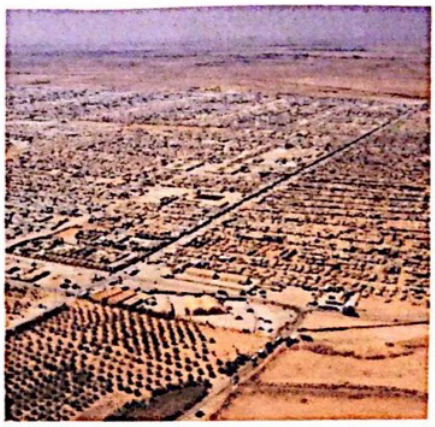
Mental Health & Psychosocial Support for Syrian Refugees in Jordan – A Capacity Analysis of the national implementation of WHO's mhGAP



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by
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Executive Summary

With 659,063 registered refugees, the Hashemite Kingdom of Jordan is one of the top three safe havens for Syrian refugees since the war in Syria escalated and forced a current total of 5.6 million Syrians out of their homes by March 2018 (UNHCR, 2018). In addition to the pre-war prevalence of mental disorders, traumatic stress and stress-related Mental Health (MH) issues pose an increasing challenge on the Mental Health and Psychosocial Support (MHPSS) system in Jordan, which is still an underdeveloped sector with limited capacity and many challenges. WHO's Mental Health Gap Action Plan (mhGAP; WHO, 2008) aims to provide governments and organizations with guidelines on how to strengthen the capacity of their Mental Health Services (MHS) Systems. Based on mhGAP, the Jordanian Government developed a comprehensive Mental Health Policy Plan to master the challenge. This policy analysis aims to assess the status quo of the mhGAP capacity in Jordan in order to formulate policy recommendations to support the process of MH Capacity Development in Jordan targeting refugees as particularly vulnerable population segment. Key focus of recommendation lies on the alignment and harmonization of donor and NGO efforts in the Mental Health Sector, the strengthening and decentralization of the national MH workforce increasingly including female health workers, while establishing a centralized monitoring and evaluation system to increase governmental ownership and oversight. Semi-Conditional cash transfers requiring refugee beneficiaries to attend regular meetings with psychosocially versed case managers in order to retrieve unconditional payments would alleviate existential pressures and therefore sources of stress and therefore mental health burden, especially for families with children. Psychoeducation programs to raise awareness among both refugee and local populations in order to reduce stigma is essential to increase health services utilization once capacities are developed.

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List of Abbreviations

ATM	Automated Teller Machine
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)
CCT	Conditional Cash Transfers
CIA	Central Intelligence Agency
CIDA	Canadian International Development Agency
CPTSR	Centre for Trust, Peace and Social Relations - Coventry University
CRS	Christian Relief Services
CSI	Change-Style-Indicator
DALYs	Disability-Adjusted Life Years
DFID	Department for International Development (United Kingdom)
ECHO	European Civil Protection and Humanitarian Aid Operations
GBV	Gender-Based Violence
GIZ	Gesellschaft für internationale Zusammenarbeit (German Society for international Cooperation)
HRH2030	Human Resources for Health 2030
IASC	Inter-Agency-Standing Committee
IFRC	International Federation of Red Cross/Red Crescent Societies
ILO	International Labour Organization
IMC	International Medical Corps
IMHE	Institute for Health Metrics and Evaluation
iNGO	international Non-Governmental Organization
IRC	International Rescue Committee
M&E	Monitoring and Evaluation
MBTI	Myers-Briggs-Type-Indicator
MENA	Middle East and North Africa
MH	Mental Health
mhGAP	Mental Health Gap Action Plan
MHPSS	Mental Health and Psychosocial Support
MHS	Mental Health Services
MoH	Ministry of Health

NGO	Non-Governmental Organization
NSCMH	National Steering Committee for Mental Health
OECD	Organization for Economic Co-operation and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PFA	Psychosocial First Aid
PTSD	Posttraumatic Stress Disorder
SGBV-SWG	Sexual and Gender-Based Violence Sub-Working Group
UCT	Unconditional Cash Transfers
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	UN Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
UNV	United Nations Volunteers
UNVFVT	United Nations Voluntary Fund for Victims of Torture
WBG	World Bank Group
WHO	World Health Organization
WPRO	Western Pacific Region Organization

1. Problem Statement

1.1. Background and Context Analysis

The Hashemite Kingdom of Jordan, with a population of 10,248,069 people in 2017 (CIA, 2017), is one of the safest and most stable countries in the MENA (Middle East and North Africa) region, whilst situated adjacent to the most conflict-ridden regions, Israel/Palestine, Iraq and Syria. Because of its relative stability, Jordan has been a reliable destination for refugees during times of crisis from neighboring countries as well as other areas. Jordan has housed Palestinian refugees for many years and the UN Relief and Works Agency (UNRWA) for Palestine Refugees in the Near East and related organizations have provided basic health services to this population. The intensification of the wars in Iraq and particularly Syria and has led to unprecedented immigration of refugees, amounting to a total of 659,063 registered refugees in Jordan today. These account for 11.8% of all Syrian refugees worldwide (UNHCR, 2018). Although exact prevalence data on mental disorders among refugees in Jordan is scarce, it is safe to assume that the sudden burden on Jordan's health system – even more so the rudimentary mental health system – is substantial (Ajlouni, 2013; IMC, 2016). According to the 2016 Global Burden of Disease study (IMHE, 2017), mental disorders among the entire Jordan population accounted for 10.01% of Disability-Adjusted Life Years (DALYs)[1] in the country. Self-harm and interpersonal violence account for an additional 1.71% of total DALYs. Those two MH-related categories combined even outweigh the burden of cardiovascular disease (cf. Annex A).

The unmet need for mental health services (MHS) is pronounced, as MH issues account for 11.72% of DALYs, but MHS are only accessible to about 36% of the population (IMC &

[1] WHO Definition: "One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability." (WHO, 2017)

SIGI-JO, 2015). For refugees, these services are even more limited, especially for those in decentralized housing outside of the refugee camps. These services consist mostly of aid provided by non-governmental organizations, such as the International Medical Corps (IMC) under the umbrella of the MHPSS Working Group, and along the guidelines of the Inter-Agency Standing Committee. Mental health services in Jordan mainly comprise tertiary prevention (i.e. residential therapy) at one of the few psychiatric institutions and outpatient clinics and focus mainly on pharmacotherapy for patients suffering from schizophrenia (NSCMH, 2011). Before the latest refugee crisis, there were basically no monitoring and evaluation (M&E) mechanisms in place regarding MHS delivery or utilization, neither locally nor nationally, which is why organizations focusing on mental health policy capacity development must rely on rough estimates and self-reporting from surveys (NSCMH, 2011; IMC, 2016). According to 2011 estimates by the National Steering Committee for Mental Health, there were 1.09 psychiatrists, 0.54 medical doctors with specialization other than psychiatry, 4.05 nurses and midwives, 0.27 psychologists, and 0.3 social workers per 1000 population. The majority of these skilled health workers are located at hospitals in urban areas, particularly in and around the capital, Amman. Only 36% of the Jordanian population is served by professional mental health professionals. (NSCMH, 2011, pp. 36-37). The sector of traditional healers and herbalists is largely unobserved, while regarded highly by the local population (Abo-Hilal & Hoogstad, 2013).

