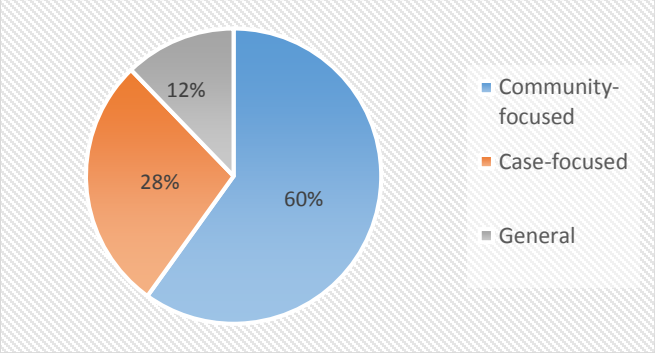

Figure 1 Proportion of activities according to their focus

Results demonstrate that 60% of the reported activities are "community-focused" such as information dissemination, community mobilization, safe spaces, psychosocial support in education, and the inclusion of psychosocial considerations in other sectors. Moreover, 28% of activities represent "case-focused" interventions, encompassing psychosocial work, psychological interventions, and clinical management of mental disorders by specialized and non-specialized providers. Approximately 12% of activities, are "general activities to support MHPSS," and these activities include work related to assessments, training/supervision and research. These results indicate a shift in focus of participating agencies from case-focused and general support activities, to community-focused activities from the 2015/2016 mapping, in which 44% of activities focused on community, 34% of activities were case-focused and 22% of activities were general activities supporting MHPSS services.

Table 1 Organizations and Activities Focus

Organization	*Community Focus*	*Case Focus*	*General Focus*
ACF		x	
ARDD-LA	x	x	x
BAK	x		
CARE	x	x	x
Caritas	x	x	x
CVT	x	x	x
DRC	x		
GIZ	x		x
Help		x	
HI	x	x	x
ICCS	x		
ICMC	x	x	
IMC	x	x	x
InterSoS	x		x
IRD	x		
JRF	x	x	
JRS	x	x	
KHCC	x	x	
LWF	x		
Medair		x	
MFH		x	
MoSD	x	x	
MSFF		x	
NHF	x		
NICCOD	x	x	
PUAMI	x	x	
SAMS	x	x	x
SCJ	x	x	x
Takaful	x	x	x
TdH	x	x	
UPP	x	x	x
VDT	x	x	
WC CAN	x	x	x
WCUK	x	x	x
WHO/MoH	x	x	x

Donors:

ACT Alliance; AFD; AICS; PRM; DFID; DANIDA; ECCB; ECHO; BMZ; Ikea Foundation; Japan Platform; Moroccan Government; MoSD; KHCC; ICMC; OCHA; Oxfam; SIDA; SwS; UN Women; UNFBA; UNHCR; UNICEF; UNVFTV War Child; USAID; other Private Funds

Partners:

***Governmental**: MoH; Municipalities; MoSd; Family Protection Department; Jordanian University; Yarmouk University, King Abdullah University Hospital, Al MAzar Youth Sports Club AlMansour; Youbla Youth Club*

***National agencies**: NHF; JoHUD JHCO Princess Basma Center – Aydoun; Princess Basma Centre;, Aman Jordanian Association, JOHUD;*

***INGOs**: World Vision; Relief International; War Child Canada; Oxfam;*

***CBOs**: Al Hussein Society; Al Khair Ma'na; Al Taqwa Society; Hala Women Charity; Sanabel AlKhair; Our Step Association, Nashama Al Khair; Al Hob Wal Ata'a, Jabal Zamzam, Al Farouq Charity; Aydoun Al Shamal Academy, Resalat Al Mafraq; Chidcare Charity Association; Souf Social Development Charity; Beit Al Kheir; Al Aramel Wa Al Aytam; Islamic Bani Hassan Association*

UN agencies: UNHCR; OCHA;

Box 1 List of Reported Donors

Donors and Partners

While some participants identified funding sources for their MHPSS activities and programs, others did not provide any information in this regard. Reported funding sources ranged from government donors, to self-funding, and private donations.

Several organizations declared partnerships for implementing their MHPSS services and activities, encompassing donors and other MHPSS actors. Additional partners were also mentioned, including cultural centers, public institutions, local community-based centers, schools and other facilities. Box 1 outlines information that was provided with respect to donors and partnering organizations.

MHPSS Workforce

Eleven organizations did not report details of their MHPSS staff. Nevertheless, remaining organizations reported 1140 individuals working providing some sort of MHPSS activities. Of those individuals, only 56 were specialized expats, compared to 262 specialized Jordanians providing MHPSS activities. Professionals who received formal structured training in a relevant MHPSS related field for at least two years were considered specialized MHPSS services providers. All other professionals, who did not receive such formal structured training, were considered non-specialized services providers, and this includes volunteers.

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

Figure 2 demonstrates the composition of the MHPSS workforce in terms of specialization. Furthermore, around 62% of reported activities had at least one psychologist involved in service delivery, compared to 9% of activities that were delivered by psychiatrists. Figure 3 shows proportions of activities by service providers.

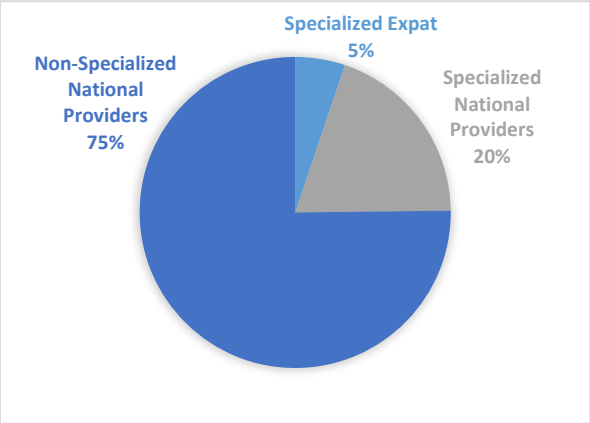

Figure 2 Composition of MHPSS Workforce

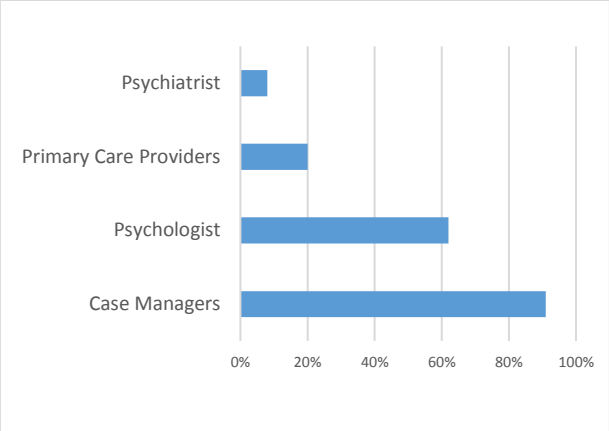

Figure 3 Concentration of activities by providers

Activities on IASC Pyramid

Humanitarian emergencies can cause significant emotional distress and contribute to the risk for developing mental disorders that may affect people in many different ways. It is key for MHPSS organizations to meet the different needs of persons affected. To this end, the Inter-Agency Standing Committee (IASC) developed a layered model of services that is known as the IASC Pyramid of MHPSS services in Emergencies[5]. According to this pyramid there are four levels of services; i) Level 1 – basic services and security, ii) Level 2 – community and family supports, iii) Level 3 – focused, non-specialized supports, iv) Level 4 – Specialized services. Services under level 3 include all MHPSS services that are provided by non-specialized professionals, with the fourth and final level of the pyramid focused on services that are delivered by specialized professionals.

