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Failures of US Foreign Aid: Jordan and its Unique History of Refugee Absorption

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Introduction

Rasha, a resettled refugee, found that she "had no idea how to raise money, and depressed as she was—way beyond tears—she was too immobilized to try" (Jones 220). She now lives in a small apartment with her two children, sister, and sister's two children, and they all continue to suffer emotionally.[1] Rasha's sister is "very nervous" while Rasha's nephew often becomes "violent and vicious," beating up his sister and young cousins; he is only seven years old (Jones 218). Her niece no longer speaks, while Rasha's own children cling to their mother's legs in constant fear (Jones 219). The majority of refugees in Jordan are originally from Palestine or Syria, having been displaced due to conflict, mass violence, and war.[2] Refugee populations have a high risk of mental health issues due to the traumatic situations they flee; these health issues inhibit their ability to recover, and contribute to social and economic dysfunction (Pumariega 590). The large refugee community is at risk, and my purpose in this essay is to explore refugee needs in order to ascertain how aid can more effectively promote sustainable social and economic growth in Jordan.

The experiences of refugees in Jordan vary widely. The Jordanian government's integration of Palestinian refugees into dominant society has proven inconsistent in terms of granting citizenship, employment, property ownership, public education and mental health care access (Al-Makhamreh 1076). These restrictions limit integration of Palestinian refugees into the Jordanian society and economy. Similarly, Syrian refugees do not qualify for Jordanian passports and thus cannot reside and work in the region unless they are able to pay upfront to do so (Ansari). Lack of full citizenship restricts refugee movement and labor capacity, causing increased economic hardship. This integration failure could exacerbate feelings of vulnerability, which contributes to mental health disorders, among all refugee populations in Jordan.

Some subgroups of refugees are affected by mental health disorders at higher rates. Refugees resettled in permanent, private housing tend to have better mental health conditions than those resettled in temporary residences (Porter 608). For many Syrian refugees in Jordan, temporary residences are the norm. Gender also plays a factor in mental health, with higher rates of mental health disorders in females (Porter 608); for example, Rasha and her sister are both women with poor mental health (Jones 219). Education level

and socio-economic status both correlate, with higher levels of both connecting with higher risk of mental health disorders (Porter 609). Many refugee subgroups can be analyzed in connection with mental health, but for the scope of this paper I will provide a more general analysis.

In order for healthcare professionals to properly diagnose a mental health disorder in patients, there must be inhibited social functioning and high levels of suffering from symptoms (Hassan 15). Such symptoms are difficult to identify, and large numbers of refugees remain undiagnosed because they lack both information about, and access to, treatment. Rasha, for instance, is unable to work because of her mental health, and others like her may not know to seek help at all. The most common mental health conditions among refugees are "post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, adjustment disorder, and somatization" (Refugee Health Technical Assistance). Without treatment, these mental health conditions can lead to social and behavioral problems, such as aggression, interpersonal difficulties, and an inability to function in everyday life (Hassan).

Children are especially vulnerable; their PTSD rates range from 50–90% (Refugee Health Technical Assistance). The violent outbursts from Rasha's nephew are most likely a manifestation of PTSD (Jones 218), since PTSD can manifest as harmful practices or behavior. The rates of mental health disorders in Syrian refugees are estimated to have increased significantly because of the ongoing nature of the violent Syrian civil war (Hassan 15). The lack of data speaks to the low level of awareness around mental health conditions in refugees (Derr 271).

Mental health issues that occur in refugee populations due to previous traumas can continue long after resettlement, thus hindering social function and participation in their new community (Hassan). A refugee interviewed in Jordan four months after his resettlement stated he "was unable to leave his apartment . . . unable to sleep. At times he was filled with rage and became 'aggressive' towards his wife . . . he was still stunned by flashbacks, confused by memory lapses" (Jones 214). The psychological and social distress because of his resettlement "manifests in a wide range of emotional, cognitive, physical, and behavioral and social problems" (Hassan). Ahmed, a refugee living in Amman "loved [his wife] desperately, yet at times he couldn't stop himself from beating her" (Jones 238). Rage and acts of aggression are manifestations of untreated mental trauma, as seen with Rasha's young nephew. Ahmed needs treatment in order to manage his anger that originated from his experiences during the pre- and post-settlement stages. Persistent and untreated mental health conditions specifically hinder the ability to acquire and manage a job. A 2002 study found that, three years after settling, roughly 55% of refugees remain unemployed as a direct consequence

health conditions (Lie 418). Furthermore, 61% of refugees experience hindered social functioning, with many unable to leave their houses or form social connections—all because of persistent mental illness symptoms (Lie 419). Clearly, long-term trauma keeps refugees in a cycle of poverty, and excludes them from participating in society (Lie 421).