In 2005, the Inter-Agency-Standing Committee (IASC), "a global humanitarian body devoted to the improvement of humanitarian coordination" (IMC, 2016, p. 2), instituted the Task Force on Mental Health and Psychosocial Support (MHPSS) in emergency settings consisting of UN agencies, IFRC societies, and NGOs. In the following two years, this group developed the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC,

2007), "to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency" (p. iii). While focused primarily on MH emergencies, the manual provides tools and guidance to develop general capacity of the MH sector. Today, these guidelines constitute one of the key resources for mental health policy planning and implementation.

1.2. Mental Health Gap Action Program (mhGAP; WHO, 2008)

In 2008, Jordan became one of the first six countries worldwide to launch the World Health Organization's (WHO's) **Mental Health Gap Action Program** (mhGAP) that aims to reduce Mental Health Disorders globally and systematically (WHO, 2008). The mhGAP manual provides thorough and culturally sensitive information and instructions for governments on approaches to developing capacity within respective mental health systems. It includes guidelines on necessary national health expenditures and strategies for acquiring additional health funding, well-proven activities and policies to improve MHS coverage, required M&E mechanisms to assure quality of services, and, most important of all, the establishment and expansion of a stable and sustainable network. The mhGAP manual notes that "[s]caling up is a social, political, and institutional process that engages a range of contributors, interest groups, and organizations. Successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community" (WHO, 2008).

Based on mhGAP, and with the assistance of the WHO and several (i)NGOs, the Jordan Ministry of Health (MoH) developed and published a 53-page "Mental Health Policy Plan" in 2011, encompassing a comprehensive strategy to scale up the mental health care sector in coming years (MoH, 2011). The Policy Plan focuses on the following 12 areas related to the provision of public mental health services:

1. Governance of Mental Health Services	7. Rehabilitation
2. Service Organization	8. Human Rights & Legislation
3. Human Resources	9. Advocacy
4. Finance	10. Psychotropic Medications
5. Information System	11. Research
6. Prevention & Promotion	12. Monitoring, Evaluation, Quality Management

The WHO (2003) suggested a pyramid model to illustrate the ideal mix of services for Mental Health (see Figure 1.1.), with Self-Care as a foundation, followed by Informal Community Care, Primary Care Services for Mental Health, Psychiatric Services in general hospitals and Community Mental Health Services, and Long-Stay Facilities and Specialist Services at the tip of the pyramid. The implication is that this final layer should comprise the smallest proportion of the MH services mix. This layering is in contrast to a 2011 analysis of the MoH, where the mix of MH services was best described as an inversion of the ideal mix.

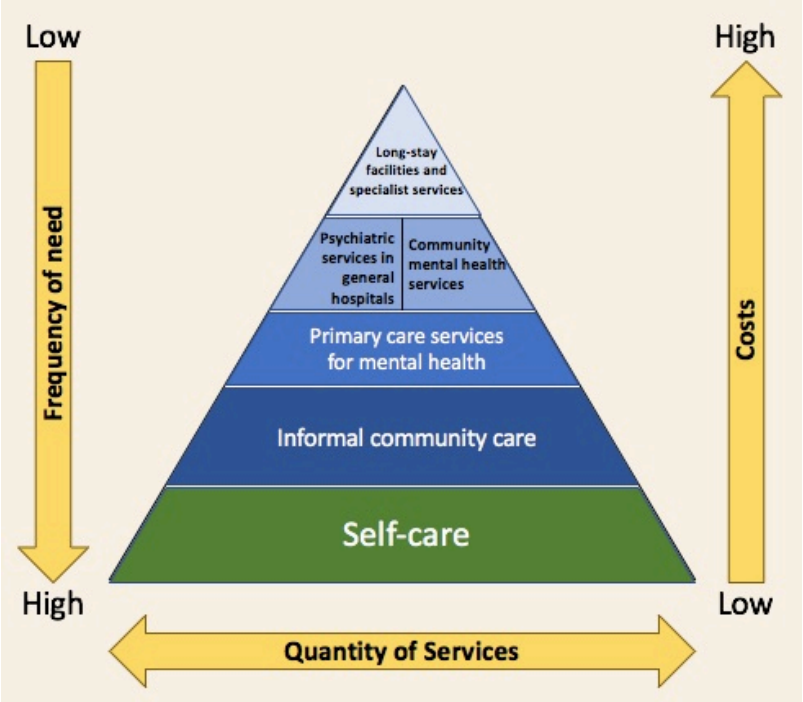

Figure 1.1. WHO Service Organization Pyramid for an Optimal Mix of Services for MH (WHO, 2003)

There is currently no comprehensive data available to compare the status of health system indicators related to the status of the health system in terms of staffing, access, and other issues. However, a recent "4Ws-Mapping Exercise" (IASC tool to map **W**ho is doing **W**hat, **W**here, and **W**hen), conducted by the IMC (2016), showed that 46 NGOs were engaged in the MH sector. Specifically, the effort included a total of at least 1,240 staff members with an average of 24 staff members per agency, but is thought to be an underestimate of MH staffing in the country. Eighty-nine percent of MHPSS services were provided, with no charge for care recipients, while 7% of services required beneficiaries to pay for a portion of the cost, and 4% were not reported. Funding was provided by donors and, in some cases, health insurance. Fifty-five percent of the total population of Jordan is covered by health insurance, with 68% of Jordanian nationals covered (Al Emam, 2016).

1.3. Mental Health Situation of Refugees in Jordan

By nature of their situation, refugees are at higher risk of suffering from mental disorders (MD) than populations without existential stress exposure (WHO, 2016). Precise MD prevalence data vary between different studies because the variation in the conditions faced by different refugee subgroups results in highly heterogeneous consequences and types of MD manifestation (e.g., PTSD, depression, anxiety, psychosomatic disorders, etc.) (WHO, 2016). In addition, most mental health questionnaires and tests are unsuitable for screening Middle Eastern populations, as profound cultural differences apply in both symptom constellations and their verbal and non-verbal expression. Few instruments have been developed for measuring MD outside of Western cultures. As a result, the MHPSS Working group offers regular training sessions and webinars for their affiliated health professionals to sensitize national and international providers to the service delivery challenges related to refugee populations. While stress disorders such as PTSD

