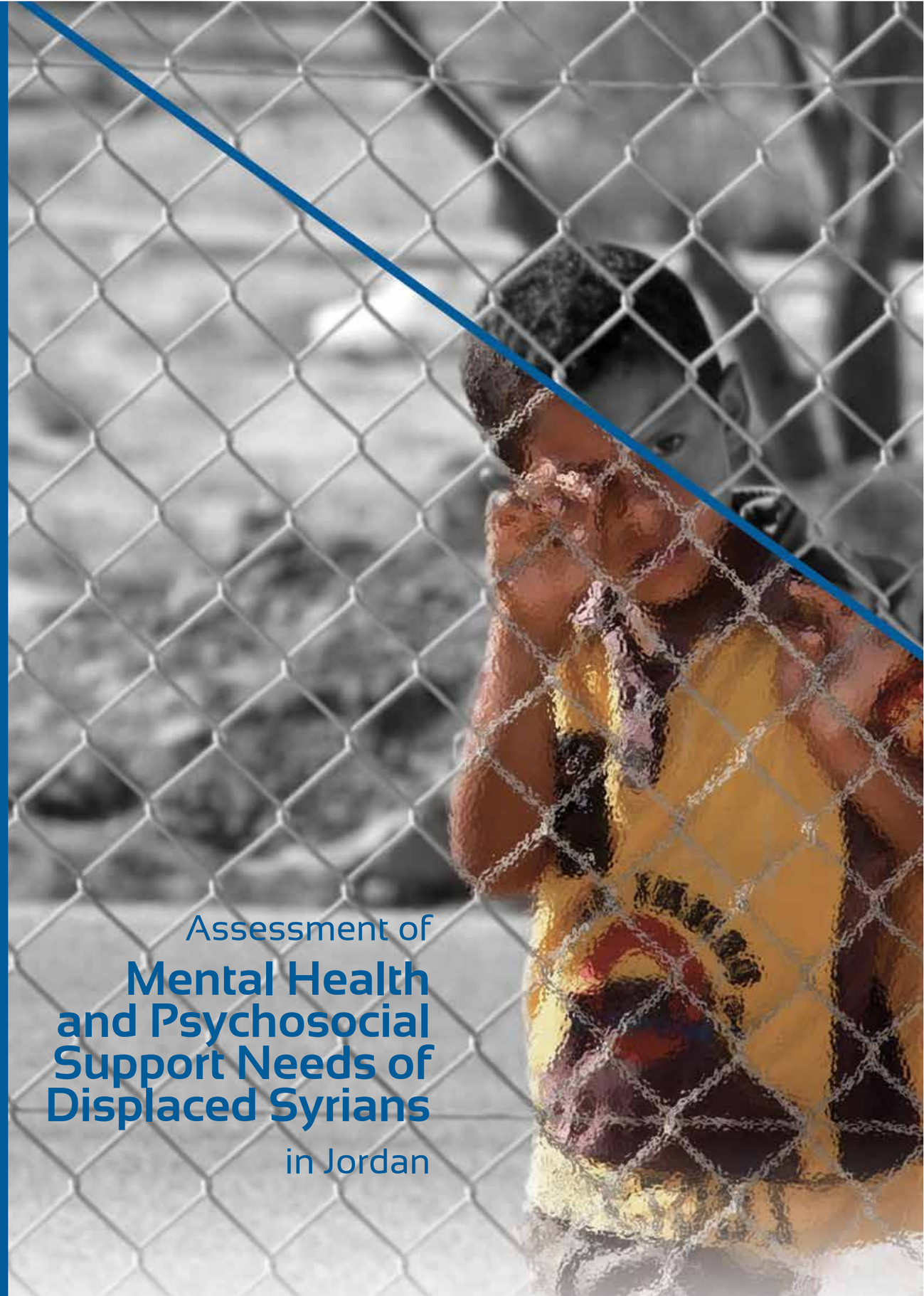

Assessment of

Mental Health and Psychosocial Support Needs of Displaced Syrians

in Jordan

A Study Funded by the
World Health Organization and International Medical Corps
In collaboration with the
Jordanian Ministry of Health and Eastern Mediterranean Public Health Network

World Health Organization

International Medical Corps

EMPHNET

وزارة الصحة

Acronyms

ACTED	Agency for Technical Cooperation and Development.
EMPHNET	Eastern Mediterranean Public Health Network.
EMR	Eastern Mediterranean Region.
IASC	The Inter-Agency Standing Committee.
IDP	Internally Displaced Person.
IMC	International Medical Corps.
INGO	International Non-Governmental Organization.
JHAS	Jordan Health Aid Society.
MHPSS	Mental health and psychosocial support.
MoH	Ministry of Health.
NGO	Non-Governmental Organization.
NICCOD	Nippon International Cooperation for Community Development.
PTSD	Post-Traumatic Stress Disorder.
MHPSS WG	Mental Health and Psychosocial Support Working Group.
SPSS	Statistical Package for Social Sciences.
UN	United Nations.
UNHCR	United Nations High Commissioner for Refugees.
UNICEF	United Nations Children's Fund.
WASSS	WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings.
WHO	World Health Organization.

Acknowledgement

This assessment was undertaken by the Eastern Mediterranean Public Health Network in collaboration with the Ministry of Health in Jordan, and with the kind support of the World Health Organization and the International Medical Corps. We acknowledge all efforts of collaboration and contribution especially of colleagues involved in the design, data collection, data entry, data analysis, and report writing.
We would like to acknowledge the full cooperation and valuable contributions of the displaced Syrian families participating in this study. We thank them for welcoming the data collectors and sharing their stories.

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Executive Summary

Since March 2011, the political unrest in Syria resulted in the displacement of Syrians to neighboring countries including Jordan, where the number of Syrian refugees is estimated by the United Nations High Commissioner for Refugees (UNHCR) to exceed 800,000 by the end of 2014, which will comprise about 16% of the total population in Jordan.

This report aims to present findings of a study undertaken to assess the mental health and psychosocial (MHPSS) problems, services, and needs of displaced Syrians in Jordan. Supported by the World Health Organization (WHO) and the International Medical Corps (IMC), in collaboration with the Ministry of Health (MOH) and the Eastern Mediterranean Public Health network (EMPHNET), the assessment was based on quantitative and qualitative tools adapted from the WHO-UNHCR Toolkit for Assessing MHPSS Needs and Resources in Humanitarian Settings [1].The study was conducted in Amman, Irbid, Mafraq and Ramtha between June to July 2013.

Findings are based on data collected from 1811 families, providing information on 7964 individuals. Information on family members was reported by the heads of households who were interviewed in this study. Most of the participants were originally from the city of Dara'a in Southern Syria, with males comprising 51.2% in the quantitative and 48.6% in the qualitative assessment, compared to females comprising 48.8% in the quantitative and 51.4% in the qualitative assessment. Approximately 65.7% of the family members were below the age of 18, while 34.3% were above 18.

When reporting mental health symptoms present 'all of the time' in the last 2 weeks, 15.1% of respondents felt so afraid that nothing could calm them down; 28.4% felt so angry that nothing could calm them down; 25.6% felt so uninterested in things that they used to like; 26.3% felt so hopeless that they did not want to carry on living; 38.1% felt so severely upset about the conflict that they tried to avoid places, people, conversations or activities that reminded them of such events; and 18.8% felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset. These figures represent average responses for both camp and non-camp settings.

Additional MHPSS concerns affecting family members included excessive nervousness, social isolation, continuous crying and somatic complains such as headaches. Seventeen percent (17%) of households with children aged 212- reported incidences of nocturnal enuresis (bedwetting) occurring at least twice in the 2 weeks preceding the study. Respondents associated the reported MHPSS problems with disruptions in their regular functioning and carrying out of activities of daily living, including a decreased ability to care for self and others. Coping strategies used by the Syrian refugees included: doing nothing (41%), socializing (15%), praying (13%), fighting or getting angry (11%), crying (6%), walking out (5%), sleeping (5%) and smoking (3%). A need for counselling or psychological support services was reported by 13% of respondents.

The assessment concludes with a set of recommendations to inform future planning and implementation of MHPSS programs and interventions. These include: promoting the early detection of mental health conditions; strengthening specialized MHPSS services and outreach; developing interventions that promote resiliency, skill-building, self-efficacy and adaptive coping strategies; supporting interventions to address MHPSS concerns in children, particularly nocturnal enuresis; supporting the development of community social support programs to foster positive family and interpersonal relationships, and promote a sense of community, involvement and belonging; and integrating MHPSS considerations in cross-sectoral programming and initiatives

1 World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.

1. Background

1.1 Introduction

Jordan is a small upper middle income country[2] in the Middle East, with a population of 6.4 million people (excluding Syrian refugees)[3]. Despite the challenges faced due to the limited natural, human and financial resources, Jordan has managed to welcome displaced individuals from neighboring countries such as Palestine, Iraq and most recently Syria.

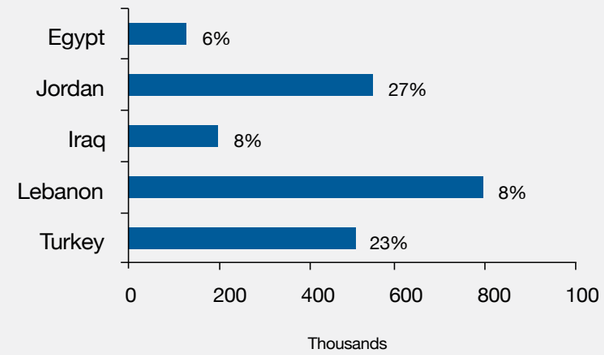
The purpose of this report is to provide the WHO, IMC, MOH and other partners working with Syrian refugees in Jordan, with evidence for the need to address mental health and psychosocial problems as part of both the emergency response for Syrian refugees in Jordan, as well as longer-term development initiatives for vulnerable Jordanians and refugees. Based on quantitative and qualitative methods, this assessment aims to provide a clearer picture of mental health symptoms and needs of displaced Syrians in Jordan, as well as contribute to prior assessments conducted to inform the design of programmatic interventions that support the MHPSS needs and resiliency of of Syrians.

1.2 Historical Perspective

The ‹Arab Spring›, a period of civil unrest, revolts and uprisings, affected millions of people across the Arab world. It began with a Tunisian uprising in December 2010, followed by similar revolts in Egypt, Libya, Yemen, Syria, Bahrain, and other Arab nations[4]. These events led to the collapse of several regimes, and called for the establishment of democratic governments. What started as peaceful demonstrations quickly turned to national unrest in many countries, continuing to date in countries like Syria and Egypt. In Syria, peaceful demonstrations abruptly changed into conflict and unrest in Damascus and Aleppo on March 15th 2011, and by June 2011, armed clashes erupted in many locations. By September 3rd 2013, over 100,000 people had been killed, over two million individuals had fled their homes seeking refuge in neighboring countries, and another four million people were forced to leave their homes within Syria.

With the escalation of political instability and general insecurity, Syrians moved to neighboring countries escaping threat and violence. Jordan has witnessed a considerably large influx of Syrian refugees since the beginning of the conflict. As of October 21st 2013, the number of Syrian refugees reported by the United Nations High Commissioner for Refugees (UNHCR) reached 2,374,331 (of which 2,325,346 are officially registered with UNHCR). More than a quarter of these refugees (27%) reside in Jordan (576,354)[5] (Figure 1).

Figure 1: Number of Syrian Refugees by Country Reported by UNHCR - August, 2013



1.3 Mental Health and Psychosocial Context

Globally, there has been a growing interest in the mental health and psychosocial status of vulnerable populations, and the need for early detection and treatment of identified problems in order to reduce any debilitating or long term effects[6]. Populations affected by situations of unrest, violence, loss, separation, and drastic changes in social and living conditions, are likely to experience a number of distressing psychological reactions such as hopelessness, helplessness, anxiety, as well as behavioral and social problems. It should be noted that these are common and normal reactions to abnormal events. Experience and research indicate that the majority of people will exhibit resiliency, and recover over time using natural coping mechanisms which can be fostered by supportive environments. A minority of people will develop more enduring mental health problems such as depression or anxiety, while others suffer from pre-existing mental health problems, and would need more specialized care.

2 World Bank, 2013. Doing Business 2013: Smarter Regulations for Small and Medium-Size Enterprises. Washington, DC: World Bank Group.

3 Jordan in Figures: 2012. Department of Statistics. Government of Jordan, 2013. Amman, Jordan.

4 Allagui, Ilhem and Kuebler, Johanne, 2011. The Arab Spring and the Role of ICTs, Editorial Introduction. The International Journal of Communication. 5:Feature 14351442-.

5 http://data.unhcr.org/syrianrefugees/regional.php - accessed 13/01/2013

6 Public health guide for emergencies.2nd Edition.2007. Johns Hopkins Bloomberg School of Public Health and the International Federation of Red Cross and Red Crescent Societies.

Such problems make it difficult for people to attend to their physical health needs, routine daily tasks, and maintain good relationships with others. Therefore, it is important to identify and address these problems early on in order to avoid deteriorations in mental health psychosocial well-being[7]. Within this context, it is useful to provide adequate information about the scope of MHPSS problems, how to access available services, and to have a strong referral mechanism in place. MHPSS problems appearing in emergency situations vary depending on individual experiences and the resources available to support coping with these problems. The IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings classifies mental health and psychosocial problems in emergencies as either being predominantly social or psychological in nature[8].