Adolescent Syrian refugees in Jordan, those 18 years and younger, reported "withdrawal" as a coping mechanism; symptoms include pulling away from families and communities and becoming increasingly isolated (Hassan 17), and also "doing nothing," which means that the refugee simply cannot function in any sort of social setting (Hassan 17). Due to lack of treatment, half of displaced Syrian children and adolescents discontinue their educations (Hassan 17). The inability for children to continue their education expresses just how untreated mental health conditions can negatively impact the long-term economic growth of a country through lowering education levels.

The context in which people become refugees increases the need for mental health services (Derr 267). Refugees go through multiple stages of trauma and "experience diverse stressors . . . over the preflight, flight, exile, and resettlement/repatriation periods" (Porter 603). Upon entering a new country, many refugees face "marginalization, socioeconomic disadvantage, loss of social support[,] and cultural bereavement," all of which can exacerbate existing mental health conditions (Porter 603). Additionally, rates of mental health disorders in refugees were higher for those whose countries of origin were still experiencing conflict (Porter 603). Mental conditions are a persistent factor in refugee populations, but must be understood in a multifaceted context to be properly addressed (Porter 611).

Refugees with access to mental health treatment facilities are better able to productively deal with their trauma. Though data is unavailable for Syrian refugees it can be assumed that their responses to mental health treatment facilities would be similar. A., a West African refugee now living in the US, was "completely lost" emotionally when he arrived. He was provided assistance to deal with his losses through individual and group counseling, and A. is now able to function socially at a much higher level (Voices of Survivors). Resettled refugees in many countries have greatly benefitted from access to mental health care.[3] Despite data indicating positive responses to mental health treatment facilities, Jordan, specifically, has barriers between refugees and access to adequate mental health care.

Structural and cultural barriers both prevent refugees from seeking mental health services; structural barriers include cost, transportation, discrimination, and accessibility of mental health services. Cultural barriers include stigma, cultural norms, and learned attitudes towards mental illness (Derr

268). Often, it is a combination of these two barriers that prevents refugees from obtaining the help they need. In both Jordanian and Syrian culture, the concept of mental illness is misunderstood, and often stigmatized (Hassan 22). Mental health facilities in Jordan are limited; service cost is prohibitive, and transportation to facilities is difficult or costly. Therefore, cultural biases, in combination with structural barriers, make access to care an arduous process for Syrian refugees in Jordan.

Mental health care needs to be a priority in Jordan. In 2008 Jordan was "identified as a country in need of intense support for strengthening the mental health system" by the World Health Organization working in partnership with Jordan's Ministry of Health ("Jordan: Mental Health in Jordan"); additionally, refugees' stories are providing further evidence of a need for mental health care. While awareness of the importance of mental health care is rising, the United States still has not prioritized this form of aid in its packages. The lack of prioritization could be because the United States sees more benefit in its own geopolitical strategies for keeping Jordan's military strong and the country as a stable ally.[4] Analyzing the history of US aid to Jordan, in the context of Jordan's unique record of refugee absorption, illustrates the lack of attention paid to mental illness in aid packages and highlights the need for mental health treatment for refugee populations in Jordan.