among refugees receive a great deal of public attention and seem a logical consequence of refugees' situation, MDs preceding the war are often overlooked, and may pose an even more pressing health need than stress disorders. Before the war, mental and substance abuse disorders, interpersonal violence and self-harm accounted for 11.63% of DALYs and 18.4% of total prevalent MH-related cases in Syria (IMHE, 2016). Conditions such as schizophrenia, schizoaffective and bipolar disorders, and dementia require uninterrupted medical treatment, because the consequences of irregular medication can be physically, mentally, and socially damaging for the patient and pose a burden on his or her social environment. Contrary to public perceptions, PTSD cannot and should not be treated before the individual is under safe conditions, which, by definition, is uncommon among refugee populations (Herman, 2015). Often, the symptoms of PTSD manifest themselves long after the threatening situation is over. It may require years to realize the psychological damage caused by a traumatic experience. Professional Psychosocial First Aid (PFA), however, aims to educate patients about their symptoms and coping strategies and provides individual guidance and support in moments of crisis. This may be a helpful tool to prevent future MDs and to alleviate refugees' acute emotional distress (IMC, 2015). In sum, refugees' psychosocial situation is indeed a special one that is comprised of pre-war MH conditions, traumatic exposures and their potential consequences, stressful living conditions faced by forcibly displaced individuals (e.g., vulnerability, resource scarcity, unemployment, competition, discrimination or hostility), and insecurity regarding a future return home or a potential final destination. The following chapter illustrates these in further detail.

1.4. Public Health Relevance of the Problem

As illustrated in the Problem Tree tool in Annex E, untreated mental health disorders among refugees have, in addition to personal tragedy, tremendous socio-economic consequences (Fisher, et al, 2000). Patients suffering from mental illness are at higher risk for diabetes, cardio-vascular disease, musculoskeletal disorders, respiratory disease, violent or self-harming behaviors, and substance abuse. Consequently, these risks may result in reduced productivity and life expectancy (cf. Insel, 2011; WHO, 2016). Considering the interaction between mental illness and non-communicable diseases (NCDs), mental health disorders accounted for 37% of DALYs globally (WHO, 2011). The inability to pursue an occupation to sustain oneself or one's family can be another consequence and driver of poverty, maintaining a vicious circle between poverty, mental disorders, and more poverty.

The Problem Tree in Annex E also illustrates other causes of mental health burden, such as the politically unstable and unsafe situation in refugees' home country, and sometimes in hosting countries. In Western societies, attacks on refugee housing through arson or direct physical aggression increased, in Germany for example by 364% from 2014 to 2015 alone (Pro Asyl, 2016), and amounted to a total of almost 3533 registered attacks on refugees in 2016 (Spiegel Online, 2017). In Jordan, xenophobic violence is much less common than in the German example. However sexual violence and -exploitation are prevalent, but largely unreported. It has been estimated that as many as 50% or more of refugees are survivors of domestic violence, sexual violence, early marriage, or "survival sex," i.e. submission to sexual acts as the only means to acquire resources and/or protection (SGBV-SWG, 2014; UNHCR, 2017). As noted earlier, cultural barriers, stigma, and insufficient mental health service capacity of both inside and outside the camps, contribute to the unmet mental health needs of Syrian refugees. In addition to the

consequences mentioned above, such as co-morbidities, reduced life expectancy, lost productivity, the vicious circle of poverty and mental health issues, there is the issue of trans-generational transmission of mental disorders, particularly Posttraumatic Stress Disorder, which poses a rarely considered long-term consequence of untreated mental disorders. For PTSD in particular, but increasingly for other mental illnesses as well, research showed that parents' untreated illness has mental health and psychosocial consequences for their children and grandchildren (cf. Hancock et al., 2013; Roth et al., 2014; Christiansen et al., 2015). Rasic et al. (2014) estimate that children of mentally ill parents in Western cultures have twice the risk of developing at least one mental disorder themselves than children of mentally healthy parents, due to an assumed mix of genetic and behavioral learning processes. Yehuda and Bierer (2007) and Yehuda et al. (2014) showed that PTSD-typical epigenetic alterations were being passed on to even the third generation after a PTSD-exposed parent.

In sum, given the socio-economic, psychosocial, and co-morbidity-related consequences of un- or under-treated mental illness among refugees, mental health disorders pose a significant public health problem.

1.5. MHPSS for refugees in camps vs. decentralized housing

In general, refugee accommodation in decentralized individual housing, is helpful in terms of integration, autonomy, and general living conditions, however, it bears the disadvantage that beneficiaries are much harder to reach, requiring that refugees rely mostly on limited services provided to the general local population in Jordan (IMC & SIGI-JO, 2015; IMC, 2016). Notwithstanding the risk to health and safety in refugee camps, an advantage of accommodating refugees in camps is that supporting organizations have a precise overview of their numbers and whereabouts. Hence, specialized health services planning and provision are facilitated by the

centralized nature of the housing situation. Also, the direct contact with the local population bears the risk of resource distribution conflicts, especially when there are services offered to refugees only, and/or general health services are burdened by additional utilization by refugees. Therefore, to keep social peace and avoid resentments in the local population, service capacity development for refugees should benefit vulnerable local populations as well (cf. ILO, 2016; CPTSR, 2018). Strengthening the general mental health services sector in the host country, in this case Jordan, is consequently the most beneficial, sustainable, and peace-conserving way to improve MHS delivery to refugees.

2. Goals, Vision, and Methods

2.1. mhGAP Goals in Jordan

The government of Jordan aims, with the technical and financial assistance of International and civil society organizations as well as other partnering governments, to develop the capacity of the MHPSS sector across the country to achieve the desired outcomes according to WHO's Health System Building Blocks (see Figure 2.1). On the governmental side, this is to be accomplished through a socio-geographically balanced distribution of specialized health care providers, and the establishment of sustainable funding mechanisms to increase supply, utilization, accessibility, and quality of mental health and psychosocial support services. Increasingly, collaborative and coordinated efforts of the (i)NGOs focus on the following eleven key activities (IMC, 2016, p. 21-22):

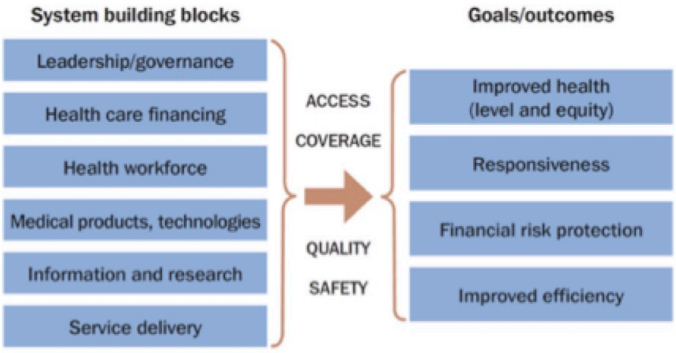

Figure 2.1. The WHO Health Systems Framework (WPRO, 2017)

1. Information dissemination to the community
2. Facilitation conditions for community mobilization, organization and ownership
3. Strengthening of community and family support
4. Providing safe spaces
5. Psychological support in education
6. Support inclusion of social/psychological considerations in other sectors
7. Psychosocial interventions
8. Psychological interventions
9. Clinical management of mental disorders by non-specialized health care providers
10. Clinical management of mental disorders by specialized health care providers
11. General activities to support MHPSS

2.2. Vision

The vision of the WHO with mhGAP is to close the gap between MHS demand and supply in order to reduce the prevalence of mental health problems and their adverse consequences for individuals and society significantly.