The Reference Group identifies family separation, safety, stigma, disruption of social networks, destruction of livelihoods, community structures, resources and trust; and involvement in sex work, as examples of significant emergency-induced social problems. Furthermore, grief, non-pathological distress, alcohol and substance abuse, depression and anxiety disorders including post-traumatic stress disorder, are identified as examples of major emergency-induced psychological problems. Other MHPSS problems in emergencies are classified under humanitarian aid-related social problems, (such as overcrowding and lack of privacy in camps, undermining community structures or traditional support mechanisms, aid dependency), and humanitarian aid-related psychological problems (such as anxiety due to a lack of information about food distribution)[9].

1.3.1 Specific Context

The influx of Syrian refugees has particularly affected the Northern part of Jordan, where Za'atari Refugee Camp was established in July, 2012. Within an area of 8.75 square kilometers, the camp holds 122,191 Syrians[9], making it the second largest refugee camp in the world[10] (Figure 2).

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

8 IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know? Geneva: WHO, 2010.

9 http://data.unhcr.org/syrianrefugees/settlement.php?id=176&country=107&region=77 – accessed 21/ 10 /2013

10 Za'atari camp one year on: Short term gains at rise without substantial increased support. Press Release. UNHCR, Amman July 29th, 2013.

Based on UNHCR data accessed on October 21st 2013, the majority of Syrian refugees in Jordan (88%) live in the local communities of Mafraq, Irbid, Zarqa, and Amman11. In light of the growing number of Syrian refugees in Jordan, and the already limited mental health services in the country, the MHPSS needs of this population represent a serious concern to health actors, and it is crucial to consider those needs in the planning and expansion of health and other services in the post-emergency phase.

Figure 2: Image and Map of Za'atari Camp

Source: UNITAR/UNOSAT

1.4 Previous Studies

Several assessments and reports were conducted by various humanitarian actors to assess the situation of Syrian refugees in Jordan. Summarized below are some of the relevant assessments conducted:

- In 2012, CARE Jordan carried out a baseline assessment to provide information on the needs and gaps in services available to Syrian refugees living in the urban areas of Amman. The assessment utilized the "UNHCR Tool for Participatory Assessment in Operations". A main finding was that Syrians in Amman suffered significant hardships in securing basic life necessities. Psychosocial activities for adults and children were found to be inadequate. The assessment recommended carrying out an in-depth analysis of psychosocial needs, risks, and coping strategies in particular for women and girls[11].

11 Baseline Assessment of Community Identified Vulnerabilities among Syrian Refugees living in Amman.Care. October, 2012.

- In 2012, the United Nations Children's Fund (UNICEF) and IMC carried out a Rapid Mental Health and Psychosocial Support assessment to describe related problems and gaps in services among Syrian refugees in Jordan. The assessment also aimed to examine current and potential coping strategies, resources, and support needed. In presenting the most compelling problems, the report identified worry, camp conditions, aggressiveness, psychological distress, and boredom as the most common. Praying or reading the Quran, and talking to people were the most commonly identified coping mechanisms among participants of the study[12].

- In early 2013, CARE Jordan conducted another participatory assessment and baseline survey of Syrian refugee households Irbid, Madaba, Mafraq, and Zarqa[13]. Results indicated that livelihoods and food security were areas of concern, and that Mafraq had the poorest households with the worst living conditions. The assessment also reported feelings of isolation, increased feelings of depression and negativity, and increased levels of family violence (both verbal and physical).

- An inter-agency assessment of gender-based violence and child protection issues among Syrian refugees, with special emphasis on early marriage, was carried out in early 2013. The purpose was to identify the risks that these families face in Jordan, and to describe the urban refugees' knowledge, attitudes, and practices towards gender-based violence and early marriage. The assessment reported high rates of early marriage (one-third of marriages below age of 18), in addition to a limited mobility of women and girls restricting their participation in work, social activities and receiving aid supplies. Also reported was that the majority of Syrian refugees did not know of any services available in their community for survivors of violence[14].

- The International Rescue Committee undertook an assessment to support the development of a cash transfer program for Syrian refugees in Jordan, with specific focus on Ramtha and Mafraq. Among other findings, the assessment reported that economic hardships affect household members' psychological well-being, which could result in increasing verbal and physical violence, particularly against women and girls. Respondents expressed preference for cash over in-kind assistance because it provides them with an increased sense of independence and dignity.

- In June 2013, UNICEF released an assessment presenting key challenges for Syrian children and women in Jordan in the areas of child protection and gender-based violence, education, water, sanitation, hygiene, nutrition, health, mental health, psychosocial support, and adolescent development and participation. The report concluded that the situation of the Syrian children in Jordan is vulnerable and critical. In the domain of MHPSS, the report recommended the provision of basic services and security, increased support for families and communities as a means of reducing threats to their mental health and psychosocial well-being, improved quality of 'focused non-specialized support' for children and their families, and the provision of specialized assistance for girls, boys and women with ongoing anxiety, aggression, depression, or 'profound stress' [15].

- In July 2013, IMC conducted a mental health/psychosocial and child protection assessment for Syrian adolescents in Za'atari refugee camp. Supported by UNICEF, the assessment aimed at identifying MHPSS problems and coping strategies among adolescents in the camp, and provided recommendations to guide MHPSS interventions. Results indicated that the main MHPSS concerns among this group were grief and fear. Withdrawal was the most commonly expressed coping strategy. The assessment concludes with a set of concrete recommendations guided by the IASC Guidelines on MHPSS[16].

1.5 Study Definitions

Specific definitions of the terms "mental health" and "psychosocial support" differ between and within aid organizations, disciplines, and countries. The following definitions are presented to familiarize the reader with the underlying conceptual principles guiding this study.

Definition – Mental Health

The WHO defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" [17].

Definition - Mental Health and Psychosocial Support

The IASC Guidelines defines mental health and psychosocial support as two complementary approaches which include "any type of local or outside support that aims to protect or promote psychosocial wellbeing, and prevent or treat mental disorder". The term "psychosocial" is used to indicate the close connection between psychological characteristics of experiences in life (our thoughts, emotions, and behaviors), and broader social experience with the environment (our relationships, traditions, spirituality, interpersonal relationships in the family or community, culture, and life tasks such as school or work)[18]. The use of the term 'psychosocial' incorporates the family and community in assessing problems and needs.

12 Displaced Syrians in Za'atari Camp: Rapid Mental Health and Psychosocial Support Assessment: Analysis and Interpretations of Findings. IMC, Amman, Jordan. August 2012.

13 Syrian Refugees in Urban Jordan: Baseline Assessment of Community-identified Vulnerabilities among Syrian Refugees Living in Irbid, Madaba, Mufraq, and Zarqa. Care, Amman, Jordan. April, 2013

14 Inter-Agency Assessment of Gender-Based Violence and Child Protection among Syrian Refugees in Jordan, with a Focus on Early Marriage, UN Women, Amman, Jordan. July 2013..

15 Shattered Lives: Challenges and Priorities of Syrian Children and Women in Jordan.UNICEF, Amman, Jordan. June 2013.

16 Mental Health/Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za'atari Refugee Camp. IMC. Amman, Jordan. July 2013.

17 http://www.who.int/features/factfiles/mental_health/en/ accessed on 10–10–2013.

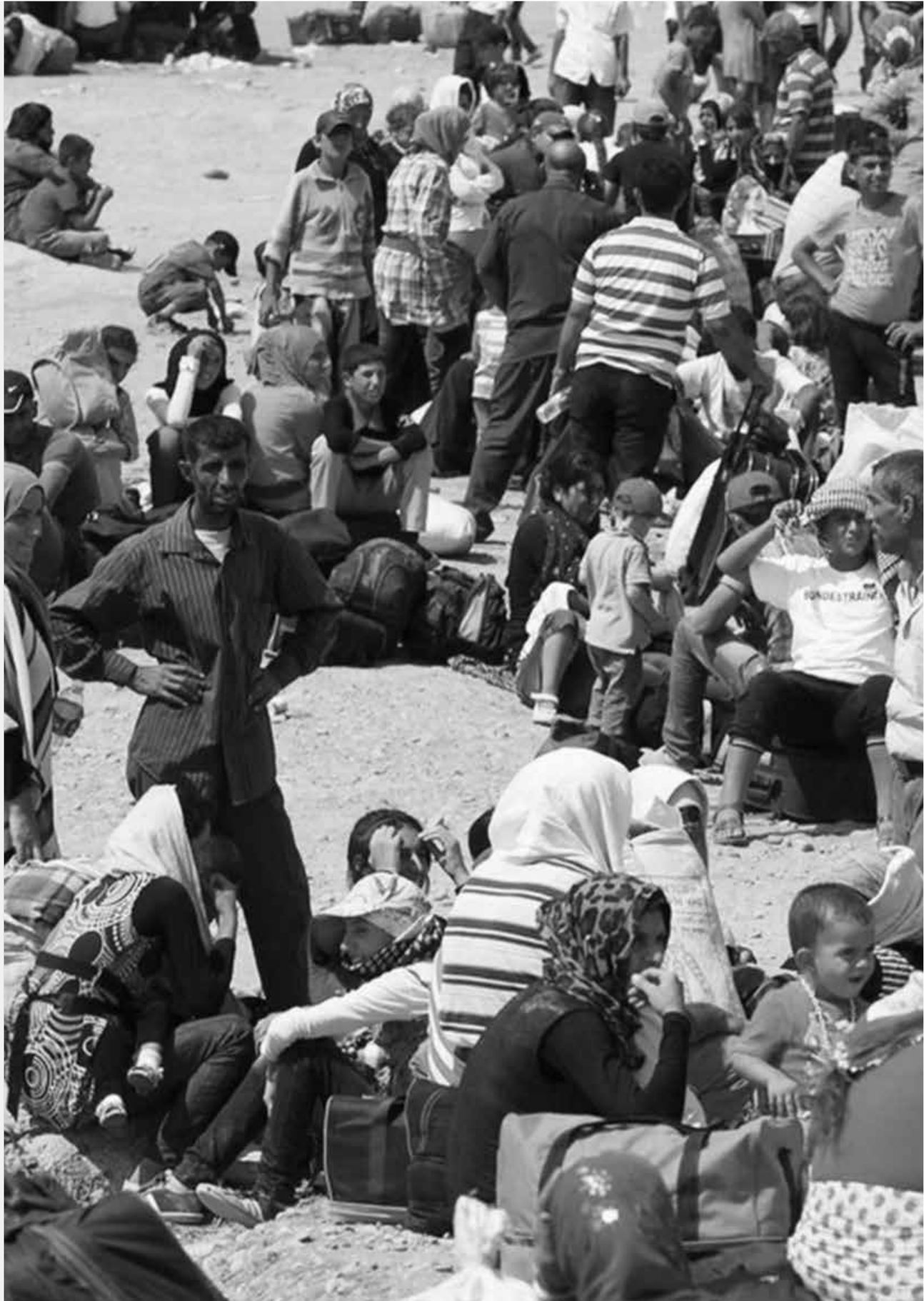
18 The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.

1.6 Study Objectives

This comprehensive assessment was conducted to provide the WHO, IMC and MOH with information necessary for planning and delivering MHPSS services to displaced Syrians in Jordan. Carried out by the Eastern Mediterranean Public Health Network (EMPHNET), the assessment consisted of quantitative and qualitative components supported by WHO and IMC, with contributions from the MHPSS Working Group. The assessment was conducted to meet the following objectives:

- Identify MHPSS problems and needs facing displaced Syrians in Jordan.
- Explore perceptions about MHPSS problems and coping strategies.
- Explore perceptions about the availability, accessibility and expressed need for MHPSS services.

This assessment also aims to provide public health and humanitarian actors with evidence for addressing mental health and psychosocial problems as part of the emergency response targeting the Syrian refugee population in Jordan. Information collected will assist partners in providing the necessary assistance to the refugees by gaining a better understanding of the mental health and psychosocial status and concerns affecting their well-being



2. Study Methodology

2.1 Assessment Tools

The WHO and UNHCR have developed a toolkit to assess mental health and psychosocial needs and resources in humanitarian settings. This toolkit includes a set of data collection tools which can be used in conducting rapid assessments to provide public health actors with information that can guide in developing recommendations to improve the mental health and psychosocial well-being of people affected by humanitarian crises[19].

Approved by the Ministry of Planning and International Cooperation (MOPIC) and the MOH, this assessment utilized two of the tools provided in the WHO/UNHCR toolkit; Tool 2: "WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings" (WASSS- Field Test Version 2012), and Tool 12: "Participatory Assessment: Perceptions by Severely Affected People" for collecting qualitative data within a rapid appraisal format[20]. Both tools were preceded by a section used to gather demographic information. Tool 2 was used to collect quantitative data in order to identify symptoms of severe distress and impaired functioning. Tool 12, a semi-structured questionnaire followed by an organized discussion, consisted of two sections; a free listing component where respondents were asked to provide a list of psychosocial problems that they experience, followed by a section where problems of interest were selected by the interviewer from the reported list in order to conduct a more thorough assessment. Both tools were translated into Arabic and field tested prior to actual data collection (Annex 1).

Qualitative and quantitative methodology was used to complement data collection and enrich the findings. Methodological triangulation was used to compare results from qualitative and quantitative components, increasing data confidence, highlighting specific findings and providing a clearer understanding of problems. Conclusions were made by analyzing results from both quantitative and qualitative components.

Quantitative Component

A cross-sectional cluster random sampling survey, proportionate to the size of population, was conducted to quantify the MHPSS problems and needs of Syrian refugees in Jordan. In an attempt to assess functional impairment and severe mental health problems, respondents were asked a set of questions related to mental health symptoms based on Tool 2. The questions were divided into two parts: Part (A) which focuses on severe, common distress symptoms and impaired functioning, and Part (B) which focuses on a broad set of mental health symptoms, including symptoms of psychosis and epilepsy[21].

