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Kaori Okada Date

Assessment of the Strengths and Challenges in the Implementation of the Mental Health and Psychosocial Support (MHPSS) Program for Palestine Refugees in Jordan from the Perspective of Healthcare Providers

By

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An abstract of
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Abstract

Assessment of the Strengths and Challenges in the Implementation of the Mental Health and Psychosocial Support (MHPSS) for Palestine Refugees in Jordan from the Perspective of Healthcare Providers

By Kaori Okada

The United Nations Relief and Works Agency for Palestine Refugees (UNRWA) reported that 19.3% of Palestine refugees needed mental health support. In response, the UNRWA has conducted the Mental Health and Psychosocial Support (MHPSS) program since 2017. As Jordan hosts the largest Palestinian refugee population, addressing these needs is critical. Therefore, this evaluation aims to identify the strengths and challenges of implementing the MHPSS program for Palestine refugees in Jordan from healthcare providers' perspectives. This evaluation utilized mixed methods, including online surveys and interviews administered to healthcare providers, including doctors, nurses, and midwives in the UNRWA health center in Jordan. The survey was conducted across all health centers, and interviews were carried out at 10 of the 25 centers in Jordan. Quantitative data were analyzed using descriptive statistics, while qualitative data were analyzed thematically with MAXQDA. Eighty survey responses were analyzed from 20 out of 25 health centers (23.1% response rate). Additionally, 38 healthcare providers from 10 health centers participated in the interviews. Both qualitative and quantitative findings demonstrated that integrating the MHPSS program into primary health care is beneficial in terms of enhancing access to mental health services, reducing stigma, preserving the privacy of patients, and using the guidelines to deliver mental health care. However, there were challenges with the need for ongoing staff training, an enduring mental health stigma, time constraints, difficulty maintaining privacy, lack of presence of mental health specialists, and sociopolitical situations. Based on the findings, recommendations include enhancing awareness of mental health among Palestinian refugees, ongoing training for healthcare providers, and improving access to limited resources. Further research is needed to support comprehensive evaluations, cost-effectiveness analyses, and investigations into stigma. These insights inform future policy and program development to improve refugee mental health care in humanitarian settings.

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Sincerely,
Kaori Okada
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Acronyms

CIFR: Consolidated Framework for Implementation Research

GHQ-12: General Health Questionnaire 12

PHC: Primary Health Care

PTSD : Post-traumatic Stress Disorder

MHPSS: Mental Health and Psychosocial Support Service

MNS: Mental, Neurological, and Substance Use Disorders

mhGAP: Mental Health Global Action Programme

SEM: Social Ecological Model

UNHCR: The United Nations Refugee Agency

UNRWA: The United Nations Relief and Works Agency for Palestine Refugees in the Near East

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Chapter 1: Introduction

Background of Mental Health Among Refugees

The UN Refugee Agency (UNHCR) (n.d.) noted that approximately 108 million people were forcibly displaced, a 19 million increase in 2022, which was the most significant number that UNHCR recorded. According to the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) (2023), the population of Palestine refugees has also increased, and it is one of the largest populations of refugees in the world. Refugees are likely to be a vulnerable group in terms of mental health, alcohol consumption, perinatal outcomes, heart disease, and oral health due to many factors, such as traumatic events and poor integration into the host society (Cuadrado., 2023).

One of the health concerns for refugees is mental health. There is a prevalence of post-traumatic stress disorder (PTSD) and depression, as these diseases tend to persist among refugees (Blackmore et al., 2020). Palestinian refugees are no exception, the UNRWA (2022) reported that 19.3% of Palestinian refugees needed psychological or mental health support. According to Turki et al. (2020), mental health conditions are more of a burden on Palestine refugees because of the intergenerational trauma that is passed down since they have been exposed to conflict for several decades. This means that if the parents' generation experienced a traumatic event, their descendants might be

prone to have mental illness. This vulnerability may result from the intergenerational transmission of psychosocial and environmental factors, such as those associated with family dysfunction caused by the trauma (Harkness., 1993). Additionally, the prevalence of people with mental illness among Palestine refugees rose during the COVID-19 pandemic (UNRWA., 2023). The war in Gaza is continuing, which contributes to the adverse effects on Palestinian refugees' mental health conditions due to exposure to violence and the loss of family members (Ahmed, 2023). Thus, addressing mental health is one of UNRWA's priorities.

Addressing the Mental Health Issues for Palestine Refugees

Mental health and psychosocial support service (MHPSS) started in 2017 in UNRWA and continues to operate today. Mental health and psychological support (MHPSS) includes a model of mental health support, local or external, that encourages well-being and prevents or treats mental health conditions (The UN Refugee Agency, n.d.). This service aims to tackle and enhance the well-being of individuals and communities among Palestinian refugees and empower their resilience. The Mental Health and Psychosocial Support (MHPSS) program is integrated into the Family Health Team approach, a comprehensive, life-course strategy designed to address the needs of Palestinian families through a multidisciplinary team of health professionals

to enhance the quality of health services (UNRWA, 2022). It also includes the training of medical staff for mental health, screening high-risk groups among Palestine refugees at all health centers and referring patients with severe mental health conditions. The initiative demonstrated that there was an increase in the number of screenings, and individuals with depression, epilepsy, psychosis, and dementia were scared to access psychological and mental health services (UNRWA, 2022). In Jordan, the number of screenings increased approximately six times from 2020 to 2023, which indicated that the MHPSS program was successfully integrated into the primary health care and family health team approach and that there were also higher needs. On the other hand, according to Turki et al. (2020), the MHPSS program in Jordan faced challenges in terms of more mental health training for medical staff and the need for technical guidelines. However, there are limited articles and reports on the strengths and challenges to support evidence to enhance the program. Thus, it is essential to evaluate the strengths and challenges of implementing the MHPSS program to improve the mental health services for Palestine refugees in Jordan.

Theoretical Framework

A Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2022) and a Social Ecological Model (SEM) (Kilanowski., 2017)

were utilized to develop the conceptual framework for strengths and challenges for the MHPSS program for Palestine refugees at UNRWA in Jordan. This conceptual framework was used to create the online survey and interview guide, codebook, and analysis for quantitative and qualitative data.

Evaluation Questions

This evaluation project aims to identify the strengths and challenges of the MHPSS program from the perspective of healthcare providers. It seeks to enhance the program to improve the mental health of Palestine refugees in Jordan. Thus, the overarched evaluation questions are: What are the strengths of the current MHPSS program for Palestine refugees in Jordan? and What are the challenges of the current MHPSS program for Palestine refugees in Jordan?

Sub-evaluation questions are: How are the guidelines for mental health training for healthcare staff (Technical instructions and management protocols for MHPSS within UNRWA's primary health care model) related to the implementation of the MHPSS program?; How does the environment, including the work environment for healthcare staff and resources for MHPSS, support or/and hinder the implementation of the MHPSS program?; How does a patient's socio-political status affect their mental health from the perspective of medical staff?

Significance of the Thesis Project

The outcome of this evaluation will contribute to improving Palestine refugees' mental health conditions. It is critical to understand the factors that contribute to its success and enhance it by uncovering the strengths of the MHPSS program in Jordan. Identifying the challenges and areas for improvement in the MHPSS program will help clarify where intervention is needed and suggestions, such as the content of mental health training, guidelines, or systems for the MHPSS program in Jordan. Moreover, these strengths may apply to other health center locations at UNRWA in Lebanon, Syria, Gaza, and the West Bank. Addressing these challenges will enable the MHPSS program to improve effectively, even under limited resources and in emergencies.

Chapter 2: Review of the Literature

Introductory Paragraph

Refugees are likely to be a vulnerable group for health (Cuadrado, 2023), including mental health. UNRWA (2023) reported that 19.3% of Palestine refugees needed psychological or mental health support as Palestine refugees tend to have mental health issues due to ongoing violence, intergenerational trauma, and experiences of loss. Notably, addressing mental health for Palestine refugees is particularly critical in Jordan, where more than 2 million refugees reside (UNRWA, n.d.). The MHPSS program strengthened the resilience of Palestinian refugees by integrating the MHPSS program

into primary healthcare to address these issues. However, challenges regarding mental health training for healthcare professionals and the need for technical guidelines remained. Therefore, this evaluation aimed to identify the strengths and challenges of the MHPSS program in Jordan is critical.

Literature Review

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

UNRWA was established in 1949 to aim for relief and human development agencies for Palestine refugees after the Arab-Israel War in 1948. Today, 5.9 million Palestinian refugees are eligible to utilize UNRWA services. UNRWA provides services to five fields: Gaza, Syria, the West Bank, Lebanon, and Jordan (UNRWA., n.d.). UNRWA services include education, health, social services, improvement of the environment and infrastructure for refugee camps, protection, microfinance, and humanitarian emergencies. UNRWA operates health centers in the health field and has 25 health centers in Jordan (UNRWA., 2023).

Mental Health Issues for Palestine Refugees in Jordan

There are common mental health issues that refugees tend to have compared with general populations. According to Charlson et al. (2019), one in five people who experienced conflict settings had PTSD, anxiety disorders, depression, bipolar disorder, or schizophrenia, which was higher prevalence than the global population. Palestine

refugees are affected similarly; the mental health conditions and well-being of Palestine refugees are greatly influenced by occupation, ongoing conflict, and lack of justice and durable solutions to the status (UNRWA, 2024). UNRWA annual report in 2023 noted that 18.6% of Palestine Refugees have a high risk for mental health disorders. In Jordan, the number of high-risk mental health issues was 3.7%, which was the lowest of the five fields. However, this outcome should be interpreted with caution, particularly in the context of the COVID-19 pandemic, during which the prioritization of mental health screening may have been more challenging than under normal circumstances. Additionally, the largest population of Palestine refugees in Jordan indicates that even if the high-risk population was low, the number of the high-risk population was significant. Moreover, according to Alduraidi and Waters (2017), there were 43% of Palestinian adult refugees in Jordan had major depressive symptoms, which were associated with lower self-reported health and less hope for returning to Palestine. Therefore, mental health issues are also critical for Palestine refugees in Jordan.

MHPSS for Palestine Refugees at UNRWA

The MHPSS program was initiated in 2017 and aims to identify and tackle mental health disorders, particularly in Gaza (UNRWA, 2024). MHPSS program is based on the Mental Health Global Action Programme (mhGAP), a strategy to tackle and enhance psychological well-being for individuals and communities and empower

resilience (UNRWA, 2017). The mhGAP is a program aimed at expanding mental health services for mental, neurological, and substance use disorders (MNS) in particularly low and middle-income countries, which was developed by the World Health Organization (World Health Organization., n.d.). mhGAP guideline for MNS is developed to facilitate the provision of MNS interventions by a non-specialist wide range of healthcare providers (World Health Organization., 2023)

The MHPSS program at UNRWA is implemented through a family health approach. These services are integrated with primary health care at 144 UNRWA health centers in all fields, including Jordan. Training for mental health is provided to doctors and nurses, with ongoing refresher courses conducted to ensure the continuity and enhancement of their skills. The initial approach for the MHPSS program is screening patients who visit the health centers using the 12-item General Health Questionnaire (GHQ-12). GHQ-12 is a screening tool for mental illness to identify the risk of having distress or the need for psycho-social support or counseling services, which is widely used throughout the world (Goldberg et al., 1997). The questionnaire was comprised of 12 questions regarding emotions, sleep, self-esteem, and stress. This screening is conducted by healthcare providers at UNRWA health centers, particularly at high-risk populations, including uncontrolled patients with diabetes and or hypertension, high-risk pregnant women, new mothers, especially during the postpartum period, caregivers

for children with growth problems, frequent visitors to the outpatient clinic, gender-based violence survivors, survivors of other traumatic events. When a GHQ screening score is higher than 6, there is a high risk of mental health disorders. Healthcare providers request that individuals with a high risk of mental health disorders ask more detailed questions or refer them to senior nurses or doctors to provide MHPSS care, including counseling, social support, and referral to mental health clinics or hospitals.

Moreover, guidelines for the MHPSS program, such as technical instructions & management protocols for MHPSS within UNRWA's primary health care model were created in 2018 to operate the MHPSS service at the health center at UNRWA. Based on these instructions, all healthcare staff at UNRWA provide the MHPSS services. The guidelines are based on the mhGAP and include prescribed medicine, treatment, psychological support, counseling, referrals, and how to cooperate with patients who have mental health illnesses. Additionally, this included the different tasks or responsibilities by occupation.

Strength and Challenges for the MHPSS for Refugees

Thirty-one articles were identified using three databases, CINAHL, PubMed, and Google Scholar, with the ten-year period from June 1st, 2014, to June 1st, 2024, to identify the strengths and challenges of implementing a mental health program for refugees. The research included peer-reviewed papers published in English on MHPSS

service implementation in settings of paper refugees, humanitarian emergencies, and low- and middle-income countries. The search terms were utilized: “MHPSS,” “Mental health and psychological support,” “Mental Health,” “Evaluation,” “Program Evaluation,” “System,” “Palestine Refugee,” “Refugee,” AND “Low and Middle-Income Countries.” Exclusion criteria were implementing the MHPSS in high income countries.

The literature review found that there were four significant themes for facilitators and themes for barriers to mental health programs or services for refugees. The themes for strengths of MHPSS were reduced stigma, the relationship between patients and health care providers, success stories, and integration of MHPSS into primary health care. Stigma and discrimination, limited resources, insufficient knowledge, lack of mental health training, imposed work on health care providers, and social gender roles were themes of barriers to implementing MHPSS services.

Strengths of Implementing the MHPSS. Four themes were identified as strengths of implementing the MHPSS program.

Theme 1: Reduced Stigma toward Mental Health. One of the strengths of implementing the MHPSS program was the positive impact on mental health stigma. In accordance with Yassin et al. (2017), an MHPSS program contributes to decreasing stigma against mental health by creating awareness within Palestine refugee

communities in Lebanon. The research showed that visits to seek mental health services were notably increased. Before the mental health program began, community members were hesitant to seek mental health treatment due to mental health stigma. However, more accepted treatment after seeing the people who obtained mental health care having their mental health conditions improved. Additionally, patients realized that mental health illness is the same as other physical diseases, resolving misconceptions. Other studies had the same outcome, which indicated that implementing the MHPSS program for Palestine refugees reduced the stigma in Gaza (Bruno et al., 2019). Additionally, not only did studies of Middle Eastern refugees, but similar findings were also revealed in Ethiopia, which showed reduced stigma due to the implementation of MHPSS services (Ayano & Assefa, 2016).

Theme 2: Relationship between Patients and Healthcare Providers. The strong connection between patients and healthcare providers was another strength of implementing MHPSS programming. According to Akita et al. (2021), the close relationship between patients and healthcare providers was a strength of implementing the MHPSS as comprehensive healthcare was provided to the entire family. This was because patients could receive mental health care from the same doctor at the same health center, and the MHPSS program was integrated with primary health care at the UNRWA health center. In addition, another study demonstrated that the family health

team approach built trust between health care providers and patients as well as adherence for following up on the next appointment as one doctor sees the same patients every time (Tamming et al., 2023). According to Noubani et al. (2021), healthcare providers in Lebanon emphasized that in the context of persistent mental health stigma, building trust through open dialogue is a critical first step in the treatment process to foster patient security. A qualitative evidence synthesis study revealed that building trust and supportive relationships was key to increasing program participation and effectiveness in MHPSS programs (Dickson & Bangpan, 2018). Healthcare providers who demonstrate compassion, flexibility, crisis response skills, and self-disclosure contribute to recovery and the promotion of dialogue. This insight indicated that it was vital to effectively enhance the MHPSS's acceptance based on the strong connection grounded in trust.

Theme 3: Success Stories. Success stories were also strengths and important outcomes of implementing mental health programs, particularly the empirical evidence of supporting Palestine refugees. Taming et al. (2023) indicated there were multiple successful cases of implementing MHPSS programs for Palestine refugees in Gaza that included supporting mental health disorders, such as anxiety disorders, suicidal ideation, and postnatal depression. In addition, the MHPSS program positively affected the management of non-communicable disease conditions, particularly diabetes. The

flexibility of implementing MHPSS was also evidence of program effectiveness. According to Taming et al. (2023), although stigma toward mental health existed in the Gaza Strip, healthcare providers reassured patients to keep confidentiality regarding mental health conditions from their family members. This behavior is critical as many Palestine refugees prefer their families not to know about their mental health conditions due to mental health stigma. These success stories may contribute to enhancing the implementation of the MHPSS program as well as health outcomes among Palestine refugees.

Theme 4: Integration of MHPSS into Primary Health Care. Another strength of implementing MHPSS was integrating MHPSS into the primary healthcare setting. Embedding MHPSS within the primary healthcare system makes it possible to deliver comprehensive physical and mental healthcare. According to Akita et al. (2021), integrating the family health team approach provides mental health services from the same regular healthcare providers at UNRWA health centers. In Lebanon, the Ministry of Health-led mental health reform reported that integrating primary health care based on the WHO mhGAP was key to success. Specifically, doctors, nurses, and social workers have received training, enabling primary healthcare facilities to provide initial MHPSS services (Noubani et al., 2021). Additionally, Ayano & Assefa, (2016)

indicated that integrating MHPSS into primary care was beneficial in terms of increasing access to mental health care and reducing stigma and cost. In low- and middle-income countries such as Jordan, Pakistan, Afghanistan, Srilanka, Lebanon, and Iraq, there have also been some notable successes in integrating mental health into primary care settings (Budosan, 2011; Hijazi et al., 2011; Jenkins, 2012; Sadiq, 2011; Ventevogel et al., 2012). These examples highlight that integrating MHPSS into primary health care can contribute to building sustainable and effective mental health care systems across diverse settings.