[5] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

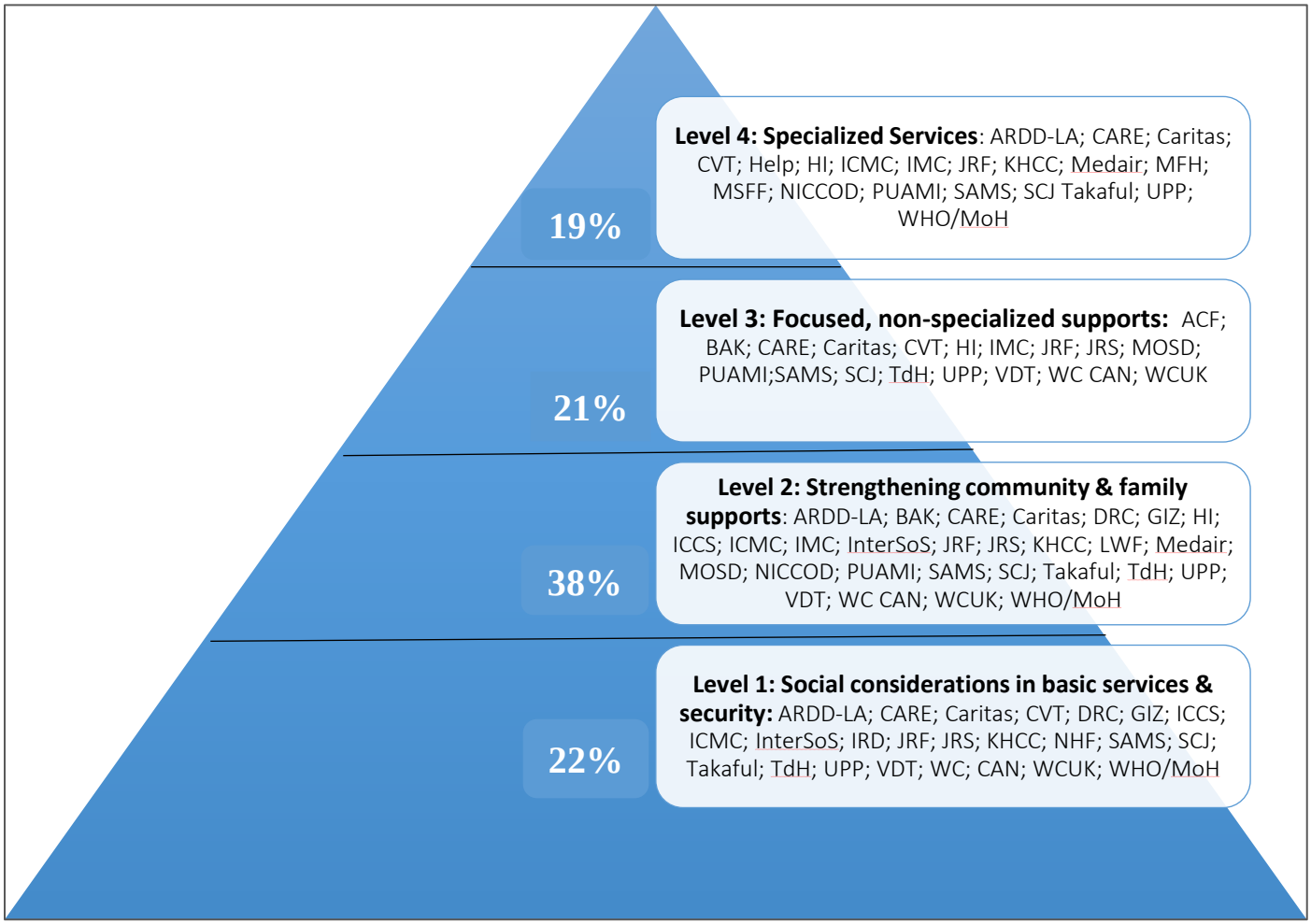

Figure 4 Organizations distribution by pyramid levels of their activities and proportions of activities

Figure 4 also demonstrates concentration of activities at each level of the pyramid. The majority of activities surveyed (38%) fell under Level 2 of the intervention pyramid 'strengthening community and family support'.

For further details on numbers of activities and its alignment with both host and refugee population, table 2 conveys the concentration of activities per governorate, the size of the host and Syrian refugee population in each governorate, and the activity concentration per 100,000 of each respective population. Figure 5 highlights the percentage of activities implemented across the four levels of the IASC pyramid, for each governorate.

Table 2 Activities & Populations

Governorate	*Activities (#)*	*Activities (%)*	*Population (#)*	*Population (%)*	*Syrians (#)*	*Syrians (%)*
Amman	257	21%	4007526	42%	181082	28%
Irbid	212	17%	1770158	19%	135599	21%
Zarqa	173	14%	1364878	14%	108050	17%
Mafraq	169	14%	549948	6%	158493	24%
Jarash	65	5%	237059	2%	9443	1%
Karak	63	5%	316629	3%	8546	1%
Balqaa	61	5%	491709	5%	18754	3%
Ajloun	60	5%	176080	2%	7510	1%
Maan	59	5%	144082	2%	7431	1%
Aqaba	39	3%	188160	2%	3505	1%
Madaba	38	3%	189192	2%	11147	2%
Tafila	36	3%	96291	1%	1561	0%

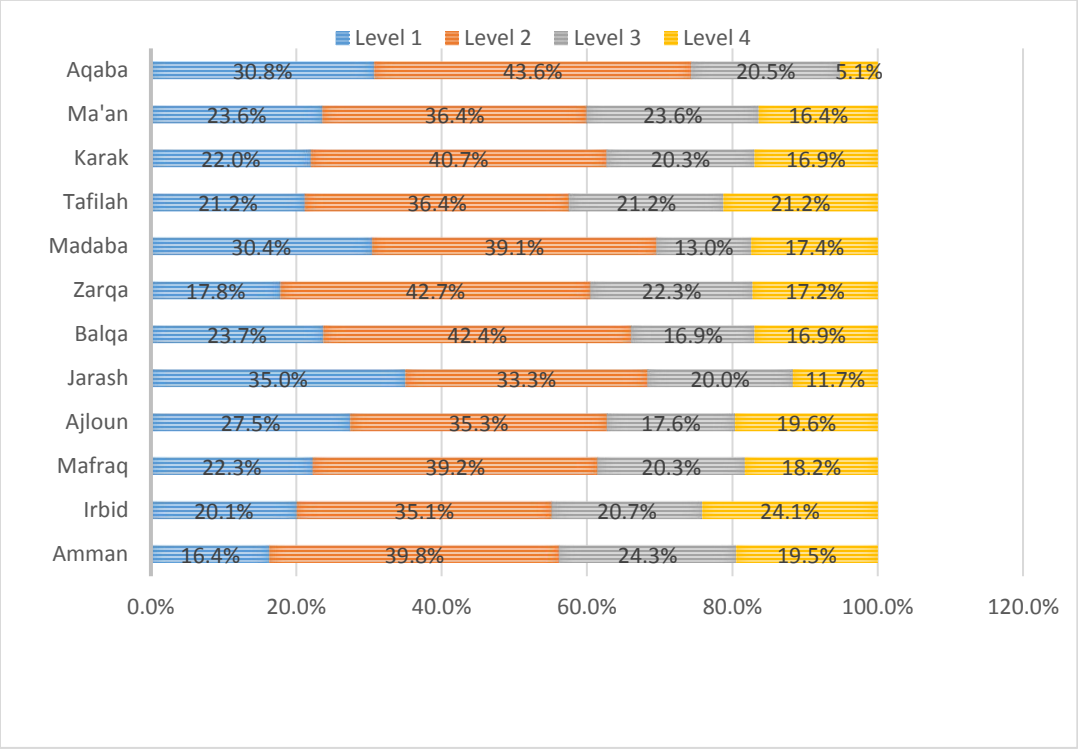

Figure 5. Level of activities implemented across various governorates.

Comparison of Activity Coverage from Previous Years

Figure 4 displays the distribution of organizations and activities on the IASC MHPSS intervention pyramid. A comparison of the relative concentrations of Levels 1-4 on the intervention pyramid is found in Figure 6, which includes data from previous mapping exercises. This demonstrates a minimal increase of 2.7% from the 2015/2016 mapping in activities at Level 2 of the pyramid.

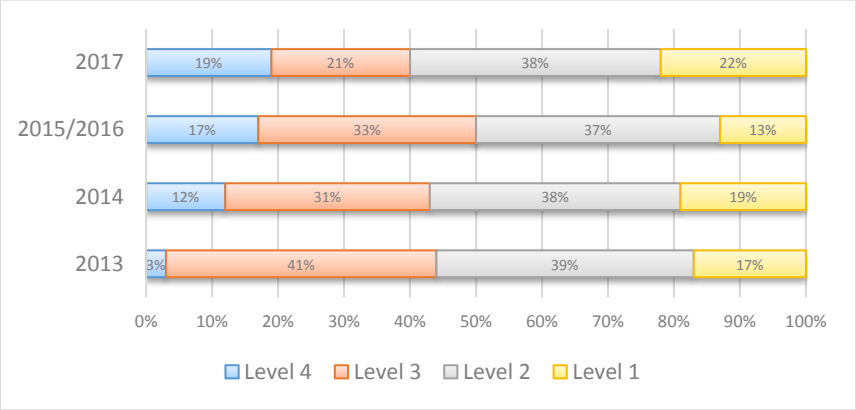

Figure 6 Comparison of MHPSS activities IASC pyramid levels with past mappings

Level 3 activities 'focused (person-to-person) non-specialized supports' accounted for 21% of the total interventions on the pyramid, corresponding to a 36% decrease from 2015/2016, and a decrease of 32% from 2014. Level 1 activities 'social considerations in basic services and security' amounted to 22% of activities on the pyramid, having increased by 69% from 2015/2016. The last 4 years have witnessed an increase in Level 4 'specialized services', from 3% in 2013, to 12% in 2014, to 17% in 2015/2016 mapping, and to 19% in 2017. This should also be interpreted in light with of the slight increase in agencies operating at level 4, in the current mapping 19 organizations reported to be operating at level 4, compared to a total of 18 organizations in 2015/2016, 13 organizations in 2014, and only 7 organizations in 2013.
It is essential to note that any increase or decrease in percentage of a particular level indicates a change that is relative to the proportion of other levels on the intervention pyramid. Overall, activities have increased in number compared to the 2015/2016 mapping. In 2015/2016, 779 activities were reportedly implemented overall, compared to this year which saw a staggering 1,195 activities being reportedly implemented.

Types of Activities

Figure 7 displays the concentration of activity categories per code (in total 11 main activity codes). The most frequently reported activities include 'strengthening of community and family supports' (activity 3) at 29%, followed by general activities (activity 11) at 12%, then 'information dissemination' (activity 1) & 'psychosocial work' (activity 7) at 11% each. Then came 'psychological intervention' (activity 8) at 10% of the activities. 'Safe spaces' (activity 4) followed at 8%.

Comparison with Previous Years

Except for the most frequent activity, ('strengthening of community and family supports'), these are markedly changed findings from the previous mapping. Psychosocial work (activity 7) and safe spaces (activity 4) were more frequent in 2015/2016 than the rest of activities. Activity 7 represented 16% of all activities in 2015/2016, while activity 4 represented 14%.

The least frequent activity was Activity 10; the clinical management of mental disorders by specialized providers. In 2017, it represented only 2% of all activities compared to 6% in 2015/2016.
It is to be expected that a lower concentration of activities is observed at the higher level of the IASC pyramid, as they target a smaller percentage of the population (for example, the clinical management of mental disorders by specialized health professionals). Overall though it is recommended that lower level activities retain a higher comparative frequency, which mirrors the findings captured through this mapping suggesting that level 1 activities are comparatively higher in prevalence (for example, facilitation of conditions for community mobilization and organization, supporting the inclusion of social/psychological considerations in other sectors).