19 *World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012.*

20 *World Health Organization & United Nations High Commissioner for Refugees. Participatory Assessment III: Perceptions by severely affected persons themselves. In: Toolkit for the Assessment of Mental Health and Psychosocial Needs and Resources in Major Humanitarian Settings. Geneva: WHO, 2012.*

21 *Guion L.A. 2002. Triangulation: Establishing the Validity of Qualitative Studies. University of Florida, Institution of Food and Agricultural Sciences http://edis.ifas.ufl.edu/pdffiles/FY/FY39400.pdf.Accessed on 10 October 2013.*

Qualitative Component

Three common types of qualitative interviewing are: 1) open-end informal unstructured interviews which are mostly conversational; 2) semi structured interviews which are guided by open ended questions; and 3) survey or standardized open ended interviews which use highly structured questions[22]. This assessment utilized semi structured interviews guided by Tool 12 to provide richer data about the experiences and perceptions of Syrian refugees on their MHPSS problems and needs.

2.2 Data Collection

2.2.1 Study Site

The first stage of the two part study was conducted in Za'atari camp, while the second stage was conducted in Amman, Irbid and Mafraq governorates, including Ramtha city, given that the highest concentrations of Syrian refugees are located in these areas. Data collection was conducted between June and July 2013.

2.2.2 Study Population

Syrian refugees in Za'atari camp, Amman, Irbid, Mafraq, and Ramtha are the populations captured in this assessment. The population of Syrian refugees as of April 17th 2013, defined by the number of Syrian refugees registered or awaiting registration with UNHCR, were 434,934. At that time, the population of Za'atari camp was estimated to be approximately 120,000 individuals, with the remaining refugees living outside camps. The planning and calculation of sample size for this assessment was based on the above figures.

2.2.3 Sampling Methodology

The quantitative part of this assessment used a multistage cluster random sample, proportionate to the size of population in each area of interest.

A. Za'atari Camp: The camp is divided into 12 districts. The number of clusters per district is proportionate to the population number (estimated) in each district. Thirty clusters were randomly selected from the camp, and each cluster contained 30 families which were systematically selected. Assessment teams started their interviews from the main road, and continued toward the end of the lanes in the camp until the targets were reached. Every other caravan/tent in the lane was interviewed. If the number of caravans/tents in the lane did not meet the survey target, the interviewers then continued to the next lane.

22 *CDC Brief 17: Data Collection Methods for Program Evaluation: Interviews. Available at http://www.cdc.gov/healthyyouth/evaluation/pdf/brief17.pdf*

The sample size for Za'atari camp was calculated with an assumption that the total population of refugees in the camp was less than 200,000; the prevalence was 50%, precision 5%, confidence interval 95%, and a design effect 2. Using Epi Info 7, the sample size for the quantitative study calculated for Za'atari was 755. After adding a 20% to cover the non-response rate, the total number of families required to be interviewed from each of the clusters from within the camp was determined to be 30 families from each cluster [(755 + 151) / 30].

B. Communities: Concentrations of Syrian refugees in the cities of Amman, Irbid, Mafraq, and Ramtha were selected by consulting local health leaders and key informed persons including relevant personnel at the MOH. The sample size and number of clusters were determined based on the information provided by UNHCR. The locations were divided into clusters or primary sampling units (based on number of Syrian refugees), and then the secondary sampling units or households were randomly selected and interviewed.
With an assumption that the total population of refugees outside the camp is less than one million persons, the prevalence of mental health problems within this population was projected to be 50%. This projection was used to gain the largest sample size, precision of 5%, confidence interval of 95%, and a design effect of 2. Using Epi Info version 7, the sample size for the quantitative study was determined to be 755. After adding 10% to cover the non-response rate, the total number of families required to be interviewed from each of the clusters outside the camp was determined to be approximately 30 families from each cluster [(755 + 75.5) / 27].

As for the qualitative part of the assessment, the number of interviews was predetermined at the start of the assessment as 25 inside Za'atari camp, and 25 outside the camp. It is worth noting that the recommended number of interviews for using this qualitative questionnaire is 10 to 15.

2.2.4 Field Work

Quantitative Component

Twenty four surveyors were selected from the MOH, WHO, IMC, Nippon International Cooperation for Community Development (NICCOD), and the Jordan Field Epidemiology Training Program. A list of surveyors is attached as Annex 2. Although these surveyors had prior interviewing experience, EMPHNET and WHO trained them on using the study questionnaire and interviewing techniques. The questionnaire was field tested in Za'atari Camp prior to starting data collection, and necessary modifications were adapted accordingly.

The surveyors were divided into 12 teams, with each team comprising of both male and female surveyors. One supervisor was assigned for every three teams, in addition to an operations leader. Camp officials and health agencies familiar with the camp and surrounding areas accompanied the data collection teams. While all teams worked together in Za'atari camp, six teams covered Amman, three teams covered Mafraq, and three teams covered both Irbid and Ramtha.

Quantitative Component

Interviews for the qualitative part of this assessment were conducted by a researcher from EMPHNET. A total of 50 interviews were conducted to collect assessment information. Of these, 25 interviews were conducted in Za'atari camp, 10 in Amman, 10 in Mafraq, and 5 in Irbid. As with other qualitative assessments, data saturation was established before completing 20 questionnaires, but a decision was made to adhere to the initially planned number of interviews.

Interviews used the semi-structured technique to collect qualitative data on MHPSS needs and provision of services. This technique helps generate expected responses and allows comparison of findings across the sample as participants respond to the same questions, while still allowing them to express their viewpoints and experiences. Probing was used to stimulate responses whenever it was deemed necessary. In addition to using guided discussions, a quantitative part was included in order to collect information on the profile of the interviewees and their families. Respondents were informed that questions on MHPSS problems pertained to the whole family rather than an individual respondent. While interviews were conducted with the primary respondent, other family members were given the opportunity to participate if they wished.

2.3 Ethical Considerations

The proposal and design of the study was shared with the MOH and Institutional Review Board of the MOH, and their approval was obtained. The design of the study was presented at a meeting with the MHPSS Working Group at the MOH, and the members were in support of the design and objectives.

Consent and Confidentiality and Information about Services

All participants joined this assessment voluntarily. Interviewers stated their affiliation with the WHO, IMC, MOH, and EMPHNET. Participants were told that they could withdraw from the assessment at any time during the interview, and were requested to acknowledge the informed consent process. The consent form was read and verbal consent was obtained (Annex 3). For the qualitative assessment, participant consent for audio recording of the interview was sought at the beginning of the session, and their approval was recorded at the start of the interview.

Detailed information and responses were kept confidential. Respondents were given the choice of not providing personal information, particularly name and phone number if they were hesitant to do so. Respondents were reassured that their responses were not to be discussed outside of the assessment team. Assessments were stored in a secure location in EMPHNET headquarters. Interviews were conducted in a manner respectful of confidentiality.

All participants reporting significant MHPSS problems were provided with full information and contact details for appropriate services/focal points to help with their problem.

2.4 Coding and Data Entry

Quantitative Component

Field supervisors checked all questionnaires for completeness of data. Two Microsoft Access databases were developed; one for all of the information and the second for information about each family member. Data entry was organized using the following steps:

- Data was entered by two professional data entry managers.
- EMPHNET technical staff member checked the accuracy and completeness of data after entering 10% of the forms. Another data entry check was performed once completing 50% of the data entry. A final check was performed after completing 75% of the data entry.
- Data cleaning, reconciling, and matching were conducted once all data was entered.

The data file was imported from MS Access to the Statistical Package for Social Sciences (SPSS) software program which was used to perform data analysis. Descriptive analysis was done using cross tabulation procedures. Analysis was conducted, and findings were presented based on the two main components of the tool: Part A and Part B.

Qualitative Component

Attention to data analysis took place during data collection by examining problem areas, and establishing a base for categorizing problems of similar content. Data describing the profile of respondents and family members was analyzed using the SPSS software program. Interviews were transcribed and translated into English, and were matched to the notes on the data collection forms taken during the interviews. Qualitative data was entered into Microsoft excel software, following which listing and enumeration of entered responses was performed using excel. Such an analytical approach is an appropriate data analysis technique that is recommended for use by humanitarian workers in listening to population needs and concerns[23]. To reduce bias, investigator triangulation was used to validate categorization of problems by using the opinion of an additional skilled research expert.

The main outcome variables of the qualitative assessment were the MHPSS problems reported by displaced Syrians and their current coping mechanisms. Categorization of problems and coping mechanisms was done with the aim of capturing priority stressor areas and coping strategies. Perceptions on the availability and accessibility of MHPSS services were explored in terms of availability, seeking behavior, and expressed need for such services. Responses for the qualitative assessment were coded by grouping problems into categories as per the following:

Mental Health and Psychosocial Problems

MHPSS problems reported by respondents varied. These problems were grouped into seven main categories:

1. Stress and psychological pressures.
2. Worry and concern over situation, relatives, and the future.
3. Fear of environmental threats.
4. Despair.
5. Depression, sadness, and grief.
6. Tension, anxiety, and short temper.
7. Stigmatization and mistreatment.

Coping Strategies

Responses to the open-ended question asking respondents to describe how they have tried to manage their problems and what coping strategies they have used were categorized into the following:

1. Nothing: reporting no use of any coping mechanisms.
2. Socializing: reporting coping through visiting or talking to family members or neighbors.
3. Praying: reporting praying or reading the Quran.
4. Crying.
5. Sleeping.
6. Smoking.
7. Walking or going out.
8. Fighting and getting angry.

23 *Public health guide for emergencies. 2nd Edition.2007. Johns Hopkins Bloomberg School of Public Health and the International Federation of Red Cross and Red Crescent Societies.*

3. Result

Results of this study are based on data collected from quantitative and qualitative interviews with the heads of households. Table 1 provides details on the number of families participating in this assessment.

Table1: Families Participating in the Assessment

Location	Quantitative	Qualitative	Total
Za'atari Camp	936	25	961
Amman	316	10	326
Irbid	119	5	124
Mafraq	323	10	333
Ramtha	67	-	67
Total	**1761**	**50**	**1811**

3.1 Quantitative Assessment

Interviews were conducted with heads of households using the questionnaire (Tool 2) included in Annex 1. Outlined below are the main results describing the profile of the interviewees and household family members, as well as a description of findings originating from the assessment questionnaire.

3.1.1 Socio-Demographic Profile

The quantitative assessment is based on survey data collected from 1,761 Syrian refugee families displaced in Jordan; 53.2% in Za'atari camp, and 46.8% in communities outside the camp. A list of names and number of clusters used to collect information from outside the camp is provided in Annex 4. All respondents were Muslims, with the majority (91.8%) reporting being registered with UNHCR (99% in the camp and 86% outside the camp). Furthermore, the majority of primary respondents (heads of households) reported being married (87.5%), and (6.6%) reported being widowed. Ages of the primary respondents ranged between 18 and 92 years, with a median of 35 years and a mean of 37.3 years (SD 12.6). Moreover, 46.8% of the respondents reported having either no years of education or primary schooling.

Nearly two thirds (63%) reported Dara'a as their home of origin (Figure 3a). The majority of respondents from Za'atari camp (89%) were also from Dara'a as opposed to those from outside the camp which were distributed across several areas of origin (Figure 3b).

Figure 3a: Distribution of Respondents by Origin

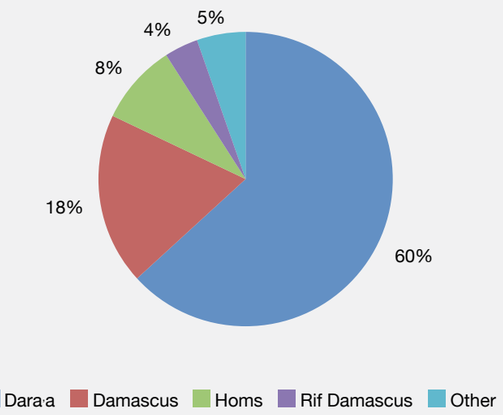
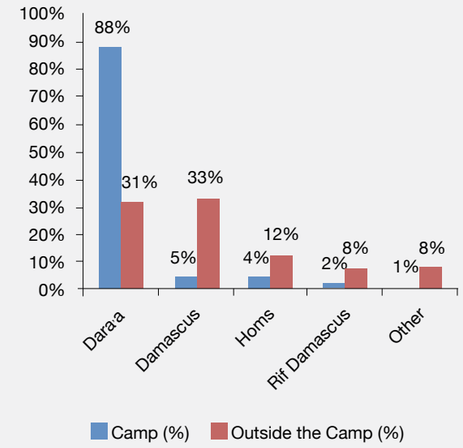


Figure 3b: Distribution of Respondents (camp and outside) by Origin



*Other Category includes: Al Quntira, Hama, Alhaska, Halab, Alragha, Edlab, Al-Azhighia, Deir El-Zoor, and Al-Swida.

The percent of male respondents (51.2%) was slightly higher than that of females (48.8%), with a slight gender variation between respondents from families inside the camp (males 51.5%, females 48.5%) and outside the camp (males 50.9%, females 49.1%). Respondents living inside Za'atari camp were residing there for a duration ranging from less than a month (n= 63 / 936 respondents) to more than a year prior to the study (n= 1 / 936 respondent reporting the longest duration of 14 months). The length of stay in Jordan for refugees living in communities outside the camp varied from less than a month (n= 47 / 825 respondents) to 27 months (n= 1 / 825). A large majority of respondents reported arriving to Jordan in the last seven months prior to the study (inside the camp 82% and outside the camp 55.4%).