2.3. Methods

The methods of this policy paper consist of two major components:

1) A comprehensive literature research on the topic and review of the Jordan Government's and key organizations' needs assessments, strategic plans, and progress reports provide qualitative and quantitative data on the present situation of the refugee shelter situation as well as the national mental health system;
2) The capacity analysis of mental health service delivery in Jordan aims to identify the gaps between supply and demand on environmental, organization, and individual level. For this purpose, the following tools will be applied: Conflict analysis tools such as the Problem Tree from Fisher et al. (2000), a stakeholder analysis following the STEP-scan-model (Aguilar, 1967), a Change Readiness Analysis (Rafferty et al., 2013), and the Key Principles of the Paris Declaration and the Accra Agenda for Action (OECD, 2017);

In 2005, the Second High Level Forum on Aid Effectiveness in Paris resulted in a declaration based on the assessment of aid effectiveness in 55 countries. This declaration resulted in principles to guide future development cooperation to ensure a sustainable impact. It outlined the following five principles for aid effectiveness (OECD, 2017):

1. **Ownership:** Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
2. **Alignment:** Donor countries align behind these objectives and use local systems.
3. **Harmonization:** Donor countries coordinate, simplify procedures, and share information to avoid duplication.
4. **Results:** Developing countries and donors shift focus to development results and results get measured.
5. **Mutual accountability:** Donors and partners are accountable for development results.

The Accra Agenda for Action followed up on the Paris Declaration in 2008, building on experience with the Paris Principles and suggested the following amendments (OECD, 2017):

1. **Ownership:** Countries have more say over their development processes through wider participation in development policy formulation, stronger leadership on aid co-ordination and more use of country systems for aid delivery.
2. **Inclusive partnerships:** All partners - including donors in the OECD Development Assistance Committee and developing countries, as well as other donors, foundations and civil society - participate fully.
3. **Delivering results:** Aid is focused on real and measurable impact on development.
4. **Capacity development** - to build the ability of countries to manage their own future - also lies at the heart of the AAA.

These guidelines provide an excellent framework for capacity analysis, the development of monitoring and evaluation indicators, and the development of substantial recommendations for development cooperation.

3. Stakeholder Analysis

The stakeholder analysis, in this case, turned out rather complex due to the high number of organizations involved. In its 2015/2016 intervention mapping exercise, the International Medical Corps (IMC), funded by UKaid, identified 46 national and international organizations that were more or less independently involved in Mental Health Services delivery (IMC, 2016). Not all organizations revealed their donors, but the ones who did reported a total of 35 donors. These included governmental development agencies such as DFID/UKaid (United Kingdom), CIDA (Canada), and BMZ/GIZ (Germany), ECHO (European Union), UN organizations such as UNESCO, UNV, UNHCR, UNICEF, UNVFVT, faith-based organizations such as Caritas, CRS, and Qatar Charity, and private sector donors such as Boeing and General Electric.

Key stakeholders (i.e. the most powerful agents) in improving of Health Services provision to both refugees and the general population in Jordan are certainly the government (MoH), the donors, and the local health care providers. Primary stakeholders/ beneficiaries of improved MHPSS in Jordan are those members of the general population affected by mental health issues (including disaster survivors), relatives of MH patients, and the refugee population. Secondary stakeholders/beneficiaries of an expanded and quality-improved mental health care sector are the health care providers. As MH care providers' workload will be more evenly distributed, and general health care providers will be able to provide better services to their patients and have a specialized psychosocial referral network at their disposal (see Annex B for Stakeholder Onion). A brief STEP-Scan stakeholder overview can be found in Annex C (Aguilar, 1967). Annex D provides an overview of the main stakeholder groups' central interests in the improvement of MHPSS service provision in Jordan.

4. Capacity Analysis of the Jordan Mental Health System

4.1. Key Principles of the Paris Declaration and the Accra Agenda for Action

Applying the principles of the Paris Declaration (2005; cited from OECD, 2017), strengths and weaknesses of the current approach become more tangible:

STRONG Ownership: With its National Mental Health Policy plan in accordance with the IASC guidelines (2007) as well as mhGAP (WHO, 2008), the government of Jordan sets a clear strategy for all partners to follow. The MoH is in the process of establishing and enforcing Monitoring & Evaluation as well as effective reporting mechanisms to oversee the agencies involved.

LIMITED Donor Harmonization: Not all donors are known, as not all agencies disclose their funding sources. All NGOs procure and manage their own funding, so Jordan is currently experiencing more of a decentralized donor situation and is in the process of long-term donor harmonization under the leadership of the International Medical Corps.

MODERATE to STRONG Alignment: The alignment between the government and the WHO regarding the Mental Health Strategy is very strong, and there exists close cooperation. NGOs active in the MHPSS sector are increasingly involved in regular steering meetings and report to the MoH.

MODERATE to STRONG Managing for results: The government and its partners have set clear goals within a clearly defined timeframe and are in the process of developing and implementing systematic Monitoring & Evaluation structures and mechanism.

LIMITED to MODERATE Mutual Accountability: Little is known about the level of accountability of NGOs to their donors. Accountability towards the government is increasing through improvements in the first four key principles.

MODERATE to STRONG Partnership: Through strengthened governmental leadership and the MHPSS sub-working group Jordan, more and more organizations participate in the "bigger picture."

MODERATE Capacity Development: While intense training programs in mental health screening and psychosocial support is a major focus of all current MH-related efforts in Jordan in order to develop capacity and integrate MH services into the Primary Healthcare System. However, the dependence on foreign aid is still strong. Therefore sustainability is still insufficient, also in large part because societal stigma is still strong and activities depend on the government's willingness. Political change could have adverse effects on the future of MH programs in Jordan.

4.2. Strengths and Challenges

Enabling Environment: Key assets in supporting an enabling environment for improved MH services nationwide include the government's strong ownership, openness, and willingness, as well as the process of creating more transparency through regular stakeholder and activity mapping, and the introduction of M&E mechanisms. However, the strong societal stigma towards individuals suffering from mental disorders is a problematic cultural challenge that requires diplomacy, patience, and culturally sensitive information campaigns. The other societal problem consists of the skeptical attitude of many Jordanians towards refugees. In order to maintain social peace and limit resentment towards refugees, any health-related service provided to refugees should therefore also be available to Jordanians or at least be matched with similar initiatives targeting the Jordanian population. Another challenge is the fact that the legal framework regarding the MH sector is still rudimentary, as is health financing, which, in the case of MH services provision, still relies mostly on foreign and domestic aid and is insufficiently integrated into the health insurance system.