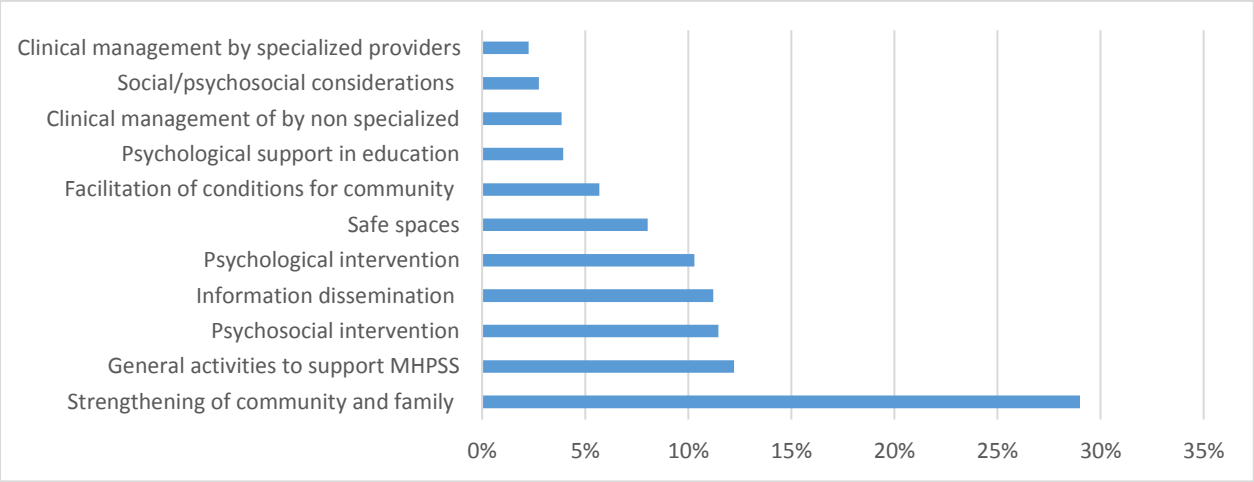

Figure 7 Activities proportions by activity code

Psychosocial Support for Staff/Volunteers

Psychosocial support for staff/volunteers is provided by 22% of the surveyed organizations. This is a decrease from the 2015/2016 mapping, when 34% of the surveyed organizations provided psychosocial support for staff/volunteers. In 2017, it was reported the large majority, 27 organizations (78%), do not provide this support.

Working with populations exposed to humanitarian crises may cause distress for humanitarian staff/volunteers; this is especially true for MHPSS service providers. Agencies should ensure that the psychosocial wellbeing of their staff and volunteers is maintained and enhanced through access to self-care and stress management activities, in addition to peer and/or professional support when needed.

Safe spaces including child friendly spaces, youth friendly spaces and women centers

Safe spaces provide a safe and secure environment to key beneficiary groups, and contribute to supporting stability and resilience in unstable humanitarian contexts. A total of 15 organizations (approximately 43%) provide safe spaces. This is a decrease compared to the 2015/2016 mapping, where 48% (22 organizations) operated safe spaces. This decrease might be representative of a reduction in funding attributed to PSS activities over the past year in the 2016-2018 JRP. Similar to the 2015/2016 mapping, the majority (41%) of these reported safe spaces are child friendly spaces, followed by youth friendly spaces (28%), and women centers (13%). However, as shown in Figure 8, there is a drop of 45% in women spaces in comparison to last mapping.

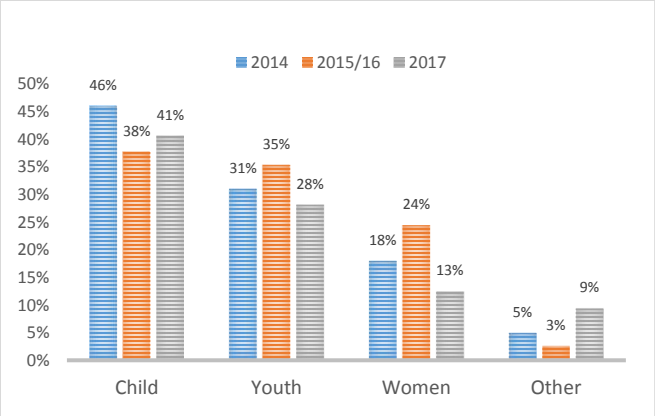

Figure 8 Distribution of safe spaces types

Of all reported safe spaces 9% were unclassified under the category 'other'. One example includes services available during summer camp for King Hussein Cancer Center patients. Other examples include seniors' safe spaces and safe spaces open to all community members.

Case management, referrals, and linking vulnerable individuals/families to resources

Figure 9 depicts that 47% of the total organizations (17 organizations) provide 'case management services, referrals and linking vulnerable beneficiaries to resources'. Moreover, this service is being provided in all governorates, which may lead to an increased ability to meet the needs of vulnerable beneficiaries requiring referral to specific services or resources, as case managers can act as a focal point to coordinate with other actors within the area.

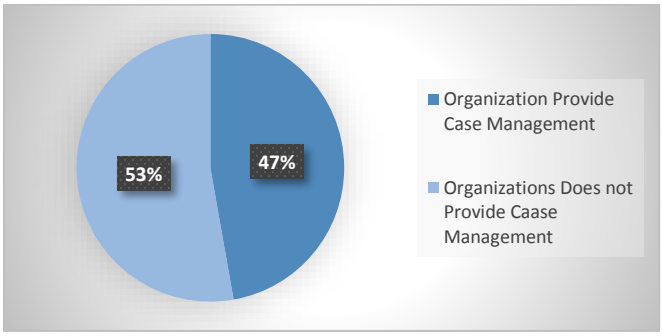

Figure 9 Proportions of Organizations Providing Case Management

Figure 10 below clarifies the distribution of case management activities across the governorates, with the highest frequency reported in Amman, Irbid, Mafraq and Zarqa respectively, while the lowest frequency of case management activities were reported in Aqaba, Tafilah, & Madaba.

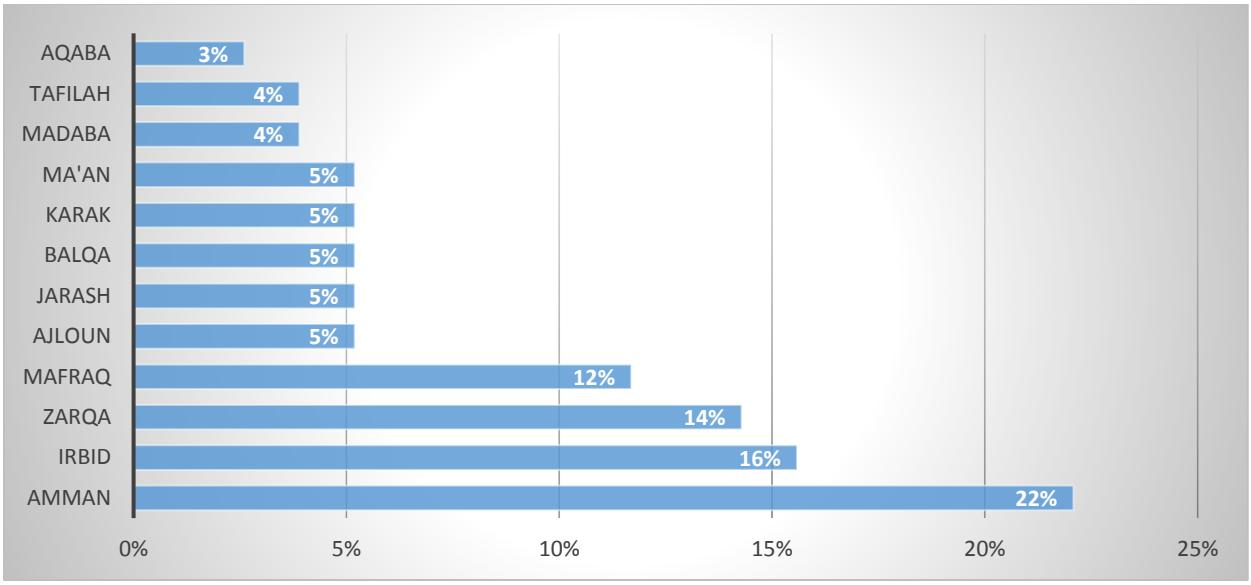

Figure 10 Case management activity by governorate

Strengthening family and community supports

Figure 11 demonstrates the distribution of main activities under the IASC pyramid level 2. Analysed data demonstrates some similarities with previous mapping reports, with safe spaces representing the most common Level 2 activity, followed by strengthening parenting and family supports. This year's mapping also showed an increase in the number of indigenous religious support activities, with 35 reported in 2017, compared to 24 reported in 2015/2016.

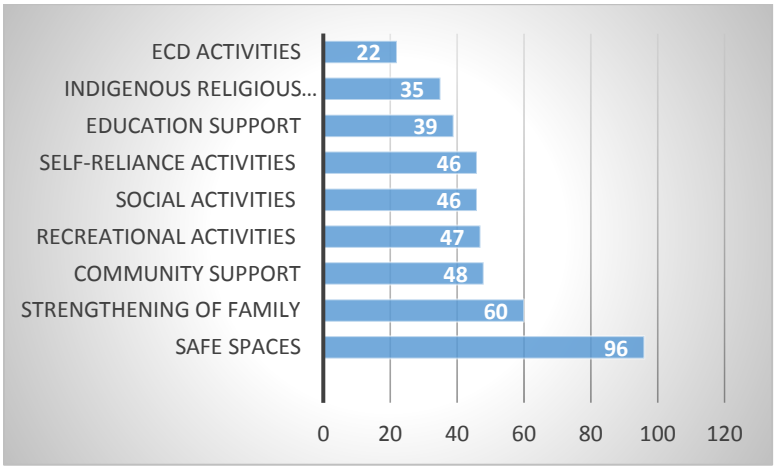

Figure 11 Proportions of level 2 activities

Clinical management of mental disorders by non-specialized health care providers

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

While the activity is provided by only 3 organizations, geographical coverage of service provision is relatively widespread, reaching all governorates, with the exception of Aqaba. This is a significant improvement from the last 2015/2016 mapping, which reported absence of such services from 5 governorates; Jarash, Ajloun, Ma'an, Tafilah, and Aqaba. Previous reports have highlighted a need for an increase in sustainable mental health care at general and primary health services by non-specialized health care providers[6]. Whilst some services do exist that aim to address this need, it represents a small proportion of actors working in this space. This recommendation regarding a need for increased services by non-specialized providers is in line with the National Mental Health Policy that highlights a shortage of specialized mental health care professionals in Jordan, and advocates for the integration of mental health in primary health care, in line with global recommendations.