Challenges of Implementing the MHPSS. Four themes were also highlighted as challenges of implementing the MHPSS program.

Theme 1: Stigma and Discrimination. One of the major challenges to implementing the MHPSS program for refugees was stigma and discrimination toward mental health. According to Turki et al. (2020), there was cultural stigma and discrimination toward mental health, which contributed to barriers to implementing the MHPSS. McKell et al. (2017) also indicated that stigma was a significant challenge to access mental health support as individuals with mental illness were labeled “crazy” by Palestine refugees in Jordan. In addition, the behavior of seeking mental health support was viewed negatively by people in Gaza due to stigma, which led to the hesitation to access mental health services from the perspective of medical providers (Tamming et

al., 2023). Other research demonstrated that while the mental health program reduced mental health stigma, stigma still existed that family members still did not accept mental health illness and criticized patients with mental health disorders (Yassin et al., 2017). A stigma toward mental health is a burden to seek mental health support, which deteriorates mental health outcomes (Corrigan et al., 2014). Additionally, the stigma toward mental health impacts more females than males since females need to be permitted to obtain treatment or support for mental health conditions from fathers or husbands. Other Arab cultures also indicated that there was a stigma toward mental health, which prevented them from seeking treatment (Almazeedi & Alsuwaidan, 2014). In Lebanon, patients may fear judgmental attitudes from healthcare providers regarding their mental health (Noubani et al., 2021). Additionally, stigma toward mental health was a major barrier to access to mental health care, including health-seeking behavior, in Arabic countries as well as in non-Arabic refugees and low-middle-income countries (Ayano & Assefa, 2016).Thus, research noted that reducing stigma was essential to improving mental health (McKell et al., 2017).

Theme 2: Limited Resources. Resource limitations were also challenges in implementing the MHPSS program. Resources included time, a shortage of health care providers, a lack of medication, mental health specialists, finances, and paper-based medical records. According to Turki et al. (2020), more than 70% of healthcare

providers at the UNRWA health centers in Jordan perceived limited resources, including the availability of medication, mental health specialists, time, and cost, as barriers to the health center at UNRWA in Jordan to implementing the MHPSS program. Other research has also consistently demonstrated the outcome of the time constraint problem for implementing MHPSS in Gaza (Tamming et al., 2023). Medical providers are overwhelmed with their workload, which led to not having enough time to provide adequate mental health care, as cooperating with people living with mental health illnesses or concerns requires more time than another job (Tamming et al., 2023). Imposed work on health care providers is also a barrier for the MHPSS program. Approximately 60% of the healthcare staff felt that working with patients living with mental health disorders or mental health concerns was a burden and challenging (Turki et al., 2020). Additionally, the rise in mental health cases and needs placed an increased burden on healthcare providers in Gaza. (Ubaid et al., 2021).

One of the challenges of implementing MHPSS is the lack of health providers, including doctors and other health staff, which can make providing adequate health care difficult (Akita et al., 2021). In other contexts, such as among refugee populations and in low-income countries like Lebanon, Myanmar, and Ethiopia, the implementation of MHPSS had been constrained by limited humanitarian capacity, including shortages of healthcare providers and mental health professionals, and insufficient time for service

delivery (Ayano et al., 2016; Elshazly et al., 2019; Dickson & Bangpan, 2018; Keynejad et al., 2018; Noubani et al., 2021).

Moreover, the financial situation for Palestine refugees was one of the limited resources. Significant factors that contribute to distress or mental health issues in Gaza include precarious financial situations, such as unemployment (Tamming et al., 2023). Additionally, healthcare providers indicated that individuals in Gaza may not have funds to cover the transportation fees to visit the health centers (Tamming et al., 2023).

The limitations in resources also included essential medical supplies and insufficient clinical infrastructure. Regarding a lack of medical supplies, challenges to implementing the MHPSS program included limited resources such as medication, guidelines for prescribed medicine, and the use of paper-based medical charts in Jordan (McKell et al., 2017). Similarly, Ubaid et al. (2021) also reported that a lack of electronic health record was one of the challenges in Gaza. According to a systematic review, using paper-based health records hindered data collection and follow-up in low and middle-income countries (Keynejad et al., 2018). The availability of psychotropic medication was inconsistent in Myanmar among Rohingya refugees and Ethiopia (Ayano et al., 2016; Elshazly et al., 2019). Limited resources, including financial constraints, shortage of mental health specialists, lack of medication, and paper-based medical records, were barriers to the implementation of MHPSS in Arabic and non-

Arabic refugees and low-middle-income countries.

Theme 3: Insufficient Knowledge among Healthcare Providers. Insufficient knowledge of mental health among healthcare providers is also a barrier to implementing the MHPSS program. Turki et al. (2020) demonstrated that 73.2% of healthcare providers at the health center at UNRWA in Jordan were not confident about having policies and plans of knowledge for mental health programs. In addition, 42.0% of healthcare staff were not confident regarding their skills for the mental health of patients. In addition, healthcare staff noted that they need more specific training on topics such as domestic violence (Tamming et al., 2023). Insufficient knowledge and skills regarding mental health among healthcare providers was also a challenge in other low- and middle-income countries implementing MHPSS. In Lebanon, although training is available, it is limited to case management, and healthcare providers lack the skills and confidence necessary to hospitalize and treat severe cases (Noubani et al., 2021). A systematic review also revealed that even with adequate staffing, concerns remained about whether healthcare providers possessed sufficient skills to address the mental health needs of patients with mental health conditions; many primary care practitioners reported lacking the necessary knowledge and competencies in mental health care (Dickson, K., & Bangpan, M., 2018).

Theme 4: Lack of Mental Health Training. The lack of mental health training

for healthcare providers was also a challenge for MHPSS programs. Most of the healthcare workers at UNRWA in Jordan did not receive mental health training at UNRWA and considered that they did not have enough mental health knowledge (Turki et al., 2020). Additionally, 88.2% of participants in this study responded to the need for mental health training to provide adequate mental health care. The lack of mental health training was not only for Palestine refugees but also in the Arab culture (McKell et al., 2017). Although mental health training was conducted in Lebanon, healthcare providers expressed concerns about insufficient refresher and follow-up training in Lebanon (Noubani et al., 2021). Even in Ethiopia, a lower-middle-income country, there was also a lack of training among general healthcare providers regarding mental health for implementing the MHPSS. Thus, Ayano et al. (2017) noted that the successful implementation of the MHPSS program required proper training and education for general healthcare providers.

Conceptual Framework for Evaluating the MHPSS Implementation at UNRWA

The evaluation advocated for an integrated approach, using a conceptual framework to evaluate the program and to develop a conceptual model for the best healthcare operations. CFIR and SEM were combined to develop the conceptual

framework to identify strengths and challenges for implementing the MHPSS program among Palestinian refugees at UNRWA in Jordan from the perspective of healthcare providers. Consolidated Framework for Implementation Research (CFIR) is a theoretical framework that systematically identifies and evaluates the barriers and facilitators that influence the implementation of innovations in practice (Damschroder et al., 2022). There are five domains: innovation, outer setting, inner setting, individuals, and implementation process. Building on the literature review, this paper discusses the development of the conceptual model by utilizing the outer setting, inner setting, and individual domains.

The conceptual model was designed with reference to the Social Ecological Model, which is the model suggesting that individual behavior or health is formed not only by individual factors but also through interaction with various factors, such as the environment, systems, or cultural norms (Kilanowski, 2017). These occur at the individual, interpersonal, community, organizational, and environmental levels. The conceptual model was developed by using the individual level, institutional level (i.e. the health center), organizational level (i.e. UNRWA operations), and macro level (i.e. conflict or stigma).

The conceptual framework was utilized to create online survey questionnaires, interview guides, a codebook, and analyses of interview transcripts -- contextual factors

affecting the program's implementation. Various complex factors could serve as barriers or facilitators when evaluating a program. The conceptual model developed by integrating the CFIR and SEM enabled the program to be systematically assessed. This integrated approach is valuable for explaining and predicting the success or failure of the intervention and for identifying effective implementation strategies (Figure. 1).

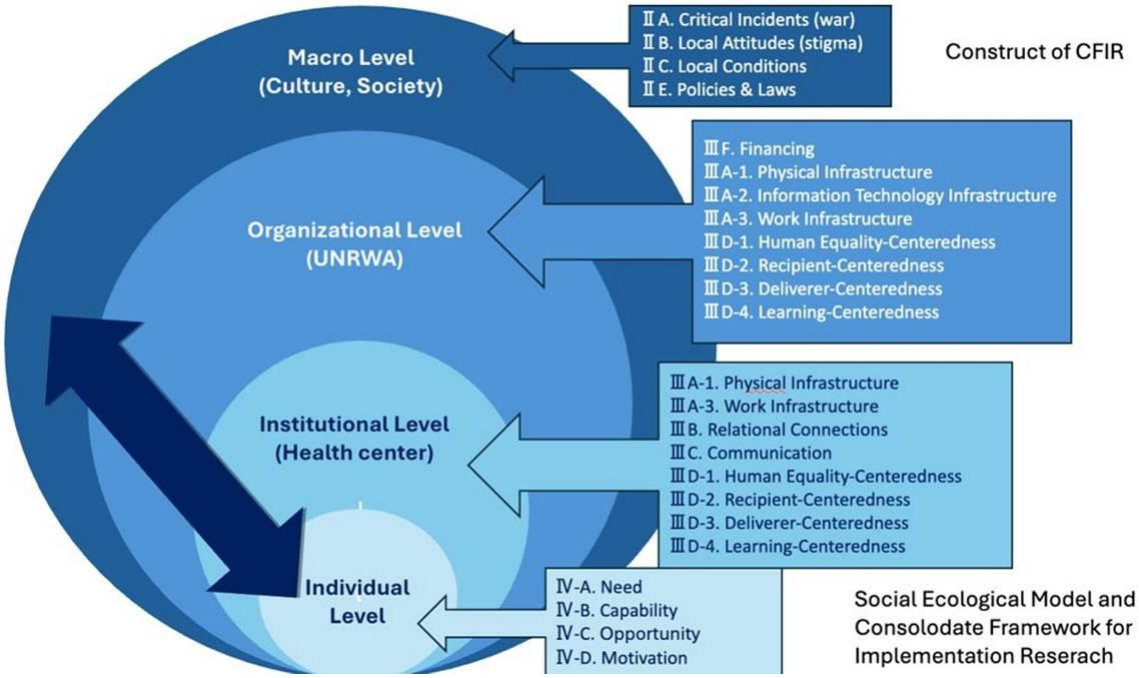

Figure1. Conceptual Model

Summary of the Challenges and Strengths of Current Implementation of the MHPSS Program among Refugees

Although the prevalence of mental health disorders in Jordan is not higher than

in other fields where UNRWA operates, the population of Palestine refugees is highest in five fields at UNRWA. The strengths of implementing the MHPSS program at UNRWA were decreased stigma toward mental health, the strong relationship between patients and healthcare workers, success stories, and integration of MHPSS into primary health care. However, previous research indicated that mental health programs for refugees had challenges such as the existence of stigma and discrimination, limited resources, and insufficient provider knowledge and training. In addition, there was less literature regarding the MHPSS program for Palestine refugees in Jordan. Therefore, this evaluation project contributes to enhancing the mental health of Palestinian refugees in Jordan by identifying their strengths and challenges and offering suggestions to improve their strengths and overcome the obstacles.

Chapter 3: Methodology

Introduction

The evaluation of implementing the MHPSS program in Jordan was conducted utilizing mixed methods to understand the strengths and challenges from the perspective of healthcare providers. The participants were doctors, senior staff nurses, staff nurses, practical nurses, and midwives. Online surveys were conducted using the developed online questionnaire for all 25 health centers in Jordan. Interviews were conducted in ten middle and large-sized health centers in Jordan using a created interview guide. Quantitative data was analyzed descriptively using Microsoft Excel. Qualitative data was used for thematic analysis utilizing MAXQDA. This project had research approval from the research review board at the UNRWA Jordan Office. Emory University Institutional Review Board approval was not needed due to the evaluation project.

Study Design

A mixed-methods approach combining a cross-sectional survey and semi-structured interviews was utilized. A literature review was conducted to develop the survey questionnaires and the interview guide. An online survey and interviews were implemented separately during a similar data collection period. The online survey was distributed to all 25 health centers across Jordan and completed independently by healthcare professionals. In person interviews were conducted with healthcare providers

in 10 selected health centers by a researcher.

Sampling and recruitment

The project was implemented at the health centers at UNRWA in Jordan from May to October 2024. The population was healthcare staff trained in the MHPSS, including doctors, senior staff nurses, staff nurses, practical nurses, and midwives working for the UNRWA health centers in Jordan. This population was determined due to their different roles in MHPSS services in health centers. All 25 health centers were selected for the survey to account for operational differences based on health center size and location, as well as the low response rate of the online survey. The online survey was distributed via e-mail by a researcher.

For semi-structured interviews, convenience and gatekeeper sampling was used to recruit, which is common for qualitative approaches (Hennink et al., 2020). The interview was conducted in selected middle or large sized of 10 health centers, with two to three from each of the four areas administrative regions in Jordan: Jabal Al-Hussien, Main Baqaa, Amman New Camp, Taybeh, Marka, Awajan, Zarka, New Irbid, Husn, and Jerash. These health centers were selected since middle- and large-sized health centers had a greater number of healthcare providers trained in the MHPSS. Due to the limited number of staff at small health centers, conducting interviews may interfere with their

work. This approach was also selected because it reached saturation for the number of interviewers from each professional category, and it was possible to access all four types of medical staff for interviews. Additionally, it explored potential regional differences. With respect to recruitment, the key informant of each UNRWA health center was to approach the participants for an interview and introduce the researcher to find a representative person among the medical staff at each health center. Interviewed participants also had an opportunity to complete a separate online survey.

Measures

Questionnaires and interview guides and were developed based on the literature review, technical instructions & management protocols for MHPSS within UNRWA's primary health care model, and conceptual model created by CFIR (Damschroder et al., 2022) and SEM (Kilanowski., 2017) in English and Arabic. Online survey questionnaires and interview guide were created in English at first and translated to Arabic by a translator. Both instruments were adjusted according to advice from the MHPSS coordinator at the Jordan field, public health coordinator, and the supervisor who is chief of disease prevention control at UNRWA regarding creating appropriate and helpful questions and cultural considerations. The Survey questionnaire consisted of 38 questions, included multiple choices, a Likert scale, and open-ended questions, while the interview guide was comprised of 24 questions with open-ended questions.

Both the survey and interview guide included questions regarding demographics such as age, gender, and number of working experiences, as well as assessing the strengths and challenges of implementing the MHPSS program, such as mental health training, guidelines for MHPSS, resources availability, work environment, stigma toward mental health, and impact of sociopolitical situations. Survey and interview guide are provided in appendix A and B.

Data Collection Procedures

An interview and an online survey were conducted on healthcare staff by a researcher at the UNRWA health center in Jordan. The survey was administered online using Microsoft Forms in both English and Arabic between 22nd July and 8th August 2024. The researcher emailed the participants with the link to the survey. Before the beginning of the survey, the participants were provided online consent. The interviews were conducted in person at 10 health centers between 16th and 29th July 2024. At each health center, interviews were conducted with one doctor, one senior staff nurse, one practical nurse, and one midwife. Participant selection and scheduling were facilitated in advance by key informants at each respective health center. The participants could select to have the interviews in English or Arabic. A researcher conducted the English interviews, while a trained interpreter implemented the Arabic interviews. The interview was recorded by audio recorder, taken note of, and transcribed to obtain accurate data

in both English and Arabic interviews. In Arabic, the transcript was translated by a translator. The ID number, which served as a unique identifier to utilize anonymized individuals in this project, was assigned to each participant to ensure their private information was not connected. The information from the survey and interview were used only for this project and shared only with the researchers. This information was confidential. The data was stored securely on OneDrive, and the audio recordings were deleted after the project had been completed.

Data Analysis Methodology

Quantitative data were analyzed using Microsoft Excel. Descriptive statistics were used to calculate frequency and proportions. Mean scores and standard deviations for each categorical variable were calculated to summarize overall responses. For the qualitative data, thematic analysis was conducted using MAXQDA 24. The codebook employs a conceptual model using CFIR and SEM to identify themes across the interviews. Inductive and deductive coding were used to code the transcript to identify themes. This analysis helped summarize themes based on the participants' responses.

Positionality

My identity as a female nurse from a non-Arabic background and non-Arabic speakers with no previous experience with the MHPSS program or refugee populations influenced the research process in both positive and challenging ways. My experience

working as a mental health and psychiatric nurse enhanced my deep analysis in terms of understanding the job contents, including the different roles of occupations, treatment for psychiatric and mental health disorders, and how important the skills to communicate with people with mental health conditions which was helpful to developed data collection tools. Additionally, I understand the busy schedules and emotional experiences of healthcare providers, which may help elicit their narratives during the interview process. In contrast, my position as a non-Arabic speaker unfamiliar with Arabic cultural background might be affected by the remaining basic analysis that could not deeply consider Arabic cultural aspects. In addition, the lack of prior experience of the MHPSS program or refugee populations may have impacted the creation of the survey or interview guide, which may have failed to capture key aspects of participants' experiences.