US Aid to Jordan: 1951

After World War I and the fall of the Ottoman Empire, the British Mandate for Transjordan was created by the League of Nations (Shaw). The League awarded Transjordan, Palestine, and Iraq to Britain, while Syria and Lebanon were awarded to France (Robinson). I argue that the League formed the Mandate as a system of foreign development aid. The United Nations recognized Jordan as an independent sovereign nation in 1946 ("Jordan Profile"). Shortly after Jordan's independence, the 1948 declaration of the state of Israel caused one-third of the 700,000 displaced Palestinians to flee the Arab-Israeli fighting and take refuge in Jordan ("Palestinian Refugees"). The influx of refugees strained Jordan's already weak social, economic, and political systems. Because Jordan has few natural resources and a small industrial base, its economy depends on external aid from abroad, tourism, remittances, and the service sector (Sharp 11). Jordan faces longstanding problems of poverty, corruption, slow economic growth, and high unemployment, and all of these factors are exacerbated during large refugee migration periods.

Refugees chose Jordan for its geographic proximity, similar historical culture and language, and Jordan's promise to assist in protecting the Palestinian state. To help absorb this influx and protect Palestinian land, Jordan annexed

the West Bank in 1950 ("Jordan Profile"). With Palestinian refugees comprising over 50% of Jordan's population, Jordan struggled to maintain social and economic stability ("History: The tragedy of Palestine"). In 1951, under the terms of the Eisenhower Doctrine, and in an attempt to stabilize Jordan, the United States gave Jordan $1.4 million in annual aid on a strictly macro level (Sayigh 104). In sum, then, the large refugee influx caused the United States to begin giving aid to Jordan—and aid has followed the refugee flows ever since as a means of maintaining political and economic stability. Over 50 years later, Jordan is receiving more aid than ever before, so what went wrong?

Due to different cultural understandings of mental health in the 1950s, both in the US and Jordan, no research or analysis of mental health issues occurred. Data for US foreign aid allocations to health services in Jordan is not available before 2000. In fact, there is a lack of data on foreign aid allocation entirely before 1965 ("U.S. Overseas Loans"). The United States provided aid to assist with the goal of stabilizing Jordan, but with high rates of mental health disorders going untreated, many refugees failed to participate in this new society (Lie 421). The social and economic dysfunction—due to high rates of unemployment—contributed to the continuation of economic and political instability (Al-Habees 673-680). The United States did nothing to combat the structural and cultural barriers preventing refugees from seeking mental health services (Derr 268). This critical need of the population was not understood or addressed in US aid packages. Left untreated, the needs of the people did not dissipate, but rather continued to hinder refugee resettlement for the years to come.

US Aid to Jordan: 1967

In 1967, "the second shift" in US foreign aid to Jordan occurred (Sayigh 104). Israel invaded the West Bank during the Six-Day War,[5] which formally began when the Egyptian President, Gamal Nasser, mobilized forces against Israel and instituted a blockade of the Straits of Tiran ("Six-Day War"). In response, Israel staged a preemptive attack and weakened Egypt's forces. Jordan entered the fight in support of Egypt and its Arab neighbors. Israel then crushed Jordan's forces, driving them out of East Jerusalem and the West Bank, claiming the land for Israel ("Six-Day War"). Following the war, Israel annexed the West Bank, which resulted in another influx of refugees to Jordan ("Jordan Profile"). The war itself had already caused an estimated 250,000 more Palestinians to enter Jordan seeking refuge from advancing Israeli forces ("Palestinian Refugees").

The loss of the West Bank is estimated to have cost Jordan roughly "40% of its Gross National Product" on top of the economic and social impact of the fighting. At this time, the international community recognized those fleeing as

internally displaced persons, not refugees ("Palestinian Refugees"). Jordan, with less land but increased population, was again at a point of requiring foreign assistance to remain socially, politically, and economically stable. Thus, in 1967, the United States gave Jordan $251 million in economic aid and $79.5 million in military aid ("U.S. Overseas Loans"). Data on health aid could not be found, which presumably means either there was none, it was not a significant amount, or it was not yet considered an aid category worthy of separate consideration.[6]

As with US foreign aid to Jordan in 1951, there was a lack of allocations to health or mental health in the United States' aid in 1967. Large portions of the refugees became twice-displaced as they moved from Palestine into the West Bank and then from the West Bank into Jordan. It should be noted, however, that not all internally displaced persons were refugees from the conflict in 1948. For those who were twice displaced, the impact of such traumatic events—now happening twice in a lifetime—furthered the risk for mental health conditions to intensify towards extremes of dysfunction (Porter 610). The need for aid towards mental health diagnosis and treatment was even higher in these refugee populations after the events of the Six-Day War. Yet this issue remained unnamed and marginalized in the United States' aid, just as in Palestinian and Jordanian society.