Specialized services provided by trained professionals

This mapping illustrates that 19% of reported activities are specialized services that fall under Level 4 of the intervention pyramid. The IASC MHPSS Guidelines define Level 4 activities as "additional support required for a small percentage of the population whose suffering, despite the supports (at other levels of the pyramid), is intolerable and who may have significant difficulties in basic daily functioning. This support may include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing services."[7]

Nineteen organizations reported providing Level 4 activities. Figure 12 shows activity distribution, with the majority (approximately 50%) including counseling for individuals and groups.

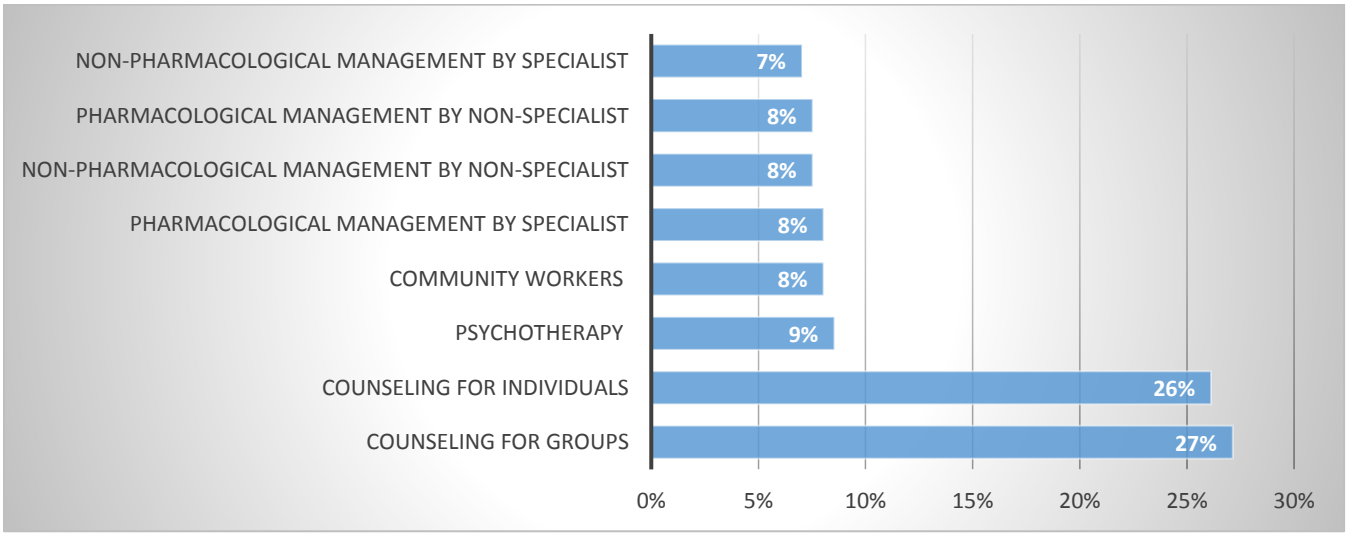

Figure 12 Proportions of level 4 activities

As illustrated in Figure 13 the highest concentration of specialized services was observed in Amman (22%), followed by Irbid (21%), Zarqa (14%), & Mafraq (13%). In the 2015/2016 year's mapping, Irbid accounted

[6] National Mental Health Policy- Ministry of Health, January 2011;

[7] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

for most Level 4 services (30%). Also in the last mapping, no level 4 activities were reported in Aqaba or Ma'an, compared to 1% & 5% of reported activities taking place in those governorates this year.

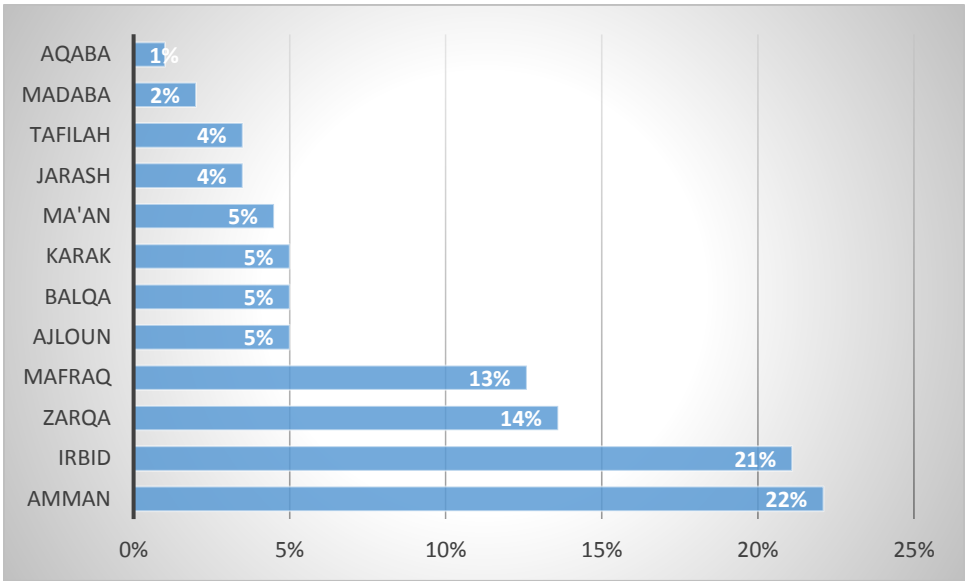

Figure 13 Level 4 activities by governorates

Interventions for alcohol/substance use disorders

Discussions among the MHPSS Working Group members suggested a need for a better understanding of available services for alcohol and substance use problems. The significance of this issue arises as the use of alcohol or drugs may sometimes be adopted by beneficiaries as a maladaptive coping strategy. Alcohol and substance use issues can be addressed through a variety of activities at the various levels of the IASC pyramid, including services provided by both non-specialized and specialized providers. No organizations were reportedly active in the management of alcohol/substance use problems. The MoH reported operation of a facility for the management of substance use disorders, however no further information was provided on the level of services offered, and staffing.

Interventions for developmental disorders/intellectual disabilities

Previous reports[8] have indicated a gap in specific interventions to address developmental disorders and intellectual disabilities. In 2015/2016, there were 3 organizations reporting activities for developmental disorders/intellectual disabilities. Unfortunately, however, in this years' mapping, only one agency reported activities for developmental disorders/intellectual disabilities. This represents a gap in service delivery that is essential to be addressed in future programming.

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

6.2. Profile of MHPSS target beneficiaries

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

By Nationality

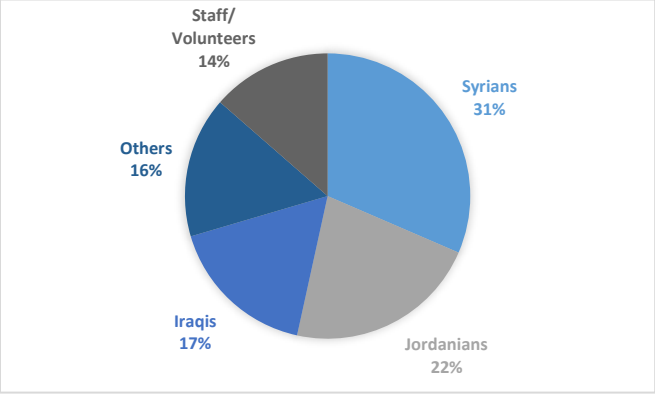

Figure 14 Proportions of beneficiaries by nationality

Figure 14 shows the distribution of beneficiaries by nationality engaged in MHPSS services in 2017. Please note the category 'staff/volunteers', refers to activities where the primary beneficiaries of activities are the staff of implementing organizations (e.g. staff wellbeing initiatives), nationality of staff was not provided for further analysis). According to UNHCR estimates[9], as of September 2017, the total population of concern registered in Jordan is over 720,000 persons, including 654,582 Syrian refugees and 64,860 Iraqi refugees. Akin to the 2015/2016 mapping, Syrians are the largest demographic group addressed by MHPSS actors, representing 31% of the reported population. At 22%, Jordanian beneficiaries represent the second largest group, followed by Iraqis at 17%. The category 'other' includes Sudanese, Somalis, Yemenis and Palestinians. Furthermore, findings identify an increased targeting of staff and/or volunteers, at 14% this year compared to 11% in 2015/2016.

A closer look at the targeted Syrian refugee population (Figure 15) illustrates that the vast majority (77%) of Syrian beneficiaries were from non-camp settings, while the remaining 23% were in camps. This is understandable given most Syrian refugees (79%) reside within urban locations.

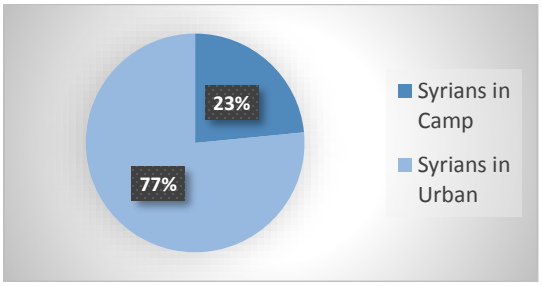

Figure 15 Syrian beneficiaries by location

[9] UNHCR Inter-Agency Information Sharing Portal
http://data.unhcr.org/syrianrefugees/country.php?id=107 (Accessed October 19th 2017)

By Age and Gender

The largest age group targeted by MHPSS services is between 0 to 18 years, representing 50.9% of the serviced population, while beneficiaries with the ages of 18 and over, represent 49.1% of the targeted population. This shows an approximately equal targeting among the two age groups. It is important to adequately target children and adolescents with MHPSS interventions, in order to support the prevention, early detection and management of MHPSS problems, which leads to better health and psychosocial outcomes for beneficiaries.