Data collected from the 1,761 families provided information on 7,579 individuals; 55% from the camp and 45% from communities outside the camp. Surveyed families constituted more males than females (52.3% males and 47.7% females), with fewer families inside the camp including female members compared to families outside the camp setting (camp: 53.3% males and 46.7% females, outside the camp: 51% males and 49% females). Furthermore, two thirds of the family members (66.5%) were children under 18 years of age, (21.4%) were children under five years of age, and (2.2%) were 60 years or above (Table 2).

Table2: Distribution of Socio-Demographic Variables of Participants

Variable	Camp	Outside Camp	Total	
	%	%	N	%
Gender				
Male	53.3	51.0	3961	52.3
Female	46.7	49.0	3618	47.7
Age Categories				
≤ 2 years	10.5	10.5	795	10.5
3-4 years	8.4	10.9	721	9.5
5-12 years	30.5	29.9	2,290	30.2
13-15 years	10.9	8.6	747	9.9
16-17 years	6.2	4.8	423	5.6
18-44 years	27.7	27.8	2,101	27.7
45-59 years	3.9	5	332	4.4
60-64 years	0.6	0.9	56	0.7
65 years and over	1.3	1.7	114	1.5
Total	**4,166**	**3,413**	**7,579**	**100**

3.1.2 Mental Health Symptoms

Used as a tool to measure and report mental health symptoms and impaired functioning, responses to questions obtained through the assessment questionnaire (tool 2) were analyzed according to the recommendation provided by the WHO/UNHCR toolkit[24]. These questions aim at seeking responses to statements which address feelings of fear, anger, fatigue, disinterest, hopelessness, or distress during the two weeks preceding the interview. Accordingly, responses on specific mental health symptoms were analyzed, and percentages were calculated based on the presence of each of these symptoms.

When reporting mental health symptoms present 'all of the time' in the last 2 weeks, 15.1% of respondents felt so afraid that nothing could calm them down; 28.4% felt so angry that nothing could calm them down; 25.6% felt so uninterested in things that they used to like; 26.3% felt so hopeless that they did not want to carry on living; 38.1% felt so severely upset about the conflict that they tried to avoid places, people, conversations or activities that reminded them of such events; and 18.8% felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset. These figures represent average responses for both camp and non-camp settings.

Table A1 (Appendix 1) shows that Syrian refugees residing in Za'atari camp expressed more frequent mental health symptoms than those in communities outside the camp. More commonly reported by camp residents was feeling angry and out of control all the time, which was expressed by more than a quarter (28.5%) of the respondents. Figure 4 illustrates severe mental health symptoms (present "all the time"), and provides a comparison between responses from camp and non-camp settings.

24 World Health Organization & United Nations High Commissioner for Refugees. Participatory Assessment III: Perceptions by severely affected persons themselves. In: Toolkit for the Assessment of Mental Health and Psychosocial Needs and Resources in Major Humanitarian Settings. Geneva: WHO, 2012.

Figure 4: Percent Distribution for Mental Health Symptoms Reported All the Time Among Syrian Refugees in Jordan

When including responses for both 'most of the time' and 'all of the time' as outlined by the WHO and UNHCR toolkit[25], results indicate an even higher prevalence of symptoms, with 53.9% and 49.4% of camp and non-camp respondents expressing feelings of anger and loss of control. It is worth noting that feelings of being unable to carry out essential activities of daily living as a result of fear, anger, fatigue, disinterest, hopelessness or upset was expressed by 46.6% and 38.1% of Syrian refugees living inside and outside the camp respectively (Figure 5).

Figure 5: Percent Distribution for Mental Health Symptoms Reported Most and All of the Time Among Syrian Refugees in Jordan

25 World Health Organization & United Nations High Commissioner for Refugees. Participatory Assessment III: Perceptions by severely affected persons themselves. In: Toolkit for the Assessment of Mental Health and Psychosocial Needs and Resources in Major Humanitarian Settings. Geneva: WHO, 2012.

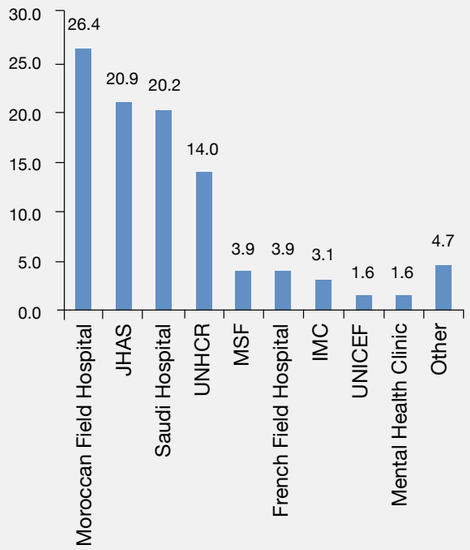
In an attempt to better understand the occurrence of treported symptoms, respondents were asked whether they have experienced these symptoms prior to the conflict in Syria. Only 6.6% indicated having experienced such symptoms (8.1% in the camp and 4.8% outside the camp). A quarter of those who responded positively indicated receiving services when they were in Syria.

3.1.3 Mental Health Services

When asked if respondents received any services since coming to Jordan to help address the mental health problem/s that they expressed, only 13.3% responded positively. Figures 6a and 6b present the entities identified by respondents when asked to provide the name of the organization that assisted them with their problems.

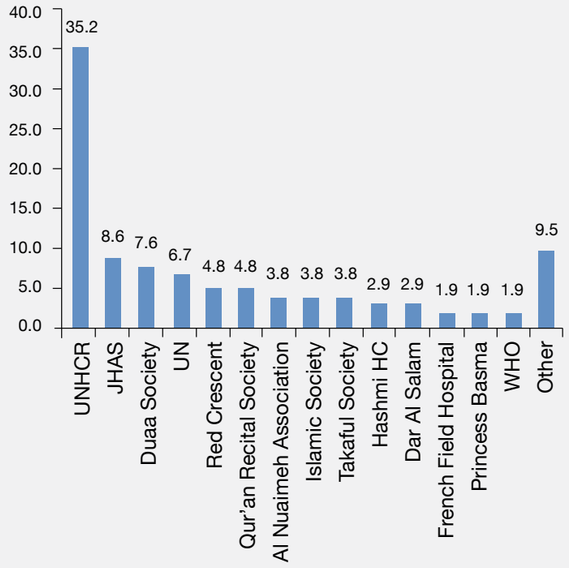
Results indicated a variety of MHPSS service providers, including INGOs, CBOs, UN agencies and governmental services. Mental health services in the camp are provided to a large extent by the Moroccan Field Hospital, Jordan Health Aid Society (JHAS) through IMC, and the Saudi Hospital. Moreover, Figure 6b shows that the provision of services to refugees living outside the camp by local NGOs and CBOs is prominent, noting that IMC provides mental health services through JHAS.

Figure 6a: Percent Distribution of Organizations Identified to Provide Mental Health Services to Syrian Refugees Living in Za'atari Camp in Jordan



*Other Category includes: Italian Hospital, Save the Children, Mafraq HC, Legal Ground Society, Human Rights, and UNRWA.

Figure 6b: Percent Distribution of Organizations Identified to Provide Mental Health Services to Syrian Refugees Living Outside Za'atari Camp in Jordan



*Other Category includes: Moroccan Field Hospital, IMC, Italian Hospital, Save the Children, Mafraq HC, Aman HC, Noor Al-Hussein Foundation, Akle Hospital, and Orphan Society.

Results indicated a need for support among Syrian refugees, where 71.7% expressed additional need for general services and support to help them with their problems. Table 3 lists the type of services and support expressed by respondents.

Results indicated that the most frequently mentioned services by camp residents were those related to environment (14.5%), health (14.1%) and food (11.9%). Alternatively, refugees outside the camp mostly expressed financial services (14.6%) and health services (13.8%). One third (34.5%) of respondents were unable to precisely indicate the type of services they needed..

Table 3: Percent Distribution of Services Requested for Relief from Current Problems among Syrian Refugees in Jordan

Type of Service	% Camp (N=695)	% Outside Camp (N=567)
Access to services	-	0.5
Education	1.3	1.1
Environment	14.5	1.4
Equipment	8.6	4.6
Financial	5.3	14.6
Food	11.9	7.9
General Condition/ overall situation	-	0.5
Health	14.1	13.8
Housing	5.3	4.4
Psychosocial	3.5	3.5
Registration with UNCHR	-	1.9
Security	0.3	0.2
Transport	0.4	-
Work	5.5	4.4
No clear answer	29.2	41.1
Total	100	100

3.1.4 Severe Symptoms of Distress and Impaired Functioning

Part B of the quantitative tool was used to assist in understanding mental health needs among Syrian families by identifying severe symptoms of distress, and identifying persons who are suffering from serious distress that need priority attention and care. Therefore, questions were asked to gather information about feelings of distress or disturbance among the primary respondents, or any of the household members who were older than 2 years. These symptoms were reported in relation to their effects on activities of daily living.

Results showed that more than a third of participants (39%) reported being distressed, disturbed or upset during the two weeks preceding the assessment, to a point of experiencing difficulties being active, reaching the point of being completely or almost completely inactive because of such feelings. These feelings were more evident among Syrian refugees living in the camp, where 47% of them reported distress compared to 29% of those living outside the camp (Table 4).

To clarify the extent of distress among Syrian refugees, respondents were asked to identify the number of days in the past two weeks where they had experienced a decreased ability to function (difficulties in carrying out essential activities of daily living). On average, about one third of respondents (31.7%) who reported being distressed, disturbed or upset (12.4% of the total population), reported being unable to function and carry out activities of daily living for at least one day during the past two weeks. This was almost double in camp residents compared to non-camp residents (63.3% and 36.7% respectively). Figure 7 displays the number of days during which respondents felt unable to cope with activities of daily living, indicating that the number of days with an inability to cope peaks at one, two, seven, ten and 14 days.

Table 4: Percent Distribution for Feelings of Distress Among Syrian Refugees in Jordan

Response	% Camp (N=3,729)	% Outside Camp (N=3,055)	Total*
Yes	47	29	39
No	51	70	60
Don't know	2	1	1
Total	**3,729**	**3,055**	**6,784**

*Total = respondents older than 2 years.

Figure 7: Percent Distribution for Number of Days Being Unable to Function Among Syrian Refugees in Jordan

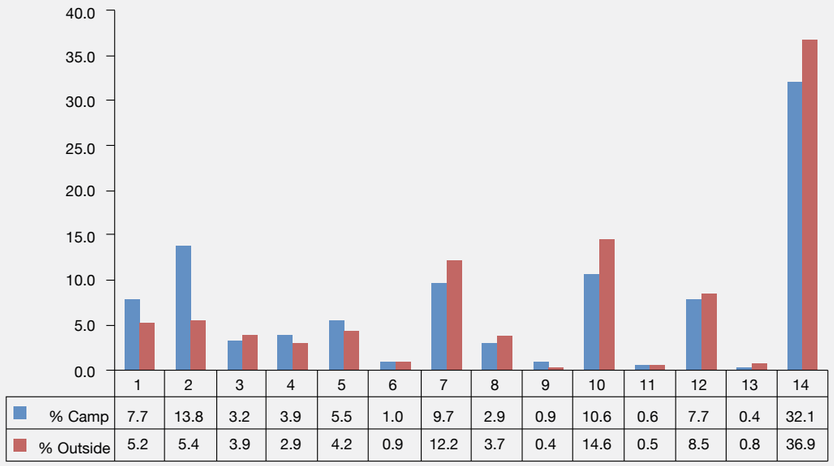


Figure 7 also shows that out of the respondents reporting distress and difficulty functioning, 33.9% of them (4.2% of the total population) reported being unable to cope with activities of daily living up to the entire two week period. Table 5 displays the frequencies for the number of days that participants reported not being able to function in achieving their day-to-day tasks.

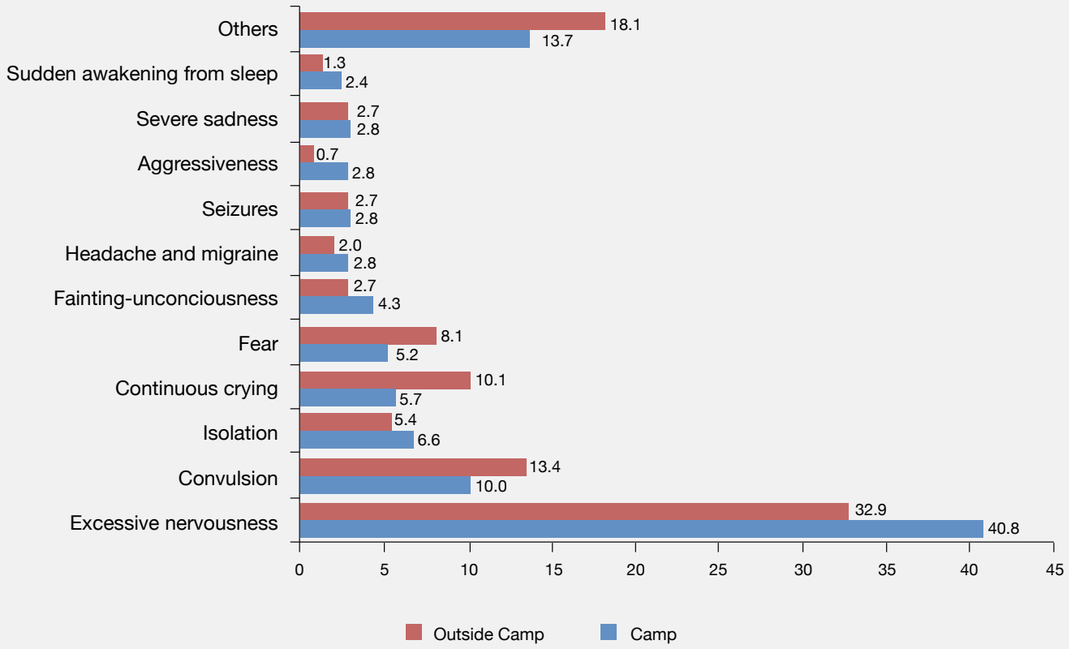
Table 5: Number of Distressed Respondents Reporting Inability to Carry out Activities of Daily Living by Number of Days

Number of Days	Camp	Outside Camp	Total
1	105	41	146
2	188	43	231
3	44	31	75
4	53	23	76
5	75	33	108
6	13	7	20
7	132	96	228
8	39	29	68
9	12	3	15
10	144	115	259
11	8	4	12
12	105	67	172
13	5	6	11
14	437	291	728
Total	**1,360**	**789**	**2,149**

3.1.5 Outcomes and Behaviors

In response to the question "Do you act in strange ways (exhibit strange or problematic behaviors) or have fits/convulsions and seizures?" 5.9% of respondents responded positively. These problems were distributed as follows: excessive nervousness was the most unfavorably reported behavior with 41% in the camp and 33% outside the camp, followed by convulsions (camp 10%, outside camp 13%), self-isolation (camp 6.6%, outside camp 5.4%), continuous crying (camp 5.7%, outside camp 10%), and fear (camp 5.2%, outside camp 8.1%). Isolation, sudden awakening from sleep, aggressiveness, headaches, fainting, and nervousness were more commonly noted among camp residents (Figure 8). Almost three quarters (74.2%) of respondents reporting unfavorable behaviors, indicated experiencing such outcomes after coming to Jordan.