Chapter 4: Results

Introduction

This study aimed to understand the strengths and challenges of the implementation of the MHPSS for Palestine Refugees in Jordan from the perspective of healthcare providers. Data collection included a quantitative online survey and qualitative interviews with healthcare providers, including doctors, senior staff nurses, and practical nurses and midwives. The quantitative data included responses from 87 healthcare providers, of which 80 were eligible for analysis. The overall response rate was 23.1%, with 20 out of 25 health centers in Jordan participating in the survey. Males made up 25% of the respondents and females 75%. The response rates percentage of respondents in each group were: medical officer, 22.5%; senior staff nurse, 11.3%; staff nurse, 12.5%; practice nurse, 32.5%, midwife, 13.8%, no answer, 7.5%. The large health centers had the highest percentage of respondents, with a response rate of 41.5%. The proportions of respondents from medium and small health centers were 7.5% and 17.5%, respectively. Additionally, 8.8% of responses were either missing size information or from health centers with unidentified sizes.

Interviews were conducted with 38 healthcare providers from ten medium and large health centers, which were Jabal Al-Hussien, Main Baqaa, Amman New Camp, Taybeh, Marka, Awajan, Zarka, New Irbid, Husn, and Jerash. Ten doctors, ten senior

staff nurses, ten practical nurses, and eight midwives were interviewed. Over 75% of participants in both the survey and interviews had more than 10 years of experience working as healthcare providers at UNRWA. The findings from analyzing qualitative and quantitative data are organized by evaluation questions. Overall, many healthcare providers considered the MHPSS service to be implemented well, even though there are challenges. Additionally, the quantitative and qualitative findings, as well as the perspectives of all healthcare provider groups, were consistent, with any discrepancies explicitly noted in the text. For further details, refer to Appendix C, Table 10.

Table 1. Demographic Characteristics for Survey and Interviews Respondents.

		Quantitative Data Analysis			Qualitative Data Analysis		
		N	%	Years- Old	N	%	Years- Old
Gender	Male	20	25.0		8	21.1	
	Female	60	75.0		30	78.9	
Age	Mean			46			47
	Max			59			59
	Min			31			36
Health Center size	Large	43	53.8		28	73.7	
	Medium	13	16.3		10	26.3	
	Small	17	21.3		-	-	
	UN	4	5.0		-	-	
	NA	3	3.8		-	-	
Occupation	Medical officer	18	22.5		10	26.3	
	Senior Staff nurse	9	11.3		10	26.3	
	Staff nurse	10	12.5		10	26.3	
	Practical nurse	26	32.5		10	26.3	
	Midwife	11	13.8		8	21.1	
	NA	6	7.5		-	-	
Education	Diploma	30	37.5		14	36.8	
	Bachelor	30	37.5		18	47.4	
	Master	11	13.8		4	10.5	
	PhD	2	2.5		-	-	
	Nursing orientation	4	5		-	-	
	Other	-	-		2	5.3	
	NA	3	3.8		-	-	

		Quantitative Data Analysis			Qualitative Data Analysis		
		N	%	Years- Old	N	%	Years- Old
Experience of UNRWA	Less than 1 year	0	0		-	-	
	1 - 3 years	2	2.5		2	5.3	
	4 - 5 years	7	8.8		1	2.6	
	6 – 10 years	10	12.5		2	5.3	
	More than 10 years	61	76.3		33	86.8	
	NA	0	0		-	-	
	Mean						18.2
	Min						2
	Max						31
Frequency of metal health education	None	0	0		-	-	
	Less than once a year	20	25		-	-	
	Once a year	43	53.8		-	-	
	2 -3 times a year	7	8.8		-	-	
	4 - 6 times a year	0	0		-	-	
	More than 6 times a year	0	0		-	-	
	NA	4	5		-	-	
	Other	6	7.5		-	-	

Key Findings of Quantitative and Qualitative Data

Overarched Evaluation Questions

What are the strengths of the MHPSS program for Palestine refugees in Jordan?

Healthcare providers indicated that the MHPSS program's strengths were enhanced awareness of mental health among patients at the UNRWA health center and fostering strong relationships with patients and the local community, which were aligned with both results from quantitative and qualitative data. Both benefits contribute to the reduction of stigma toward mental health.

Relationships with the Local Community and Patients. From the survey and

interviews, one of the facilitators of the MHPSS program is relationships with the community. Notably, 85% of survey participants agreed or strongly agreed that the relationship with the community was beneficial to providing the MHPSS services.

Table 2. Distribution of Relationship with the Community

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
15. Relationships with the community help to provide MHPSS services.						
All health care providers	10 (12.5)	58 (72.5)	11 (13.8)	0 (0)	1 (1.3)	0 (0)
Doctors	2 (11.1)	13 (72.2)	2 (11.1)	0 (0)	1 (5.6)	0 (0)
Senior Staff Nurses	0 (0)	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)
Staff nurse	1 (10.0)	7 (70.0)	2 (20.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	20 (76.9)	5 (19.2)	0 (0)	0 (0)	0 (0)
Midwives	2 (18.2)	9 (81.8)	0 (0)	0 (0)	0 (0)	0 (0)

In the interviews, 25 out of 38 healthcare practitioners mentioned that their relationship with patients was more robust and closer to patients by building trust, which allowed them to open discussions concerning their mental health conditions. A female midwife shared, "It has created an atmosphere of trust between us and the women in the community, so our advice has become trusted by patients, which positively reflects on their physical and mental health." These positive relationships between patients and healthcare providers also can reduce stigma as many people trust medical professionals. Accordingly, patients ask questions and share information regarding mental health. A

male doctor mentioned, “The people on the outside, didn’t know, this patient didn't know how to go to doctor. But after the implementation of this attempt (MHPSS program), and as I've told you before, we got a good relationship with our refugees, and they have got the confidence, so they have started coming here and seek the services by themselves, so come in here. So, the stigma has started to disappear little by little.”

Raising Awareness of Mental Health. Another key advantage of MHPSS was increased awareness of mental health for patients at the UNRWA health centers, which reduced the stigma toward mental health. Thirty-two out of 38 healthcare staff indicated that people have become more aware of mental health regarding disorders, symptoms, or concerns of mental health, and talked about it with healthcare providers more frequently. A female midwife noted, “Encouraging women to talk and open up, and the sense of security in the clinic is a strength. Awareness among women has also increased.” (A female midwife, suggesting that building trust has promoted openness among female patients. Additionally, increased awareness of mental health contributes to reduced stigma among Palestine refugees who come to visit UNRWA health centers compared with the program started. A female senior staff nurse shared, "Awareness has increased, and stigma has decreased."

What are the challenges of the MHPSS program for Palestine refugees in Jordan?

Stigma and financial conditions among Palestine refugees are key obstacles to accessing to mental health care. These challenges have similar findings from both quantitative and qualitative data.

Stigma toward Mental Health. One of the challenges regarding implementing the MHPSS program, which was supported by both quantitative and qualitative data, was the stigma among Palestine refugees. Table 3 highlights that 67.5% of healthcare providers who participated in an online survey "strongly agreed" or "agreed" that there was a stigma toward mental health among Palestine refugees. On the other hand, according to the survey findings, there was less stigma among healthcare providers than among refugees. Regarding stigma among healthcare providers, the responses showed an approximately equal distribution: 38.8% reported "strongly agreed" or "agreed" that stigma exists. In comparison, another 40.1% stated "strongly disagreed" or "disagreed" that it does not. Notably, among doctors and midwives, approximately 45% of the respondents disagreed that there was a stigma toward mental health among healthcare providers, which is 10 to 15 percent higher than respondents in other occupations.

Table 3. Distribution of Stigma toward Mental Health

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
27-1). There is a stigma about mental health among Palestine refugees.						
All health care providers	14 (17.5)	40 (50.0)	9 (11.3)	15 (18.8)	0 (0)	2 (2.5)
Doctors	3 (16.7)	9 (50.0)	3 (16.7)	3 (16.7)	0 (0)	0 (0)
Senior Staff Nurses	3 (33.3)	4 (44.4)	1 (11.1)	1 (11.1)	0 (0)	0 (0)
Staff nurse	1 (10.0)	6 (60.0)	1 (10.0)	1 (10.0)	0 (0)	1 (10.0)
Practical Nurses	3 (11.5)	15 (57.7)	1 (3.8)	6 (23.1)	0 (0)	1 (3.8)
Midwives	3 (27.3)	3 (27.3)	2 (18.2)	3 (27.3)	0 (0)	0 (0)
27-2). There is a stigma about mental health among health care providers.						
All health care providers	1 (1.25)	30 (37.5)	15 (18.8)	29 (36.3)	3 (3.8)	2 (2.5)
Doctors	0 (0)	4 (22.2)	5 (27.8)	8 (44.4)	1 (1.25)	0 (0)
Senior Staff Nurses	0 (0)	4 (44.4)	1 (11.1)	3 (33.3)	1 (11.1)	0 (0)
Staff nurse	0 (0)	3 (30.0)	1 (10.0)	4 (40.0)	1 (10.0)	1 (10.0)
Practical Nurses	1 (3.8)	12 (46.2)	4 (15.4)	8 (30.8)	0 (0)	1 (3.8)
Midwives	0 (0)	4 (36.4)	2 (18.2)	5 (45.5)	0 (0)	0 (0)

All interviewees showed that stigma toward mental health remains a significant challenge for the MHPSS program regarding experiencing shame, being labeled, and fear of community judgment. From the perspective of healthcare providers, Palestine refugees often held negative feelings toward mental health, including embarrassment, shame, or fear. A male doctor stated, "This is because patients here suffer from a culture of shame and are embarrassed to talk about mental health issues." Additionally, people were afraid to be labeled "crazy," which led to patients hesitating to talk about their

mental health conditions. A female practical nurse shared, "The stigma, everyone thinks that a mental health patient is crazy or has a disability." Thus, Palestine refugees were afraid of other people discovering their mental health issues, especially their families and relatives, including husbands and mothers-in-law, or communities, as their communities are very close. They fear "judgment" from the community, as when people find out about mental health in the family, people see them differently. A female senior staff nurse mentioned, "Yes, for example, a patient may refuse to let us talk to her relatives. They fear the neighbors' judgment, who might say that there is a mental illness in the family or that someone might see her, or they fear that people will treat them differently."

This social stigma hindered access to or engagement in treatment. Some healthcare providers indicated that people refused to create new mental health records and, even if they could, patients often did not return to follow-up. A female Senior staff nurse told us that, “When you diagnose a case and want to continue, the patient may call and say her family doesn’t want her to continue the treatment due to the fear of stigma.”

Financial Situation of Patients. Another barrier to the implementation of the MHPSS program was the financial conditions among Palestine refugees. Based on the

survey data, lack of basic needs and worsening economic conditions among Palestine refugees were challenges for engaging in the MHPSS program in terms of impact on mental health conditions among Palestine refugees. Quantitative data indicated that respectively, 98.8% and 100% of participants responded “strongly agreed” or “agreed” regarding limited basic needs and the deteriorating economic situation as factors affecting the mental health conditions among Palestine refugees.

Table 4. Distribution of Financial Situation among Palestine refugees

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
28 The lack of basic needs for Palestine refugees influences their mental health conditions.						
All health care providers	57 (71.3)	22 (27.5)	1 (1.25)	0 (0)	0 (0)	0 (0)
Doctors	11 (61.1)	7 (38.9)	0 (0)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	6 (60.0)	4 (40.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	17 (65.4)	8 (30.8)	1 (3.8)	0 (0)	0 (0)	0 (0)
Midwives	10 (91.0)	1 (9.1)	0 (0)	0 (0)	0 (0)	0 (0)
29. The deteriorating economic situation influences mental health conditions among Palestine refugees.						
All health care providers	62 (77.5)	18 (22.5)	0 (0)	0 (0)	0 (0)	0 (0)
Doctors	12 (66.7)	6 (33.3)	0 (0)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	9 (100)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	7 (70.0)	3 (30.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	19 (73.1)	7 (26.9)	0 (0)	0 (0)	0 (0)	0 (0)
Midwives	10 (91.0)	1 (9.1)	0 (0)	0 (0)	0 (0)	0 (0)

In the interviews, 24 out of 38 healthcare providers mentioned that economic

conditions among Palestine refugees were also a notable challenge for the MHPSS program in terms of factors of mental health conditions and access to mental health care. Consistent with the quantitative findings, financial hardship influenced adverse mental health conditions. A female senior staff nurse mentioned that “Social conditions, financial situation, and many psychological problems are caused by poverty and the inability to meet basic needs.” Thus, healthcare providers at the UNRWA health center considered that economic hardship was one of the factors that contributed to mental health issues among Palestinian refugees in Jordan. Moreover, some refugees were unable to afford transportation fares to access health services due to financial hardship. A male doctor stated that, “But another barrier is that social status people inside our community is very bad. Especially inside the camps. That's why they sometimes, they don't have enough money to come to the health center for normal usual services, not for mental health services. Some of them are not able to come to that center because of the transportation fees. They don't have transportation fees and economy status is coming are going to more difficult way.” Therefore, accessing mental health specialists at an external hospital or clinic through a referral is also a burden for Palestine refugees due to financial conditions.

Sub Evaluation Question1

How is mental health training for healthcare staff and guidelines (Technical instructions and management protocols for MHPSS within UNRWA's Primary Health Care Model) related to implementation of the MHPSS program?

Mental Heatlh Training for Healthcare Staff. The quantitative and qualitative data demonstrated that mental health training for healthcare staff and the guidelines (technical instructions and management protocols for MHPSS within UNRWA's Primary Health Care Model) were beneficial for supporting mental health providers in implementing the MHPSS program. All healthcare providers, including doctors, senior staff nurses, staff nurses, practical nurses, and midwives, were satisfied with mental health training for healthcare staff in terms of improved knowledge of mental health. They found the training especially helpful in screening and working with patients who have mental health concerns and disorders. These findings were consistent with both quantitative and qualitative results.

According to the survey result, healthcare providers perceived the training contents delivered through the MHPSS program training conducted by UNRWA since the program's start, particularly regarding counseling and advice, assessment and evaluation, and providing education as helpful. The interview results indicated that

among doctors, the training served as a valuable opportunity to revisit and consolidate existing knowledge and skills in mental health. In contrast, nurses demonstrated that the training was beneficial for enhancing the quality of care. Although the training was beneficial for improving knowledge, there were suggestions that more training is needed, such as continuous training, more specific knowledge, and practical mental health training among all groups of healthcare workers, such as doctors, senior staff nurses, staff nurses, practical nurses, and midwives.

The guidelines for the MHPSS, including GHQ-12 as a screening tool, were considered convenient by healthcare providers in terms of clarity, ease of understanding, and communication with patients. Notably, among doctors and senior staff nurses, guidelines were found to be beneficial to practical references when seeking information on mental health and encountering complex clinical cases. Therefore, all categories of healthcare professionals, including doctors, senior staff nurses, practical nurses, and midwives, mentioned that the guidelines, including GHQ-12, were comprehensive and sufficient.

Strength of Mental Health Training for Healthcare Staff. The key strengths of mental health training among healthcare providers were increased knowledge, and quality of care. As indicated by the quantitative analysis, most healthcare providers were

satisfied with mental health training in terms of improved knowledge of mental health (92.6%) and quality of care (93%). Additionally, more than 90 % of healthcare workers reported that this training was beneficial for screening and working with patients who have mental health concerns. There were no substantial differences across professional roles. Furthermore, in the mental health training, the topic of counseling and advice for patients, assessment and evaluation of mental health conditions, and providing education for patients were beneficial as the topic of mental health training. Among the respondents, 18.4%, all healthcare providers comprising doctors, senior staff nurses, staff nurses, and midwives, reported that topics on counseling and advising patients were perceived as beneficial. Additionally, there were slight differences in the topics considered beneficial among different professional groups. 13.4% of doctors, senior staff nurses, and staff nurses considered the topic of assessment evaluation valuable. In contrast, 13.4% of practical nurses and midwives responded that the topic of providing education to patients was beneficial.