Overall, the mapping reveals a relatively similar distribution of the four age/gender groups as beneficiaries targeted by MHPSS services. Females (24.8% women, 24.9 % girls) represent 49.7% of the targeted population, while males represent the remaining 50.3% (24.4% men, 26.0% boys). These findings suggest that men are getting slightly more attention than before with a 3% increase in proportion of services addressing their needs.

6.3. Cost of MHPSS Service Provision

Similar to previous years, the majority of MHPSS services (79%) are provided free of charge by organizations to all target population groups (see figure 16). A small number of organizations (3%) reported charging partial or minimal fees for their services, while 18% of surveyed organizations did not report on fees and costs.

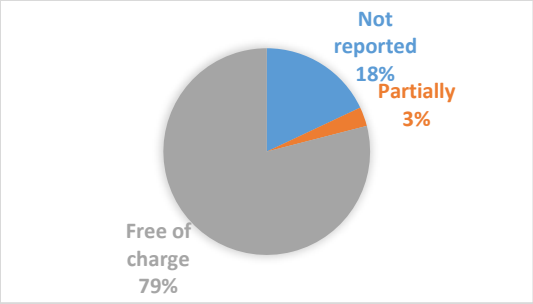

Figure 16 Cost of services

6.4. Where?

The following section provides an overview of the frequency and distribution of MHPSS services across governorates. While the section addresses geographic distributions of overall activities, specific breakdown for selected activities/sub-activities across governorates has also been mentioned in the previous sections.

Table 3 Organizations by governorates

Governorate	Active Organizations
Amman (n=23)	ARDD-LA; CARE; Caritas; CVT; DRC; GIZ; Help; HI; ICCS; IMC; InterSoS; JRF; JRS; KHCC; Medair; MoSD; NHF; PUAMI; SCJ; UPP; WC CAN; WHO/MoH
Irbid (n=20)	ACF; ARDD-LA; CARE; Caritas; GIZ; ICCS; ICMC; IMC; InterSoS; JRF; LWF; MoSD; MSFF; NHF; SAMS; SCJ; Takaful; TdH; UPP; WHO/MoH
Mafraq (n=22)	ARDD-LA; CARE; Caritas; GIZ; Help; HI; ICCS; ICMC; IMC; InterSoS; JRF; LWF; Medair; MFH; MSFF; NHF; NICCOD; SCJ; TdH; VDT; WCUK; WHO/MoH
Ajloun (n=7)	Caritas; ICCS; ICMC; IMC; JRF; NHF; TdH
Jarash (n=9)	HI; ICCS; ICMC; IMC; JRF; NHF; SCJ; TdH; WCUK

Balqa (n=6)	Caritas; ICCS; ICMC; IMC; JRF; NHF; SCJ
Zarqa (n=22)	ARDD-LA; BAK; CARE; Caritas; CVT; GIZ; Help; HI; ICCS; ICMC; IMC; JRF; Medair; MoSD; NHF; NICCOD; PUAMI; SCJ; TdH; UPP; WCUK; WHO/MoH
Madaba (n=3)	Caritas; JRF; NHF
Tafilah (n=3)	ICCS; IMC; JRF
Karak (n=6)	Caritas; ICCS; IMC; InterSos; JRF; SCJ
Ma'an (n=7)	ICCS; IMC; InterSos; JRF; MoSD; SCJ; WHO/MoH
Aqaba (n=4)	ARDD-LA; ICCS; JRF; SCJ
Roving (n=2)	HI; IRD

Similar to the previous year's mapping, the 2017 findings illustrate a continued concentration of activities in the Northern and Central areas of the Kingdom, mirroring the larger proportion of Syrian refugees (and Jordanian host population) in these areas. The highest percentage of MHPSS activities is concentrated in the four governorates of Amman (21%), Irbid (17%), Mafraq (14%) and Zarqa (14%). The Southern governorates of Aqaba, Tafilah and Ma'an, in addition to the Central governorate of Madaba, showed the least concentration of activities with the lowest being in Madaba (3%), Tafilah (3%), & Aqaba (1%).

Unfortunately, the tool did not collect information related to specific towns/villages of activities being implemented, therefore the reach to rural and/or remote area of each governorate is unknown. Data from the 2013, 2014, 2015/2016, and current 2017 mapping was juxtaposed to portray the geographical distribution of activities per governorate over the past 4 mapping exercises. Figure 17 below suggests that, in general, there has been a wider reach of MHPSS services across governorates over the years, as well as a slightly more even distribution between the various locations.

At 21% (n=257), Amman remains the governorate with the highest concentration of MHPSS activities in this year's mapping, mirroring this finding over the last 3 years. Similarly, at 17% (n=212), Irbid had remained the second highest concentration of activities, followed by Mafraq (n=169) and Zarqa (n=173) governorates both at 14%. The percentage of activities for Zarqa is similar to the 2015/2016 mapping, with a 10% decrease of reported activities in Irbid, and a 17% decrease of activities reported in Mafraq. Again, it should be emphasized that these figures represent proportional estimations relative to the collective amount of activities reported in all governorates, as opposed to independent changes in frequencies for each governorate.

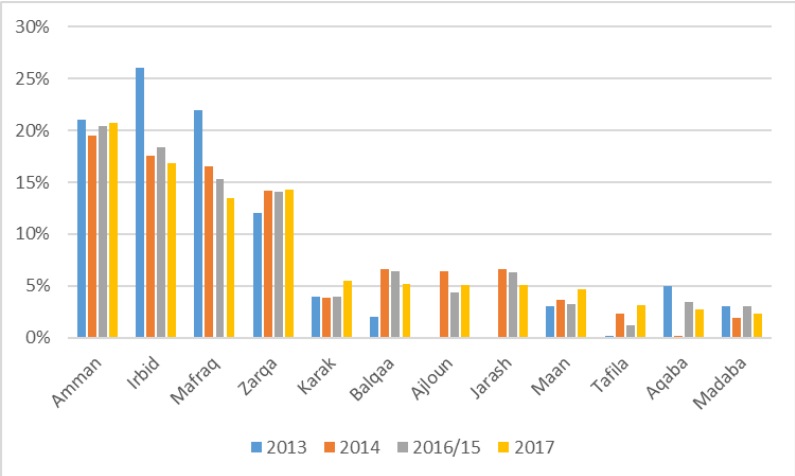

Figure 17 Activities concentration by governorate from 2013

Geographic divisions were mapped out to delineate the Northern region (Irbid, Mafraq, Ajloun and Jarash), the Central region (Amman, Zarqa, Madaba and Balqa), and the Southern region (Aqaba, Ma'an, Tafileh and Karak). Table 4 indicates that 41% of MHPSS services are located in the Northern governorates, while 43% are concentrated in the Central areas. The South is served by only 16% of services. This pattern of activity distribution by region is very similar to findings from the 2014 mapping.

Table 4 Activities by region

North	Activities (#)	501
	Activities (%)	41%
	Population (#)	2733245
	Population (%)	29%
	Syrians (#)	311045
	Syrians (%)	48%
Centre	Activities (#)	524
	Activities (%)	43%
	Population (#)	6053305
	Population (%)	64%
	Syrians (#)	319033
	Syrians (%)	49%
South	Activities (#)	207
	Activities (%)	16%
	Population (#)	745162
	Population (%)	8%
	Syrians (#)	21043
	Syrians (%)	3%

Around 66% of services were delivered in community centers, and 19% of services were taking place in schools. Only 8% were based in client's residences. Moreover, this year's mapping reported 29% of services taking place in a primary care facility. Nevertheless, 17% of services reported to be provided in specialized clinic/center, which is somehow consistent with results from 2015/2016 mapping (see Figure 18).

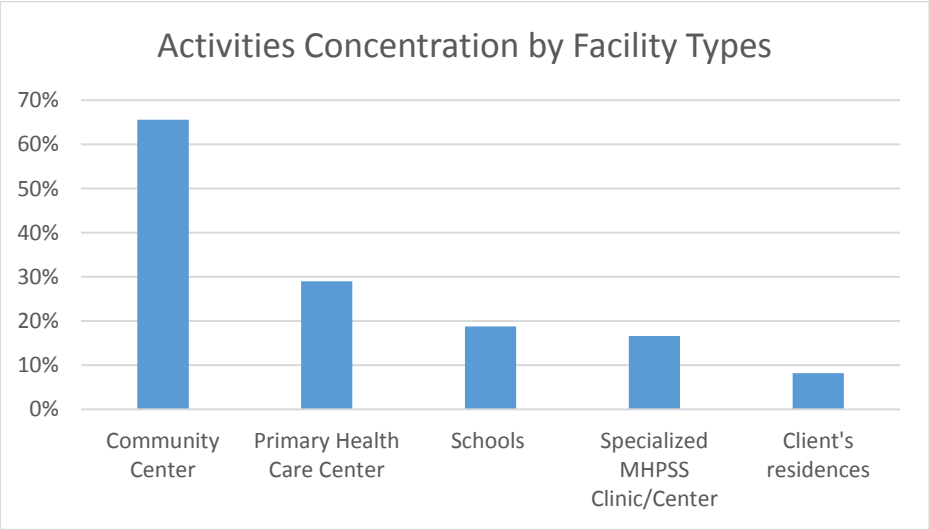

Figure 18 Settings of MHPSS services

The vast majority of reported activities took place in urban settings (see Figure 19). With, only 19% of activities delivered in rural areas and/or camps. It is important to note; however, that these findings are not mutually exclusive, and it is possible that one activity had reached out to both rural and urban areas within one governorate.