Figure 8: Percent Distribution of Unfavourable Conditions (out of positive responses) Among Syrian Refugees in Jordan



*Other Category includes: Tachycardia, forgetfulness, not being able to speak, Dyspnea, not eating, and involuntary movement.

Table 6: Percentage of Children Aged 12-2 Years Experiencing Bedwetting Prior to One Year

Bedwetting Prior to One Year	Camp (N=263)	Outside Camp (N=249)	Total (N=512)
Yes	60.8	63.1	61.9
No	39.2	36.9	38.1

Refugee children appear to be affected in different ways by extreme events. Most commonly, refugee children suffer from observed symptoms such as difficulty sleeping, behavioral problems and nocturnal enuresis that could be linked to adjustment difficulties. Respondents of households with children between 2 and 12 years of age were asked if children experienced nocturnal enuresis (bedwetting) at least twice during sleep in the two weeks preceding the study. Seventeen percent (17%) of households with children aged 2 - 12 years reported such incidents. Table 6 shows that 38.1% of these children did not urinate during their sleep one year ago.

Thirty three percent (33%) of respondents indicated that a family member over 12 years of age has stopped caring for his/her self because of feeling so distressed/disturbed or upset. Of these respondents, 68% of them (22.5% of the total population) reported problems in properly caring for their children due to feeling distressed, disturbed or upset.

3.2 Qualitative Assessment

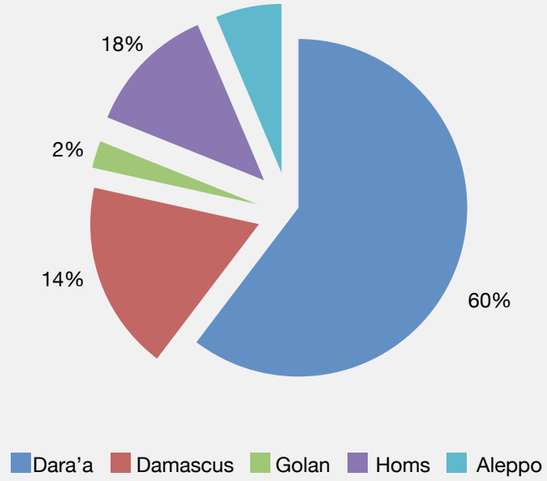
The duration of qualitative interviews ranged from 10 to 50 minutes with an equal mean and median of 25 minutes. These interviews were conducted with heads of households guided by a semi-structured questionnaire (Annex 1). Following are the main results presented to describe the profile of the interviewees and the household family members, as well as an analysis of the reported MHPSS problems, services, and needs.

3.2.1 Socio-Demographic Profile

Interviews were conducted with 32 (64%) females and 18 (36%) males. Ages of respondents ranged between 18 and 80 years, with a mean of 42.3 years (SD 4.3). All respondents were Muslims, and reported being registered with the UNHCR. The time duration for being in Jordan ranged between one week and 15 months with a median of 6.5 months and a mean of 7.2 months (SD 4.1).

The majority of respondents were married (90%), coming from Dara'a (60%) in Southern Syria (Figure 9). With the average number of years of schooling being 5.8 years (SD 4.5), 30% of respondents reported not receiving any form of schooling. It is worth noting that 44% of the interviewees living in Za'atari camp resided in tents, and that the remaining 56% in caravans.

Figure 9: Distribution of Respondents by Origin



A total of 385 individuals were recorded as members of interviewed families displaced in Jordan (including the interviewees). With a slightly higher percentage of females than males (51.4% and 48.6% respectively), half of the interviewees' family members were from Za'atari camp, and one fifth was from Mafraq (Figure 10). The number of family members ranged from 2 to 22 with a mean of 7.7 members (SD 4.3). Almost two thirds of the families (64%) included 5 to 8 members.

Figure 10: Distribution of Family Members by Location

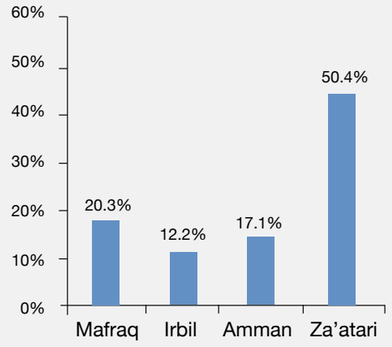
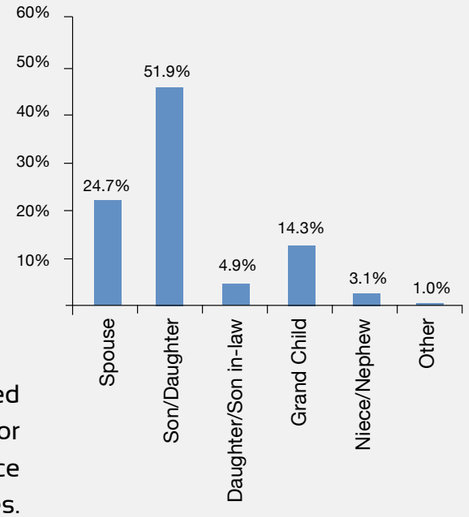
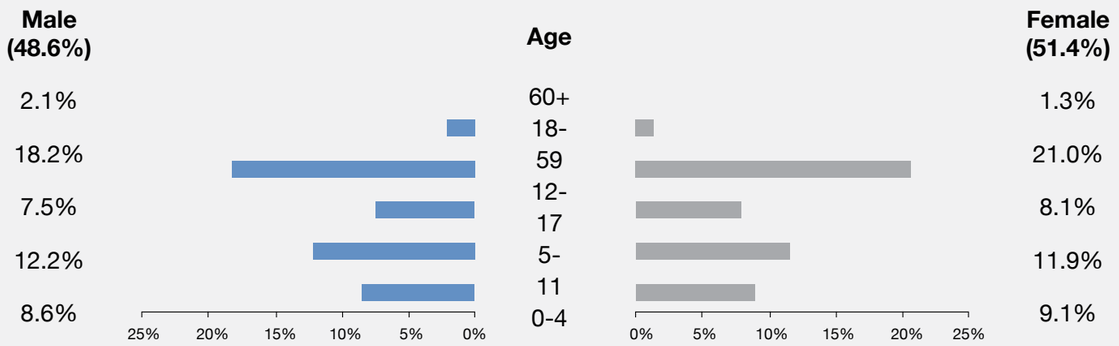


Figure 11: Distribution of Family Members by Relation to Household Family Member



One quarter of the family members were identified as spouses, and slightly more than half were sons or daughters (Figure 11). Results indicated no difference in the age distribution between males and females. With an equal median of 14 years, males tended to have a slightly higher mean age (20.1 years, 95% CI: 17.5, 22.7) than females (19.2 years, 95% CI: 17.0, 21.4). One fifth of both male and female family members were children less than 12 years of age (Figure 12).

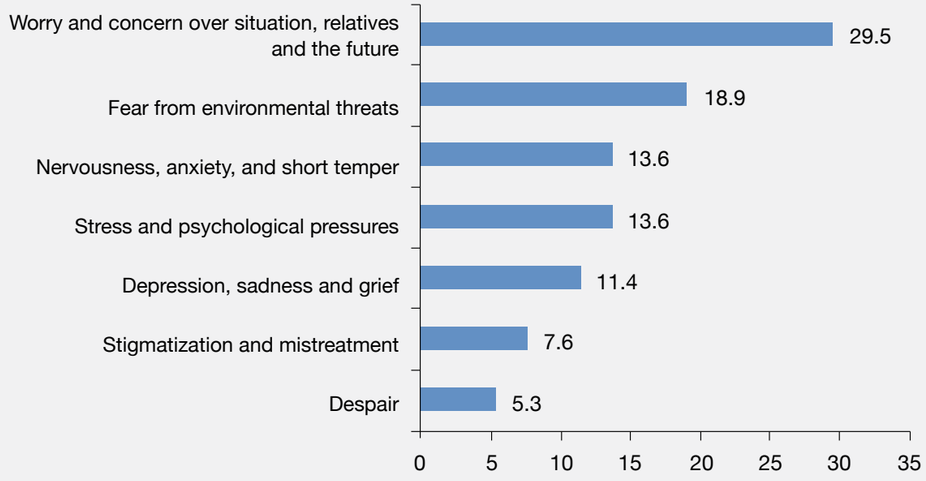
Figure 12: Age Distribution of Interviews' Family Members by Gender



3.2.2 Mental Health and Psychosocial Needs

Displaced Syrians reported a variety of mental and psychosocial problems that were classified into seven categories as shown in Figure 13. A total of 132 problems were recorded with slightly more problems being reported by Syrian families living in Za'atari camp (56.8%).

Figure 13: Percent Distribution of Mental Health and Psychosocial Problems Among Displaced Syrians in Jordan



Worry and concern over the situation and relatives in Syria was the most commonly expressed problem by the respondents representing 29.5% (39 responses). This problem was equally addressed by Syrians displaced in Za'atari camp and outside the camp. Almost one quarter (9 responses) reported being worried about expenses, high cost of living, and lack of income. In addition, there were seven instances where respondents reported being worried about the education and behaviors of their children.

> *"We are worried about schooling. Our children need schools. We are afraid that the situation will take a long time. Our children need routine, they need to learn and see the world. It is difficult to register at schools."*
> **A female respondent - Amman*

> *"I am worried about my children, daughters and wife. The situation is not safe. I worry because of the problems."*
> **A male respondent – Za'atari*

Fear of environmental threats was the second most commonly stated problem (18.9%). The majority (72%) of reported problems in this category came from respondents living in Za'atari camp, with apprehension from living in tents being clearly noted during the interviews. This category included problems like fear of illness and lack of medical treatment (7 responses). It also described a fear and worry about family members with particular emphasis on daughters (7 responses), fear for their children and excessive noise caused by fireworks (6 responses), and fear from rodents and insects as a result of living in a tent (3 responses).

> *"We are afraid to get sick. We don't go outside. Each health facility refers us to another. All health facilities are not true, they don›t do examination; they just write prescriptions. We are scared to get sick, scared to die. We don›t know what to do.*
> **A female respondent – Za'atari*

Nervousness, anxiety and having a short temper were reported by 13.6% with less likely occurrences among respondents in Za'atari (44%). Although causes underlying the reported feelings of anxiety and nervousness varied, the general crisis situation and lack of peace of mind were mostly noted (6 responses), followed by financial constraints and lack of jobs (5 responses), and loneliness (3 responses).

> *"I am nervous and tense from the general situation. I am not comfortable. There is no peace of mind. We were living a different life, look where we are now."*
> **A male respondent – Za'atari*

Stress and psychological pressure was reported by 13.6%, with more frequent reporting by respondents living in Za'atari camp (10 responses). Almost all respondents who reported experiencing stress or "psychological pressures" attributed the general situation, change in their circumstances and hardship of living conditions as underlying causes. The majority of the respondents reported being emotionally tired and upset due to their situation.

> *"We are psychologically tired because we lost everything and had to migrate. We have no money."*
> **A male respondent – Amman*

Depression, sadness and grief were reported by 11.5% of respondents with the majority being from Za'atari (66.7%). Most respondents who reported being sad and depressed related these feelings to the underlying crisis and situation that they have to endure. Some expressed sadness and grief over loss of relatives, while others expressed being sad because of separation from family members, and also expressed a desire to return to Syria.

> *"Anger is piling and increasing every day.It increases the depression. We have lots of worries."*
> **A female respondent – Za'atari*

Stigmatization and mistreatment was reported by 7.6% with the majority noting stigmatization (70%). The three respondents who reported mistreatment as a problem were from Za'atari camp, saying that they have been; insulted felt discriminated against, and have not received just treatment. Feeling discriminated against just for being Syrian was commonly expressed by those who responded under the stigmatization category, also indicating that this mistreatment and discrimination has caused them feelings of discomfort.