Organizational Level: Central strength at the organizational level is the demand-driven donor support (based on an assessment of actual needs rather than needs assumptions or estimates) approach focusing around Primary Health Care Centers, the educational sector and implementing or supporting NGOs. The lack of Human Resources is a central weakness in the MH sector in Jordan, due to the longstanding focus on tertiary prevention as a central form of MH care provision as institutionalization was the medical "best practice" for centuries across the world. Government, NGOs and primary healthcare providers are currently working on the integration of the more modern approach to integrate MH services into the Primary Health Care System. Capacity development by training of somatic health care staff in MH issues as well as the training of specialized MH care providers is currently a priority in the sector. Knowledge transfer, however, seems to be another insufficiently resolved challenge. Also, "brain drain" of skilled health care workers is a problem. A study by USAID, PEPFAR, and HRH2030 on women's decision-making participation in the health workforce, as well as health care worker retention, found that Jordanian health care workers are most likely to leave their job and/or the country if there is a lack of financial incentives, medical supplies and infrastructure; lack of opportunities for career advancement and ongoing professional training; prevalence of high workload, aggression and conflict among colleagues and from superiors; and "disjointed human resource management practices" (Dieleman & Kleinau, 2017, p. 52). Regarding gender aspects, the general national female labor participation rate has only risen from 9% in 1990 to 15% in 2017 (World Bank, 2017). Culturally, women prefer or even require health treatment through female health care providers only, and is positively reflected in a female health workforce participation rate of 50%, albeit women are hardly ever in a decision-making capacity (USAID, 2017).

Another challenge is the regional imbalance of services availability. As mentioned before, MH care specialists operate mostly in urban areas, serving only about 36% of the population.

Individual Level: As mentioned above, stigma towards MH issues and affected individuals affected negatively affect both the readiness for MH care services utilization as well as the societal standing of individuals utilizing them. A definite strength of the project is, therefore, the strong focus on community information, integration of MH issues into general education, and community mobilization. The integration of MH care into the primary care sector is an excellent way to protect the confidentiality of MH patients as well as to normalize MH issues by treating individuals with MH problems treated in the same facility as patients with communicable and non-communicable diseases.

4.4. Change Readiness Analysis

Institutional Level/Enabling Environment: Factors promoting readiness to change include a high level of change readiness on the side of the government and legislative bodies and strong governmental ownership. Resistance can be expected only on a cultural level (stigma, gender issues). However, there is no information about the change readiness of the private sector, as MH care is predominantly a public service to be included in Primary Health Care, so there is untapped potential regarding public-private partnership in health care service provision; Lack of sustainable financial resources is a major concern limiting change readiness.

Organizational Level: Judging from reports and recent coordination activities, civil society organizations in Jordan are vibrant, active, and dynamic. However, readiness to change may be limited when it comes to harmonization of donor support, and lack of alignment with government objectives when compliance involves abandoning a focus that the organization identified itself with strongly or sharing funding sources with other initiatives. Also, as there are many

faith-based organizations involved, there might be friction between organizations as well as limited capability for shifts in focus, mandates and objectives.

Individual Level: Due to stigma and traditional gender roles, change readiness is generally rather moderate among the population; however, psychoeducation provided to the population about nature and treatment of mental disorders, and public MH awareness campaigns have the proven potential to go a long way (cf. IMC, 2016). Generally, medical staff proves to be very receptive towards knowledge acquisition that helps them provide better care to their patients, so change readiness among the healthcare workforce can be expected to be high, and as long as gender roles are not being challenged, there are no significant cultural obstacles to be expected.

5. My Potential Leadership Role in Refugee MHPSS in Jordan

If I had absolute freedom of choice regarding my professional role in MHPSS for refugees in Jordan, and considering my background and level of training in Individual Mental and Global Public Health, I would choose to be the independent Regional Inter-Agency Mental Health Coordinator. This role would include a neutral focal point, M&E specialist, and consultant for providers, NGOs and the government. Before I explain my vision for culturally sensitive leadership in MHPSS in Jordan, the following two chapters will illustrate the results of my style assessments to better understand strengths and challenges of my leadership.

5.1. Leadership Style Assessment Results

Courtesy of my Rotary Peace Fellowship, I had the privilege to do the MBTI twice, once in Rotary Cornerstone Class, and a second time half a year later in our Public Health Spring Break Leadership Retreat.

Interestingly, my MBTI-style had slightly changed on the scale that was already was fairly close to the middle, so apparently, my nuance on the S/N scale had shifted slightly from ESTJ (Extraversion, Sensing, Thinking, Judgment) to ENTJ (Extraversion, Intuition, Thinking, Judgment):

MBTI: **ESTJ** *(August 31, 2016:* ***ENTJ****)*

February 10, 2017:	*August 31, 2016:*
E= 20 (clear)	E= 25 (clear)
S= 8 (moderate)	N= 2 (slight)
T= 2 (slight)	T= 4 (slight)
J= 15 (moderate)	J= 13 (moderate)
Polarity index = 69	Polarity Index = 50

Change Style Indicator: 6 – Pragmatist with conserver orientation

As J.F. Kennedy was planning to say November 22nd, 1963, and never got the chance to as he was shot on the way to his speech: “Leadership and learning are indispensable to each oth-

er." (Kennedy, 1963). Leadership (LS) is a skill that requires continuous lifelong learning and refinement, and the Rotary Peace Fellowship provided me with exactly that opportunity. The self-tests and reflection papers added new perspectives, and the class made me reflect on my current set of values, styles, and goals, too, as they are susceptible to change over life's course. I also believe LS is best learned from experiencing truly great leaders live or at least on video.

After initial surprise, I came to the conclusion that both results are valid and I am a person who pays attention to both the sensory cues that reach me from the outside as well as what impulses I perceive from the inside. I value both symbols and hands-on experience equally, and have a need for the collection of facts, but also a strong drive to understand the abstract bigger picture and multiple perspectives.

I very much agree with the Change Style Indicator (CSI) as it describes me very accurately. I am open to new ideas, methods, proceedings. However I need to be convinced that they have an advantage over "the old ways." I enjoy working in diverse teams, both in terms of inter-cultural and inter-ideological aspects. Respectful disagreement within an open working environment and constructive dialogue is the most empowering dynamic I can imagine for change processes. I disagree with the potential challenges described by the CSI though ("reluctant decision-maker"): I am a strong and quick decision maker (too quick, oftentimes), and I often plan too far ahead. Not knowing what is going to happen to me (like at this stage in my career) is a burden to me and increases stress and pressure on me tremendously. Before deciding to do an MPH at UNC Chapel Hill, I used to have my life planned out until my death, with enough flexibility and back-up plans not to be constrained or opposed to spontaneous opportunities and forks along the way.