Table 5. Distribution of Strengths for Mental Health Training

11-1). Mental health training at UNRWA for medical staff has enhanced my mental health knowledge.						
All health care providers (N=80)	19 (23.8)	55 (68.8)	2 (2.5)	2 (2.5)	0 (0)	2 (2.5)
Doctors (N=18)	2 (11.1)	14 (77.8)	1 (5.6)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses (N=9)	3 (33.3)	6 (66.7)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse (N=10)	4 (40.0)	6 (60.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses (N=26)	5 (19.2)	18 (69.2)	1 (3.8)	1 (3.8)	0 (0)	1 (3.8)
Midwives (N=11)	5 (45,5)	5 (45.5)	0 (0)	1 (9.1)	0 (0)	0 (0)
11-2). Mental health training at UNRWA for medical staff has enhanced the quality of care for patients with mental health.						
All health care providers	17 (21.5)	57 (71.5)	2 (2.5)	2 (2.5)	0 (0)	2 (2.5)
Doctors	5 (27.8)	12 (66.7)	1 (5.6)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	3 (33.3)	6 (66.7)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	3 (30.0)	7 (70.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	21 (80.8)	1 (3.8)	1 (3.8)	0 (0)	2 (7.7)
Midwives	5 (45.5)	5 (45.5)	0 (0)	1 (9.1)	0 (0)	0 (0)
20-1). Mental health training at UNRWA for medical staff has been helpful in screening people with mental health concerns and mental health disorders.						
All health care providers (N=80)	18 (22.5)	54 (67.5)	5 (6.3)	3 (3.8)	0 (0)	0 (0)
Doctors	5 (27.8)	12 (66.7)	1 (5.6)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	3 (33.3)	6 (66.7)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	3 (30.0)	6 (60.0)	1 (10.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	4 (15.4)	17 (65.4)	3 (11.5)	2 (7.7)	0 (0)	0 (0)
Midwives	3 (27.3)	6 (54.5)	1 (9.1)	1 (9.1)	0 (0)	0 (0)

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
20-2). Mental health training at UNRWA for medical staff has been helpful for working with patients who have mental health concerns and mental health patients.						
All health care providers	10 (12.5)	63 (78.8)	3 (3.8)	2 (2.5)	2 (2.5)	0 (0)
Doctors	1 (5.6)	17 (94.4)	0 (0)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	1 (11.1)	8 (88.9)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	3 (30.0)	7 (70.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	2 (7.7)	19 (73.1)	2 (7.7)	1 (3.8)	2 (7.7)	0 (0)
Midwives	2 (18.2)	7 (63.6)	1 (9.1)	1 (9.1)	0 (0)	0 (0)

21. Which mental health training topic for medical staff at UNRWA has been helpful to you in providing mental health services? (Multiple responses)

	1	N (%)	2	N (%)	3	N (%)
All health care providers (N=141)	Counselling & Advice	26 (18.4)	Assessment & Evaluation	19 (13.4)	Providing education	19 (13.4)
Doctors (N=33)	Assessment & Evaluation	6 (18.2)	Knowledge of disease	6 (18.2)	Counselling & Advice	5 (15.2)
Senior Staff Nurses (N=12)	Counselling & Advice	5 (41.7)	Assessment & Evaluation	2 (16.7)		
Staff nurse (N=15)	Counselling & Advice	4 (26.7)	Assessment & Evaluation	3 (20.0)		
Practical Nurses (N=49)	Providing education	7 (14.3)	Counselling & Advice	6 (12.2)	Knowledge of disease	5 (10.2)
Midwives (N=14)	Counselling & Advice	3 (21.4)	Providing education	3 (21.4)		

According to qualitative findings, the significant benefit of mental health training at UNRWA was increased knowledge regarding mental health among all healthcare providers in terms of identifying mental health cases and working with patients. Notably, a review of mental health disorders and medication knowledge was particularly beneficial among doctors. In addition, nurses responded that mental health training enhanced the quality of mental health care.

Increased Knowledge. 37 out of 38 healthcare providers mentioned that the mental health training increased their knowledge of how to identify mental health cases and how to work with patients. Besides, doctors particularly benefit from a review of mental health and psychotropic medications.

The training enabled healthcare staff to better identify individuals at high risk for mental health conditions or who have concerns requiring follow-up on their behavior. A male doctor shared that, "Actually, it helped me of course because it gave me the essential information how to detect terrible disease. " Additionally, the training particularly enhanced nurses' ability to identify patients with mental health conditions, which they had not been able to recognize before the training. A female practical nurse stated, "Now we recognize patients and can distinguish who needs psychological support and more time with them."

Furthermore, mental health training enhanced healthcare providers' knowledge

of how to work with patients at high risk of mental illness or diagnosed with mental illness. A female midwife told us, "We also learned about communication techniques" Thus, by enhancing their knowledge of mental health, healthcare providers could provide reassuring and confident care to patients with mental health conditions.

Among doctors, the strength of training was the review of mental health and medication knowledge. The refreshing knowledge of mental health was beneficial for doctors, as they had already learned about mental health at medical school or in their diplomas. A doctor stated that, “It was the very useful and I have previously a background regarding mental health since medical or medical status in the faculty of Medicine, but it makes a refreshment of my knowledge and to my experiences a lot in the way of.” Additionally, training in prescribing medication and understanding its availability was helpful in enhancing doctors' knowledge. A male doctor mentioned that “All of the staff members when having self-confidence after the training that they can deal with these cases, and doctors can diagnose and prescribe medications.”

Enhanced Quality of Mental Health Care among Nurses. In contrast to a survey, only nurses, including senior staff nurses, practical nurses, and midwives, responded that the training on mental health also increased the quality of mental health services. Due to the training, nurses reported that it is possible to provide psychological support for patients who need the support, which improved the quality of care. A female

practical nurse mentioned that “I have become more meticulous, and even if I can provide psychological support, the care has improved.” Thus, mental health training was beneficial for nurses to provide psychological support when patients need it.

Challenges of Training for Healthcare Staff. Quantitative findings showed that most health care providers considered that more training was needed and that it should be tailored. 87.6% of health care providers who took mental health training still desired more training. Additionally, 93.8% of participants agreed that mental health training should be tailored by roles and responsibilities, as they differ by occupation and authority.

Table 6. Distribution of Challenges for Mental Health Training

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
12. I think that I need more training for mental health.						
All health care providers	21 (26.3)	49 (61.3)	8 (10.0)	2 (2.5)	0 (0)	0 (0)
Doctors	5 (27.8)	12 (66.7)	1 (5.6)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	2 (22.2)	6 (66.7)	1 (11.1)	0 (0)	0 (0)	0 (0)
Staff nurse	5 (50.0)	5 (50.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	4 (15.4)	16 (61.5)	4 (15.4)	2 (7.7)	0 (0)	0 (0)
Midwives	2 (18.2)	7 (63.6)	2 (18.2)	0 (0)	0 (0)	0 (0)
20-3). Mental health training at UNRWA for medical staff needs to be tailored to their varied roles and responsibilities within the MHPSS program.						
All health care providers	7 (8.8)	68 (85.0)	4 (5)	0 (0)	1 (1.3)	0 (0)
Doctors	1 (5.6)	16 (88.9)	1 (5.6)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	1 (11.1)	8 (88.9)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	2 (20.0)	7 (70.0)	1 (10.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	2 (7.7)	22 (84.6)	1 (3.8)	0 (0)	1 (3.8)	0 (0)
Midwives	1 (9.1)	10 (91.0)	0 (0)	0 (0)	0 (0)	0 (0)

In the interviews, healthcare providers reported a need for continuous and practical mental health training, more specific knowledge, including both refreshment and updating of knowledge regarding mental health. A female practical nurse shared the need of training. “Refresher trainings because we are encountering new cases and need updated information from more experienced professionals.” Additionally, the refreshed training was suggested to be conducted, including updating information on mental health as medical science improves rapidly. A male doctor mentioned that “I think

mental health should be refreshed every year or every two years for the staff members, in order to, to be ready for that training, and to be updated with each information that is needed." The mean number of times the interviewee had received mental health training was 1.7, with the duration of training ranging from one to 14 days. Thus, healthcare providers need contiguous training.

Moreover, healthcare providers indicated that more detailed knowledge was needed, including how to work with patients, counseling, medication, social support, and treatment. A female midwife stated that, "Training on how to encourage them to talk more and how to help them out of their condition, and how to reassure them." Thus, healthcare providers indicated that more practical training is needed than theoretical.

Guidelines for the MHPSS (Technical Instructions and Management Protocols for MHPSS within UNRWA's Primary Health Care Model)

Strength of Guidelines. Both quantitative and qualitative findings demonstrated that the guidelines were beneficial for implementing the MHPSS program. Overall, similar responses indicated that all categories of healthcare professionals found the guidelines and the GHQ-12, a screening questionnaire, easy to use and useful for daily practice, including working with patients. Particularly in the qualitative data, both doctors and nurses found the guidelines to be a valuable

reference when addressing mental health concerns and managing complex clinical cases. Additionally, most all types of healthcare providers responded that the guidelines including GHQ-12 need not be modified.

According to the quantitative findings, participants indicated that guidelines and GHQ-12 were convenient in terms of being clear, concise, and straightforward, making them accessible to all medical staff, regardless of their prior experience with mental health care, which was 77.5% and 76.3%, respectively. Additionally, over 70% of interviewees indicated that both guidelines and GHQ-12 were practical for screening and working with patients who have mental health concerns and mental health disorders.

Table 7. Distribution of Strengths for Guideline

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
22-1). MHPSS Technical instructions* is clear, concise, and straightforward, making them accessible to all medical staff, regardless of their prior experience with mental health care.						
All health care providers	4 (5.0)	58 (72.5)	12 (15.0)	3 (3.8)	2 (2.5)	1 (1.25)
Doctors	0 (0)	14 (77.8)	3 (16.7)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	1 (11.1)	6 (66.7)	2 (22.2)	0 (0)	0 (0)	0 (0)
Staff nurse	2 (20.0)	6 (60.0)	2 (20.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	20 (76.9)	2 (7.7)	2 (7.7)	1 (3.8)	0 (0)
Midwives	0 (0)	7 (63.6)	2 (18.2)	1 (9.1)	1 (9.1)	0 (0)
22-2). MHPSS Technical instructions* is helpful in screening for patients who have mental health concerns.						
All health care providers	7 (8.8)	59 (73.8)	9 (11.3)	1 (1.3)	2 (2.5)	2 (2.5)
Doctors	1 (5.6)	16 (88.9)	0 (0)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	2 (22.2)	4 (44.4)	2 (22.2)	0 (0)	0 (0)	1 (11.1)
Staff nurse	2 (20.0)	7 (70.0)	1 (10.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	21 (80.8)	2 (7.7)	0 (0)	2 (7.7)	0 (0)
Midwives	1 (9.1)	6 (54.5)	3 (27.3)	1 (9.1)	0 (0)	0 (0)
22-3). MHPSS Technical instructions* is helpful in working with patients who have mental health concerns and mental health disorders.						
All health care providers	3 (3.8)	62 (77.5)	10 (12.5)	2 (2.5)	2 (2.5)	1 (1.3)
Doctors	0 (0)	16 (88.9)	1 (5.6)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	2 (22.2)	6 (66.7)	1 (11.1)	0 (0)	0 (0)	0 (0)
Staff nurse	1 (10.0)	9 (90.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	0 (0)	20 (76.9)	3 (11.5)	1 (3.8)	2 (7.7)	0 (0)
Midwives	0 (0)	7 (63.6)	3 (27.3)	1 (9.1)	0 (0)	0 (0)

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
23-1). MHPSS GHQ-12** is clear, concise, and straightforward, making them accessible to all medical staff, regardless of their prior experience with mental health care.						
All health care providers	4 (5.0)	57 (71.3)	10 (12.5)	6 (7.5)	1 (1.3)	2 (2.5)
Doctors	0 (0)	14 (77.8)	3 (16.7)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	2 (22.2)	4 (44.4)	2 (22.2)	1 (11.1)	0 (0)	0 (0)
Staff nurse	1 (10.0)	8 (80.0)	1 (10.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	19 (73.1)	2 (7.7)	2 (7.7)	1 (3.8)	1 (3.8)
Midwives	0 (0)	8 (72.7)	2 (18.2)	1 (9.1)	0 (0)	0 (0)
23-2). MHPSS GHQ-12** is helpful in screening for patients who have mental health concerns.						
All health care providers	7 (8.8)	50 (62.5)	13 (16.3)	6 (7.5)	1 (1.3)	3 (3.8)
Doctors	1 (5.6)	14 (77.8)	2 (11.1)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	3 (33.3)	4 (44.4)	1 (11.1)	1 (11.1)	0 (0)	0 (0)
Staff nurse	1 (10.0)	7 (70.0)	1 (10.0)	1 (10.0)	0 (0)	0 (0)
Practical Nurses	1 (3.8)	16 (61.5)	4 (15.4)	2 (7.7)	1 (3.8)	2 (7.7)
Midwives	1 (9.1)	6 (54.5)	3 (27.3)	1 (9.1)	0 (0)	0 (0)
23-3). MHPSS GHQ-12** is helpful in working with patients who have mental health concerns and mental health disorders.						
All health care providers	5 (6.3)	52 (65.0)	13 (16.3)	6 (7.5)	1 (1.3)	3 (3.8)
Doctors	0 (0)	15 (83.3)	2 (11.1)	0 (0)	0 (0)	1 (5.6)
Senior Staff Nurses	2 (22.2)	5 (55.6)	1 (11.1)	1 (11.1)	0 (0)	0 (0)
Staff nurse	1 (10.0)	5 (50.0)	2 (20.0)	1 (10.0)	0 (0)	1 (10.0)
Practical Nurses	1 (3.8)	18 (69..2)	3 (11.5)	2 (7.7)	1 (3.8)	1 (3.8)
Midwives	1 (9.1)	6 (54.5)	3 (27.3)	1 (9.1)	0 (0)	0 (0)

24. How have the MHPSS Technical Instructions and GHQ-12 helped you in providing mental health services? (Multiple responses)						
All health care providers (N=101)	Assessment	28 (27.7)	Working with patients	8 (7.9)	Knowledge about mental health	7 (6.9)
Doctors (N=25)	Assessment	7 (28.0)	Screening	4 (16.0)	Working with patients	3 (12.0)
Senior Staff Nurses (N=11)	Assessment	5 (45.5)	Other	5 (45.5)		
Staff nurse (N=15)	Assessment	4 (33.3)	Advice	2 (16.7)		
Practical Nurses (N=33)	Assessment	8 (24.2)	Providing advice	3 (9.1)	Working with patients	3 (9.1)
Midwives (N=11)	Assessment	3 (27.3)	Helpful	2 (18.1)		

The interview data revealed that healthcare providers indicated that the guidelines and GHQ-12 were beneficial as practical references. This finding was particularly evident among doctors and senior staff nurses. Additionally, all category healthcare providers indicated that guidelines, including GHQ-12, were comprehensive and sufficient, requiring no modifications.

Practical Reference. 28 out of 38 healthcare staff members, particularly doctors and senior staff nurses (19 out of 28), noted that the guidelines were helpful as a reference for seeking information regarding mental health concerns, managing complex cases, and working with patients. A female senior staff nurse mentioned that

“Very nice technical instruction. We read it all the time if we face any problem, we return to the technical instruction.” The guidelines include the steps for treatment, such as screening, assessment, diagnosis, medication prescribing, and referral to another hospital, which was beneficial for healthcare providers. A doctor shared, “When we started screening, dealing with the symptom diagnosis and giving medication and all the steps will use the technical instruction.” In addition, healthcare staff perceived the guidelines as particularly beneficial when facing challenges in patient care, particularly in facilitating communication with individuals with mental health conditions A senior staff nurse noted that "Yes, in cases where we find it difficult to deal with them, and also to remind myself of the steps and how to provide correct education." Therefore, guidelines were helpful for doctors and senior staff nurses to provide mental health services.

GHQ-12 Questionnaire. Nurses including senior staff nurses, practical nurses and midwives demonstrated that the GHQ-12 questionnaire was useful for quickly identifying mental health issues. Notably, six out of 28 nurses (5 out of 18 practical nurses and midwives) reported that the GHQ-12 questionnaire was beneficial for screening. A female midwife shared that, “They helped me quickly understand the case and make the appropriate decision regarding the patient, whether they need a doctor’s intervention.”

Comprehensive and Sufficient Guidelines and GHQ-12. Nineteen out of 38 participants indicated that the guidelines and GHQ-12 provided comprehensive and sufficient information for which no modification was necessary. This finding was stated among all categories of healthcare providers, including doctors, senior staff nurses, practical nurses, and midwives. A female midwife mentioned that "They are comprehensive and sufficient, no changes are needed."

Sub Evaluation Question 2

How does the environment, including the work environment for medical staff and resources for MHPSS, support or/and hinder the implementation of the MHPSS program?

There were obstacles regarding the working environment, including time constraints, a shortage of staff, and paper-based medical records for the MHPSS program, which were aligned with both quantitative and qualitative data. Moreover, the survey indicated that an increase in the number of patients with mental health concerns and illnesses is one of the challenges of the MHPSS program. Additionally, privacy for patients, a need for mental health specialists, and lack of available medications for mental health were identified as obstacles by interviews.

Challenges of the Environment and Resources for MHPSS Program.

Quantitative data revealed that more than 75% of healthcare providers considered that working with patients who have mental health disorders is an extra burden on their job responsibility, a shortage of staff, and not enough time to engage with patients about their mental health. In addition, over 90% of participants indicated that the number of patients with mental health illnesses has increased. Furthermore, more than 65% of healthcare professionals (all groups of providers except for midwives) indicated that paper-based medical charts affected the quality of mental health care. The proportion of midwives who reported this impact was more than 20% lower than that of other healthcare providers.

