HEALTH ACCESS AND UTILIZATION SURVEY

Access to Healthcare Services Among Syrian Refugees in Jordan
December 2018

FOR:

UNHCR
The UN Refugee Agency

By:

Dajani Consulting

Amman- Jordan

Dajani Consulting
Management & Economic Consultants

DOCUMENT CONTENTS

Table of Contents

List of Figures

List of Tables

Executive Summary

UNHCR monitors the health access and utilization behaviors of non-camps refugees regularly since 2014. The perception of refugees with regards to healthcare services supported by UNHCR differs each year as a result of increased cost of healthcare, economic conditions and policy changes. Currently, more than 81% of the 671,000 Syrian refugees in Jordan live outside camps[1]. UNHCR uses the annual survey data to understand the situation of healthcare services among Syrian refugees, in order to improve the policies and services for whom who live outside camps.

Health access and utilization survey was conducted in December 2018 by Dajani Consulting on behalf of UNHCR to assess a number of aspects among Syrian refugee population in Jordan, applied to a sample of 400 households, following the standard methodology of this survey and employing the standard data collection tool (questionnaire) used previously.

Sample structure

- Syrian refugees living in non-camp settings are concentrated in Amman (35%), Irbid (27%) and Mafraq (18%).
- Among the 400 interviewed Syrian households, 2,075 members were reported living within these households given an average of 5.2 members per household.
- An average of 2 child were reported living among the 400 interviewed Syrian households
- About 97.8% of the households confirmed the arrival of the first member of their household to Jordan happened more than two years ago.

Health services access and awareness

- 96.8% of the Syrian refugees households carry a valid MOI card.
- 81.5% of the registered Syrian refugees households are actually aware of the subsidized access to governmental facilities provided by the MOI card.
- Almost all of the Syrian households (91%) have issued the security card in the governorate that they reside in.

Children vaccination

- The access to MMR and polio vaccination improved in 2018, where 96% of households reported that their children had the MMR vaccination and 97% reported that their children had the polio vaccination compared to 90% and 93% respectively in 2017.
- Only 1% of the Syrian households faced difficulties in obtaining vaccination in 2018.
- Governmental health centers in Jordan were the main source of vaccination among Syrian refugees, with 96% of households.

Antenatal care

[1] Data portal of UNHCR, https://data2.unhcr.org/en/situations/syria/location/36#_ga=2.8587701.1005338321.1547557493-123898027.1542277584

- The females who needed antenatal care were 17% of the females in the reproductive age group (15 – 49 years), while 90% of the pregnant females received antenatal care during the last two years.
- The percentage of the pregnant women who had difficulty accessing ANC was 16%.
- The highest number of pregnant females faced difficulties in user fees (55%) and transport cost (23%) in 2018, which were less in 2017 (46% and 19% respectively).
- An increase in child deliveries witnessed among Syrian households in 2018, with 86% females delivering newborns compared to 74% in 2017.
- Pregnant females who visited the antenatal clinics more than 4 visits represent 67.9%.
- Deliveries location are divided among governmental hospitals (48%) and private clinics/hospitals (46%).

Chronic diseases

- Among the Syrian households members who have chronic diseases, 27% have hypertension, 19% have diabetes and 14% have Asthma or COPD.
- From those who needed medicine for their chronic condition, 74% of them were unable to access medicine mainly due to unaffordable cost of medicine (52%).
- The unavailability of medicine for chronic disease was noticed in 19% of the Syrian households members.
- 22% of the Syrian refugees with chronic diseases were unable to access medical services in 2018 compared to 39% in 2017, mainly due to the inability to afford the medical services cost (49%).