5.2. Core Leadership Values

In everything I do or say, whether I am buying bread or fulfilling a leadership role, I want to be truthful, fair to all concerned, appreciative, respectful, understanding, non-judgmental and base my decisions on utmost integrity. Kant's Categorical Imperative of course is a key rule underlying behavioral and interactional decision-making for me. I was raised according to the principles of Max Weber's Protestant ethics in the sense of "Service above Self" and the dedication of one's self to work and productivity. Standing by my word is extremely important to me and whenever I am not able to for whatever reason, it bothers me a lot. I am practicing these ethical and value-based principles to the point where it becomes self-harming as I am incapable of 1) saying no to anyone who asks me for help, and 2) hiding what I think of people who do not live up to my ethical expectations, who behave selfishly, disrespectfully, in a power-hungry manner, and schemingly. German culture is one of the most direct communication cultures, which is perceived as rude and insulting by many (particularly Middle Eastern) cultures. Despite intensive experience abroad, I sometimes still fall into the cultural directness trap and unintentionally offend, which can cause problems in the intercultural context.

Returning to my values, I firmly believe that everybody is equally responsible for society's well-being and care for the needy and poor. Nobody can escape responsibility, and nobody has the right to ever lean back and decide they are good enough the way they are. The core summary of my ethical values, however, does not only stem from Protestant Ethics, but was also coined by Japanese philosopher, Aikido Martial Art Founder Morihei Ueshiba (2002):

> *"The Art of Peace begins with you. Work on yourself and your appointed task in the Art of Peace. Everyone has a spirit that can be refined, a body that can be trained in some manner, a suitable path to follow. You are here to realize your inner divinity and manifest your innate enlightenment. Foster peace in your own life and then apply the Art to all that you encounter." (p.1)*

5.3. My Leadership Role in MHPSS in Jordan

Being the personality that I am, I see myself in the role of a link and mediator between all stakeholders. In this role, I do not only want to be an ombudsman, but rather an active missing link between beneficiaries, organizations, and the Jordanian government, bringing everybody to the table, mediating different interests, negotiating new solutions and applying my highly creative and inclusive problem-solving skills as well as my talent to make the cake bigger. I want to be in the position to both advocate for those in need and improve the quality and feasibility of the mental health policy in a country, and to explain the national policy and service delivery strategy to its recipients. I consider this position a true peacebuilding role as the social peace in high-volume refugee immigration situations can be extremely fragile. Professional, inclusive, and diplomatically sensitive management of the refugee crisis is absolutely essential to keep tensions and civil unrest from arising in hosting societies. I believe that in this role, my strengths will help me thrive and succeed. This way, all my combined expertise and training in Psychology, Psychotherapy, Global Public Health, and Peace & Conflict Resolution would be applied to a worthy cause where I could find meaning and fulfillment in what I am doing.

6. Conclusions and Recommendations

In general, the progress that has been made since 2008 in capacity development of the MH sector in Jordan is remarkable and puts Jordan in the position of a global best-practice example when considering the limited resources and level of development at the onset of the refugee crisis. The previous lack of coordination, oversight, accountability, and M&E is being tackled by leading organizations under the auspices of the MoH in order to map, align, and harmonize all relevant agencies' and donors' activities with the National Mental Health Policy Plan. The approach suggested by the MoH as well as WHO, UNICEF, and the International Medical

Corps is very comprehensive, up-to-date according to both medical and international development standards, and culturally sensitive. Based on the challenges and gaps identified in this analysis, as well as review of the recommendations through the MoH (2011) and the International Medical Corps (2016), the study conducted by CARE International (2017), and the joint report of IMC and SIGI-JO (2015), the analysis concludes in the following recommendations:

6.1. Enabling Environment

If not already in process, a focal point for MH capacity development at the MoH should be established to develop the government's capacity to continuously map and oversee MH efforts in the country, practice M&E, and hold organizations accountable for their actions. This office can also serve as a central information hub, which would enable organizations to build on each other's experience, avoid parallel efforts, or the repetition of unsuccessful strategies. Also, knowledge transfer for the phase after hand-over would be enhanced for local organizations taking over the tasks of former (i)NGOs. Health financing is a huge challenge that needs to be tackled in cooperation with international organizations and partner governments, including the challenges associated with health insurance coverage and MH risk pooling. On a legislative level, governing MHPSS professions and setting professional standards is a key long-term investment in health care services quality in the country.

6.2. Community and Individual Level

The current approach of community mobilization, psychoeducation of the general public and generating awareness of mental illness as a normal part of life rather than something shameful is absolutely key and should be pursued. The establishment of community peer support networks is a cost-effective way to provide psychosocial first aid among locals, especially in re-

mote, underserved areas. Chapter 6.3 provides more details on interventions targeting both the community- and organizational level.

6.3. Organizational Level

Economic growth and poverty reduction are rarely acknowledged, yet potentially influential factors to improve mental health in vulnerable populations (cf. Hanandita & Tampubolon, 2014; Patel & Kleinman, 2003; Lund et al., 2010; WHO, 2007). The info-graphic in Annex F illustrates different socio-economic factors scientifically shown to be associated with mental health in low- and middle-income-countries (WHO, 2007, p. 2). Consequences of refugees' poverty, all with potential direct or indirect effects on mental wellbeing, include underpaid labor or survival sex, selling-on of essential in-kind aid[2] (e.g., food, clothing), child labor, child marriage, insufficient living spaces, aggression between family members and gender-based violence (IRC, 2012).

Among all the stress factors refugees are exposed to, the burden of being in a low-resource setting is one of the most pressing. Reducing the dependency on material or financial donations is not only an issue of granting forcibly displaced individuals financial autonomy and dignity, but also stimulating the hosting country's local economy as financially fluid immigrants become paying customers and clients. Reducing dependency also enables refugees to start businesses or occupations of their own. Cash transfers pose a potent instrument to reach these goals. For example, pilot projects, with Syrian refugees in Lebanon, evaluated the outcomes of conditional cash transfers for heating supplies among refugees located in the Lebanon Mountains. This project yielded very promising results among those refugees, who at least had sufficient resources to cover basic needs such as food, water, and clothes (Lehman & Masterson, 2014). In

[2] "Flows of goods and services with no payment in money or debt instruments in exchange." (OECD, 2007)

their 2012 report, the International Rescue Committee (IRC) concludes that cash transfer is an effective and efficient instrument to support refugees. The IRC further expects that conditional cash transfers through pre-paid ATM[3] cards tied to "the participation in awareness-raising and information campaigns that cover GBV-related issues as well as legal support, service providers and referral paths" (IRC, 2012, p. 3) significantly reduced GBV, early marriage, and child labor, and increased school enrollment. These outcomes are significantly associated with the socio-economic status of refugee families as well as their stress-levels, hence mental wellbeing (Hagen-Zanker et al., 2017). The awareness-raising and information campaigns refugees need to participate in to receive their cash transfers should be combined with mental health screenings and the opportunity to approach mental health professionals in a culturally appropriate and feasible manner.