Table 8. Distributions of Environmental Challenges

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
13. Working with patients who have mental health disorders is an extra burden.						
All health care providers	20 (25.0)	40 (50.0)	8 (10.0)	11 (13.8)	1 (1.3)	0 (0)
Doctors	4 (22.2)	9 (50.0)	1 (5.6)	3 (16.7)	1 (5.6)	0 (0)
Senior Staff Nurses	2 (22.2)	3 (33.3)	1 (11.1)	3 (33.3)	0 (0)	0 (0)
Staff nurse	3 (30.0)	5 (50.0)	0 (0)	2 (20.0)	0 (0)	0 (0)
Practical Nurses	7 (26.9)	14 (53.8)	2 (7.7)	3 (11.5)	0 (0)	0 (0)
Midwives	3 (27.3)	7 (63.6)	1 (9.1)	0 (0)	0 (0)	0 (0)
14. The number of patients who experience mental health issues is increasing.						
All health care providers	27 (33.8)	47 (58.8)	2 (2.5)	2 (2.5)	2 (2.5)	0 (0)
Doctors	5 (27.8)	11 (61.1)	1 (5.6)	0 (0)	1 (5.6)	0 (0)
Senior Staff Nurses	5 (55.6)	4 (44.4)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	3 (30.0)	7 (70.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	7 (26.9)	16 (61.5)	1 (3.8)	1 (3.8)	1 (3.8)	0 (0)
Midwives	3 (27.3)	8 (72.7)	0 (0)	0 (0)	0 (0)	0 (0)
18. A shortage of the staff makes it difficult to engage with patients regarding mental health.						
All health care providers	38 (47.5)	37 (46.3)	3 (2.8)	2 (2.5)	0 (0)	0 (0)
Doctors	6 (33.3)	10 (55.6)	1 (5.6)	1 (5.6)	0 (0)	0 (0)
Senior Staff Nurses	2 (22.2)	7 (77.8)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	3 (30.0)	7 (70.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	16 (61.5)	7 (26.9)	2 (7.7)	1 (3.8)	0 (0)	0 (0)
Midwives	8 (72.7)	3 (27.3)	0 (0)	0 (0)	0 (0)	0 (0)

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
19. There is not enough time to engage with patients regarding mental health.						
All health care providers	34 (42.5)	29 (36.3)	10 (12.5)	7 (8.8)	0 (0)	0 (0)
Doctors	7 (38.9)	5 (27.8)	4 (22.2)	2 (11.1)	0 (0)	0 (0)
Senior Staff Nurses	1 (11.1)	5 (55.6)	2 (22.2)	1 (11.1)	0 (0)	0 (0)
Staff nurse	3 (30.0)	5 (50.0)	1 (10.0)	1 (10.0)	0 (0)	0 (0)
Practical Nurses	13 (50.0)	8 (30.8)	2 (7.7)	3 (11.5)	0 (0)	0 (0)
Midwives	5 (45.5)	5 (45.5)	1 (9.1)	0 (0)	0 (0)	0 (0)
25. Paper medical records affect the quality of care for mental health patients.						
All health care providers	16 (20.0)	39 (48.8)	20 (25.0)	5 (6.3)	0 (0)	0 (0)
Doctors	4 (22.2)	8 (44.4)	6 (33.3)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	4 (44.4)	4 (44.4)	1 (11.1)	0 (0)	0 (0)	0 (0)
Staff nurse	1 (10.0)	6 (60.0)	3 (30.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	6 (23.1)	13 (50.0)	4 (15.4)	3 (11.5)	0 (0)	0 (0)
Midwives	0 (0)	5 (45.5)	4 (36.4)	2 (18.2)	0 (0)	0 (0)

Qualitative findings demonstrated that the majority of health care providers face challenges that hinder the implementation of the MHPSS in terms of time constraints, shortage of staff, using paper-based medical records for mental health programs rather than electronic medical records, limited privacy for patients, and needs for mental health specialists and medication for mental health.

Time Constraints and Shortage of Staff. One of the major challenges for implementing the MHPSS services was that healthcare providers did not have enough time to work with patients with mental health concerns. 29 out of 38 participants

reported that there were time constraints. Doctors and nurses had approximately 50 to 100 patients a day, which could provide only 4-5 minutes per patient. A male doctor shared, ”The problem with workload. We are almost 80 to 100. 100 patients per day. So right now we don't have enough time to sit with people with mental or depression.” However, patients with mental illness require longer than usual patients, such as non-communicable diseases or pregnant women, to talk about their situations, conditions, and feelings to diagnose or seek treatment and counsel them, which increases the providers’ workload. A senior staff nurse mentioned that “A mental health patient requires a long time, around 45 minutes, which impacts other services.” In addition, the limited timeframe frustrated not only healthcare workers but also patients, as patients needed to wait a long time and were in a hurry. Another male doctor noted, “And if you are going to get the clients the time that he needs, the other clients waiting outside, they get a lot of frustration and a lot of anger..... It is also frustrating for them and for us, especially when you say that you have to deal with at least 50 patients per day.”

Furthermore, 16 out of 38 healthcare providers reported that another challenge for implementing the MHPSS was limited staff, particularly doctors, senior staff nurses and practical nurses. One male doctor mentioned at interview, “The main barrier that we don't have enough medical staff.” Additionally, the staff shortage contributed to time constraints and an increased workload, further limiting their capacity to provide care. A

female senior staff nurse mentioned, “In some days, they (Nurses) can’t conduct assessments due to staff shortages, absences, and holidays.” Thus, healthcare providers suggested increasing the number of staff at UNRWA health center. “Increasing the staff because there are a lot of patients and assigning specific individuals to the program.” (A female practice nurse)

Paper-based Medical Record. Paper-based medical chart was also a challenge in implementing the MHPSS program. Ten out of 38 interviewees, primarily doctors and senior staff nurses (9 out of 20 participants), noted this point. There were electronic medical charts for other programs, including non-communicable diseases and maternal-child programs. However, in the area of mental health, medical records, including GHQ-12, have not yet been integrated into the agency-wide e-health system. Writing medical records by hand and transferring mental health data of them into the computer system, which was primarily the nurses' responsibility, was time-consuming. A female senior staff shared, “We are entering our data electron on excel sheet, if we did 300 screening in this clinic, we will enter the 300 on excel sheet..... And this takes a lot of time.” In addition, the use of yellow paper-based mental health chart is related to the stigma toward menta health. The yellow color of these records has become widely recognized as indicating a mental health file, which can reinforce stigma. A female senior staff nurse noted that, “The yellow file has become known to everyone as a mental health file, and

some staff find the questions difficult."

Furthermore, the utilizing of paper-based medical records, combined with mental health stigma, has hindered effective follow-up with patients. A doctor noted that "If the patient didn't tell me or I'll ask here but she hide this information for me, I will look more. So include mental health file is very important." Thus, 10 out of 38 interviewees mentioned that the electronic chart might be helpful in saving time and ensuring privacy. A male doctor told us that "If it was integrated into the e-health it would be much, much easier."

Required Privacy for Patients. 23 out of 38 participants noted that protecting privacy for patients with mental disorders is also a prominent challenge. Healthcare providers shared that, due to the clinic structures and culture in Jordan, there was limited privacy and confidentiality when patients were provided mental health services. Among six health centers, 9 out of 38 participants responded that the buildings of health centers required a private room. Practical nurses and midwives noted a lack of private rooms for seeing patients; often there were two or three nurses in an examination room. A female practical nurse noted, "The work environment here is not supportive because, in this clinic, there are no empty rooms, and there is no privacy." Additionally, during the interview with patients, there can be disruptions, including constant knocking on the door or inquiries from people, even in private rooms. Thus, there are no private, quiet

places to talk about mental health at many health centers. The participants suggested a private room for mental health care at the health centers to mitigate stigma. A midwife mentioned that “Providing more privacy to prevent negative outcomes and more time for patients, such as private rooms, to educate them about mental health.”

Limited Mental health Specialist. The lack of mental health specialists at the UNRWA clinics was another key barrier. 29 out of 38 participants noted that having a mental health specialist, such as a psychiatrist, psychologist, psychology background nurse, and/or social worker, at the clinic at least once a week would help care for patients with mental health issues. A practical nurse suggested that “If we had a specialist for one day a week, it would be better.” 14 out of 38 participants indicated that either psychiatrists or psychologists were particularly needed, as many patients cannot access private healthcare services due to financial constraints or stigma. A midwife suggested, “Providing more medications, and specialists because patients can't go to private health services due to the cost.” A midwife also shared that it would be helpful to have, “a specialist (even if it's a nurse with a psychology background) and someone dedicated to giving them enough time.”

Medication for mental health. 20 out of 38 interviewees responded that limited medication availability was a challenge to implementing the MHPSS program. A female senior staff nurse shared that, “Regarding medications, we only have Fluoxetine and

Risperdal, while others are available at the Ministry of Health." Some patients diagnosed with mental illness seek treatment at UNRWA health centers. However, these centers often lack the necessary medications that they want, which contributes to patients discontinuing their treatment. A female practical nurse mentioned that "Providing medications [is a challenge] because most of the people who come here for treatment do not find what they need, which is why they do not continue their treatment with us." In addition, psychiatric medications are expensive, so patients may discontinue medications prematurely due to financial burden. One female midwife told us that, "Also, medications are expensive, and they ask us why the agency doesn't have the medications."

Sub Evaluation Question 3

How does a patient's socio-political status affect their mental health from the perspective of medical staff?

Socio-political situations, including ongoing war, greatly influenced mental health conditions for Palestinian refugees, both patients and staff at health centers, as many providers had family and relatives in Gaza. They suffered not only psychologically but also physically. There was an alignment in these findings between the qualitative and quantitative data.

Based on quantitative findings, socio-political situations greatly affected the mental health of Palestine refugees in Jordan. More than 90% of participants responded "strongly agree" or "agree" that human emergency situations impacted mental health.

Table 9. Distribution of Mental Health Impact on Socio-political Situation

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
31. The ongoing conflict in Gaza affects the mental health condition among Palestine refugees in Jordan.						
All health care providers	60 (75.0)	18 (22.5)	0 (0)	0 (0)	0 (0)	2 (2.5)
Doctors	13 (72.2)	5 (27.8)	0 (0)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	7 (77.8)	2 (22.2)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	7 (70.0)	3 (30.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	20 (76.9)	6 (23.1)	0 (0)	0 (0)	0 (0)	0 (0)
Midwives	10 (91.0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (9.1)
32. Sociopolitical situations such as war are impacting the implementation of the MHPSS program.						
All health care providers	49 (61.3)	24 (30.0)	5 (6.3)	2 (2.5)	0 (0)	0 (0)
Doctors	10 (55.6)	7 (38.9)	0 (0)	1 (5.6)	0 (0)	0 (0)
Senior Staff Nurses	8 (88.9)	1 (11.1)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	5 (50.0)	4 (40.0)	1 (10.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	15 (57.7)	8 (30.8)	3 (11.5)	0 (0)	0 (0)	0 (0)
Midwives	7 (63.6)	3 (27.3)	1 (9.1)	0 (0)	0 (0)	0 (0)

All interviewees indicated that socio-political status greatly influenced Palestine refugees both psychologically and physically. Moreover, they mentioned that its effects were not only on Palestine refugees but also on everyone, including healthcare

staff. A female midwife mentioned that "It certainly affects everyone, not just the patients. Even we, as employees, support each other psychologically."

28 of 38 interviews of healthcare providers reported that the ongoing war has adversely affected mental health conditions, such as stress, depression, frustration, sadness, and anxiety, as well as daily functioning, including sleeping, appetite, and psychological fatigue. In addition, Palestinian refugees in Jordan often have relatives and family members in Gaza, which contributes to elevated levels of stress and anxiety. A female practical nurse shared that “Most people have re2atives in Gaza, and every day there are cases of crying, insomnia, depression, loss of appetite, and psychological fatigue due to the martyrdom of their relatives or the explosions that occur, or the loss of communication or forced displacement.” Palestine refugees in Jordan experienced the loss of family and traumatic news from Gaza, which negatively affected their mental and physical health. Those who have non-communicable diseases, including high blood pressure and diabetes, can experience a worsening of their conditions. A female practical nurse mentioned, "It definitely has an impact because everyone has relatives in Gaza. It affects their blood pressure, diabetes, and unstable readings."

Summary of Findings

Implementation of the MHPSS program was successfully conducted from the

perspective of healthcare providers at UNRWA health centers regarding enhanced awareness of mental health as well as the fostering of strong relationships with patients and the local community. Healthcare providers considered that these strengths contributed to reducing stigma toward mental health among Palestine refugees as they realized through their daily work that patients were seeking help, talking, or asking questions with healthcare staff regarding their mental health condition or illness compared with before the program. This happened because healthcare providers gained knowledge of mental health and skills to work with people with mental health concerns and mental health illness by training and using guidelines, which enhances the strong and better relationship with patients. Notably, the guideline was beneficial as a reference seeking information on mental health and encountering complex clinical cases among doctors and senior staff nurses. These improvements and ideal cycles were based on the MHPSS program.

In contrast, the findings also indicated that certain challenges persist. At the individual level, challenges were needed for continuous and more specific training in mental health. Moreover, environmental challenges at the organizational and institutional level were time constraints, a shortage of staff, and paper-based medical records, which were aligned with both quantitative and qualitative findings. Based on the survey, there were challenges that Patients with mental health conditions often

present with complex needs that require additional time and resources and the number of patients with mental health conditions. Additionally, maintaining privacy for patients, lack of mental health specialists, including psychiatrists and psychologists, and limited availability of medication for mental health were recognized as barriers to implementing MHPSS in the interview. Macrolevel challenges were stigma, financial conditions, and sociopolitical situations. Stigma toward mental health persisted among Palestine refugees in Jordan. According to qualitative findings, Palestine refugees experience shame and fear of being judged or labeled as having mental health from their close community, which prevents seeking help or treatment. Additionally, economic hardship was a factor that influenced the mental health conditions of Palestine refugees. In the interview, healthcare providers noted that low socioeconomic status also impacted access to mental health care. The ongoing war greatly affected everyone, including Palestine refugees, as well as staff at the health center, which was consistent with both surveys and interviews.

Chapter 5: Discussion, Public Health Implications, and Conclusions

Introduction and Summary of Study

The purpose of this assessment was to identify the strengths and challenges of the MHPSS program among Palestinian refugees in Jordan from the perspective of healthcare providers. Both qualitative and quantitative findings demonstrated that integrating the MHPSS program into primary health care is beneficial in terms of enhancing access to mental health services, reducing stigma, maintaining the privacy of patients' mental health conditions, and using the guidelines to deliver mental health care. However, participants shared challenges with the need for ongoing training for staff, enduring stigma toward mental health, time constraints, difficulty maintaining privacy, lack of presence of mental health specialists, and sociopolitical situations.

Discussion of Key Results

Strengths of Implementing the MHPSS

Integrating the MHPSS program primary health care and mental health guidelines for the MHPSS were identified as strengths of implementing the MHPSS program based on the findings.

Integrating Primary Health Care. Integrating the MHPSS program into

primary health care is one of the strengths of the MHPSS program. The quantitative and qualitative findings showed the benefits of integrating mental health care into primary health care in terms of enhancing the seeking and access to mental health services. This is aided by the perspective of reducing stigma toward mental health and ensuring confidentiality about mental health conditions. Findings that implementing the MHPSS program reduces stigma were aligned with previous research (Bruno et al., 2019; Yassin et al., 2017).

Findings reinforce the strength of the training, which enhances knowledge of mental health, quality of care, screening, and working with people with mental health disorders or mental health concerns. The mental health training for healthcare staff who are non-mental health specialists at UNRWA health centers in Jordan facilitated early detection and intervention by enhancing their expertise in mental health. This training improved the quality of mental health care by equipping staff with the skills necessary to provide counseling, guidance, and education to patients with mental health conditions and concerns.

These well-trained healthcare staff in mental health contributed to strengthening the relationships between healthcare providers, patients, and the local community by fostering trust and advocating mental health through daily practice. These positive relationships between healthcare providers and patients were consistent

with a previous study for Palestine refugees (Akita et al., 2021). According to Dickson and Bangpan (2018), previous research regarding facilitators of MHPSS programs in humanitarian emergencies such as Rwanda and Guatemala also showed that trusting and supportive relationships with providers promote recovery and emotional healing. Consequently, this led to greater awareness of mental health among patients and a reduction in stigma associated with mental health, which contributed to the seeking of mental health care, including engaging in treatment and discussions on mental health.

Furthermore, integrating the MHPSS program into primary health care is beneficial for maintaining confidentiality regarding mental health conditions. This approach enhances seeking mental health support including talking with doctors, nurses and midwives at health centers. In contrast, if mental health specialists, similar to cardiologists or gynecologist consultations who come to consultation at health centers, were available for consultations, their presence might make it apparent that a patient is receiving mental health care, potentially exposing them to stigma. Accordingly, integrating mental health services within general healthcare settings mitigates this issue by allowing patients to communicate with primary healthcare providers in daily practice.

Moreover, integrating the MHPSS program into primary health care facilitates the early detection and intervention of mental health conditions that may arise from uncontrolled physical conditions such as high blood pressure or high blood sugar.

According to the qualitative findings, the sociopolitical situation greatly affected not only mental health conditions but also physical health among Palestine refugees. Research has demonstrated that mental health conditions, such as depression and anxiety, negatively affect the management of chronic diseases, including blood pressure and blood sugar control (Pan et al., 2015; Rajan et al., 2022). Therefore, integrating mental health services within general healthcare settings might mitigate this issue and increase early detection or management by allowing patients to communicate with primary healthcare providers in daily practice.

Guidelines for the MHPSS. Previous studies in Jordan indicated the need for guidelines (Turki et al., 2020). However, the existence and the usefulness of the guidelines were demonstrated based on the findings. The guidelines were beneficial for healthcare providers as they were clear, well summarized, and pointed out step by step what the healthcare provider should do. Therefore, the guidelines helped healthcare professionals to save time and effort as well as enhance the quality of care. Notably, there were differences in the benefits of guidelines between doctors and senior staff nurses and between practical nurses and midwives. Doctors and senior staff nurses indicated that the guidelines were beneficial in referencing the instructions from screening to treatment and referring to another hospital because their role in the MHPSS program is to manage mental health patients. On the other hand, practical nurses and

midwives referenced the GHQ-12 as important in screening the people who visit the UNRWA health center. Differences across healthcare professions and roles revealed the distinctions in the usage of guidelines.

Challenges of Implementing the MHPSS

The MHPSS program, which included training for staff regarding mental health, mitigated the stigma toward mental health and enhanced the seeking of mental health care. However, challenges remained in mental health training and persistent stigma. Additionally, environmental challenges including time constraints, limited availability of medication, challenges in maintaining patient confidentiality, and a shortage of mental health specialists, and socio-political status were barriers to implementing the MHPSS program. The same challenges of limited resources, including the availability of medication, mental health specialists, and time constraints, have continued to be barriers to implementing the MHPSS at the UNRWA health center in Jordan since 2017. (Turki et al., 2020).