Mental Health Funding Data

Obtaining mental health funding data has proved difficult. The emphasis on data to justify aid delivery impedes actual aid delivery. It narrows the United States' focus to more measurable results, such as reproductive health, while excluding the less measurable but, I argue, more impactful area of mental health care. It has been challenging to locate factsheets and allocations of US aid to Jordan prior to 2000. Non-governmental websites offer some information[7] and allocation breakdowns, but their data sources are unclear. Though several government agencies were contacted, none have responded with any information: either because they do not have the foreign aid information required or because they are unable to release that information. Perhaps the amount of foreign aid the United States gave was not deemed important enough to publish at the time, or maybe the government did not want the specifics of foreign aid to Jordan to be general knowledge due to the large amounts of military aid the United States gave to Jordan. This information gap has caused some difficulties, but I argue that it further illustrates the importance of the issues covered in this paper. Inability to locate funding data has rendered a wholly comparative analysis of US foreign aid to Jordan impossible at present. However, from historical context and post-2000 foreign aid patterns, I can

draw several conclusions. First, though the United States has given large amounts of foreign aid to Jordan, there has never been a substantial section of that aid specifically devoted to the treatment of mental health conditions. Second, since 1948, Palestinian refugees have not had easy access to mental health care or treatment facilities in Jordan, in part due to the lack of direct US foreign aid funding and awareness. Syrian refugees have also faced barriers in their attempts to access treatment facilities in Jordan due to lack of funding, but the awareness around mental health has been increasing with many NGOs and media outlets discussing the "Syrian mental health crisis (Leigh)."

US Aid to Jordan and Syrian Refugees Now

Since 1951, the United States has expanded aid systems in Jordan to address macro-, meso-, and micro-levels. Refugees arriving from different places, or entering the country at different times, were given different types of aid from Jordan and the United States due to cultural climate, geopolitical strategies of donor and receiving countries, and trial and error. Currently, the United States is one of the largest contributors of aid to Jordan. The United States pledged $1 billion in foreign aid to Jordan for the fiscal year 2016 ("Jordan Foreign Assistance"); of this, 5% is dedicated towards health care assistance ("Jordan Foreign Assistance"). The United States Foreign Assistance website has sorted healthcare aid into three categories; "Family Planning and Reproductive Health," "Water Supply and Sanitation," and "Maternal and Child Health ("Jordan Foreign Assistance")." Mental health care is notably absent; yet the United Nations High Commissioner for Refugees (UNHCR), a non-direct channel through which the United States gives aid to Jordan, posted a report stating "the effects of conflict on Syrian mental health and psychosocial wellbeing are profound" (Hassan 14).

US foreign aid policy has failed to identify the growing importance of mental health care in refugee populations, and by ignoring mental health care funding, the United States has, perhaps unintentionally, deemed mental health care unimportant. Jordan's calls for international donor support continue to be underfunded by the United States and other governments and organizations. Analysts suggest that the implications for this unheard plea are that "without additional aid and a sustainable response . . . Jordan will continue to restrict the protection space for Syrians . . . [increasing] the long-term risks of instability in Jordan and the region" (Francis). An estimated 630,000 registered Syrian refugees currently live in Jordan, though the actual number is probably much higher (McNeely 13). In February

of 2016, King Abdullah stated that Jordan could no longer take in Syrian refugees ("Jordan Profile"). With the Syrian refugee crisis expanding, now is the time to adjust foreign aid policy to better fit the needs of the populations it is meant to serve.