The only challenge in cash transfer programs for refugees is the maintenance of social peace. To financially support refugees while neglecting poor local population segments would bear the risk of civil unrest as local populations may protest the preferential treatment of immigrants. This risk needs to be avoided, which is why the government needs to harmonize and coordinate donor investments to make sure that its Social Protection Program is benefitting the poor sufficiently. Thankfully, the Jordanian Social Protection Provision is considered one of the strongest and best organized in the entire MENA-region (Zureiqat & Shama, 2015; Röth et al., 2017), so that cash transfers for refugees could be implemented without high risk of social tension. It should, however, be accompanied by a targeted and transparent information campaign explaining the economic benefits to local businesses and population by choosing to provide refugees with cash support to sustain themselves.

[3] Automated Teller Machine

In terms of quality management, sustainability and the fulfillment of the Paris and Accra principles, the organizations should, in cooperation with the MoH, develop a strategy when and how to hand over all activities and services regarding mental health care. Currently, there is no exit strategy, which is a problem regarding long-term national ownership and sustainability. Funding cycles should be extended in order to enable organizations to plan ahead and reach a reasonable exit point.

Comprehensive M&E and reporting mechanisms need to be established in order to harmonize and align efforts, as well as to ensure mutual accountability. All organizations licensed to engage in the field should be required to report to a central focal point at the MoH.

In terms of human resources, capacity development of existing primary health care staff by training current health care workers and, crucially, community health workers in the field of mental health, is a key success factor for sustainability, societal acceptability, and accessibility. An increase in the specialized MH workforce takes time but needs to be approached parallel to MH service delivery assistance through international organizations. Incentives, such as tax cuts, bonuses, privileges, and continuous professional development are important to retain the skilled staff long-term. The establishment of a comprehensive referral system is another key to sustainability.

Alcohol- and substance abuse are completely neglected MH issues that urgently need to be included with utmost cultural sensitivity as they are highly taboo in Islamic culture, i.e. "should not exist", yet cause a tremendous amount of secret suffering. Especially on the community and individual level, there is still potential to strive for culture change, de-stigmatization and problem sensitization.

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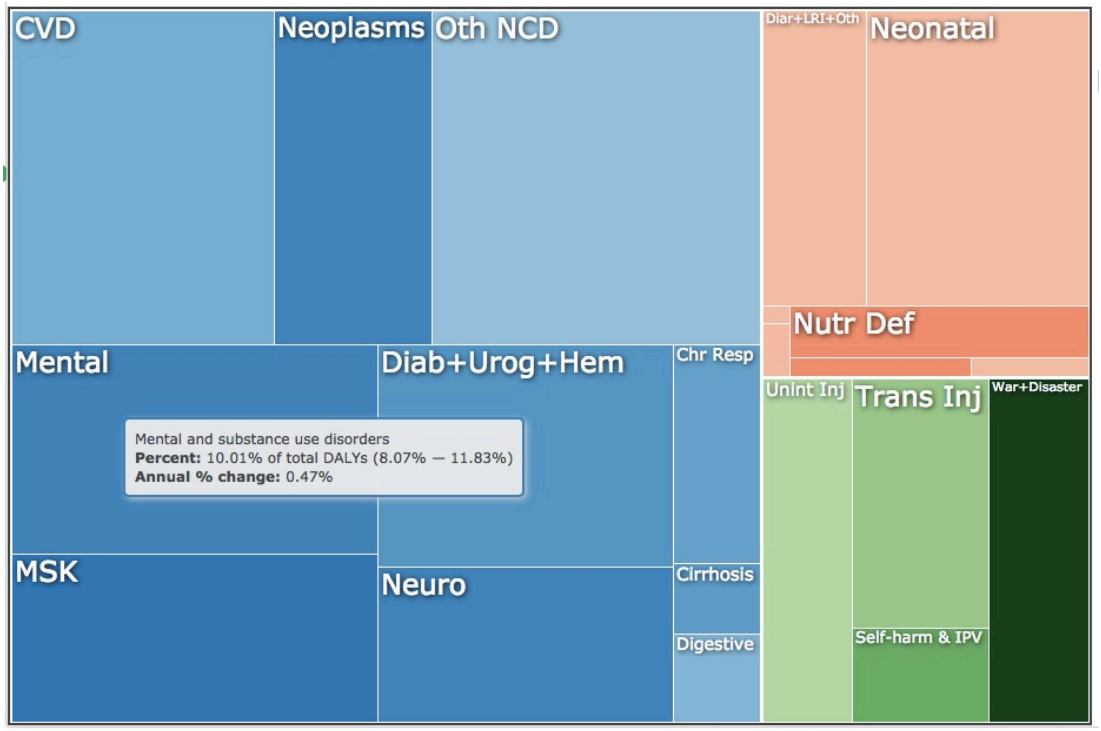
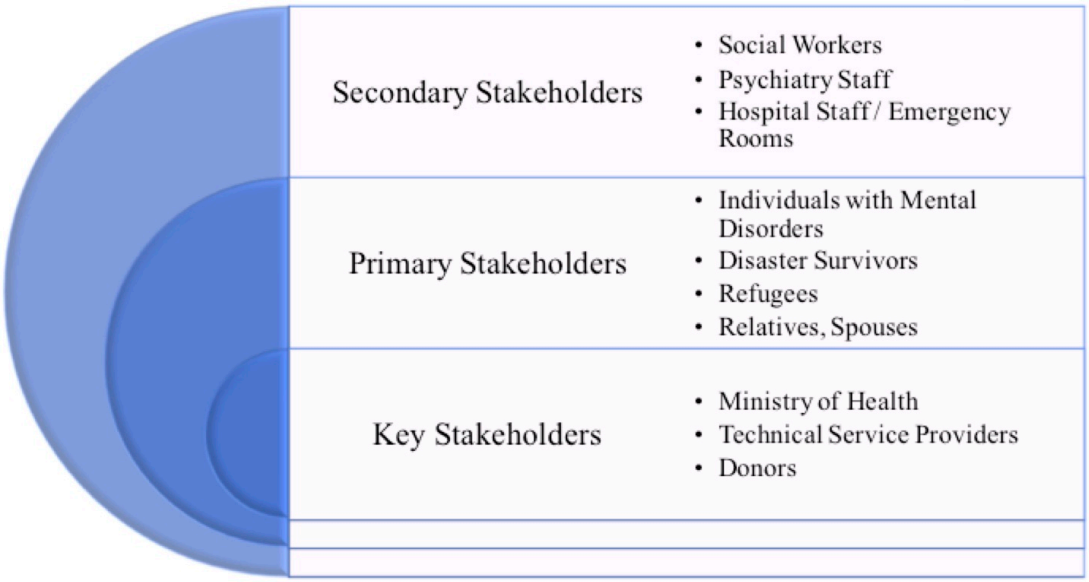
Annex

