

ADDRESSING MENTAL HEALTH, PSYCHOSOCIAL SUPPORT (MHPSS) AND NCDs IN URBAN JORDAN: ACTING AT THE INTERSECTION

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Purpose

The aim of this policy brief is to highlight the mental health and psychosocial needs of persons with noncommunicable disease (NCD) and provide examples of interventions that address these comorbidities among urban residents. In recognition of the complexity that exists in Jordan, as a result of the humanitarian needs of refugees, and the long-term needs of citizens, this brief addresses both populations. This document is based upon a 3-phase process that took place in 2018 and 2019 and included (1) a scoping review of the NCD intervention literature from urban refugee contexts in the Middle East and North Africa, (2) a qualitative NCD study conducted in Jordan with urban based Syrian refugees⁴ and (3) an expert consultative convening, hosted in Amman, to identify intervention and policy recommendations.

Scoping review: NCD interventions for refugees in urban MENA.

Qualitative study: Experience of refugees with NCDs residing in urban Jordan.

Expert consultative process: Prioritize focal areas with health, education, humanitarian and academic actors in Jordan.

The first two phases focused on the NCD needs of refugees in urban settings. However, in an effort to ensure equity and access for all communities, the third phase and the final recommendations address common NCD needs across all urban populations residing in Jordan. This brief is aligned with Jordanian health policies and research and implementation efforts conducted in the MENA region, as well as policy and practice examples from diverse settings across the globe. Opportunities exist to better address the mental health and psychological wellbeing of people diagnosed with noncommunicable diseases.

Jordanian health sector strategies and responses

Jordan has achieved measurable improvements in health and development, while managing social and economic pressures including conflicts in neighboring nations and the recent influx of more than one million refugees. More specifically, Jordan has made impressive strides in the health domain, including the reduction of child mortality from 37 per 1,000 live births in 1990 to 18 per 1,000 live births in 2015, and the reduction of maternal mortality from 110 per 100,000 live births in 1990 to 58 per 100,000 live births in 2015.^{5 6} In addition, life expectancy stands at 74.4 years and the nation has effectively addressed vaccine preventable diseases including measles and polio.⁷

Building on these achievements, the 2015-2019 Health Sector Strategy outlines further advances in health with commitments to universal health coverage and the incorporation of mental health services into primary and secondary care. The strategy articulates a focus on reducing the stigma of using mental health services and calls for increasing the number of psychiatrists. In addition to addressing MHPSS among Jordanian citizens, the government also highlights these issues among refugee populations, as described in the 2018-2020 Jordan Response Plan (JRP). The JRP presents specific health objectives focused on improving the quality and access to primary, secondary and tertiary care

and improving the quality and uptake of community interventions. This policy brief is well aligned with Jordan's National Health Sector Strategy and the 2018-2020 Jordan Response Plan (JRP), and emphasizes the need to address NCDs through investing in MHPSS efforts that improve health outcomes and reduce morbidity. The following sections outline NCD challenges in Jordan and provide recommendations and case examples from the MENA region and diverse settings across the globe.

The NCD burden

In 2018, NCDs accounted for 71% of all deaths globally,^{8,9} 74% of deaths in the MENA region and 76% in Jordan.¹⁰⁻¹¹ The vast majority of deaths are due to cardiovascular disease, chronic respiratory disease, cancer and diabetes.¹² The prevalence of these diseases and their risk factors are particularly high in Jordan.¹³⁻¹⁵ In 2018, Abujbara et al. conducted a national survey in Jordan that identified hypercholesterolemia (a risk factor for cardiovascular disease) in 44.3% of the adult population, a two-fold increase from 1994.¹³ Diabetes and impaired fasting glucose prevalence was also high -- 25% in 2008, with obesity prevalence at 51.7% of the population.^{13,16} Jordanians share a similar epidemiologic profile to Syrians, and as a result, the influx of refugees has increased the burden of disease.

In addition to the adverse impact of NCDs on the health of the population, NCDs also threaten economic development.¹² They decrease productivity among the employed, increase disability as a result of secondary complications and cause catastrophic spending, pushing families further into poverty.^{12,17} NCDs are an urgent concern to all stakeholders who are promoting wellness among both Jordanians and displaced populations. National health systems and humanitarian actors are challenged by these pressures and are called to adapt and innovate. Opportunities exist to recognize and manage comorbidities among people with NCDs, with a focus on addressing mental disorders and psychosocial wellbeing.

Why invest in mental health and psychosocial support (MHPSS)?