In the midst of Jordan's Arab Spring uprising in 2011 ("Jordan Profile"), the Syrian civil war began, and as a result, Jordan began absorbing great numbers of Syrian refugees, causing the country's current struggle to maintain stability.[8] At that time, the United States gave Jordan $678.18 million in foreign assistance; health-related aid comprised 7% of the allotted funds. Unlike in 2015, foreign aid the US provided had four categories in health: the three stated above and one, the smallest, titled "Health – General" ("Jordan Foreign Assistance"). The description of "Health – General" states that the category is "used when Health sectors are unknown or foreign assistance is allocated to multiple sectors within this category" ("Jordan Foreign Assistance"). However, 0% of foreign aid was allocated to the "Health – General" category. This was the case for fiscal years 2012-2015. Years 2013 and 2014 included categories for "Other Public Health Threats" and "HIV/AIDS," yet all of those received 0% of the funding as well.

The United States Agency for International Development (USAID) in Jordan fails to discuss mental health care. USAID is a government agency that uses US foreign policy to "end extreme global poverty and enable resilient, democratic societies to realize their potential." Operating in over 100 countries, USAID tackles poverty through nine difference approaches, one of which is health services ("Who We Are"). In examining health services, USAID states that the pressure on health services has increased due to the refugee crisis ("Essential Public Services"). However, the only health concerns mentioned are the increased "demand for family planning and reproductive health services" ("Essential Public Services"). The wording of USAID's statement shows disconnect between the needs of the people and the allocations of healthcare aid; if USAID was more aware of the people's needs, mental health would be included in the mentioned health concerns. The Unites States is more focused on family planning because of the high amount of data and measurability of results. This reliance on data alone has led to mental health care being ignored because it is harder to quantify. Although family planning and reproductive health services are important, so is mental health care, particularly in regards to long-term economic growth.

As a global superpower, the United States also provides funding for Jordan through United Nations agencies. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) operates health clinic programs in Jordan that serve more than 1.1 million people—

over half of registered Palestinians in Jordan ("Health in Jordan"). The United States has contributed over $4.9 billion since UNRWA's inception in 1950 ("Israel-Palestine Conflict"). Since 2007, the United States' contributions have averaged over $200 million annually to UNRWA ("Israel-Palestine Conflict"). In fact, in 2014 the United States was the largest contributor to UNRWA, giving roughly $408,751,396 in funding, with the next largest donation being $139,402,221 from the European Commission ("Israel-Palestine Conflict"). Not all funding goes to Jordan; however, UNRWA's purpose for this funding is humanitarian assistance for Palestinian refugees, of which a large number remain in Jordan.

Even in the UNRWA, there is an absence of investment in, or resources for, mental health care. There is no mention of mental health care assistance on UNRWA's "Health in Jordan" webpage, nor are mental health statistics or data included ("Health in Jordan"). However, mental health care is mentioned in the description of their Family Health Teams (FHT) program, implemented in 2011 ("Heath: Family Health Teams"). In outlining the health services FHT offers, UNRWA only listed "community mental health and psychosocial support (in the occupied Palestinian territory)" ("Health: Family Health Teams"). This qualification means that mental health care through UNRWA is confined to those in the occupied territories, excluding Jordan. Under their "Life Cycle Approach" description, mental health is not mentioned at all, nor is "psychosocial support" ("Health: Life-Cycle Approach"). The absence of mental health discussion speaks to the lack of awareness in those determining funding allocation. The lack of discussion then perpetuates the gap in mental health care, leaving many, like Rasha and her family, in need.

According to UNHCR's "Syrian Situation 2016: Regional Refugee and Resilience Plan (3RP) and Humanitarian Response Plan (HRP)," as of April 26, 2016, the US has given $34,387,069 in funding to Jordan to assist with the Syrian refugee crisis—the largest amount of any one donor, both governmental and nongovernmental ("Syrian Situation 2016"). US aid to Jordan through the UNHCR is considerably less than US aid to Jordan through the UNRWA. The difference between the two funding channels has the UNHCR money focused solely on assisting Syrian refugees while UNRWA's funding goes towards Palestinians in the Middle East.