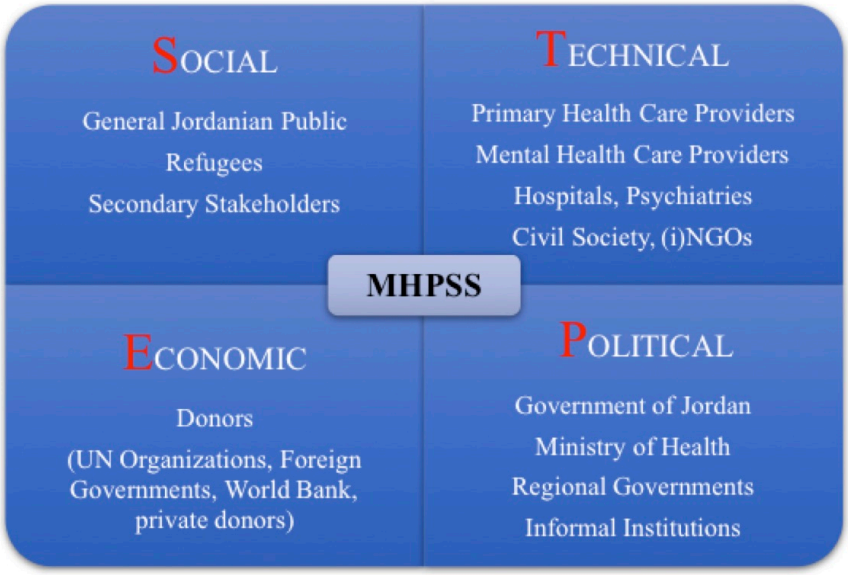
A. Disability-Adjusted Life Years (DALYs) – Treemap Jordan (IHME, 2017)



B. Stakeholder Onion (tool: Fisher, 2000)



C. STEP-Scan Stakeholder Analysis (Aguilar, 1967)



D. Stakeholder Interest Analysis

Jordanian Government / Partnering Governments: Strengthening the Health Care Sector; Provision of high-quality medical services as service to the population, to increase productivity, decrease DALYs and improve health indicators, create sources of revenue (e.g. medical tourism); secure social peace by balancing support for refugees and local population;

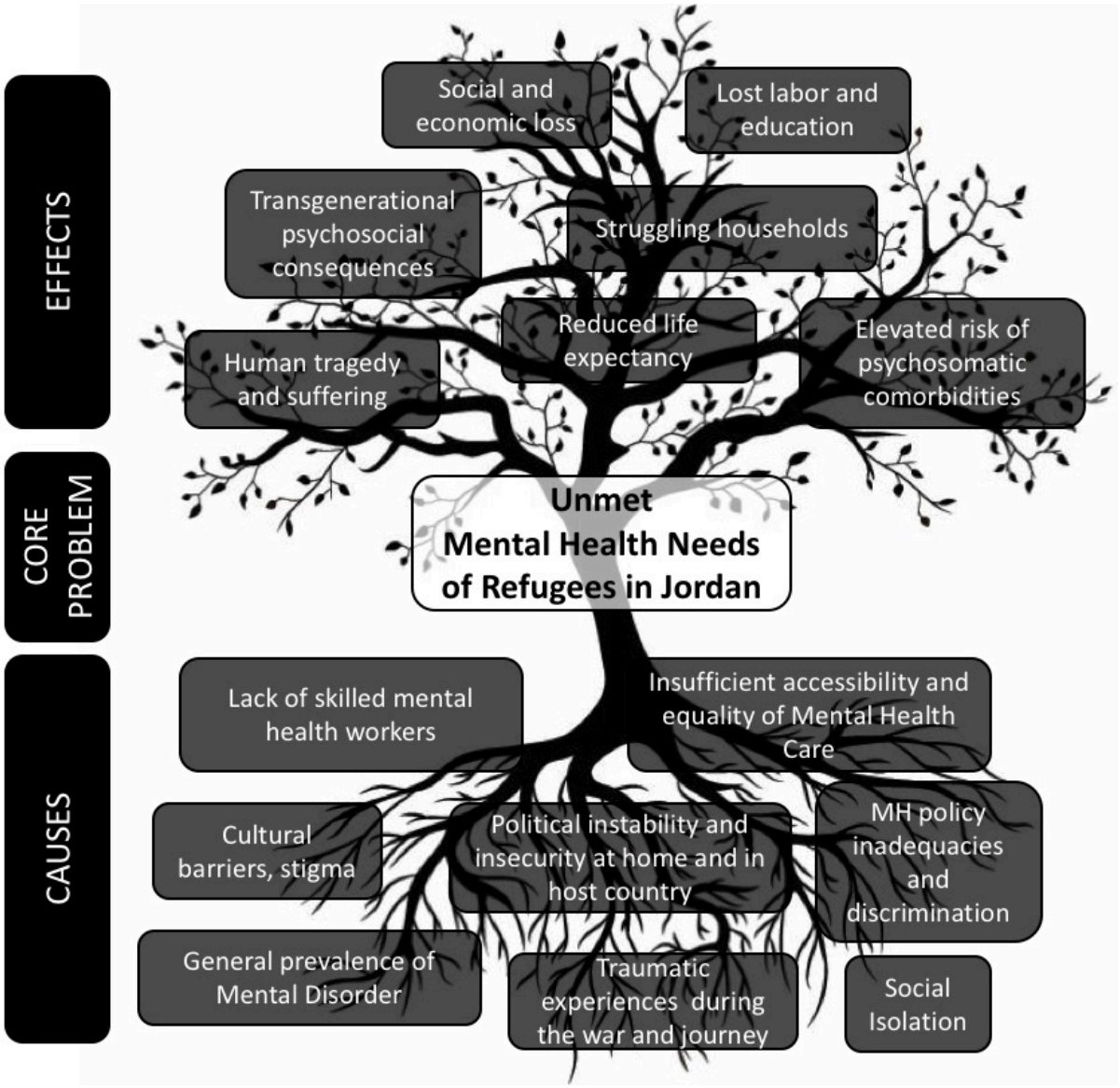
46 (i)NGOs involved in MHPSS: Develop sustainable capacity in the Health Care Sector; Provide humanitarian and technical assistance short-term in order to build a sustainable, locally owned and run health care system long-term;

MHPSS/Health Care Facilities/trained medical staff: Improve quality and quantity of health care services to population; increase and retain sufficient and qualified staff to achieve best-possible health outcomes; Acquire sustainable funding sources for steady maintenance of service provision; receive financial incentives to serve even remote locations;

Population / Refugees: Receive timely and best-possible (mental) health care without catastrophic health expenditure or excessive travel for entire family; confidentiality regarding culturally stigmatized conditions;

Health Care Providers: Receive continuous professional development including MH expertise to improve quality of care; focus on primary health care duties and have a competent network to refer patients to specialized providers if indicated;

E. Problem Tree of Mental Disorders among Refugees in Jordan (tool: Fisher, 2000)



F. The Cycles and factors linking Mental Health & Development and Mental Ill-Health & Poverty (WHO, 2007)