Mental Health Training. Mental health training was greatly beneficial for healthcare staff, but healthcare providers recognized the value of enhancing their knowledge of mental health. Additionally, healthcare staff reported needing continuous training to learn updated information and recall mental health knowledge. These results

were consistent with previous research findings in Jordan (Turki et al., 2020). Therefore, ongoing education to reinforce existing knowledge and acquire new information on mental health, along with practical training to improve communication with patients, may be beneficial.

Stigma toward Mental Health. Although stigma toward mental health was reduced due to the implementation of the MHPSS program in Jordan, a persistent stigma exists. This finding aligned with previous research (Turki et al., 2020). From the perspective of healthcare providers at UNRWA health center in Jordan, Palestine refugees felt the stigma of mental illness because they were afraid of being labeled as crazy or judged by neighbors. This form of labeling persists, as noted by McKell et al. (2017). Labeling also affected the feeling of embarrassment about having a mental health illness. Therefore, stigma toward mental health still exists among Palestine refugees in Jordan. Due to this stigma, patients may discontinue treatment, including refusing the creation of mental health medical charts, taking psychotropic medication, and referral to mental health specialists, as people are afraid to disclose their mental health condition in the community. This connection between stigma and not seeking support for mental health was recognized not only by Palestine refugees in Gaza but also in Jordan (Taming et al., 2023). Additionally, in Lebanon and Syria, which also has

a similar Arab culture, the stigma toward mental health was one of the barriers to access and utilization of mental health care (Hendrickx et al., 2019; Noubani et al., 2021). Therefore, it is critical to reduce the stigma toward mental health to improve mental health among Palestine refugees, as suggested by McKell et al. (2017).

Environmental challenges.

Time constraints for healthcare providers. One of the key limitations of implementing the MHPSS program in Jordan was the time constraints for healthcare providers. This limitation, caused by a shortage of staff, the use of paper medical charts, an increasing number of patients with mental health conditions, and the need for longer consultation times for these patients, led to high workloads for healthcare staff. It was consistent with a previous study in Gaza (Tamming et al., 2023). In some health centers, doctors need to see 50 to 90 patients per day, limiting appointments to about 5 minutes per patient. However, screening patients or listening to patients' concerns needs more time than 5 minutes. Moreover, the use of paper-based mental health records and the paper-based GHQ-12 contributed to time constraints, as completing these forms is time-consuming and requires additional effort to convert the data into a summarized format. In Gaza, the paper-based medical chart was also a challenge to implementing the MHPSS program (Ubaid et al., 2021). These time constraints reduce the time to communicate with patients with mental health conditions. These obstacles directly

influence the quality of mental health care, which contributes to burnout for health care providers. Therefore, one of the suggestions to tackle these challenges is to initiate digital-based medical records. This may save time on documenting medical records as well as supporting patient's follow-up care.

Privacy. Maintaining patient privacy is also challenging in implementing the MHPSS program in Jordan. Overcrowding, facility design, and paper-based medical records can compromise patient privacy during consultations with healthcare providers. During consultations, doctors, patients, and staff continuously come to the room or knock on the door. Besides, practical nurses' and midwives' examination rooms are not private, and patients may hesitate to talk about mental health issues due to stigma. Additionally, sometimes paper mental health medical charts identify patients as having issues with mental health conditions; these factors contribute to difficulties in keeping privacy for patients. Therefore, it is helpful to determine whether keeping a doorkeeper or having a private room is better.

Limited Availability of Medications. Medication availability is also a limitation when implementing the MHPSS program in Jordan. These challenges are also consistent with findings from previous studies on Palestinian refugees in Jordan as well as in low-middle-income countries (Turki et al., 2020; Keynejad et al., 2017). Although there are several psychotropic medications available in health centers, certain types of

medication may not be available. The lack of medication availability prevents comprehensive mental health care at the UNRWA health center. Some patients were prescribed psychotropic medication from another private clinic. However, Palestine refugees often cannot afford medication fees at a private clinic as it is expensive. According to Ayano and Assefa (2016), ensuring a continuous supply of medication for mental health treatment remains a significant challenge; treatment is often interrupted due to frequent medication shortages in Ethiopia. Therefore, to provide comprehensive mental health care to improve adherence to care, it is beneficial to increase the availability of psychiatric medication.

Mental health specialist. In the interviews, many healthcare providers suggested the presence of mental health specialists such as psychiatrists, psychologists, and social workers. The lack of mental health specialists was consistent with previous studies in Jordan as well as Rohingya refugees in Myanmar (Turki et al., 2020; Elshazly et al., 2019). If the specialist is at a consultation at a health center in Jordan, they have enough time to listen to the patient's problems or conditions, freeing up other healthcare providers. Additionally, specialists, in particularly psychiatrists, prescribe psychotropic medication. Psychologists can provide therapy to patients, which is also needed for treatment. Finally, it is possible to train or obtain advice from mental health experts in a timely manner for difficult cases, which leads to less stress for healthcare providers.

It is beneficial to patients to receive mental health treatment at the health centers in their community. The financial status and stigma were affected by access to mental health care for Palestine refugees, such as lack of transportation and medication fees. Therefore, the healthcare providers at the UNRWA Health Center in Jordan suggest having a mental health specialist as a consultant.

Sociopolitical situation. Socio-political situations were one of the challenges in implementing the MHPSS program. This ongoing situation significantly affects both physical and mental health among Palestine refugees in Jordan as Palestine refugees have family and relatives in Gaza, which creates more anxiety or depression due to the loss of loved ones and not being in contact with them. In addition, this conflict is influenced not only by patients at health centers but also by healthcare staff in Jordan. Thus, everybody, including staff at the UNRWA clinic, needs mental health support.

Strengths and Limitations

The assessment is advantageous to adopt because it has a mixed methods approach, the inclusion of diverse healthcare provider perspectives, and my positionality as a mental health and psychiatric nurse. The use of mixed methods for collecting data provided in-depth information on the strengths and challenges of implementing the MHPSS program. The quantitative data included responses from 80 healthcare providers from 20 health centers, and 38 healthcare providers from 10 health

centers were interviewed. Additionally, the findings included perspectives from a variety of healthcare providers, including doctors, nurses, and midwives, which facilitated an in-depth understanding of the comprehensive strengths and challenges of implementing the MHPSS program. Moreover, my positionality as a mental health and psychiatric nurse experience stands out. My positionality allowed me to expect the challenges, including limited time for patients and burnout, and strengths, including knowledge of mental health treatment and medication as well as needs what patients need from the perspective of healthcare providers, which helped to develop the data collection tools as well as analysis.

However, this project had limitations in terms of limited to study design, the perspective of healthcare providers, sampling bias (including limited representation from smaller health centers and healthcare staff with limited years of service), and my lack of positionality from an Arabic cultural background.

One limitation of this evaluation was the cross-sectional nature of this study, which allowed for the identification of current factors impacting implementation of the MHPSS program. However, the cross-sectional study design does not permit causal inferences or assessment of the long-term effect of MHPSS implementation. Therefore, a longitudinal study is needed for further research to understand the changes over time and better evaluate the program's sustained effects.

Another limitation was that the study only included the perspectives of healthcare providers. The perspectives of people related to the MHPSS program, including patients or stakeholders, including non-healthcare providers at the UNRWA health center, headquarters, and Jordan field office, referral hospital, ministry of health, donors, or NGOs, were not included in assessing the implementation of the MHPSS program. Thus, it is critical to include other people associated with the MHPSS program in future evaluations. Moreover, interviews were conducted only at large and midsize health centers, thus the qualitative data did not reflect the opinion of small health centers. Thus, the findings might not translate to another small health center in Jordan. Additionally, more than 75% of participants for both the survey and interviews had 10 years+ of working experience at UNRWA. Accordingly, the opinions of people with little experience were not reflected much, and they may have different strengths and issues that were not captured.

Another limitation was that the researcher had a non-Arabic cultural background as well as being non-Arabic speaker, which may have influenced the research process, particularly in data collection and analysis. Due to unfamiliarity with Arab culture, there was an increased risk of preventing culturally appropriate questions, building trust, and interpreting culturally significant elements accurately. Consequently, the findings may not fully reflect the Arab cultural context. In order to minimize cultural

misunderstandings, the evaluation process was conducted by collaborating closely with the interpreter, translator, as well as public health coordinator, and MHPSS coordinator at UNRWA.

Therefore, future evaluation should consider interviews at the small health centers and with healthcare workers with less experience at UNRWA, as well as collaboration with local staff to analyze the data to reduce cultural bias.

Implications for Public Health Research and Practice

This evaluation was conducted to identify the strengths and challenges of implementing the MHPSS program at the UNRWA health center in Jordan from the perspective of healthcare professionals. The data from both quantitative and qualitative provided various insights regarding the strengths and challenges of implementing the MHPSS program. A key strength was the integration of the MHPSS program into primary health care, which increased mental health awareness and reduced stigma for Palestine refugees and the usage of guidelines implementing program. However, there were challenges that remain in terms of continuous mental health training, stigma toward mental health, limited resources such as medication, privacy, mental health specialists, and socio-political status for Palestine refugees.

For public health practice, developing educational materials for Palestine refugees using applications, posters, and brochures to increase awareness of mental

health and availability of treatment and more consistent mental health training, including practice for every staff member may be suggested. In addition, electronic mental health charts for mental health may be proposed to save time and maintain the privacy for patients. Moreover, expanding the availability of psychiatrists or psychologists and medication for mental health are also suggested. Details of recommendations are provided as follows.

Recommendations

Develop education materials for Palestine refugees using applications, posters, brochures to increase awareness of mental health and availability of treatment. Increasing awareness is critical to reduce social mental health stigma as well as mitigating mental illness. Pages on mental health conditions, such as depression, could be added to current existent applications for NCD and MCH programs. Additionally, by creating a large, noticeable, clear, and attractive posters and brochures or leaflets explaining symptoms and services, the negative image of mental health could be reduced. It is recommended that these educational materials initially be distributed at health centers where the gradual reduction of stigma toward mental health has established trust between healthcare professionals and patients.

Develop more consistent mental health training including practice for every staff member. The medical staff desired additional training in mental health.

UNWAR could consider creating a video or recording the training for mental health, such as mental health illness, treatment medication, counseling, and available social services. Using this content, new and daily paid staff can take the training more easily. Additionally, it is possible to prevent increased workload, which creates a shortage of staff to train everyone at the same time. Updated training can be online once a year. After watching the contents, on-the-job training from a staff member who has the same job and the same responsibility at the same health center or the same region could be conducted over a year.

Introducing electronic mental health charts for mental health and conducting cost-effective research. Paper-based patient charts increase the workload burden, which leads to time constraints. Additionally, the yellow color file for mental health enhances mental health stigma. Introducing electronic mental health charts is expensive, so the evaluation of the feasibility of electronic mental health charts is critical.

Creating a privacy room by developing listening time, which is setting the private room and time for patients with mental health concerns or mental illness a couple of hours weekly but no label on the door. Set the private place and time for the mental health room for a couple of hours weekly. Creating a space and time for patients who want to talk about the mental conditions or concerns in the

existing room as a mental health room, to keep privacy using a doorkeeper to prevent someone from coming to the room or knocking. It is significant to decide the place and time when it is not a busy time and make weekly appointments for mental health visits. However, the room should not be labeled on the door to prevent stigma. Patients might be unable to wait to talk, but setting the time is also essential to set boundaries.

Expanding the availability of psychiatrists or psychologists and medication for mental health. Mental health specialists, including psychiatrists and/or psychologists, should be added at least once a week at every clinic for treatment. The combination of medicine and psychological support is an effective treatment. In addition, psychiatrists and medical doctors should reconsider the availability of certain medications, as some medications are not used even though they are available at the UNRWA clinic. In the process of choosing the medication, it is significant to understand the prevalence of the disease as well as the rate of the symptoms of mental health.

Future evaluation efforts should use a comprehensive approach, including the perspectives of patients, non-healthcare providers at the UNRWA health center, and stakeholders involved in the MHPSS program. Understanding their viewpoints is crucial, given the potential divergence from the perspectives of healthcare providers. Additionally, evaluating the cost-effectiveness of interventions when integrating the

digital health medical record system or distributing applications, posters, and brochures regarding mental health is also needed, as interventions, particularly integrating the system, will be expensive. Moreover, the impact of stigma on help-seeking behaviors among Palestine refugees warrants further investigation, as stigma remains one of the most significant barriers to accessing mental health services. It is necessary to support the improvement of the mental health of Palestinian refugees.

Conclusions

Overall, implementation of the MHPSS program was successfully conducted from the perspective of healthcare providers at UNRWA health centers regarding integrating into primary healthcare settings and guidelines. These strengths were connected to reducing stigma toward mental health. However, there was still a stigma toward mental health among Palestine refugees. Additionally, remaining barriers continued to affect implementation., including a need for more mental health training for providers at the individual level, environmental challenges, including limited availability of medication, lack of maintaining patient confidentiality, shortage of mental health specialists at the organizational level, and stigma, socio-political status at the macro level, among Palestine refugee. Recommendations include increasing awareness of mental health among Palestinian refugees, ongoing training for healthcare

providers and improving access to limited resources. Further research is needed to support comprehensive evaluations, cost-effectiveness analyses, and investigations into stigma.

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Appendix A: Survey

Assessment of the Strengths and Challenges in the Implementation of MHPSS

تقييم نقاط القوة والتحديات في تنفيذ برنامج الصحة النفسية والدعم النفسي والاجتماعي

Survey Duration: 16th July - 30th July 2024

مدة الدراسة الاستقصائية: 16 يوليو - 30 يوليو 2024

The purpose of this project is to identify the strengths and challenges of MHPSS service to improve the MHPSS program among Palestine refugees in Jordan. The survey will take approximately 15 to 20 minutes to complete. Thank you for your cooperation and your feedback will greatly contribute to improving the MHPSS program.

إن الغرض من هذا المشروع هو تحديد نقاط القوة والتحديات التي تواجه خدمة خدمات الصحة والدعم النفسي والاجتماعي لتحسين برنامج خدمات الصحة والدعم النفسي والاجتماعي بين لاجئي فلسطين في الأردن. سيستغرق استكمال الاستبيان من 15 إلى 20 دقيقة تقريباً. شكرا لكم على تعاونكم وملاحظاتكم ستسهم بشكل كبير في تحسين برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي.

Section 1: Project Informed Consent

القسم 1: مشروع الموافقة المسبقة

Project Information

1. **معلومات المشروع**

Title of the project: Assessment of the Strengths and Challenges in the Implementation of the Mental Health and Psychosocial Support (MHPSS) for Palestine Refugees in Jordan

عنوان المشروع تقييم نقاط القوة والتحديات في تنفيذ برنامج الصحة النفسية والدعم النفسي الاجتماعي للاجئي فلسطين في الأردن

Primary Researcher: Kaori Okada

الباحثة الرئيسية: كاوري أوكادا

Rollins of Public Health, Emory University - United States

United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) - Jordan

رولينز للصحة العامة، جامعة إيموري - الولايات المتحدة الأمريكية

وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا) - الأردن

Research group:

مجموعة البحث:

Shatha Albeik: Health Department, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) - Jordan

Aradhana Thapa: Rollins of Public Health, Emory University - United States

Rachel Waford: Rollins of Public Health, Emory University - United States

Elizabeth Walker: Rollins of Public Health, Emory University - United States

El-khatib Zoheir: Health Department, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) – Jordan

شذى البيك: إدارة الصحة، وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا) – الأردن

أرادانا ثابا رولينز للصحة العامة، جامعة إيموري - الولايات المتحدة الأمريكية

راشيل وافورد رولينز للصحة العامة، جامعة إيموري - الولايات المتحدة الأمريكية

إليزابيث ووكر رولينز للصحة العامة، جامعة إيموري - الولايات المتحدة الأمريكية

زهير الخطيب إدارة الصحة، وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا) – الأردن

2. Introduction

2. مقدمة

You are being asked to participate in this project. This consent form is designed to tell every information to consider participation for consent (agreement) in this project or not. It is all your choice. You can change your mind at any time and withdraw from this project if you decide to be a part of this project. Additionally, you can skip the question

when you do not want to answer.

يُطلب منك المشاركة في هذا المشروع. تم تصميم استمارة الموافقة هذه لإخبارك بكل المعلومات التي يجب عليك أخذها بعين الاعتبار للمشاركة (الموافقة) في هذا المشروع من عدمه. الخيار لك. يمكنك تغيير رأيك في أي وقت والانسحاب من هذا المشروع إذا قررت أن تكون جزءاً من هذا المشروع. بالإضافة إلى ذلك، يمكنك تخطي السؤال عندما لا ترغب في الإجابة.

Before deciding to enroll, please read this form carefully and feel free to ask about anything you do not understand. Please take as much time as you need to think about whether you would like to participate. By agreeing to this form, you are not waiving any legal rights.

قبل أن تقرر التسجيل، يرجى قراءة هذا النموذج بعناية ولا تتردد في السؤال عن أي شيء لا تفهمه. يرجى أخذ الوقت الذي تحتاجه للتفكير فيما إذا كنت ترغب في المشاركة. بموافقتك على هذا النموذج، فأنت لا تتنازل عن أي حقوق قانونية.

3.Purpose of this project

3. الغرض من المشروع

The purpose of this project is to identify the strengths and challenges of MHPSS program to improve the MHPSS among Palestine refugees.