> *"The School Director said: we don't like Syrians; the Taxi driver said: you are cowards, why did u leave your country?".*
> **A female respondent – Amman*

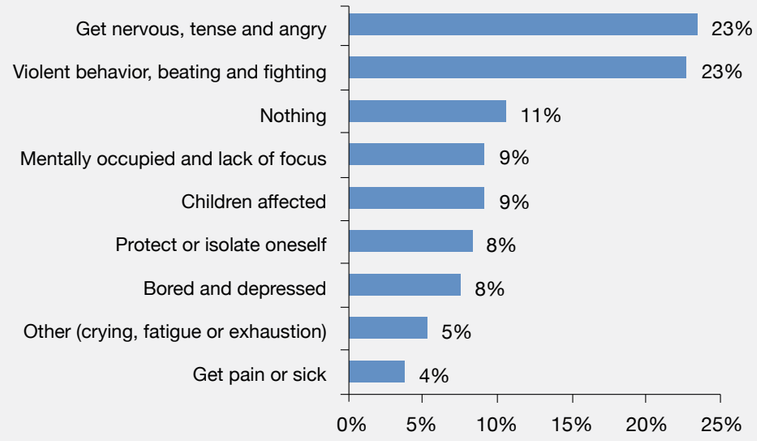
Despair was reported by 5.3% of which 85.7% were from Za'atari camp. Feelings of despair included: feelings of being lost, helpless, defeated, and frustrated. Two respondents explicitly noted that they wished to die, both of which were from Za'atari camp.

> *"We lack of peace of mind, and suffer from despair and frustration. We wish to die."*
> **A female respondent – Za'atari*

3.2.3 Mental Health Outcomes - Symptoms

Respondents were asked to state the effect of the reported problems on their daily lives. Responses were grouped into major categories based on consistency. Analysis indicated that: 1) becoming nervous, tense or angry (23%), and 2) having violent behavior, fighting or assault (beating) (23%) were the most encountered outcomes (Figure 14).

Figure 14: Percent Distribution of Outcomes of Mental Health and Psychosocial Problems Among Displaced Syrians in Jordan



Additional outcomes included being mentally occupied and lacking focus (9%), protecting or isolating self or children by staying indoors (8%), becoming bored or depressed (8%), developing somatic and other symptoms like headaches, lack of appetite, spasms (4%), and other outcomes such as crying, fatigue, or exhaustion (5%). One in every ten respondents (11%) did not report any outcomes or reported having adapted to their current circumstances.

3.2.4 Coping Strategies

Mental health and psychosocial problems depend on the type of stressor, duration of exposure to the stressor, and coping mechanisms of the individual. In this context, the assessment attempted to explore the coping mechanisms adopted by respondents in dealing with their reported problems.

> *"This is not a life that we are living. My husband leaves in the morning because of the problems."*
> **A female respondent – Za'atari*

Figure 15: Percent Distribution of Coping Strategies for Mental and Psychosocial Problems Among Displaced Syrians in Jordan

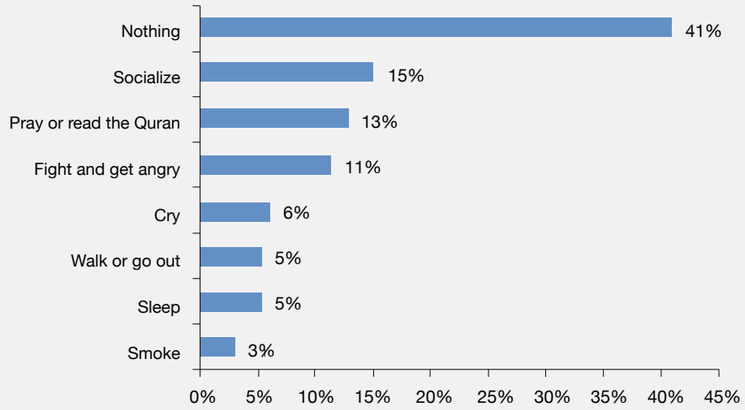


Figure 15 indicates that 41% of respondents reported not using any type of coping strategy as a mechanism to help address the problems that they face. Other coping strategies included socializing (15%), praying or reading the Quran (13%), fighting and getting angry (11%), crying (6%), walking or going out (5%), sleeping (5%), and smoking (3%). A list of coping mechanisms recited by respondents is included in Appendix 2.

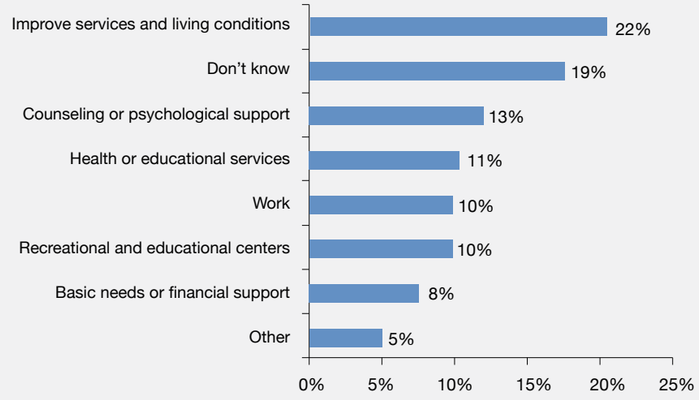
3.2.5 Support Services Requested to Help Manage MHPSS Problems

The qualitative assessment explored perceptions about the type of services needed to help respondents manage their reported MHPSS problems. Only 13% of respondents reported having tried to seek support to assist them in solving their problems. In addition, only 8% reported receiving some kind of support.

> *"We need the usual basic house necessities. I have no money to get anything for the children. I need to secure basic life needs."*
> **A male respondent – Mafraq*

When asked whether there was a felt need for support services, 74% of participants responded positively by either providing precise requests or general statements. Figure 16 displays the areas of expressed need and support identified by respondents, where almost a quarter of them (22%) indicated a need for improving services and living conditions. It is worth noting that most responses were related to improvements in basic necessities such as food, clothing, clean water, and sanitation. Furthermore, almost every interviewee from Za'atari camp living in a tent expressed a need for receiving a caravan similar to other camp residents provided with caravans. One fifth of participants who expressed a need for additional support services were unable to specify this need despite probing for a response. Some of these respondents indicated not having any knowledge about any specific services, but wished that someone could help them in any way possible.

Figure 16: Percent Distribution of Additional Support or Services Requested for Mental Health and Psychosocial Problems Expressed by Displaced Syrians in Jordan



Furthermore, the need for counseling or MHPSS services was reported by 13%, where respondents repeatedly expressed a need for someone to talk and listen to them, visit them, or comfort them. In two of these instances, respondents mentioned a need for religious services and lessons such as "Wu'ath" (religious sermons). In addition, a need for improved health or educational services (schools) was expressed by 11%, with an almost similar expressed need for finding a job or securing work for a family member, as well as the need to have recreational activities for children to spend their time productively.

> *"I need someone to help me to get rid of what is inside, so that we do not get on each other's nerves."*
> **A male respondent – Za'atari*

> *"There is no solution here in the camp. The solution is to go back home."*
> **A female respondent – Za'atari*

A group of respondents expressed a desire for unspecified support services, indicating a need for the situation to be resolved in Syria in order to end their problems.

> *"Need someone to talk to... just to feel that we are human beings."*
> **A male respondent – Amman*

4. Discussion and Recommendations

This study integrated data and information from the quantitative and qualitative assessments, as to strengthen findings and ascertain validity of results[26]. Results of both assessments were compared to highlight important findings that are critical for understanding the mental health and psychosocial problems, and the coping and adjustment of Syrian refugees.

Because of the multi-faceted nature of MHPSS needs, recommendations of this assessment are classified and presented according to the various areas targeted by this study. Recommendations were formulated with the aim of mobilizing existing capacities and resources to ensure access of displaced Syrians to MHPSS services. In addition, multi-sectoral collaboration is important for ensuring the delivery of multi-layered, multi-sectoral and coordinated responses.

4.1 Mental Health and Psychosocial Problems

The assessment revealed various mental health and psychosocial problems reported by respondents, including feelings of distress, fear, hopelessness, anger and disinterest. Family members also reported worry and concern over the situation, fear of environmental threats, worry about expenses, and worry over the education and behaviors of children. Other problems included nervousness, stress, depression, stigmatization, and feelings of despair. Results indicate that MHPSS symptoms are significantly prevalent among both camp and non-camp populations, especially feelings of distress, anger, and hopelessness. These reported problems are concerning, with some of them representing symptoms of mental disorders as outlined in the Diagnostic and Statistical Manual for the Classification of Diseases (DSM-5) or the International Classification of Diseases (ICD-10).

The need for MHPSS services was noted by respondents in camp and non-camp settings (3.5% in the quantitative assessment and 13% in the qualitative assessment), presenting evidence for ensuring availability and access to adequate MHPSS services when planning and implementing programs for Syrian refugees in Jordan. Early detection of symptoms can assist in improving psychological well-being and adjustment, and decrease from the exacerbation of symptoms and deterioration in functioning.

Recommendations

- ***Promote early detection of mental health conditions by providing:*** Mental health screening will allow health providers to identify refugees who are in need of specialized care, and make referrals according to the individual needs of the beneficiary. Developing a mental health screening tool and training health providers in its use could be beneficial.

- ***Strengthen specialized MHPSS services and support mental health outreach services:*** Outreach services are needed to provide refugees with educational information about mental health symptoms, resources and coping mechanisms, including the provision of MHPSS services at home when needed, and referral to mental health services for people in need of specialized care.

- ***Promote safety and security especially in the camp:*** The qualitative assessment highlighted feelings of fear and worry about family members, with particular emphasis on daughters. Continuing the efforts of protection partners to increase security measures especially within the camp is recommended (e.g. increasing security posts and patrol provision, and strengthening the reporting of security incidents and threats).

4.2 Additional Support Services

Quantitative data revealed that only 13.3% of respondents reported having received services for their expressed MHPSS problem since coming to Jordan. This corresponds to qualitative data where 13% of respondents indicated trying to seek services to assist in solving their problems. Quantitative data also revealed a larger variety of mental health service providers in the camp, including the Moroccan Field Hospital, JHAS/IMC and UNHCR/IMC, whereas services indicated outside the camp were predominantly local NGOs. In addition, the qualitative assessment provided a strong conception held by some Syrian refugees that no one can assist them and that even if they did try to seek support they will not benefit. This was typically noted among those who reported no attempts to seek support.

Results provide consistent evidence confirming a need for additional support and services to manage reported problems, with an average of 72.9% of participants indicating such a need. Results also highlighted the specific type of services and support needed, with quantitative data identifying environmental (14.5%), health (14.1%), and nutritional (11.9%) areas as the most pressing services needed inside the camp, and financial (14.6%) and health (13.8%) needs outside the camp. Qualitative data corresponded to this finding by revealing that 22% of those indicating a need for additional services requested an improvement of environmental issues. The need for improved health or educational services (schools) was noted by 11% of the qualitative data. Finding a job or securing work for a family member, as well as the need to have recreational activities for children were other needs equally noted in the qualitative assessment.

Based on these results, displaced Syrians can benefit from additional services which can allow them to shed some of the concerns and problems. Reducing the hardship of MHPSS problems inflicted by inadequate basic necessities should be addressed in order to alleviate concern, worry, and stress that affect mental health and psychosocial wellbeing. Therefore, securing additional services, that are not purely mental health and psychosocial in nature, needs to be considered when making recommendations.

26 *Kopinak, J. K. (1999) 'The Use of Triangulation in a Study of Refugee Well-being', Quality and Quantity 33: 169–183.*

Recommendations

■ ***Improve living conditions of Syrian refugees particularly in Za'atari Camp:*** Fear of environmental threats and the need to improve living conditions were mostly acknowledged by Syrian refugees living in Za'atari camp. Almost every interviewee from the camp who lived in a tent expressed a need for having a caravan. Most of the needs were expressed in relation to improvement in basic necessities such as food, shelter, clothing, clean water, and sanitation. The following interventions are recommended in support of this recommendation:

- Continue efforts towards replacing tents with caravans.
- Conduct health awareness sessions focusing on hygiene, waste management and other relevant topics.

■ ***Ensure access to basic health and education services:*** Increase coverage for health and education services in areas of need, and assess obstacles to accessing services in order to decrease these barriers. Ensure the availability of information on these services through various means and channels (pamphlets, leaflets, educational sessions, community initiatives and groups.

■ ***Meet the needs of refugees relevant to financial stability and food provision:*** The expressed need for securing an income, together with the need for nutritional services, were highlighted in this study. Preoccupation with lack of income, unemployment and inability to secure basic necessities for the family can escalate mental health problems by affecting feelings of self-worth, guilt, shame, helplessness, anger, and despair. This particular recommendation requires collaboration among different sectors with the following suggested interventions:

- Provide appropriate vocational training and rehabilitation opportunities for women and men, promoting a sense of productivity and functioning.
- Facilitate the provision of appropriate opportunities for income generation for women and men.

4.3 Distress and Coping

Syrian respondents reported feelings of discomfort and dissatisfaction with life and living conditions, and are largely distressed. A significant percentage (39%) stated that their feelings of distress interfered with their functioning and ability to engage in activities of daily living. This is a concerning finding as it affects various aspects of life for the refugees including social and family, educational, vocational, personal and recreational areas. Addressing mental health problems and concerns is essential for promoting the mental health and wellbeing of this population.

Findings also showed that 41% reported not using any type of coping strategy as a mechanism to help deal with the reported problems. While the most common coping strategies; socializing and religious practice, were adaptive or positive in nature, most of the remaining reported strategies had maladaptive or negative effects (fighting and getting angry, crying, escaping into sleep and smoking). As the assessment indicated community and family support as an important coping strategy adopted by the refugees, promoting initiatives that can capitalize and expand on these support structures is useful.