Under UNHCR's health plan is the sub-sector, Task Force on Mental Health and Psychosocial Support (MHPSS), which was established in 2005[9] to address the need for concrete guidance on how to organize mental health and psychosocial support in emergencies" ("Who is Doing What" 2). MHPSS analyzed "target beneficiaries for MHPSS activities" found that refugees in Jordan represented the second largest group of beneficiaries, and Syrian refugees in Jordan represent most of the targeted beneficiaries ("Who is Doing

What" 37). The Task Force is currently deployed to assist with the Syrian refugee crisis. In 2015, the Task Force found that "the most under-represented services were 'clinical management of mental disorders by non-specialized health care providers' ... and 'psychological support in education'" ("Who is Doing What" 11). This is corroborated by the finding that refugee children are disproportionately affected by mental health disorders, with roughly half of displaced Syrian children unable to continue their educations (Hassan 17). The Task Force mapped 46 organizations in Jordan that deliver MHPSS programs, services, and community activities ("Who is Doing What" 5). Overall, their findings "revealed a limited management of mental disorders...as well as limited psychosocial work in education" ("Who is Doing What" 41). These findings are consistent with the argument of this paper: mental health funding does not meet the needs of refugee populations, specifically those in Jordan.

Policy Recommendations

The United States needs to promote more awareness of mental health conditions in refugee populations by allocating funding specifically for mental health education. This is crucial for Jordan because refugees constitute over half of its population. The absence of mental health services leaves many refugees in Jordan, like Ahmed (with uncontrollable aggression), Rasha (too depressed to work), and her family, suffering from mental health conditions that are undiagnosed, untreated, and even undetected. In 2010, just prior to the beginning of the Syrian refugee crisis, a mere 12% of Jordanian schools offered counseling services ("Jordan: Mental Health in Jordan"). It would seem that mental health access is important for the non-refugees in Jordan as well; all citizens deserve easy, affordable access to this form of healthcare. The United States' direct and non-direct government assistance through UN agencies vary in their treatment of mental health care. At best, these agencies, task forces, or sub-sectors only request more funding and assistance for treating mental health disorders. At worst, they ignore mental health completely.

After analyzing and reflecting on aid systems in the Jordanian socio-economic context, it is clear the United States can make foreign aid to Jordan more effective and sustainable by focusing specifically on mental health treatment in aid programs. Cutting the amount of aid given for military spending and diverting that aid to mental health could be a method of reallocating resources to explicitly address mental health needs. Mental health aid is a comparative bargain, and it will pay off exponentially in the long term, especially for individuals like Rasha. Policies regarding aid should include funding positions for

"cultural brokers," locals who can assist refugees "access medical services, locate a pharmacy, understand dosages, and reconnect to medical care as needed" (McNeely 15). Cultural brokers would help break down both structural and cultural barriers to seeking mental health care, creating easier access to resources for refugees like Rasha. There also needs to be applied research funding for improving mental health services for refugees, as well as more integration of studies on refugees' mental health and their connection to aid policies. By applying these practices, investing more in researching and evaluating mental health care in refugee populations, the economic, social, and cultural potential of refugees will increase. Because of increased investment and economic potential, the need for foreign aid will decrease over time. And this, after all, should be the ultimate goal of developmental aid.

Works Cited

Al-Habees, Mahmoud A. and Mohammad Abu Rumman. "The Relationship Between Unemployment and Economic Growth in Jordan and Some Arab Countries." *World Applied Sciences Journal* vol. 18, no. 5, 2012, pp. 673-680.

Al-Makhamreh, Sahar, Stefanos Spaneas, and Gregory Neocleous. "The Need for Political Competence Social Work Practice: Lessons Learned from a Collaborative Project on Iraqi Refugees – the Case of Jordan." *British Journal of Social Work* vol. 42, no. 6, 2012, pp. 1074-1092.

Ansari, Dima. "Jordan's refugees – a human timeline of regional crisis." *IRIN: The Inside Story on Emergencies,* 2014, www.irinnews.org/timeline/2014/12/09/jordans-refugees-human-timeline-regional-crisis.

"Convention and Protocol Relation to the Status of Refugees." United Nations High Commissioner of Refugees (UNHCR), Communications and Public Information Service, 2010, www.unhcr.org/protection/basic/3b66c2aa10/convention-protocol-relating-status-refugees.html.

Craft, Paul. "Re-thinking Foreign Aid: Paul Collier's The Bottom Billion and Dambisa Moyo's Dead Aid." *Stanford Review,* 13 Mar., 2009, www.stanfordreview.org/article/re-thinking-foreign-aid/.