This policy brief is focused on the integration of MHPSS and NCD care. Mental disorders among Jordanian communities cause enormous suffering and reduced functionality.¹⁸ Among refugees, mental disorders are also key issues, as are less clinical concerns such as family separation. Mental disorders are a risk factor for NCDs, and as a result, a significant portion of people with depression and anxiety have NCDs.^{19,20} Globally, prevalence of depression among those with hypertension, diabetes and cancer have been shown to be as high as 29%, 27% and 33% respectively.²¹ The 2007 Jordan Behavioral Risk Factor Surveillance Survey identified that 10% of the population had mental distress and 18% had hypertension, both likely underestimated due to self-report bias.¹⁸

People with mental health and NCD comorbidities receive lower quality care, have poorer health outcomes and higher health expenses.¹⁹ One study found that 23.6% of people with comorbid depression and hypertension were unable to control their hypertensive symptoms.¹⁹ A qualitative study conducted in Jordan identified similar findings -- refugees with NCDs had emotional distress and an inability to control NCD symptoms.²² The recommendations outlined in this brief are aligned with the WHO's mental health Gap Action Programme (mhGAP), the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings and Jordan's Ministry of Health reforms. Investment in MHPSS can aid Jordan in improving dignity, health and healthcare quality, as well as reducing health expenditures for both citizens and refugees.

Recommendation #1: Strengthen human resources for mental health through task-shifting and expanded education

Mental health has been prioritized in low-and middle-income countries and supported by WHO's mhGAP. However, human resource limitations have made it challenging to operationalize frameworks that encourage integration into primary care and NCD services. Barriers include insufficient numbers of practitioners (i.e., psychologists, psychiatrists) and an emphasis on specialists over generalists (i.e., lay health workers).²³ Mental health needs are high and while specialists are important, the field requires greater investment in the training of general practitioners, the development of lay health worker roles, as well as a focus on family and community supports, and self-help.²³⁻²⁶

WHO and other actors champion the development of lay worker roles and specifically the concept of task-shifting, the redistribution of health worker functions from specialized to less specialized roles. The benefits of task shifting include the expansion of access by increasing the number of available providers and the reduction of costs due to decreased expenses for education and hiring. Task shifting has been effective in other aspects of health care including minor surgery and diagnostic testing.²⁷ Lay health workers may also be particularly appropriate for mental health services because they are more likely to gain the trust of the community, limit the exposure to stigma, and create supportive group experiences.²⁸ Lay workers may also be most effective at meeting the needs of marginalized groups, particularly when they have a shared identity (i.e., women, youth and refugees).

Education and training have also been explored as methods for strengthening mental health services and integrating them into NCD and primary care. Several studies have noted that general practitioners in low-resource settings face challenges identifying depression, anxiety and other mental disorders. Education and training opportunities may aid clinicians in recognizing symptoms, utilizing well established diagnostic tools and incorporating MHPSS into their daily practice.²⁷

Problem Management Plus (PM+) Case Study: Pakistan²

The World Health Organization's mental health Gap Action Programme (mhGAP) promotes mental health interventions that can be provided by lay health workers in low-and middle-income crisis-affected settings. One intervention example is Problem Management Plus (or PM+). In response to mental health needs and scarce human resources in Peshawar, Pakistan, PM + was introduced and identified as feasible for **lay health workers**. A randomized clinical trial of the PM+ intervention was conducted between 2014 and 2016 with 346 patients.

PM + was conducted in individual 90-minute sessions for 5 weeks. The intervention included (1) stress management, (2) problem solving, (3) behavior activation, and a focus on (4) strengthening social support. PM+ was applied to depression, anxiety and post-traumatic stress disorder (PTSD). The 5 sessions explored a variety of activities including motivational interviewing, slow breathing activities and problem solving exercises. Sessions were facilitated by lay health workers with high school or college level education. These teams were trained for 8 days. Upon approval to function independently, they received supervision once per week.

The outcomes of the intervention were measured after three months and the intervention group had significant reductions in anxiety and depression.

Recommendation #2: Introduce and expand e-mental health interventions

Human resource shortages, particularly the shortages of mental health and psychosocial workers, are a major challenge in low-and middle-income settings. The 2011 WHO-AIMS report on the Mental Health System in Jordan stated that there were 1.09 psychiatrists, .27 psychologists and .3 social workers per 100,000 population. In response to this global challenge, electronic mental health (e-mental health) interventions have been introduced as one method for improving access to services, reaching people in distant locations or those affected by conflict and, reducing feelings of stigma.

There is great diversity in the types of e-mental health interventions that are available. Several applications are synchronous, meaning the patient and a health worker/peer engage with one another live on the internet. Other applications are asynchronous, where the patient views videos, completes writing assignments, communicates with peers or takes short clinical assessments, but does not speak to a health worker/peer in real-time. E-mental health applications can be used on computers but are increasingly accessed on cellular smart phones. These applications may provide self-help tools, guided coaching, reflective exercises, as well as real-time cognitive behavior-based therapy.^{1 23}

Important considerations for e-mental health interventions include the need to adapt to cultural contexts, address the costs of phone usage and develop strategies for protecting confidentiality.¹ Cultural adaptation may include translation into local languages and dialects, co-designing with affected populations (with attention to ethical considerations) and pilot testing. Several applications make phone usage free for patients with a cost for the provider or the organization. Confidentiality is of great concern to patients as well and several tools exist for encryption of communications but further research may be required to ensure they meet the needs of the most vulnerable users (i.e., victims of gender-based violence, refugees).²⁹ These efforts have been effective at addressing PTSD, insomnia and anxiety among diverse groups.^{1 23}

e-Mental Health Case Study: Iraq¹

To address PTSD in Iraq, an internet-based cognitive behavioral therapy intervention was adapted and implemented with 159 patients (79 treatment, 80 control). For a 5-week period, patients interacted twice per-week with an online platform (45 minutes per session).