إن الغرض من هذا المشروع هو تحديد نقاط القوة والتحديات التي تواجه برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي لتحسين خدمات الصحة النفسية والدعم النفسي والاجتماعي بين لاجئي فلسطين.

.4 Procedures:

4.الاجراءات

You will be asked to answer the questions for the survey about the MHPSS program and its operations. The survey will be conducted online and will take approximately 15 minutes.

سيُطلب منك الإجابة عن الأسئلة الخاصة بالاستبيان حول برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي ، سيتم إجراء الاستبيان عبر الإنترنت وسيستغرق حوالي 15 دقيقة.

5. Risks and discomforts:

5. المخاطر والمضايقات:

The risks of participating in this project are minimal. However, participants may

experience discomfort or upset when answering certain questions of this project if they have had negative experiences. The research team will take steps to minimize the likelihood of this occurring to prevent discomfort and to recognize the significance of maintaining confidentiality and privacy. Participants can stop the survey at any time or not answer questions.

مخاطر المشاركة في هذا المشروع ضئيلة للغاية. ومع ذلك، قد يشعر المشاركون بعدم الارتياح أو الانزعاج عند الإجابة على أسئلة معينة من هذا المشروع إذا كانت لديهم تجارب سلبية. سيتخذ فريق البحث خطوات للتقليل من احتمالية حدوث ذلك لمنع الانزعاج وإدراك أهمية الحفاظ على السرية والخصوصية. يمكن للمشاركين إيقاف الاستبيان في أي وقت أو عدم الإجابة عن الأسئلة.

6. Benefit from the project

6. الاستفادة من المشروع

You may not benefit directly from participating in the project. However, you can help improve the MHPSS program for Palestine refugees in Jordan.

قد لا تستفيد مباشرة من المشاركة في المشروع. إلا أنه بإمكانك المساعدة في تحسين برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي للاجئي فلسطين في الأردن.

.7 Compensation:

7. التعويضات

You will not be compensated for being in this project.

لن يتم تعويضك عن مشاركتك في هذا المشروع.

.8 Extent of anonymity and confidentiality:

8. مدى عدم الكشف عن الهوية والسرية

The information you shared with us through the survey will only be used for this project, and this information is confidential. The project number will be used for this project rather than your name. Any other identifying information, including your name, will not appear in any presentation or publication of the project results.

سيتم استخدام المعلومات التي قمت بمشاركتها معنا من خلال الاستبيان لهذا المشروع فقط، وهذه المعلومات سرية. سيتم استخدام رقم المشروع لهذا المشروع بدلاً من اسمك. لن تظهر أي معلومات تعريفية أخرى، بما في ذلك اسمك، في أي عرض أو نشر لنتائج المشروع.

.9 Contact Information:

9. معلومات الاتصال

If you have questions about the assessment process, scheduling, or any other questions or concerns about the project or your role of the project, contact us below by phone or e-mail.

إذا كان لديك أسئلة حول عملية التقييم أو الجدولة أو أي أسئلة أو استفسارات أخرى حول المشروع أو دورك في المشروع، اتصل بنا أدناه عبر الهاتف أو البريد الإلكتروني.

KaoriOkad

_Shatha Albeik

Do you agree to participate in this project? You are not giving up any legal rights by agreement of this question. (Yes / No)

1. هل توافق على المشاركة في هذا المشروع؟ أنت لا تتنازل عن أي حقوق قانونية بموافقتك على هذا السؤال (نعم / لا)

(Chose date)

2 - (اختر التاريخ)

If you answered No. 1 question as "Yes", please chose date below.

إذا كانت إجابتك على السؤال رقم 1 بـ "نعم"، يرجى اختيار التاريخ أدناه.

Thank you for taking the time to consider the survey. We understand that you may not be able to participate in the survey. We appreciate your consideration and your time.

نشكرك على تخصيص بعض الوقت للنظر في الاستبيان. نحن نتفهم أنك قد لا تتمكن من المشاركة في الاستبيان. نحن نقدر لك اهتمامك ووقتك.

Section 2: Demographics

القسم 2: الخصائص الديموغرافية (السكانية)

We would like to ask you about yourself in section 2.

Please answer the questions below.

نود أن نسألك عن نفسك في القسم (2)

يرجى الإجابة على الأسئلة أدناه.

What is your age? 3. ما هو عمرك؟

What is your gender? (Male, Female) 4. ما هو جنسك؟ ((ذكر، أنثى

What is your health center? 5. ما اسم المركز الصحي الذي تعمل فيه؟

What is your role in the health center ?

(Medical officer, Senior staff nurse, Staff nurse, Practical nurse, Midwife)

6 . ما هو وظيفتك في المركز الصحي؟ (مدير/ة المركز الصحي، رئيس/ة التمريض ، ممرضة / ممرض قانوني، ممرضة /ممرض، قابلة قانونية)

What is your highest level of education? (Diploma, Bachelor, Master, PhD, Other)

7. ما هو أعلى مستوى تعليمي لك؟ (دبلوم، بكالوريوس، بكالوريوس، ماجستير، دكتوراه، غير ذلك

How long have you worked at UNRWA? (Less than 1 year, 1- 3 years, 4 - 5 years, 6 – 10 years, more than 10 years)

8. منذ متى وأنت تعمل في الأونروا؟ (أقل من سنة، 1 - 3 سنوات، 4 - 5 سنوات، 6 - 10 سنوات، أكثر من 10 سنوات)

Have you received mental health training at UNRWA? (Yes, No)

9. هل تلقيت تدريباً في مجال الصحة النفسية في الأونروا؟ (نعم، لا)

How often do you receive training on mental health topics? (None, Less than once a year, Once a year, 2 -3 times a year, 4 - 6 times a year, More than 6 times a year, Other)

10. كم مرة تلقيت تدريباً حول مواضيع الصحة النفسية؟ (لا شيء، أقل من مرة واحدة في السنة، مرة واحدة في السنة، من 2 إلى 3 مرات في السنة، من 4 إلى 6 مرات في السنة، أكثر من 6 مرات في السنة، غير ذلك)

Section 3: Strengths and Challenges for the MHPSS program

القسم 3: نقاط القوة والتحديات التي يواجهها برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي

In section 3, we would like to ask you about the MHPSS program and its operations.

Please indicate how much you agree with each of the following statements.

(Strongly Disagree, Disagree, Neutral/Unsure, Agree, Strongly Agree)

في القسم 3، نود أن نسألك عن برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي وعملياته.

يرجى الإشارة إلى مدى موافقتك على كل من العبارات التالية.

(غير موافق بشدة، غير موافق، محايد/غير متأكد، موافق، موافق بشدة، موافق بشدة)

Personal Strengths / Challenges (Individual level)

1) نقاط القوة / التحديات الشخصية (على المستوى الفردي)

Mental health training at UNRWA for medical staff: (11-12)

11. التدريب على الصحة النفسية في الأونروا للموظفين الصحيين (11-12)

1). has enhanced my mental health knowledge.

1). عززت معرفتي بالصحة النفسي

2). has enhanced the quality of care for patients with mental health.

2). عززت جودة الرعاية المقدمة للمرضى الذين يعانون من الصحة النفسية

(Strongly Disagree, Disagree, Neutral/Unsure, Agree, Strongly Agree)

((غير موافق بشدة، غير موافق، محايد/غير متأكد، موافق، موافق بشدة، موافق بشدة

I think that I need more training for mental health.

12. أعتقد أنني بحاجة إلى مزيد من التدريب في مجال الصحة النفسية

Working with patients who have mental health disorders is an extra burden.

13. يشكل العمل مع المرضى الذين يعانون من اضطرابات نفسية عبئاً إضافياً

Health center Strengths / Challenge (Institutional Level)

2) نقاط قوة/تحديات المركز الصحي (المستوى المؤسسي)

Please rate your level of agreement with each of the following statements.

يرجى تقييم مستوى موافقتك على كل من العبارات التالية.

The number of patients who experience mental health issues is increasing.

14. يتزايد عدد المرضى الذين يعانون من مشاكل في الصحة النفسية

Relationships with the community help to provide MHPSS services.

15. تساعد العلاقات مع المجتمع المحلي على توفير خدمات وزارة الصحة والسكان والخدمات الاجتماعية

Referring to other staff at the health center can be done smoothly.

16. يمكن التحويل إلى موظفين آخرين في المركز الصحي بسلاسة

Referral to the hospital system of the MHPSS program can be done smoothly.

17. يمكن أن يتم التحويل إلى نظام المستشفيات التابع لبرنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي بسلاسة.

A shortage of the staff makes it difficult to engage with patients regarding mental health.

18. نقص عدد الموظفين يجعل من الصعب التعامل مع المرضى فيما يتعلق بالصحة النفسية

There is not enough time to engage with patients regarding mental health.

19. لا يوجد وقت كافٍ للتعامل مع المرضى فيما يتعلق بالصحة النفسية.

Organizational Strengths/Challenges (Organizational level)

(3 نقاط القوة/التحديات التنظيمية (على المستوى التنظيمي)

Please indicate your level of agreement or provide an answer to each of the following statements.

يُرجى الإشارة إلى مستوى موافقتك أو تقديم إجابة على كل من العبارات التالية.

Mental health training at UNRWA for medical staff: (21-22)

20. التدريب على الصحة النفسية في الأونروا للموظفين الصحيين (21-22)

1). has been helpful in screening people with mental health concerns and mental health disorders.

1). كان مفيدًا في فحص الأشخاص الذين يعانون من مشاكل الصحة النفسية واضطرابات الصحة النفسية.

2) has been helpful for working with patients who have mental health concerns and mental health patients.

2) كان مفيدًا في العمل مع المرضى الذين يعانون من مشاكل في الصحة النفسية ومرضى الصحة النفسية

3) needs to be tailored to their varied roles and responsibilities within the MHPSS program.

3) يجب أن تتناسب مع أدوارهم ومسؤولياتهم المتنوعة ضمن برنامج

Which mental health training topics for medical staff at UNRWA help provide mental health services? (e.g. Mental health disorder, Medicine, Assessment, Education, Counselling, Management, MHPSS services, Resources)

ما هي مواضيع التدريب في مجال الصحة النفسية للموظفين الصحيين في الأونروا التي تساعد في تقديم خدمات الصحة النفسية؟ (مثل اضطرابات الصحة النفسية، والطب، والتقييم، والتثقيف، وتقديم المشورة، والإدارة،

وخدمات الصحة النفسية والصحة النفسية، والموارد)

MHPSS Technical instructions* & GHQ-12** are:

22. التعليمات الفنية لنظام إدارة الصحة والسلامة والصحة المهنية* واستبيان الصحة العامة - 12** هي:

* MHPSS Technical instructions:

*MHPSS التعليمات الفنية الخاصة بـ

Technical Instructions and Management Protocols for MHPSS within UNRWA's Primary Health Care Model

التعليمات الفنية وبروتوكولات الإدارة الخاصة بخدمات الصحة النفسية والدعم النفسي والاجتماعي المتنقلة ضمن نموذج الأونروا للرعاية الصحية الأولية.

** GHQ-12 : General Health Questionnaire 12

** GHQ-12 : استبيان الصحة العامة 12

1). clear, concise, and straightforward, making them accessible to all medical staff, regardless of their prior experience with mental health care.

1). واضحة وموجزة ومباشرة، مما يجعلها في متناول جميع العاملين في المجال الطبي، بغض النظر عن خبرتهم السابقة في مجال الرعاية الصحية النفسية.

2). helpful in screening for patients who have mental health concerns.

2). مفيد في فحص المرضى الذين يعانون من مشاكل في الصحة النفسية

3). helpful in working with patients who have mental health concerns and mental health disorders.

3). مفيدة في العمل مع المرضى الذين يعانون من مشاكل الصحة النفسية واضطرابات الصحة النفسية

How have the MHPSS Technical Instructions and GHQ-12 helped you in providing mental health services?

23. كيف ساعدتك الإرشادات الفنية لنظام الصحة النفسية والدعم النفسي والاجتماعي واستبيان الصحة النفسية 12 في تقديم خدمات الصحة النفسية؟

Paper medical records affect the quality of care for mental health patients.

24. تؤثر السجلات الطبية الورقية على جودة الرعاية المقدمة لمرضى الصحة النفسية

Lack of financial support is affecting the implementation of the MHPSS program.

25. يؤثر الافتقار إلى الدعم المالي على تنفيذ برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي

Environmental strengths / challenges (Macro level)

نقاط القوة/التحديات البيئية (المستوى الكلي)

Please rate your level of agreement with each of the following statements.

يرجى تقييم مستوى موافقتك على كل من العبارات التالية :

There is a stigma for mental health among

26. هناك وصمة عار للصحة النفسية في أوساط

1). Palestine refugees. 1). اللاجئين الفلسطينيين

2). health care providers. 2) مقدمو الرعاية الصحية

The lack of basic needs for Palestine refugees influences their mental health conditions.

27. إن نقص الاحتياجات الأساسية للاجئي فلسطين يؤثر على ظروف صحتهم النفسية

The deteriorating economic situation influences mental health conditions among Palestine refugees.

28. يؤثر الوضع الاقتصادي المتدهور على أوضاع الصحة النفسية بين اللاجئين الفلسطينيين.

Palestine refugees in Jordan do not have enough information about how to access mental health services.

29. ليس لدى لاجئي فلسطين في الأردن معلومات كافية حول كيفية الحصول على خدمات الصحة النفسية

The ongoing conflict in Gaza affects the mental health of condition among Palestine refugees in Jordan.

30. يؤثر الصراع الدائر في غزة على حالة الصحة النفسية للاجئي فلسطين في الأردن

Sociopolitical situations such as war are impacting the implementation of the MHPSS program.

31. تؤثر الأوضاع الاجتماعية - السياسية مثل الحرب على تنفيذ برنامج وزارة الصحة والسكان والصحة العامة والسلم الاجتماعي.

Thank you for taking the time to complete the survey. Your cooperation is invaluable to improving the MHPSS program. We appreciate your consideration to participate in the project and your time.

شكراً لك على الوقت الذي قضيته في إكمال الاستبيان. إن تعاونكم لا يقدر بثمن في تحسين برنامج برنامج خدمات

الصحة النفسية والدعم النفسي والاجتماعي نحن نقدر لك اهتمامك بالمشاركة في المشروع ووقتك

Appendix B: Interview Guide

Assessment of the Strengths and Challenges in the implementation of the Mental Health and Psychosocial Support

(MHPSS) for Palestine Refugees in Jordan

تقييم نقاط القوة والتحديات في تنفيذ مشروع الصحة النفسية والدعم النفسي و الاجتماعي للاجئين الفلسطينيين في الأردن

Interview Guide:

دليل المقابلات

Informed consent for interview

الموافقة المطلع عليها لإجراء المقابلة

Project Information

1.معلومات المشروع

Title of the project: Assessment of the Strengths and Challenges in the implementation of the Mental Health and Psychosocial Support (MHPSS) for Palestine Refugees in Jordan

عنوان المشروع : تقييم نقاط القوة والتحديات في تنفيذ مشروع الصحة النفسية والدعم النفسي الاجتماعي للاجئين الفلسطينيين في الأردن

Primary Researcher: Kaori Okada

الباحثة الرئيسية: كاوري أوكادا

Name of organization: Rollins of Public Health, Emory University - United State, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) -Jordan

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Research group:

مجموعة البحث:

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شذى البيك: إدارة الصحة، وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا) - الأردن

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Introduction

2. مقدمة

You are being asked to participate in this project. This consent form is designed to tell every information to consider participation for consent (agreement) in this project or not. It is all your choice. You can change your mind at any time and withdraw from this project if you decide to be a part of this project. Additionally, you can skip the question and pause or stop during the interview at any point.

يُطلب منك المشاركة في هذا المشروع. تم تصميم استمارة الموافقة هذه لإخبارك بكل المعلومات التي يجب عليك أخذها بعين الاعتبار للمشاركة (الموافقة) في هذا المشروع من عدمه. الخيار لك. يمكنك تغيير رأيك في أي وقت والانسحاب من هذا المشروع إذا قررت أن تكون جزءاً من هذا المشروع. بالإضافة إلى ذلك، يمكنك تخطي السؤال

والتوقف مؤقتاً أو التوقف أثناء المقابلة في أي وقت.

Before deciding to enroll, please read this form carefully and feel free to ask about anything you do not understand. Please take as much time as you need to think about whether you would like to participate. By agreement of this form, you are not waiving any legal rights.

قبل أن تقرر المشاركة، يرجى قراءة هذا النموذج بعناية ولا تتردد في السؤال عن أي شيء لا تفهمه. يرجى أخذ الوقت الذي تحتاجه للتفكير فيما إذا كنت ترغب في المشاركة. بموافقتك على هذا النموذج، فإنك لا تتنازل عن أي حقوق قانونية.

Purpose of this project:

3. الغرض من هذا المشروع

The purpose of this project is to identify the strengths and challenges of MHPSS service to improve the MHPSS among Palestine refugees.

إن الغرض من هذا المشروع هو تحديد نقاط القوة والتحديات التي تواجه خدمة خدمات الصحة النفسية والدعم النفسي والاجتماعي لتحسين خدمات الصحة النفسية والدعم النفسي والاجتماعي بين لاجئي فلسطين.

Procedures:

4. الإجراءات

You will be asked to answer the questions for an interview about the MHPSS program and its operations. The interview will take approximately 30 minutes. The interview will be recorded, taken notes, and transcribed to ensure accuracy.