Curtis, Benjamin and Serena Cosgrove. *Understanding Global Poverty: Causes, Capabilities, and Human Development*. Routledge Press [2017].

de Jong, Joop T.V.M., Ivan Komproe, Mark Van Ommeren, et al. "Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings." *JAMA* vol. 286, no. 5, 2001, pp. 555-562.

Derr, Amelia Seraphia. "Mental Health Service use Among Immigrants in the United States: A Systematic Review." *Psychiatric Services* vol. 67, no. 3, 2016, pp. 265-274.

Deudney, Daniel H. "Geopolitics: Political Science." Encyclopaedia Britannica, 12 Jan 2006. www.britannica.com/topic/geopolitics.

Francis, Alexandra. "Jordan's Refugee Crisis." Carnegie Endowment for International Peace, 21 Sept., 2015, carnegieendowment.org/2015/09/21/jordan-s-refugee-crisis/ihwc.

Hassan, Ghayda, Laurence J. Kirmayer, Abdelwahed Mekki-Berrada, Constanze Quosh, Rabih el Chammay, Jean-Benoit Deville-Stoetzel, Ahmed Youssef, Hussam Jefee Bahloul, Andres Barkeel-Oteo, Adam Coutts, Suzan Song, and Peter Ventevogel. *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict.* UNHCR, 2015, pp. 1-52. www.unhcr.org/55f6b90f9.pdf.

"Health: Family Health Teams." United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), 2015, www.unrwa.org/what-we-do/family-health-teams?program=39.

"Health in Jordan." UNRWA, 2016, www.unrwa.org/activity/health-jordan.

"Health: Life-Cycle Approach." UNRWA, 2015, www.unrwa.org/what-we-do/life-cycle-approach?program=39.

"History: The tragedy of Palestine." The Hashemite Kingdom of Jordan, 2015, www.kinghussein.gov.jo/his_palestine.html

"Israel-Palestine Conflict: General Reference." *ProCon.org*, 2015, israelipalestinian.procon.org/view.answers.php?questionID=000592.

Jones, Ann. *War is Not Over When It's Over: Women Speak Out From the Ruins of War*. Metropolitan Books, 2010.

"Jordan: Essential Public Services." USAID, 15 Dec. 2015, www.usaid.gov/jordan/essential-public-services.

"Jordan: Foreign assistance." USAID, 2015, beta.foreignassistance.gov/explore/country/jordan.

"Jordan: Mental health in Jordan." World Health Organization, 2015, www.emro.who.int/jor/jordan-news/mental-health-in-jordan.html.

"Jordan profile – Timeline." *BBC News*, 13 April 2016, www.bbc.com/news/world-middle-east-14636713.

Leigh, Karen. "Syria's Mental Health Crisis" *The New York Times*, 1 Aug. 2014, kristof.blogs.nytimes.com/2014/08/01/syrias-mental-health-crisis/

Lie, Birgit. "A 3-Year Follow-Up Study of Psychosocial Functioning and General Symptoms in Settled Refugees." *Acta Psychiatrica Scandinavica*, vol. 106, 2002, pp. 415-425.

McNeely, Clea A. and Lyn Morland. "The Health of the Newest Americans: How US Public Health Systems Can Support Syrian Refugees." *AJPH*, vol. 106, no. 1, 2016, pp. 13-15.

"Mental Health." Refugee Health Technical Assistance, 2011, refugeehealthta.org/physical-mental-health/mental-health/.

Obeidat, Omar. "Third of Jordan's Population Lives Below Poverty Line at Some Point of One Year – Study." *The Jordan Times*, 2 July 2014, www.jordantimes.com/news/local/third-jordan%E2%80%99s-population-lives-below-poverty-line-some-point-one-year-%E2%80%94-study.

"Palestinian Refugees." Anti-Defamation League, 2016, www.adl.org/israel-international/israel-middle-east/content/AG/palestinian-refugees.html?referrer=https://www.google.com/#.Vz-JmRhUrKb8.

Porter, Matthew and Nick Haslam. "Pre-Displacement and Post-Displacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons." *JAMA*, vol. 294, no. 4, 2005, pp. 602-612.