They completed a series of writing activities aimed at exploring traumatic events and shifting perspectives on these events. Patients had experienced various types of trauma including sexual violence, the murder of a family member and exposure to war-related violence. Patients did not interact with therapists in real-time but received feedback and coaching based on their writings.

Therapists were recruited from across the globe including the UAE, Iraq, Palestine and Syria and were either psychiatrists or psychotherapists. They participated in a 1-week training on e-therapy and the general protocol. They were supervised weekly and managed their own patient caseload. During the 5-week period, patients had 10 writing assignments and therapists responded to each with feedback, questions and prompts for the following assignment.

The study team conducted a parallel group randomized trial. PTSD symptoms were significantly reduced and remained so during the 3-month follow up for the treatment group, whose chance of recovery was 74.19 times higher than those in the treatment group.

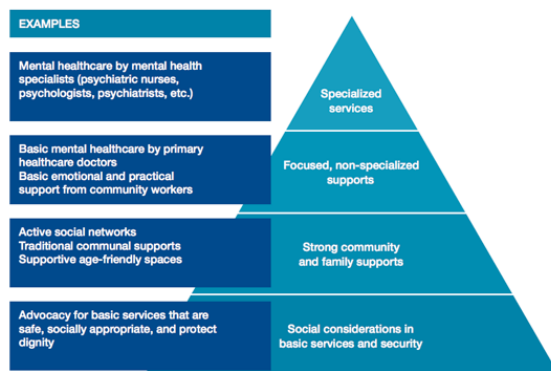
Recommendation #3: Make psychosocial support (PSS) broadly available for populations affected by socio-economic and crisis-related pressures

Specialized mental health services are important for those with severe mental disorders. However, the vast majority of any population will not need these services but will benefit from more community-centered, psychosocial supports. The Inter-Agency Standing Committee (IASC) promotes holistic systems of PSS (see pyramid) with a focus on making non-specialized services and supports broadly available for people affected by a crisis as well as daily stressors such as socio-economic pressures.²⁵ Such programs come in various forms -- from support groups for adults with NCDs, to play and art activities for children and the elderly. PSS efforts promote wellbeing through fostering a sense of safety, trust and inclusion, and providing emotional support.

PSS initiatives are not new for people affected by NCDs. Programs have been developed for people with cancer and parents of children with autism. Across this spectrum of illnesses, various actors recognize the need to support the psychosocial wellbeing of people affected by chronic conditions. Improved psychosocial wellbeing is a desired outcome but also a method for averting the onset of major depression and anxiety.

PSS is often relational in nature, and can be facilitated by laypersons. Examples include grief support and livelihoods initiatives. For people with NCDs, PSS may include group cooking sessions or dance classes that encourage socializing and physical activity. Significant psychosocial support does not come from specialists but rather from networks of people who sustain one another in the face of adversity.

INTERVENTION PYRAMID



Source: Adapted from IASC, 2007

Psychosocial Support and Social Cohesion Case Study: Jordan³

7000 people in Jordan (Jordanians and refugees) participated in a psychosocial support program administered by an NGO, Action Contre la Faim (ACF) in 2014. The intervention had many components (i.e., assistance with water and sanitation and cash assistance). ACF also offered specific support groups to help participants deal with their distress and have safe environments to discuss feelings and emotions.

Some support groups were general in nature, while others focused specifically on shared issues (i.e., parenting difficulties, being a single mother, having anger management issues). Topics covered in the supportive sessions included stress management, addressing discrimination, education for children and accessing health services.

The sessions took place weekly (for 5-6 weeks) and were moderated by psychosocial workers (PSWs). PSWs did not need specific educational qualifications but were trained and supervised by a psychologist. Training prepared them to manage conflict and create respectful environments.

The program was evaluated using qualitative focus groups with participants but did not measure health outcomes. Participants expressed satisfaction with the program and specific appreciation for reducing their sense of isolation and improving communication within their families.

Conclusion

The rising burden of NCDs in Jordan calls for a multipronged strategy that prioritizes the recognition and treatment of people with mental disorders and NCD comorbidities. This challenge requires inventive and resourceful solutions that build on the strength of the Jordanian health system and introduce new models of care. These new models will expand access to larger numbers of people and to those for whom health facilities are inaccessible. These approaches will also lower health care costs by reducing visits to facilities and shifting tasks to less specialized staff.

Mental health services have traditionally been considered as separate from NCDs and primary care. This separation exists both in clinical practice and upstream in the financing of service delivery. This approach is fragmented, resource-intensive and inefficient. It is also ineffective at improving health outcomes for people affected by either or both NCDs and mental disorders.^{30 31} The situation in urban Jordan calls for a more holistic approach to health and wellness, one that integrates NCD care with civic and lay efforts to support mental health and psychosocial wellbeing.

Strengthen human resources for mental health through **task-shifting** and expanded education.

Introduce and expand **e-Mental Health** interventions.

Make **PSS** available for populations affected by socioeconomic and crisis-related pressures.

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