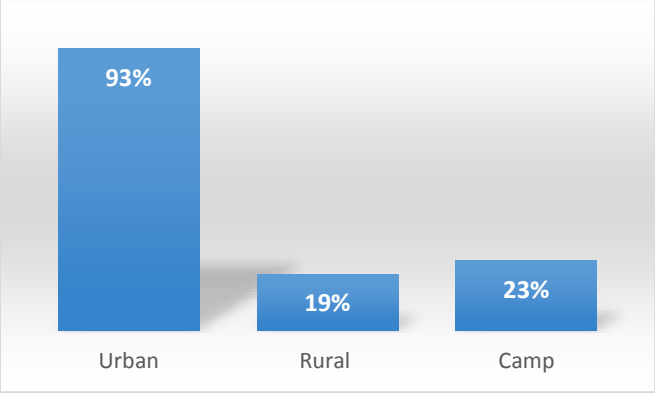

Figure 19 Outreach of MHPSS activities

Proportions of activities that address the needs of adolescents and children were reported at 86% (see Figure 20). However, only half of activities reported including older persons within the community, and only 37% included individuals with a disability. Given the proportion of activities addressing different age and sex groups are almost equal, there is a need to pay more attention towards addressing the needs of older persons within the community, and also increasing accessibility for clients with disabilities.

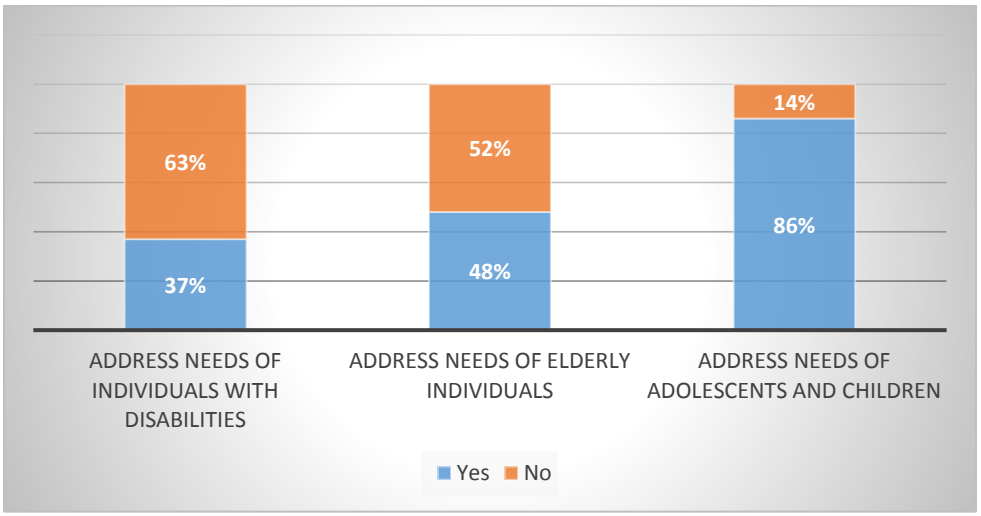

Figure 20 Proportions of activities addressing special needs of vulnerable populations

6.5. When?

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

Figure 21 shows the breakdown of activities as related to their status of implementation. Respondents indicated that the majority (77%) of their activities are 'currently under implementation'; while 11% are 'funded but not yet implemented', and 1.3% are 'un-funded and not yet implemented'[10]. For activities reported as 'un-funded and not yet implemented', some participants noted that project proposals are awaiting donor approval. Projects that were un-funded and not yet implemented were excluded from analysis.

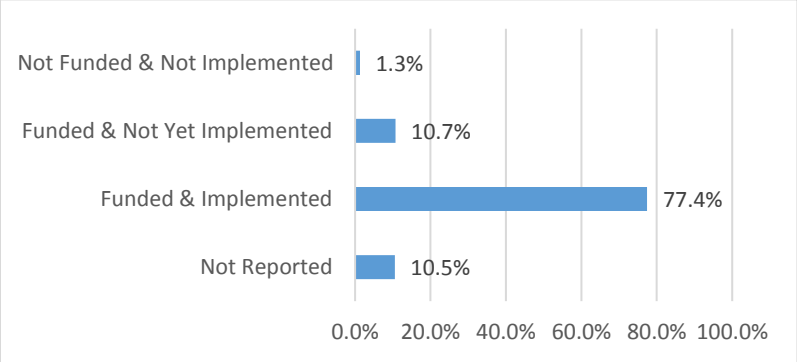

Figure 21 Funding Status

Figure 22 shows the length of funding (or funding cycles) for reported activities. Findings indicate that the majority of funding cycles (64%) fall in the '12 months' category, which was also listed as the highest category in the previous year at 33%. The projects that are more than 12 months also witnessed a decrease from 23% in 2015/2016 to 16% in this year's mapping.

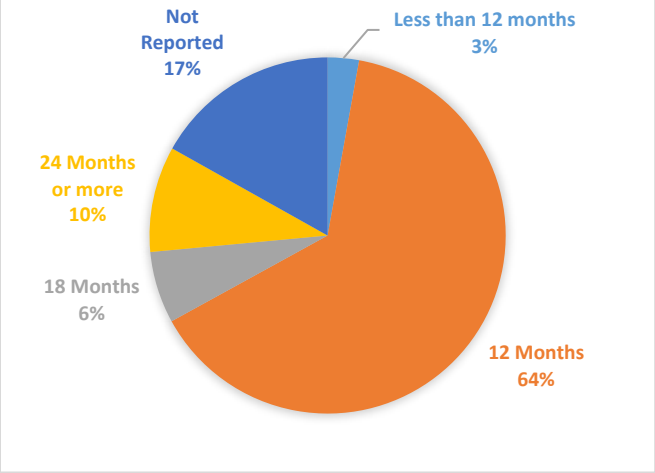

Figure 22 Funding cycle

[10] Projects "unfunded and unimplemented" were not included in the analyses of the 4Ws

7. DISCUSSION

7.1. Tool-specific challenges and limitations

Feedback following the 2015/2016 mapping exercise indicated that responders found it generally easy to complete the 4Ws tool. The codified data points for activity, sub-activity and target groups were simple to complete, and the tool has become relatively familiar to most agencies. Nevertheless, some challenges and limitations did emerge, as the input entered was sometimes inconsistent between different organizations, or sometimes even within the same organizational entry, possibly as different staff members may have been completing the information for different activities. Moreover, there is still a need to ensure a more unified use of specific terminology among MHPSS actors. Anecdotal observations suggest that different agencies tend to define their provided MHPSS services in various ways, leading to inconsistencies in some reported activities. IMC attempted to mitigate this challenge by holding discussions with stakeholders whose information appeared unclear, or inaccurate, based on their knowledge of MHPSS working group members and their activities.

This year, an orientation workshop was held for all MHPSS working group members. An online live 4Ws tool was discussed, and is currently being developed and translated into Arabic. An online tool may help increase standardization of the information provided; for example, outlining fixed municipalities/districts, human resource categories, broad training topics, as well as other possible options. It may also be faster tool, and provide the opportunity to update the 4Ws findings more frequently.

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

7.2. Sectoral challenges and limitations

Knowledge transfer challenges

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

Staff and training

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

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

Informal discussion with agencies continues to highlight the challenge of staff turnover in the sub-sector, as well as the limited availability of qualified workforce. The ability of MHPSS agencies to deliver quality services and achieve positive outcomes is highly contingent on a trained and qualified MHPSS work force. The National Mental Health Policy emphasizes a key need for increased and more qualified staff for mental health care delivery.[11] Few training programs in Jordan offer clinical supervised practice as part of the formal education of mental health professionals. As such it is imperative that agencies active in MHPSS service provision provide regular supervision and training opportunities for staff.

7.3. Type of Activities

Some important findings were borne out of the most recent 4Ws exercise, when compared to previous years mapping. Despite the finding that activities targeting Level 1 of the IASC pyramid were reportedly increased in this year's mapping, there is still a need for awareness initiatives highlighting the IASC guidelines and how MHPSS key issues and considerations can be integrated within other sectors. Furthermore, the mapping highlighted the need for increased services at Level 3 of the pyramid by non-specialized providers. In terms of populations of interest, it appears that in line with findings from previous year's mappings, there remains a gap in service provision for persons with developmental delays and disabilities, and persons with substance use disorders. With respect to geographical reach of services, whilst four new governorates were reached by MHPSS services in this year's mapping, southern governorates and the central governorate of Madaba remain less targeted.

Activities Across the IASC Pyramid Levels

On the contrary to prior mappings, data reveals a higher proportion of Level 1 activities. While there is substantial provision of Level 1 services by the Government of Jordan and local communities, with the support of international partners (i.e. security, shelter, food, etc.), limited activities are reported to target the inclusion of social/psychological considerations in other sectors, which is especially important to enhance preventative and protective measures that promote MHPSS wellbeing.

As this remains an area for increased action by the sub-sector, it is recommended orientations/sensitization on key MHPSS issues (e.g. IASC Guidelines) be delivered, in addition to the increased facilitation of conditions to promote community-led mobilization and organization.

Despite findings evidencing an increased proportion of Level 4 activities on the intervention pyramid; the most reported activities by MHPSS actors remain under Levels 2 and 3, including activities intended to strengthen family and community support, psychosocial work and safe spaces. This is in line with IASC recommendations, indicating a higher need for non-specialized services by a larger proportion of beneficiaries. However, there is still a limited availability of the management of MHPSS problems by non-specialized health care workers, despite global mental health recommendations on the importance of this intervention as a bridge on the continuum between community activities and specialized services.[12] This is especially true for the governorate of Aqaba, where this activity is generally unavailable. However, and

[11] National Mental Health Policy- Ministry of Health, January 2011;

[12] WHO Mental Health Gap Action Program (mhGAP)

despite the extended reach to 4 new governorates compared to 2015/2016 mapping, there is a need to further explore the extent and quality of MHPSS clinical management by non-specialized providers.

Gaps in Service Delivery

Furthermore, the breakdown of specialized services points to the virtual absence of interventions for developmental disorders and intellectual disabilities, with only one organization offering an intervention targeting this population. This is a major setback after having limited availability in 2015/2016. Instead of building up on these efforts, services have been further reduced, with only one service for developmental disorders and intellectual disabilities reported this year. This area has been a constant gap carried over from previous 4Ws mappings, field observations as well as findings by other relevant reports.[13] In addition, no interventions for alcohol and substance use were reported in this year's exercise, with the exception of the MoH facility.