Pumariega, Andres J., Eugenio Rothe, and JoAnne B. Pumariego. "Mental Health of Immigrants and Refugees." *Community Mental Health Journal*, vol. 41, no. 5, 2005, doi: 10.1007/s10597-005-6363-1.

Robinson, Nova. "The Mandate System." Seattle University, 28 Jan. 2016, Seattle, WA. Lecture.

Sayigh, Yezid, and Avi Shlaim. *The Cold War and the Middle East*. Clarendon Press, 2003.

Segal, Uma A., Doreen Elliot, and Nazneen S. Mayadas. *Immigration Worldside: Policies*, Practices, and Trends. Oxford University Press, 2009.

Sharp, Jeremy M. "Jordan: Background and U.S. relations." Congressional Research Service, 2015, www.fas.org/sgp/crs/mideast/RL33546.pdf.

Stephens, Elizabeth. "America, Israel and the Six Day War." *History Today*, vol. 57, no. 6. 2007, www.historytoday.com/elizabeth-stephens/america-israel-and-six-day-war.

"Six-Day War: Middle East [1967]." *Encyclopedia Britannica*, 30 April 2015, www.britannica.com/event/Six-Day-War.

"Syria Situation 2016: Regional Refugee and Resilience Plan (3RP) and Humanitarian Response Plan (HRP)." UNHCR, 10 Jan. 2017, reporting.unhcr.org/sites/default/files/Syria%20Situation%20Funding%20Update%2010%20January%202017.pdf

"Who We Are." USAID, 2015, www.usaid.gov/who-we-are.

"U.S. Overseas Loans and Grants to Jordan." *Inside* Gov, 2016, us-foreign-aid.insidegov.com/1/88/Jordan.

"Voices of Survivors." The Refuge Media Project, 2016, refugemediaproject.org/blog/voices-of-survivors/.

Wenger, Martha. "US Aid to Israel." *Middle East Research and Information Project*, vol. 164, 2015, www.merip.org/mer/mer164-165/us-aid-israel.

"Who is Doing What, Where and When (4Ws) in Mental Health & Psychosocial Support in Jordan." International Medical Corps, 29 Feb. 2016, pp. 1-51, reliefweb.int/report/jordan/who-doing-what-where-and-when-4ws-mental-health-psychosocial-support-jordan-20152016.

Yapp, Malcolm Edward and Shaw, Stanford Jay. "Ottoman Empire: Historical Empire, Eurasia and Africa." *Encyclopaedia Britannica*, 22 December 2016, www.britannica.com/place/Ottoman-Empire.

Notes

[1] This book is a compilation of different refugees experiences worldwide. For the sake of this paper I used it to illustrate the refugee experience in general, even though some of these stories aren't necessarily about refugees settling in Jordan.

[2] 1951 United Nations Refugee Convention defines refugees as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear or being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (Convention and Protocol Relation to the Status of Refugees 2010).

[3] For specific stories, please see "Voices of Survivors." The Refuge Media Project. 2016. http://refugemediaproject.org/blog/voices-of-survivors/

[4] Geopolitical strategies are tactics used by the nation state, which inform influence of geography and economics on power relationships in international relations (Deudney 2016).

[5] Also known as the June War or Third Arab Israeli War.

[6] Interestingly enough, the United States had given roughly $13 million to Israel that year as well (Elizabeth Stephens 14). Roughly 30% of US aid to Israel between 1960 and 1969 was military aid (Wenger). So the United States was funding both sides of the conflict, especially in terms of military aid.

[7] I contacted the Congressional Research Service, and attempted to reach of Jeremy Sharp, the Specialist in Middle Eastern Affairs. Mr. Sharp was away and no one else responded to my questions. I also contacted USAID and was unable to obtain any information that was not already on their website.

[8] Due to the constraints of this essay I have omitted much of the history of Jordan. Please see Bibliography for sources to learn more about Jordan's history.

[9] There is a lack of research on the factors that caused the UN to concede the importance of mental healthcare in 2005. D irections for future research could investigate what happened to make UNRWA focus on mental health care in 2005 while the United States did not?