Recommendations

■ ***Develop community based interventions*** that focus on resilience, skill building, self-efficacy, and capacity building for refugees, and promote adaptive coping skills and strategies. Such interventions can increase motivation and hope, provide a sense of productivity, and replace negative coping behaviors with positive strategies that enhance wellbeing..

■ ***Support the development of community social support programs*** by encouraging interventions that build protective factors related to positive family and interpersonal relationships, and promote a sense of community, involvement and belonging. Such programs can provide opportunities to discuss common problems, express concerns and provide mutual support.

■ ***Support the strengthening of religious support services*** as a coping mechanism expressed by displaced Syrians. This can include self-help groups and religious cermons "Wu'ath".

■ ***Expand access to recreational areas*** where children can safely engage in productive and recreational activities. This can include educational, social, cultural and sport activities.

4.4 Unfavorable Outcomes and Behaviors

A number of unfavorable behaviors and problems were reported by participants, including excessive nervousness, feeling angry, and fighting. One area flagged by the qualitative interviews is concerning gender-based violence and child protection issues, where male family members interviewed indicated being physically aggressive toward female spouses and children.

Other negative behaviors and symptoms revealed included convulsions, continuous crying, fear, isolation, sudden awakening from sleep, inability to focus, sadness, boredom, fatigue and somatic complaints such as headaches. Additionally, findings revealed concerning incidences of bedwetting in children aged 2 - 12 years, as well as the decreased ability to care for self and children.

Stigmatization was a noteworthy result obtained from the qualitative assessment. Although this was not captured quantitatively, stigmatization was reported by 7.6% of respondents in the qualitative assessment, which raises a concern over social adaptation of Syrian refugees in Jordan.

Recommendations

■ ***Provide MHPSS interventions tailored to the specific needs of refugees,*** including interventions for managing anger and nocturnal enuresis.

■ ***Build capacity of providers in facilitating supportive care*** including case-management, comprehensive interventions and follow up, with a focus on enhancing wellbeing as well as illness management.

■ ***Support projects which build community engagement in joint activities between Syrian refugees and local communities in Jordan.***

5. Study Limitations
6. Conclusion

5. Study Limitations

Some limitations of this assessment are presented below in order to identify unintended influences on information acquisition:

- The use of structured and semi-structured questionnaires allowed for less flexibility during data collection.
- As most parts of this assessment targeted perceptions of refugees, subjective bias resulting from the respondents' personal or cultural views, prejudices, individual experiences and expectations is notable.
- Negative responses may have been exaggerated intentionally due to the belief that this will lead to obtaining increased assistance.
- Lack of uniformity and variation in some of the variables related to the type, severity and perception of the respondents' past and current circumstances made it difficult to disaggregate data according to these variables, for example; time elapsing since displacement, past experience related to the conflict and displacement, and extent of family support.
- Low awareness or ability to detect MHPSS symptoms in some families could have led to the under-reporting of some problems.
- The lack of common language in describing MHPSS symptoms and problems may have led to the mislabeling of some problems.

6. Conclusion

Conflict situations, such as wars and displacement, are known to have a negative impact on the mental health and psychosocial wellbeing of populations. Many individuals exposed to such extreme events may endure negative reactions including sadness, anger, fear, anxiety and hopelessness, as well as behavioral and social difficulties. While most people often demonstrate resiliency and employ natural coping, a smaller number will develop more enduring mental health problems, and yet others will have pre-existing disorders. Addressing the MHPSS needs of displaced populations is of utmost importance in the humanitarian response.

This assessment revealed that many displaced Syrians in Jordan experience a variety of MHPSS problems including distress, sadness, fear, anger, nervousness, disinterest and hopelessness. They also suffer from behavioral and social difficulties as a result of these problems such as social isolation and fighting with others. Of concern is also the incidence of nocturnal enuresis in children, as well as the decreased ability to care for self and others. Most notably, the reported MHPSS problems were identified to cause disruption in the daily functioning of Syrian refugees. While some Syrians adopted positive coping strategies such as socialization and engaging in religious practices, others carried our negative strategies such as anger and fighting, or passive behavior such as sleeping and crying.

Recommendations from this assessment include: promoting the early detection of mental health conditions; strengthening specialized MHPSS services and outreach; developing interventions that promote resiliency, skill-building, self-efficacy and adaptive coping strategies; supporting the development of community social support programs to foster positive family and interpersonal relationships, and promote a sense of community, involvement and belonging; and integrating MHPSS considerations in cross-sectoral programming and initiatives.

Annexes and Appendices

Annex 1: Assessment Tools

Mental Health Assessment of Syrian Refugees in Jordan
Questionnaire - Tool 12
(Adapted from WHO UNHCR Toolkit for Humanitarian Settings, 2012)
June 2013

Questionnaire No.

Interviewers information:			
Full Name		Date:	
Organization		Time:	
Contact number			
Signature			
Locality Information			
Governorate		Camp	
District		Sector	
Village		Block number	
House number			
Demographic Information of the interviewee			
Full Name		Level of Education	
Age		Marital Status	
Sex		Address in Jordan	
Residence in Syria		Contact Information	
Religion		Registered at UNHCR	
Information about family			
Number of Family members		How long have you been in Jordan?	

	Age	Male	Female	Relationship		Age	Male	Female	Relationship
1					6				
2					7				
3					8				
4					9				
5					10				

1. Psychological and social Distress

Could you list the problems you are currently experiencing because of the humanitarian situation? [WHEN THE PERSON STOPS LISTING PROBLEMS, YOU CAN PROBE WITH] What other problems are you currently experiencing because of the humanitarian situation? [WHEN THE PERSON AGAIN STOPS LISTING PROBLEMS, PROBE WITH] What else? What other problems are you currently experiencing because of the humanitarian situation?
1.1
1.2
1.3
1.4
1.5
1.6
1.7
1.8
1.9
1.10
1.11
1.12
1.13
1.14

- Probe further for psychological and relational problems when the interviewee does not list any mental health or any social issues.Have you experienced problems in your relations with other people? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do other people stigmatize you or not give you support? Are you not as involved in community activities as you would like to be?]
- Have you been experiencing problems with your feelings? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do you feel sad or angry, or are you afraid?]
- Have you been experiencing problems with the way you think? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, do you have problems concentrating? Are you thinking too much? Are you forgetting things?]
- Have you been experiencing any problems with your behaviour? If 'yes', what type of problems? [PROBE FURTHER IF NECESSARY. For example, are you doing things because you are angry? Are you doing things other people have found strange?]

2. Social Support and Coping
I am especially interested in [insert any relevant psychosocial and mental health problems mentioned above]. [For Each Problem of interest, as the following questions].
2.1 Could you tell me how [insert problem] affects your daily life?
2.2 Have you tried to find support for this problem?
2.3 Could you describe how you have tried to deal with this problem? What did you do first? And after that?
2.4 Have you received support from others in dealing with this problem?
2.5 Who gave you this support?
2.6 What kind of support did you get?
2.7 To what extent did this help you to deal with the problem?
2.8 Do you feel you need additional support with this problem?

Mental Health Assessment of Syrian Refugees in Jordan
Questionnaire - Tool 2
(Adapted from WHO UNHCR Toolkit for Humanitarian Settings, 2012)
June 2013

Questionnaire No.

Interviewers information:			
Full Name		Date:	
Organization		Time:	
Contact number			
Signature			
Locality Information (interviewee)			
Governorate		Camp	
District		Sector	
Village		Block number	
House number			
Demographic Information of the interviewee			
Full Name		Level of Education	
Age		Marital Status	
Sex		Address in Jordan	
Residence in Syria		Contact Information	
Religion		Registered at UNHCR	
Information about family			
Number of Family members			

Relationship with interviewee	Age	Sex

		Female	Male
1-			
2-			
3-			
4-			
5-			
6-			
7-			
8-			
9-			
When did you come to Jordan?			
How long have you been living in Jordan?			
Part A			
A1. The next questions are about how you have been feeling during the last two weeks. About how often during the last two weeks did you feel so afraid that nothing could calm you down? Would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?			
1. All of the time			
2. Most of the time			
3. Some of the time			
4. A little of the time			
5. None of the time			
6. (IF VOL) Don't know			
7. (IF VOL) Refused			
A2. About how often during the last two weeks did you feel so angry that you felt out of control? Would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?			
1. All of the time			
2. Most of the time			
3. Some of the time			
4. A little of the time			
5. None of the time			
6. (IF VOL) Don't know			
7. (IF VOL) Refused			
A3. During the last two weeks, about how often did you feel so uninterested in things that you used to like, that you did not want to do anything at all? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)			
1. All of the time			
2. Most of the time			
3. Some of the time			
4. A little of the time			
5. None of the time			
6. (IF VOL) Don't know			
7. (IF VOL) Refused			
A4. During the last two weeks, about how often did you feel so hopeless that you did not want to carry on living? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)			
1. All of the time			
2. Most of the time			
3. Some of the time			
4. A little of the time			
5. None of the time			
6. (IF VOL) Don't know			
7. (IF VOL) Refused			

A5. You may have experienced one or more events which have been intensely upsetting to you, such as the recent conflict/living outside your country. During the last two weeks, about how often did you feel so severely upset about the emergency/conflict/war or another event in your life, that you tried to avoid places, people, conversations or activities that reminded you of such event? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)	
1. All of the time	
2. Most of the time	
3. Some of the time	
4. A little of the time	
5. None of the time	
6. (IF VOL) Don't know	
7. (IF VOL) Refused	
A6. The next question is about how these feelings of fear, anger, fatigue, disinterest, hopelessness or upset may have affected you during the last two weeks. During the last two weeks, about how often were you unable to carry out essential activities for daily living because of these feelings? (IF NEC: all of the time, most of the time, some of the time, a little of the time, or none of the time?)	
1. All of the time	
2. Most of the time	
3. Some of the time	
4. A little of the time	
5. None of the time	
6. (IF VOL) Don't know	
7. (IF VOL) Refused	
A7. Have you (your family member if applicable) experienced this problem previously before the conflict in Syria? (pick one)	
Yes	
No	

A7.1. If yes, have you (your family member if applicable) received services for this problem previously in Syria?	
Yes	
No	
A8. Have you received any services to address this problem since arriving in Jordan?	
Yes	
No	
A8.1 If Yes:	
a- Where (location, organization/agency)?	
b- Did this help with the problem?	
Yes	
Somehow	
No	
A 9. Do you feel you need additional services or support with this problem?	
Yes	
No	
A 9.1. If yes, What kind of services or support would you need for this problem?	
1-	
2-	
3-	

	Less than 2 years		More than two years					2-12 years		More than 12 years	
			Ask these questions about all household members older than (2) years old					Ask these questions about all children household members between 12-2 years Old		Ask these questions about all adolescent/adult household members more than 12 years old	
	B0A	B0B	B1	B2	B3	B4	B5	B6A	B6B	B7A	B7B
						(only ask this question if the response was yes to B 3)	(only ask this question if the response was yes to B 3)		(only ask this question if the response was yes to B06A)		(only ask this question if the response was yes to B07A)
Who else live in your household right now? (only ask questions B-1B7 about household members older than 2)	Age	Sex	During the last two weeks was s/he so distressed/ disturbed/upset that s/he was completely inactive or almost completely inactive because of such feeling?	During the last two weeks for how many days was s/he so distressed/ disturbed/upset that s/he was unable to carry out essential activities for daily living because of any such feeling?	Is s/he acting in strange ways or having fits/convulsions/ seizures?	Could you describe in a few words the fits/convulsions/ seizures of behaviour that seems strange to you?	When did the strage bevahiour start? Comment: if date unknown, ask whether the behaviour started or increased after war or coming to Jordan)	During the last two weeks did s/he urinate at the least wo times in his/her bed during sleep?	did s/he have this problem one year ago?	During the last two weeks did s/he stop caring properly for his/herself because s/he is feeling distressed/ disturbed/upset?	During the last two weeks did s/he stop caring properly for children s/he is responsible because s/he is feeling distressed/ disturbed/upset?
1- Mother	98= don't know	1- female	1= no	98= don't know	1= no			1= no	1= no	1= no	1= no
2- Father	99= refused	2- Male	2= yes	99= refused	2= yes			2= yes	2=yes	2=yes	2= yes
3- Sibiling			8= don't know		8=don't know			7= not applicable	7= not applicable	7= not applicable	7= not applicable
4- Children			9= refused		9= refused			8= don't know	8= don't know	8= don't know	8= don't know
5- relatives								9= refused	9= refused	9= refused	9= refused
6- none relatives											

Annex 2: List of Surveyors for Quantitative Assessment

Mental Health Survey Team Members

#	Names	Organization
1	Ayesha Alawai	MoH
2	Nisirn Nehad	NICCOD
3	Dr. Mohammad Al Azhari	MoH
4	Yosouf Al Naoimi	MoH
5	Islam Al Araj	WHO
6	Sana Ali	MoH
7	Mohammad Omer	MoH
8	Ibtehal Al Zobi	MoH
9	Aamer Batayenah	MoH
10	Mohamad Al Reshidat	MoH
11	Abdul Rehman Haza	MoH
12	Hana Al Jabal	MoH
13	Rakan Razi	MoH
14	Razan Al Saghal	MoH
15	Hadeel Al Far	WHO
16	Khairat Al Hesban	MoH
17	Asma Nashawati	WHO
18	Dr. Mohammad Maaia	MoH
19	Anas Mahawati	IMC
20	Fatema Massed	MoH
21	Rand Bashir	MoH
22	Walid Al Aasi	MoH
23	Farah Al Sayed	IMC
24	Zein Ayoub	WHO

Annex 3: Oral Consent Form

Mental Health Assessment of Syrian Refugees in Jordan June 2013

Oral Consent Form

Hello,

My name is _____ from _____, and we are working on the implementation of a survey on the mental health of Syrian refugees in Jordan.
We will ask you a few questions about your mental situation and services provided to you so that the Ministry of Health, the World Health Organization, and the International Medical Corps can improve the services provided to you.