Similarly, data is also minimal for psychological support offered in education, with 3.5% of activities occurring in this context. However, this is most likely due to the limited representation of such activities in the mapping. As the 4Ws exercise is completed by the Mental Health and Psychosocial Support Working Group members, services delivered by agencies that are not part of this group might not be captured. Future mappings should strive for greater inclusion of such activities through ensuring input from the Ministry of Social Development, Ministry of Education, and additional education actors. This can be achieved by utilizing the MHPSS working group as a coordination mechanism to link with the relevant ministries who are available to provide such data.

Activity code 11 is related to general activities to support MHPSS, including the provision of psychosocial support for staff and volunteers. Managing stress enables the organization to fulfill its field objectives, protect the wellbeing of individual staff, teams and beneficiaries, as well as increase safety and security. Despite its importance, results reveal that the majority (78%) of MHPSS agencies do not provide this support. It is highly recommended that more organizations are committed to supporting staff wellbeing either directly through access to self-care and stress management activities, peer and professional support, or through facilitating access to this care by external entities. Such activities may be supported through HR processes that help to establish programs that emphasize the importance of staff wellbeing.

7.4. Priority Populations

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

Most activities targeting Syrian refugees are located in urban areas, while almost one quarter of the interventions are directed towards Syrians in camps, which is consistent with population estimations in urban areas and camps.[14] An analysis of activities disaggregated by age and gender reveals a very similar distribution of activities targeting girls, boys, men and women. Akin to last year's mapping, girls and boys are targeted by a slightly higher frequency of activities than women and men, with girls and boys receiving

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

[14] UNHCR Inter-Agency Information Sharing Portal http://data.unhcr.org/syrianrefugees/country.php?id=107 (Accessed October 19th 2017)

more community/family supports and psychological interventions, while women and men receive more individualized support to support emotional wellbeing. These differences are very minimal however, and overall, it appears that MHPSS activities are similarly supporting girls, boys, women and men.

7.5. Geographic Areas

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

While a small increase in MHPSS services was noted in the south of Jordan, service provision in the south continues to remain a gap as identified by previous mappings. Similarly, a general review of activity concentrations across districts/neighborhoods suggests some uneven distribution in certain governorates (e.g. in Amman where the majority of activities are located within the city limits, are do not reach the outskirts of Amman governorate). Overall, rural and remote areas remain under-served for MHPSS activities in relation to the more populated urban locations. Whilst rural and remote areas might be less populated, it is undeniable that community members within these locations are often at increased vulnerability due to increased poverty, less access to services overall, and for those employed often illegal and exploitative work conditions.

8. RECOMMENDATIONS

Overall the mapping provides an overview of the relatively extensive coverage of multi-layered MHPSS services throughout Jordan. Some important gaps are identified in the areas of substance misuse, and the provision of programs for the support of children with developmental delays and/or disabilities. Data collected allows for recommendations to be made for future program planning and to inform future mapping exercises to ensure data collected is most meaningful. The recommendations below were discussed and agreed upon by active members of the MHPSS working group, in a workshop where the key findings of the 4Ws mapping was provided. Key recommendations by members of the group are as follows.

- The mapping found slightly stronger representation of activities at Level 1 of the IASC pyramid compared to previous mapping, however the MHPSS working group emphasized the need for further awareness activities to highlight the importance of MHPSS considerations across sectors. It is **essential Level 1 activities are continually integrated** within various sectors, to ensure multi-sectoral MHPSS sensitive programming.
- Level 2 activities are fundamental to supporting the prevention and promotion of mental health and psychosocial wellbeing for children, youth, families and communities. This mapping found strong coverage of such activities across urban locations, however it was not explored if such activities conducted outreach to more rural locations. The working group believes it is likely rural and hard-to-reach communities are less likely to access and benefit from MHPSS services due to logistical barriers (e.g. transport). As such it is recommended that while MHPSS programming should continue to be supported in urban areas, an additional focus of programming should be on the **outreach to community members in rural or remote locations** to support community coping

mechanisms and access to MHPSS services. Furthermore, future mapping exercises should attempt to gather data on outreach activities conducted within rural and remote locations in an effort to map activities occurring within such communities.

- The mapping highlighted a growing proportion of Level 4 services over the years. This demonstrates an increase in complex psychological, psychiatric or social interventions being provided by specialized staff. This finding led the working group to consider the quality assurance of such activities. All MHPSS staff, including those with specialized backgrounds, require professional development opportunities in the form of **ongoing training to develop their skills, and continuous supervision** to monitor their activities and outputs.
- The current mapping was not able to provide in-depth information on the frequency and quality of trainings conducted to MHPSS staff. However it is recommended that MHPSS service providers emphasize professional development and supervision opportunities for all their staff, with an emphasis on non-specialist providers to ensure appropriate training is received.
- The mapping revealed limited activities focusing on the management of mental disorders by non-specialized health workers (e.g. general health/PHC staff). It is recommended such activities are increased. Bringing evidence-based interventions to support mental health and psychosocial wellbeing to scale, is an issue receiving considerable attention as of late. General consensus by experts in the field, led by WHO, is that in order to bring such programs to scale, less reliance on services being provided by specialized personnel (i.e. level 4) should be favored, for programs being delivered by non-specialized personnel who are trained, supervised and supported to provide evidence-based interventions. The working group acknowledges the challenges inherent in creating an over-reliance in the provision of services by highly-skilled MHPSS experts, and thus recommends an **enhanced focus on level 3 activities that can support mental health and psychosocial programming by non-specialist workers** to be more accessible to a larger proportion of the population.
- This mapping revealed only one reported intervention **supporting persons with developmental delays and/or disorders**, and one MoH facility specifically managing persons presenting with alcohol and/or substance use problems. This is an unsurprising finding that is echoing that of previous assessments. It is concerning that to date little progress has been made in these two areas of intervention. Unfortunately, no data exists to determine the true magnitude of both presentations within Jordan, however anecdotally members of the working group have agreed both areas require considerable attention and actors are needed with specialization in these areas to ensure such vulnerable populations are being adequately serviced.
- Other gaps identified in MHPSS services currently being offered, relate to **psychosocial programming in the education sector**. While more than half of the MHPSS activities target persons under the age of 18 years, few actors provide services within the education system which can be a crucial point of integration. The IASC guidelines recommend the integration of psychosocial considerations into the education sector which can take the form of direct service provision to students, and education of psychosocial considerations to teachers to ensure they are supported to recognize, and support the psychosocial wellbeing needs of students. It is recommended that actors engage more with the education system and coordination mechanisms within Jordan to ensure MHPSS considerations are suitably integrated. The mental health working group can support to facilitate this process, through its continued engagement with the education

coordination group, to ensure in both sectors the importance of integration and collaboration is emphasized.

- While half of services included older persons within the community in their programs, very few focused specifically on this age group and did not specifically cater to their unique needs. The working group highlighted this as an area that requires further consideration as the needs of older members of the community can often be ignored in favor of younger community members. It is important that MHPSS actors not only allow for the inclusion of older persons within the community, but that they also make an effort to specifically target this population and to tailor their interventions to this unique population.
- While this mapping collected information on the donors providing funding to the MHPSS sector, further information could be collected to facilitate the analysis of such data. Furthermore, it would be interesting to determine how the funding shortfall evident in MHPSS activities in Jordan, and across the region in general in response to the Syrian crisis, has impacted MHPSS service provision and availability more generally. Future mapping activities should attempt to address this limitation, to strengthen the quality of the mapping analysis.

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	11	Information, education & communication (IEC) materials on the current situation, relief efforts or available services
			12	Messages on positive coping
			13	Mass Campaigns (Events, TV, Radio, etc)
			14	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	21	Support for emergency relief that is initiated by the community
			22	Support for communal spaces/meetings to discuss, problem-solve and organize community members to respond to the emergency
			23	Other (describe in row 5 of MHPSS Services Info sheet)
	3	Strengthening of community and family support	31	Support for social support activities that are initiated by the community
			32	Strengthening of parenting/family supports
			33	Facilitation of community supports to vulnerable persons
			34	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.

			35	Structured recreational or creative activities (do not include activities at child/ youth/ women spaces that are covered in 4.1, 4.2, 4.3)
			36	Early childhood development (ECD) activities
			37	Facilitation of conditions for indigenous traditional, spiritual or religious supports
			38	Self-reliance activities (income-generating activities, life skills, literacy classes, etc)
			39	Other (describe in row 5 of MHPSS Services Info sheet)
	4	Safe spaces	41	Child-friendly spaces
			42	Youth-friendly spaces (ages 15 - 24)
			43	Women centres
			44	Other (describe in row 5 of MHPSS Services Info sheet)
	5	Psychological support in education	51	Psychosocial support to teachers/other personnel at schools/learning places
			52	Psychosocial support to classes/groups of children at schools/learning places
			53	Other (describe in row 5 of MHPSS Services Info sheet)
	6	Supporting the inclusion of social/psychosocial considerations in other sectors (e.g., protection, health, nutrition, food aid, shelter,	61	Orientation, training or advocacy with aid workers/agencies on including social/psychosocial considerations in programming (provide details and specify sector in row 5 of MHPSS Services Info sheet)

		site planning, or water and sanitation services)	62	Other (describe in row 5 of MHPSS Services Info sheet)
Case-focused MHPSS	7	Psychosocial intervention	71	Psychological first aid (PFA)
			72	Case management, referrals and linking vulnerable individuals/families to resources (e.g. health services, cash assistance, community resources, etc).
			73	Other (describe in row 5 of MHPSS Services Info sheet)
	8	Psychological intervention	81	Basic counseling for individuals (specify type in row 5 of MHPSS Services Info sheet)
			82	Basic counseling for groups or families (specify type in row 5 of MHPSS Services Info sheet)
			83	Psychotherapy (specify type in row 5 of MHPSS Services Info sheet)
			84	Interventions for alcohol/substance use problems (specify type in row 5 of MHPSS Services Info sheet)
			85	Interventions for developmental disorders/intellectual disabilities (provide details and specify type in row 5 of MHPSS Services Info sheet)
			86	Other (describe in row 5 of MHPSS Services Info sheet)
	9	Clinical management of mental disorders by non specialized	91	Non-pharmacological management of mental disorder by non-specialized health care providers (where possible specify type using categories 7 and 8)

		health care providers (e.g. PHC staff, post-surgery wards)	92	Pharmacological management of mental disorder by non-specialized health care providers
			93	Action by community workers to identify and refer people with mental disorders and to follow up on them to ensure adherence to clinical treatment
			94	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)	101	Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type using categories 7 and 8)
			102	Pharmacological management of mental disorder by specialized health care providers
			103	In-patient mental health care
			104	Other (describe in row 5 of MHPSS Services Info sheet)
General MHPSS	11	General activities to support MHPSS	111	Situation analyses/assessment (provide details and specify type in row 5 of the MHPSS Services Info sheet)
			112	Structured Training
			113	Technical or clinical supervision
			114	Psychosocial support for staff/volunteers (including refugee volunteers)