سيُطلب منك الإجابة عن الأسئلة الخاصة بالمقابلة الشخصية حول برنامج الصحة النفسية والدعم النفسي الاجتماعي وعملياته. ستستغرق المقابلة حوالي 30 دقيقة. سيتم تسجيل المقابلة وتدوين الملاحظات لضمان الدقة.

Risks and discomforts:

5. المخاطر والمضايقات

The risks of participating in this project are minimal. However, participants may experience discomfort or upset when answering certain questions of this project if they have had negative experiences. The project team will take steps to minimize the likelihood of this occurring to prevent discomfort and to recognize the significance of maintaining confidentiality and privacy. Participants can stop the survey at any time or not answer questions.

مخاطر المشاركة في هذا المشروع ضئيلة للغاية. ومع ذلك، قد يشعر المشاركون بعدم الارتياح أو الانزعاج عند

الإجابة على أسئلة معينة من هذا المشروع إذا كانت لديهم تجارب سلبية. سيتخذ فريق المشروع خطوات للتقليل من احتمالية حدوث ذلك لمنع الانزعاج وإدراك أهمية الحفاظ على السرية والخصوصية. يمكن للمشاركين إيقاف الاستبيان في أي وقت أو عدم الإجابة عن الأسئلة ..

Benefit from the project

6. الاستفادة من المشروع

You may not benefit directly from participating in the project. However, you can help improve the MHPSS program for Palestine refugees in Jordan.

قد لا تستفيد مباشرة من المشاركة في المشروع. إلا أنه بإمكانك المساعدة في تحسين برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي للاجئي فلسطين في الأردن.

Compensation:

7. التعويضات

You will not be compensated for being in this project.

لن يتم تعويضك عن مشاركتك في هذا المشروع.

Extent of anonymity and confidentiality:

8. مدى عدم الكشف عن الهوية والسرية

The information you shared with us during the interview will only be used for this project, and this information is confidential. The project number will be used rather than your name. Any other identifying information, including your name, will not appear in any presentation or publication of the results.

لن يتم استخدام المعلومات التي قمت بمشاركتها معنا أثناء المقابلة إلا لهذا المشروع، وهذه المعلومات سرية. سيتم استخدام رقم المشروع بدلاً من اسمك. لن تظهر أي معلومات تعريفية أخرى، بما في ذلك اسمك، في أي عرض أو نشر للنتائج.

Contact Information:

معلومات الاتصال

If you have questions about the assessment process, scheduling, or any other questions or concerns about the project or your role of the project, contact us below by phone or e-mail.

إذا كان لديك أسئلة حول عملية التقييم أو الجدولة أو أي أسئلة أو استفسارات أخرى حول المشروع أو دورك في المشروع، اتصل بنا أدناه عبر الهاتف أو البريد الإلكتروني.

Kaori Okada

Shata Albeik

Introduction:

مقدمة:

I am Kholoud Abu-Hameideh and will be conducting the interview today in place of Kaori. Initially, I would like to thank you for your time and participation in the project. Regarding this project, I am interested in the strengths and challenges for MHPSS program. Therefore, the project aims to identify the strengths and challenges of the MHPSS program from the perspective of medical providers. It seeks to enhance the program to improve the mental health of Palestine refugees in Jordan. The data from the interview will be used to write a final report and thesis.

أنا خلود أبو حميدة وسأجري المقابلة اليوم بدلاً من كاوري. في البداية، أود أن أشكرك على وقتك ومشاركتك في المشروع.

فيما يتعلق بهذا المشروع، أنا مهتمة بنقاط القوة والتحديات التي تواجه برنامج الصحة النفسية والدعم النفسي و الاجتماعي .

ولذلك، يهدف المشروع إلى تحديد نقاط القوة والتحديات التي تواجه برنامج الصحة النفسية والدعم النفسي والاجتماعي من منظور مقدمي الخدمات الطبية.

ويسعى إلى تعزيز البرنامج لتحسين الصحة النفسية للاجئي فلسطين في الأردن. سيتم استخدام البيانات المستمدة من المقابلة لكتابة التقرير النهائي والأطروحة

Ethical issues:

القضايا الأخلاقية:

I would like to ensure that you are comfortable with the interview before we begin. The information you share with me through the interview, including your personal information, is only used for this project and this conversation is confidential. In addition, identifiable information such as your name or any identical information will be deleted from the outcome of this final report for not identifying the individual. The

interview will last 30 minutes, but I will ensure that it does not take more than 30 minutes. Please remember that you can pause or stop the interview at any point. Additionally, you do not need to answer the question if you feel uncomfortable because the question may be sensitive. I would like to record this interview, take notes, and transcribe our conversation for accuracy. These are the details about conducting the interview. Before we start the interview, I would like to obtain informed consent. Do you agree with participating in this project under this condition?

أود التأكد من أنك مرتاح للمقابلة قبل أن نبدأ. المعلومات التي تشاركها معي من خلال المقابلة، بما في ذلك معلوماتك الشخصية، ستستخدم فقط لهذا المشروع وستكون هذه المحادثة سرية. بالإضافة إلى ذلك، سيتم حذف المعلومات التي يمكن التعرف عليها مثل اسمك أو أي معلومات متطابقة من نتيجة هذا التقرير النهائي لعدم تحديد هوية الفرد. ستستغرق المقابلة 30 دقيقة، لكنني سأحرص على ألا تستغرق أكثر من 30 دقيقة. يرجى تذكر أنه يمكنك إيقاف المقابلة مؤقتاً أو إيقافها في أي وقت. بالإضافة إلى ذلك، ليس عليك الإجابة عن السؤال إذا كنت تشعر بعدم الارتياح لأن السؤال قد يكون حساساً. أرغب في تسجيل هذه المقابلة وتدوين الملاحظات وتدوين محادثتنا للتأكد من دقتها. هذه هي تفاصيل إجراء المقابلة. قبل أن نبدأ المقابلة، أود الحصول على موافقة مسبقة. هل توافقين على المشاركة في هذا المشروع تحت هذا الشرط؟

Thank you for agreeing. Let's proceed with the questions now.

شكراً لموافقتك. لننتقل الآن إلى الأسئلة

Opening Questions:

الأسئلة الافتتاحية

At first, please tell me about yourself.

في البداية، من فضلك أخبرني عن نفسك:

What is your age?

1- ما هو عمرك؟

What is your occupation?

2 - ما هي مهنتك؟

What is your highest level of education?

3 - ما هو أعلى مستوى تعليمي لديك؟

How long have you worked at UNRWA?

4 - منذ متى وأنت تعمل في الأونروا؟

Have you received mental health training at UNRWA?

هل تلقيت تدريباً في مجال الصحة النفسية في الأونروا؟ -5

How often and how many times do you receive training on mental health topics?

كم عدد المرات التي تلقيت فيها تدريبًا حول مواضيع الصحة النفسية وكم مدى تكرار التدريب ؟ -6

What is your role for the MPHSS program?

7. ما هو دورك في برنامج MPHSS؟

In what ways is mental health a part of your role?

8. ما هي النواحي أو الطرق التي تشكل الصحة النفسية جزءًا من دورك؟

Specific Questions:

أسئلة محددة:

Now, I want to move on to ask about the MHPSS program.

Please remember that if you do not want to talk about it or wish to stop, you can.

والآن، أريد أن أنتقل إلى السؤال عن برنامج MHPSS ،

أرجو أن تتذكر أنه إذا كنت لا تريد التحدث عن ذلك أو ترغب في التوقف، يمكنك ذلك.

Personal strengths/challenges (Individual level)

1) القوة/التحديات الشخصية (على المستوى الفردي)

What kind of mental health training have you received at UNRWA?

9. ما نوع التدريب على الصحة النفسية الذي تلقيته في الأونروا؟

What kind of mental health training have you received outside of UNRWA?

10. ما نوع التدريب الذي تلقيته في مجال الصحة النفسية خارج الأونروا؟

How was mental health training for medical staff helpful for you?

11. كيف كان التدريب على الصحة النفسية للموظفين الصحيين مفيدًا لك؟

(Probe: Screening? Working with patients? Enhancing mental health knowledge? Quality of care?)

(استقصاء: الفحص؟ العمل مع المرضى؟ تعزيز المعرفة بالصحة النفسية؟، جودة الرعاية؟)

What kind of additional training do you think is needed to best serve refugees with mental health challenges?

12.ما نوع التدريب الإضافي المطلوب في رأيك لخدمة اللاجئين الذين يعانون من تحديات الصحة النفسية على أفضل وجه؟

(Probe: Screening? Working with patients? Enhancing mental health knowledge? Quality of care? Learning the system of MHPSS)

(استقصاء:(الكشف؟ العمل مع المرضى؟ تعزيز المعرفة بالصحة النفسية؟ جودة الرعاية؟ تعلم نظام برنامج الصحة النفسية والدعم النفسي والاجتماعي)

Health centers strengths/challenges (Institutional level):

2) نقاط قوة/تحديات المراكز الصحية (المستوى المؤسسي):

How does your work environment influence the implementation of the MHPSS program?

13. كيف تؤثر بيئة عملك على تنفيذ برنامج الصحة النفسية والدعم النفسي والاجتماعي ؟

(Probe: Shortage of staff? Limited time? Increase of mental health patients? Relationship with staff and community?)

(تحقيق: نقص الموظفين؟ وقت محدود؟ زيادة عدد مرضى الصحة النفسية؟ العلاقة مع الموظفين والمجتمع؟)

What kind of resources are beneficial to prevent adverse mental health outcomes for Palestine refugees at your health center?

14. ما نوع الموارد المفيدة لمنع النتائج السلبية على الصحة النفسية للاجئي فلسطين في مركزكم الصحي؟

(Probe: Staff, Cost, Training?) (التحقيق: الموظفين، التكلفة، التدريب) ؟)

How do you cooperate with other organizations to provide mental health services to refugees? (Only Medical Officer and Senior Staff)

15.كيف تتعاون مع المنظمات الأخرى لتقديم خدمات الصحة النفسية للاجئين؟ (مدير العيادة ورئيسة التمريض فقط)

3) Organizational strengths/ challenges (Organizational level)

3)) نقاط القوة/التحديات التنظيمية (المستوى التنظيمي

When do you use technical instructions & management protocols for MHPSS within UNRWA's Primary Health Care Model? How?

16.متى تستخدمون التعليمات الفنية والبروتوكولات الإدارية الخاصة بخدمات برنامج الصحة النفسية والدعم النفسي والاجتماعي في إطار نموذج الأونروا للرعاية الصحية الأولية؟ كيف؟

How could the technical instructions & management protocols for MHPSS within UNRWA's Primary Health Care Model be helpful in conducting MHPSS services?

17. كيف يمكن أن تكون التعليمات الفنية وبروتوكولات الإدارة الخاصة بخدمات الصحة النفسية والدعم النفسي والاجتماعي في إطار نموذج الأونروا للرعاية الصحية الأولية مفيدة في تقديم خدمات الصحة النفسية والدعم النفسي والاجتماعي؟

How could the technical instructions & management protocols for MHPSS within UNRWA's Primary Health Care Model be improved?

18. كيف يمكن تحسين التعليمات الفنية وبروتوكولات الإدارة الخاصة بخدمات الصحة النفسية والدعم النفسي والاجتماعي في إطار نموذج الأونروا للرعاية الصحية الأولية؟

What are the MHPSS program's strengths in serving Palestine refugees at a health center in Jordan?

19. ما هي نقاط قوة برنامج الصحة النفسية والدعم النفسي والاجتماعي في خدمة لاجئي فلسطين في المركز الصحي في الأردن؟

(Prove: Strong relationship with community? increase of awareness of mental health for patients, technical instructions? mental health training?)

(إثبات: علاقة قوية مع المجتمع؟ زيادة الوعي بالصحة النفسية للمرضى؟ تعليمات فنية؟ تدريب على الصحة النفسية؟)

What do you think needs to be improved in the MHPSS program to better Palestine refugees?

20. ما الذي تعتقد أنه يجب تحسينه في برنامج خدمات الصحة النفسية والدعم النفسي والاجتماعي لتحسين أوضاع اللاجئين الفلسطينيين؟

(Probes: Access? Education to medical staff? Education for Palestine refugees about mental health? Resources?)

(استقصاء: الوصول؟ تثقيف الطاقم الطبي؟ تثقيف لاجئي فلسطين حول الصحة النفسية؟ الموارد؟)

Environmental strengths/challenges (Macro Level)

3) نقاط القوة/التحديات البيئية (المستوى الكلي)

How do you think the stigma toward mental health impacts the implemented MHPSS program?

21. كيف تعتقد أن وصمة العار تجاه الصحة النفسية تؤثر في رأيك على تنفيذ برنامج الصحة النفسية والدعم النفسي والاجتماعي؟

What barriers do you think Palestine refugees in Jordan experience in trying to engage in mental health services?

22. ما هي برأيك المعيقات التي يواجهها لاجئو فلسطين في الأردن في محاولتهم الاستفادة من خدمات الصحة النفسية؟

(Probe: Access to health center, stigma, gender, economic problem faced by the refugees?)

(تحقق : الوصول إلى المركز الصحي، وصمة العار والنوع الاجتماعي والمشاكل الاقتصادية التي يواجهها اللاجئون؟)

How do you think that the ongoing conflict in Gaza influences the mental health condition of Palestine refugees in Jordan?

23. كيف تعتقد أن الصراع الدائر في غزة يؤثر على حالة الصحة النفسية للاجئي فلسطين في الأردن؟

Closing Questions:

الأسئلة الختامية:

That's all for the questions.

هذا كل شيء بالنسبة للأسئلة.

Finally, do you have anything else you would like to share or talk about?

24. وأخيراً، هل لديك أي شيء آخر تود مشاركته أو التحدث عنه؟

Thank you for taking the time to participate in the interview despite your busy schedule. Your cooperation is invaluable to improving the MHPSS program. We appreciate your consideration to participate in the project and your time.

أشكرك على تخصيصك الوقت للمشاركة في المقابلة على الرغم من جدولك المزدحم. إن تعاونك لا يقدر بثمن في تحسين برنامج الصحة النفسية والدعم النفسي والاجتماعي. نحن نقدر لك اهتمام

Appendix C: Table 10.

Table 10: Distribution of the Responses from Healthcare Providers in the Online Survey

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
26. Lack of financial support is affecting the implementation of the MHPSS program.						
All health care providers	38 (47.5)	39 (48.5)	2 (2.5)	1 (1.3)	0 (0)	0 (0)
Doctors	10 (55.6)	8 (44.4)	0 (0)	0 (0)	0 (0)	0 (0)
Senior Staff Nurses	5 (55.6)	4 (44.4)	0 (0)	0 (0)	0 (0)	0 (0)
Staff nurse	4 (40.0)	6 (60.0)	0 (0)	0 (0)	0 (0)	0 (0)
Practical Nurses	11 (42.3)	15 (57.7)	0 (0)	0 (0)	0 (0)	0 (0)
Midwives	6 (54.5)	3 (27.3)	1 (9.1)	1 (9.1)	0 (0)	0 (0)
30. Palestine refugees in Jordan do not have enough information about how to access mental health services.						
All health care providers	13 (16.3)	42 (52.5)	15 (18.8)	10 (12.5)	0 (0)	0 (0)
Doctors	2 (11.1)	10 (55.6)	4 (22.2)	2 (11.1)	0 (0)	0 (0)
Senior Staff Nurses	1 (11.1)	2 (22.2)	3 (33.3)	3 (33.3)	0 (0)	0 (0)
Staff nurse	1 (10.0)	7 (70.0)	0 (0)	2 (20.0)	0 (0)	0 (0)
Practical Nurses	4 (15.4)	16 (61.5)	4 (15.4)	2 (7.7)	0 (0)	0 (0)
Midwives	2 (18.2)	6 (54.5)	2 (18.2)	1 (9.1)	0 (0)	0 (0)

	Strongly Agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly Disagree N (%)	Not Answered N (%)
16. Referring to other staff at the health center can be done smoothly.						
All health care providers	13 (16.3)	51 (63.8)	6 (7.5)	9 (11.3)	1 (1.3)	0 (0)
Doctors	2 (11.1)	14 (77.8)	1 (5.6)	1 (5.6)	0 (0)	0 (0)
Senior Staff Nurses	1 (11.1)	5 (55.6)	1 (11.1)	2 (22.2)	0 (0)	0 (0)
Staff nurse	2 (20.0)	6 (60.0)	1 (10.0)	1 (10.0)	0 (0)	0 (0)
Practical Nurses	4 (15.4)	18 (69..2)	0 (0)	3 (11.5)	1 (3.8)	0 (0)
Midwives	3 (27.3)	4 (36.4)	2 (18.2)	2 (18.2)	0 (0)	0 (0)

17. Referral to the hospital system of the MHPSS program can be done smoothly.						
All health care providers	6 (7.5)	39 (48.8)	25 (31.3)	6 (7.5)	4 (5)	0 (0)
Doctors	0 (0)	10 (55.6)	7 (38.9)	0 (0)	1 (5.6)	0 (0)
Senior Staff Nurses	1 (11.1)	4 (44.4)	2 (22.2)	1 (11.1)	1 (11.1)	0 (0)
Staff nurse	2 (20.0)	5 (50.0)	3 (30.0)	0 (0)	0 (0)	0 (0)
Practical Nurses	2 (7.7)	12 (46.2)	9 (34.6)	3 (11.5)	0 (0)	0 (0)
Midwives	1 (9.1)	5 (45.5)	2 (18.2)	2 (18.2)	1 (9.1)	0 (0)