Your participation in this study is voluntary. We hope that you will agree to participate, noting that your refusal to participate will not affect you in any way.

Note that if you agree to participate, the information that you provide will remain confidential, and will not be shared with anybody other than those involved in the study.

Also note that it is your right to refrain from answering any question, or to stop completing the questionnaire at any time.

For more information, please refer to ----------.

Would you like to participate?

1. Yes 2. No

Name Witness

تقييم الصحة النفسية للّاجئين السوريين في الأردن حزيران ٢٠١٣

نموذج الموافقة الشفوية

مرحباً،

إسمي _____ من (_____)، ونحن نعمل على تنفيذ دراسة مسحية حول الصحة النفسية للاجئين السوريين في الأردن.
سنطرح عليك بعض الأسئلة حول أوضاعكم النفسية والخدمات المقدمة لكم حتى تستطيع وزارة الصحة ومنظمة الصحة العالمية والهيئة الطبية الدولية تحسين الخدمات المقدمة لكم.

إن مشاركتكم في هذه الدراسة طوعية، ونأمل منكم الموافقة، علماً أن رفضكم لذلك لن يؤثر عليكم بأي حال من الأحوال.

وفي حال الموافقة على المشاركة، ستبقى المعلومات التي تقدمونها سرية، ولن يطّلع عليها أحد غير القائمين على الدراسة.

كما أن من حقكم الامتناع عن الإجابة على أي سؤال أو التوقف عن استكمال الإستبيان في أي وقت.
لمزيد من المعلومات، يمكنكم الرجوع

إلى_____
هل توافق على المشاركة؟

١. نعم ٢. لا

الإسم: _____ بحضور: _____

Annex 4: List and Names of Clusters Studied

Governorates	Localities	Families interviewed
Amman	Jabal Hussein	67
Amman	Al Hashemia	34
Amman	Tabarbor	34
Amman	Al Yasmin	30
Amman	Al Akhdar	32
Amman	Al Nuzha	30
Amman	Al Swailah	34
Amman	Wadi Al Seir	36
Amman	Ab Alanda	20
Mafraq	Al Khaldeya	36
Mafraq	Al hamra	30
Mafraq	Al HaiJonubi	49
Mafraq	Al Zaatri	69
Mafraq	Qasaba Mafrak	37
Mafraq	Hai Husseinia	101
Irbid	Al Sarih	35
Irbid	Al Hasba	50
Ramtha	Al Ramtha	34
Ramtha	Al Tora	33
Irbid	Al Nueima	34
Total		**825**

Appendix 1: Mental Health Symptoms

Table A1: Percent Distribution for Responses to Mental Health Symptoms

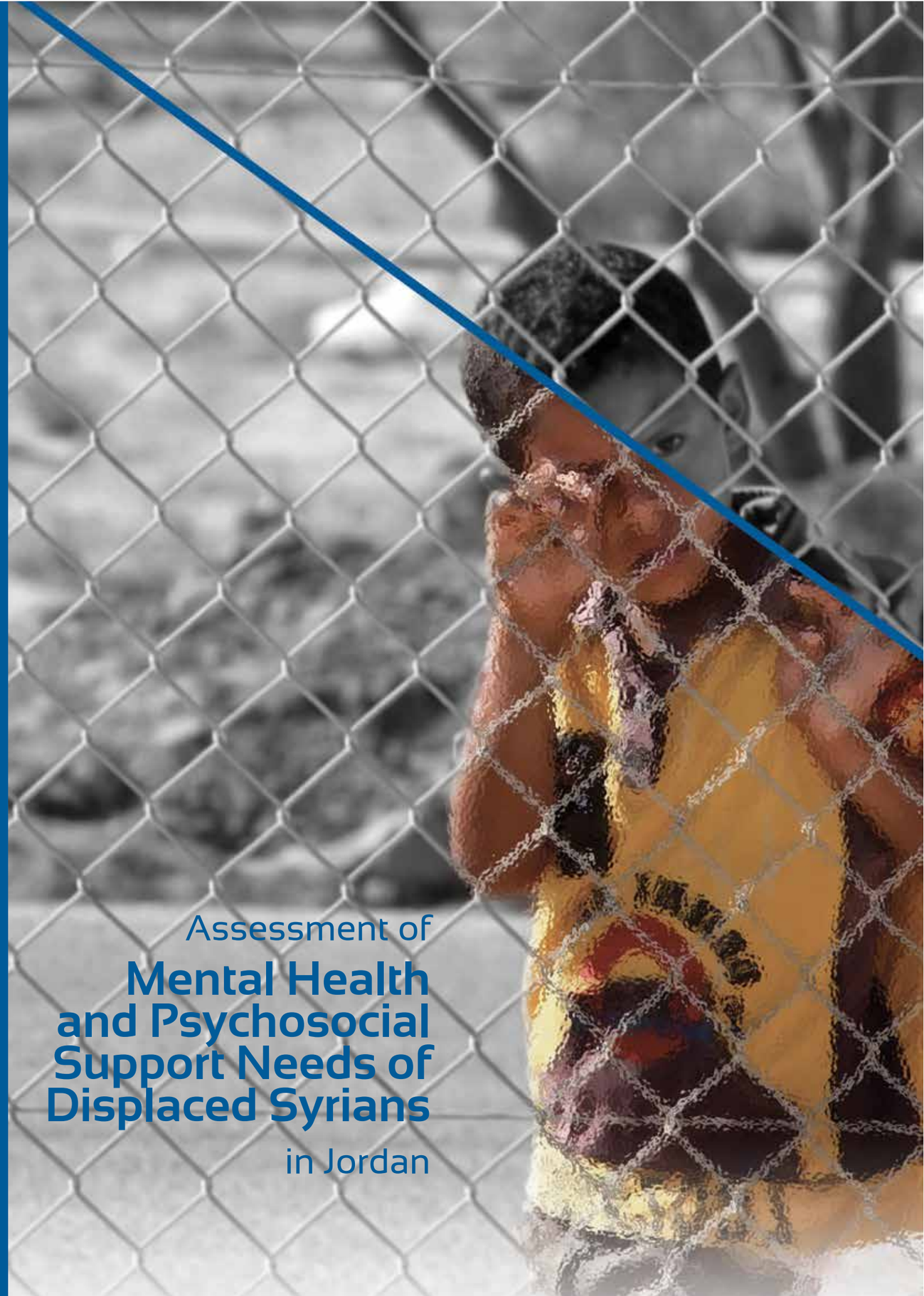
Among Syrian Refugees in Jordan by Site

Mental Health Symptom	Site	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Refused	No answer
A1: Felt so afraid that nothing could calm them down in the last 2 weeks.	Camp	15.3	14.5	16.3	13.5	39.7	0.5	0.0	0.1
	Outside Camp	14.9	17.9	13.5	9.6	43.3	0.5	0.1	0.2
	Total	**15.1**	**16.1**	**15.0**	**11.6**	**41.4**	**0.5**	**0.1**	**0.2**
A2: Felt so angry that they felt out of control in the last 2 weeks.	Camp	30.1	23.8	20.3	10.5	14.6	0.3	0.0	0.3
	Outside Camp	26.7	22.7	21.2	13.5	15.6	0.1	0.0	0.2
	Total	**28.5**	**23.3**	**20.7**	**11.9**	**15.1**	**0.2**	**0.0**	**0.3**
A3: Felt so uninterested in things that they used to like, that they did not want to do anything at all in the last 2 weeks.	Camp	27.5	22.2	20.5	14.5	14.2	0.9	0.0	0.2
	Outside Camp	23.6	22.3	19.2	17.5	16.7	0.2	0.1	0.4
	Total	**25.7**	**22.3**	**19.9**	**15.9**	**15.4**	**0.6**	**0.1**	**0.3**
A4: Felt so hopeless that they did not want to carry on living in the last 2 weeks.	Camp	30.6	16.0	15.0	11.9	26.1	0.4	0.1	
	Outside Camp	21.9	16.2	13.3	11.6	35.6	0.8	0.4	
	Total	**26.5**	**16.1**	**14.2**	**11.8**	**30.6**	**0.6**	**0.2**	
A5: Felt so severely upset about the emergency/conflict/war or another event in their life, that they tried to avoid places, people, conversations or activities that reminded them of such event in the last 2 weeks.	Camp	39.4	16.8	11.9	7.2	23.9	0.5	0.1	0.2
	Outside Camp	36.7	13.8	14.1	10.5	23.9	0.6	0.0	0.4
	Total	**38.2**	**15.4**	**12.9**	**8.7**	**23.9**	**0.6**	**0.1**	**0.3**
A6: Felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset in the last 2 weeks.	Camp	19.9	20.5	24.5	16.3	17.9	0.4	0.0	0.4
	Outside Camp	17.6	21.1	23.5	18.1	18.2	0.7	0.1	0.7
	Total	**18.8**	**20.8**	**24.0**	**17.1**	**18.1**	**0.6**	**0.1**	**0.6**

Appendix 2: List of Recited Coping Strategies

Coping Strategies Recited by Respondents

- I cry. The situation is not comfortable. Headache is increasing. God will help us.
- I cry. Fear increases as I get closer to the date of delivery.
- We cry and we talk about the problem.
- I cry with my children. I can't get out of the camp; even if I want to get out I can't because I have Diabetes and my children are young and need care.
- I cry and I complain to God.
- I cry. I smoke. I visit neighbors.
- I cry and sleep. I have a problem with a gland and I need to take medication. Sometimes I start to shake and get very upset.
- Best thing is death. I hope God gives us relief. I cry and I complain to neighbors and friends. My husband feels that he is suffocating. There is no work and no money.
- We have to be patient. We are under stress. We fight with each other.
- At the beginning the condition was not like this.
- Rely on God. We cannot bear each other. Strong stress. No room for getting along with each other.
- We are powerless. I am nervous; I cannot control my temper and nerves.
- I beat my children then I cry.
- I keep Silent and quiet.
- We fight, we drink tea, and we talk to each other.
- I hand it over to God. I try to forget. We only have God to rely on.
- Nerves are a wreck.
- One day we fight; the next day we reconcile.
- I get nervous and then it goes away. It's normal.
- I shout at them; they get quiet and listen.
- Anti-depressants. Wife does not obey if he shouts and fights.
- I answer back. I don't keep silent.
- I am upset, I can't do anything.
- I convince myself that God will relieve everything. Belief and prayer.
- There is no power except the power of God. I pray and I say that.
- Syrians are stronger than anything. Most important thing is to believe in God and have faith.
- We pray and ask for God's mercy and comfort. We pray and plea.
- Read Quran, drink water and go back to sleep. Worry when sleeping about bombs and attacks. It's getting worse.
- God is my only relief and help. This is a crisis and we need to tolerate. I can understand that because I am old, but the children have no patience.
- There is only God.
- Patience. I appeal to God for help.
- At the beginning I was upset and had no feeling to do anything. Then I pray and pray to God to help my children. When I do that I feel better.
- We give command to God.
- Lectures at the mosque. I want to learn Quran.
- I pray to God and call for forgiveness. I complain to neighbors.
- When I remember I get defeated. I pray to God and cry and get a little comfort from doing so.
- I keep trying to call. I read Quran, and pray every day. There is nothing to do, life is empty.
- I submit and yield to God. The problem is new. I got sick the first 4 days.
- Each one of us is alone. I read Quran.
- Read Quran and pray to God.
- We got separated and split to solve the problem. Mother and daughters go to Syria because they have Tawjihi.
- We stay up late at night watching TV and we sleep until noon.
- We sleep and rely on God.
- Drinking tea and coffee, and sleeping.
- I sleep and rely on God. I surrender.
- I tried to go to UNHCR but they don't help. They have a room where children can color. I isolate myself and sleep. I don't watch the news, I just browse the net.
- Isolation.
- Smoking.
- I smoke hookah.
- I smoke.
- Smoke more and sleep more
- Meeting with people and complaining about the problem, and asking for change.
- I try to forget. I sit with other people to run away from reality.
- We keep each other company, talk and laugh together and remember the past.
- Relatives talk to me and calm me down and tell me to be patient.
- We talk and complain to neighbors and family. We share feelings together.
- Nothing. I visit neighbors and come back. I sit alone then go visit neighbors and come back. If I had a caravan then maybe I can get a TV.
- We give them toys, we have mobiles. We talk to them and reassure them.
- I keep Silent and quiet. I know this is not a permanent problem. I go to neighbors.
- Entertainment with friends.
- We joke, talk and reassure the children.
- I go out to see people and come back.
- With talk, discussion and guidance.
- I talk to my friend or wife to feel better.
- I try to talk to my wife to feel better.
- I try to help them forget. I take them out to visit relatives. I encourage them and read Quran and I let them go to the mosque.
- Wife goes with a friend to visit other houses that are in need.
- I take medication for headache. I talk to neighbors.
- Relatives. Used to have a husband and a sister. Now the depression is less.
- We talk about the problem and try to agree. Wife has to be understanding and understand the husband.
- I talk to the children. I give them advice. School. And try to provide for them.
- Husband leaves in the morning because of the problems.
- I go out and walk around.
- Children go out to play and don't come back so as not to be beaten.
- I sit alone and I go out to the street.
- I go outside and sit alone then come back.
- I leave the house and go see friends. When I return home, I get tired and get pain.
- We roam the streets. I go to market. I walk to the mosque.



Assessment of

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in Jordan