			115	Research
			116	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 and acronym)	*Address of organization*	*Name of the focal point at the organization*	*Phone number of focal point*	*Email address of focal point*
Action Against Hunger (ACF)	#57 Abdulhameed Badees str. Shmeisani - Amman	Valentina Ferrante, Julie Calafat	077 84 65 150	dcdprograms@jo.missions-acf.org
Arab renaissance for Democracy & Development (ARDD-Legal Aid)	Amman, Jordan	Dr. Lina Darras	077 84 00 548	ldarras@ardd-legalaid.org
Bayt Al Kol Association (BAK)	Masoum - Zarqa -Jordan	Ashraf Bdour	077 71 35 723 05 39 32 856	a.bdour@baytalkol.org
CARE International/ Jordan	Head office -Um Uthaina , Dejlah 27 Amman Jordan	Angela Atrozi Mariam AlSalahat	079 12 20 331 079 71 17 249	Angela.atrozi@care.org mariam.alsalahat@care.org
Caritas - Jordan	Alweibdeh, Amman	Lana Snobar	077 54 44 525	lanas@caritasjordan.org.jo
The Minnesota Center for Victims of Torture (CVT)	Amman: Building number (7), Talha Bin Ebid' Allah street, Abdali,	Moath Asfour	079 56 39 016	masfoor@cvt.org
Danish Refugee Counsel (DRC)	14 Al Basra St. Um Uthaina, Amman	Yasmeen hijjawi	078 91 11 255	yasmeen.hijjawi@drc-jordan.org
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Project office: 19, Maarouf Ar-Rasfi St., Shmeisani, Amman, Jordan	Dr. Christine Mueller	079 09 26 031	christine.mueller@giz.de
Handicap International (HI)	Amman- Maqadeshoo St, Bulding No 4	Madiha Aljazi	078 00 34 980	Pta.jord.@hi-me.org
Islamic Charity Center Society (ICCS)	Amman- Abdali	Fawaz Al Mazrawai	079 50 54 944	fawaz1960@hotmail.com
International Catholic Migration Commission (ICMC)	Al Husseini Group, 9th floor Office 901, Zahran Street, between 7th and 8th Circle	Georgia Swan	079 14 70 819	swan@icmc.net

International Medical Corps (IMC)	Global Investment House, 9 Abd Alhamid Sharaf St. , Al Shmaisani, Amman	Dr. Ahmad Bawa'neh Dr. Michelle Engels	079 85 16 131 079 00 40 686	abawaneh@internationalmedicalcorps.org mengels@internationalmedicalcorps.org
INTERSOS	Shmeisani – 47 Prince Shakir ben Zaid Street, Alnajah building, 3rd & 4th floor, Amman, Jordan	Marcello Rossoni	079 66 14 738	jordan@intersos.org
International Relief and Development (IRD)	Abdali boulevard building #1 (SGBJ) | Floor 5 & 6, Ayla street, Abdali	Nawal Najjar Wejdan Jarrah	079 01 01 345 079 88 98 316	w.jarrah@ird-jo.org, n.najjar@ird-jo.org
Jordan River Foundation (JRF)	Amman – 7th circle, near Cozmo Queen Rania Center	Mohammad Al Horani	079 10 95 959	y.musleh@jrf.org.jo
Jesuit Refugee Services (JRS)	Jabal Al Hussein , Amman	Insherah Musa	079 08 44 181	Insherah.mousa@jrs.net
King Hussein Cancer Center (KHCC)	201 Queen Rania al Abdullah St, Amman	Dr. Bassam Kamal	777415581	bkamal@khcc.jo
Lutheran World Federation (LWF)	3463 Um Simmaq 11821 Amman	Protection Coordinator	079-112-4151	prtcc.jo@lwfdws.org
Medair	Medair, Office No. 202, Building No. 20, Paris Street, Swefieh, Amman, Jordan	Edwin Visser	079 50 30 844	countryrep-jor@medair.org
Moroccan Field Hospital (MFH)	Zaatari Camp, D3, Mafraq	Ashour Abd alsamed	791921574	asuoerabdssamed@yahoo.fr
MoSD: Dar Al Wifaq	Marka: Urban Development	Dr. Zain Al Abbadi	077 54 00 991 06 48 99 935	NA
MoSD: Child Care Center/Hashemi Shamali	Hahshemi Ash Shamali, Amman	Imad As Suhaibeh	077 54 00 964 06 50 59 176	NA
MoSD: Child Care Center/Shafa Badran/Amman	Shafa Badran: Opposite Health Care Center	Ashraf Khatatbeh	077 54 00 977 06 52 31 408	NA

MoSD: Dar Al Hanan Girls Care Center/Irbid	Irbid	Sawsan Hadad	079 85 18 278 02 74 04 359	NA
MoSD: Girls Care Center/Rusaifeh	Rusaifeh: Near Rusaifeh Police/Station	Raghda Al Azzeh	077 54 00 972 05 37 43 667	NA
MoSD: Girls Education and Rehabilitation Center/Amman	Amman: Um Uthaina, Opposite the Ministry of Transport	Suhad Mubaydeen	077 54 00 965 06 55 37 083	NA
MoSD: Juvenile Education and Rehabilitation Center/Amman	Tareq area, Near General Army Command	Jamal Al Amlah	077 54 00 978 06 50 51 904	NA
MoSD: Al Hussein Social Institute/Amman	Ashrafiyeh: Amman	Nziha Al Shatrat	06 56 79 327	NA
MoSD: Juvenile Education and Rehabilitation Center/Irbid	Irbid: Hai At Twal	Aiman Al Labpon	077 54 00 973 02 72 58 612	NA
MoSD: Juvenile Education Center/Rusaifeh	Rusaifeh: Near Rusaifeh Police Department	Mohammed Al Khawaldeh	077 54 00 970 05 37 50 782	NA
MoSD: Juvenile Education and Rehabilitation Center/Ma'an	Ashrafiyeh: Amman	Nziha Al Shatrat	06 56 79 327	NA
Doctors without Borders (MSF)	Alqubba Circle, Assalem Complex, 1st floor Office 3	Muna Anabousi	079 16 99 805	msff-irbid-psy@paris.msf.org
Noor Al Hussein Foundation, Institute for Family Health (NHF/ IFH)	Sweileh, near the Educational Development School	Areej Samreen	06 53 44 190 Ext: 8	areej@ifh-jo.org
Nippon International Cooperation for Community Development (NICCOD)	P.O. Box 927177, Amman, 11190 Jordan Ahmad Urabi Street, Bldg #46, Rm #3, Amman	Mr. Hiroyuki Morio Ms. Yuiko Isoda	079 84 56 899 079 66 57 673	morio@kyoto-nicco.org isoda@kyoto-nicco.org
Premire Urgence International (PUIAM)	Luwibdeh-Amman	Rosanna Rosengren-Klitgaard Shimaa Jararr	079 10 99 521 079 10 99 524	jor.protectionpm@pu-ami.org Jor.po@pu-ami.org

Syrian American Medical Society (SAMS)	Jordan-Amman-wasfi altall street- alaqad bui. 75 B floor no 3	Noor Amawi	077 84 00 421	noor.amawi@sams-usa.net
Save the Children Jordan (SCJ)	180 Mecca St. Um Al Summaq- Amman	Sana Hyari	079 22 22 116	sana.alhyari@savethechildren.org
Takaful NGO	Ramtha - Sahel Houran, south bus station	Ahmed Munais	079 83 44 030	ahmad.Jor88@yahoo.com
Terre des hommes Lausanne in Jordan (TdhL-J)	Amman - Jabal El weibdeh - Nimr Edwan St. Building 37 - 2nd floor	Blerta Spahiu	079 70 28 174	blerta.spahiu@tdh.ch
Un Ponte Per (UPP Jordan)	Jabal Alwebdeh - Kulliat Al-Sharia St., Building 46 - 2nd Floor, P.O. Box 910615 Amman, 11191 Jordan	Eleonora Biasi - Head of Office	077 67 82 238	eleonora.biasi@unponteper.it
War Child Canada-(WCCan)	Amman- 7th circile- Ziad compound	Lamis Shishani Talal Ibrahim	077 71 99 966 077 71 99 986	Lamis@warchild.ca Talal@warchild.ca
War Child UK (WCUK)	Sweefieh, Park Plaza, 8th floor, Office 806	Hadeel Abedo	079 60 78 226	hadeela@warchild.org.uk
World Health Organization (WHO)	Amman/ interior circle	Hadeel Al Far	079 56 92 285	alfarh@who.int
Help - Hilfe zur Selbsthilfe	Um Othaina, Balqees Street, No 2 P.O.Box 811945 - 11181 Amman, Jordan	Help - Hilfe zur Selbsthilfe	06 55 15 758	www.help-ev.de

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