Disability & impairment

- Members of Syrian households who suffer from physical impairment reached 64% from total Syrian refugees in 2018, compared to 50% in 2017.
- The natural cause was the dominant reason (49%) for disability among Syrian refugees in 2018.
- The main place of first treatment for disability and impairment therapy was Jordan (47%), while Syria came as the second main location for first treatment (42%).
- Surgical treatment of disability and impairment was the highest among other types of treatments (42%) followed by psychological treatment which reached 31%.
- Only 27% reported to have proper treatment for their disability / impairment in 2018 compared to 38% in 2017.

Monthly health access assessment

- Healthcare services were needed by 49% of household members in 2018 compared to 37% in 2017.
- About 45% of the Syrian refugees' households members actively sought healthcare services.
- Syrian refugees households members who sought healthcare services were mainly concentrating on the private pharmacy as a first facility (37%), while 21% concentrated on JHAS clinics, 15% concentrated on private hospital/clinic, and 14% concentrated on government hospital.
- According to the interviewed households, the average expenditure on healthcare was 97.7 JD which is 63.9% of their total income.

1.Introduction

Background and Objective

The increase in the number of refugees from the Syrian Arab Republic (Syria) across the region in 2018 continued and the need remains for a large-scale response to address the needs of refugees already present in the host community. At the end of 2018, 671,350 Syrian refugees were registered with UNHCR, including refugees hosted in urban, peri-urban and rural areas, in addition to camps population.

Overview of Health Services Available to UNHCR PoCs in Jordan

In 2018, UNHCR continue supporting the provision of healthcare service to all camp resident and vulnerable Syrian in urban as well as rural setting through implementing partners and affiliated hospitals. While UNHCR maintains essential healthcare services for vulnerable Syrian refugees, it works to improve Syrian refugees' utilization of the governmental healthcare services at the Primary and Secondary Health Care levels.

Research context

The Government of Jordan had allowed Syrians registered with UNHCR to access healthcare services free of charge in Ministry of Health (MOH) primary healthcare centers (PHCs) and hospitals, as of March 5, 2012. However, in November 2014 this policy was withdrawn and Syrian refugees were required to pay the non-insured Jordanian rate when they use all types of health services provided by the Ministry of Health. Early 2018 GoJ has reduced the level of access to all refugees where 80% of foreigner rate adopted; prior to this decision, the majority of registered Syrians were able to receive healthcare services at subsidized rate at all level of care. However, the non-insured Jordanian rate was normally affordable for non-vulnerable individuals especially at secondary and tertiary level of care. The new policy and huge inflation in cost of health services is expected to cause considerable hardship for all refugees and may affect the access to healthcare facilities and utilization behaviors among urban refugees.

There were important exceptions made to this as all expanded program on immunization (EPI) vaccinations are provided free of charge to children and pregnant women. Furthermore, treatment for communicable diseases such as Leishmaniosis, TB and other communicable disease of public health concern are also provided free of charge to Syrians.

In December 2012, the government of Jordan introduced a "service card" or so-called "security card"; that is issued to all Syrians residing in Jordan and upon the registration with the Ministry of Interior (MoI). This administrative procedure has been implemented effectively but imposes some challenges on healthcare services accessibility for refugees. Refugees can only access the public healthcare center that falls under the area of registration of the security card in the first visit, and if the refugee relocates, he finds difficulties accessing healthcare services.

Research design & methodology

Methodology

Quantitative Interviews were carried out among a sample of target respondents through telephonic Interviews. The sample was provided by UNHCR from ProGress database, based on random sampling criteria. The sample included the head of the household name, gender, contact information,

governorate and other variables. The call agents were trained by UNHCR representative on the data collection tool, as well as the developed Kobo application. A piloting exercise was carried out by all five call agents to test the data collection tool, in order to amend if necessary. The call agents performed the survey utilizing the call center technology under supervision of survey supervisor on daily basis.

Target respondents

A sample consisting from 400 Syrian refugees households who live in non-camp settings, with additional substitute sample for replacement depending on the attrition rate. The head of the household was contacted as the representative of the other household members.

Data analysis

Data was collected using CATI (Computer Aided Telephonic Interviews) through Kobo / ODK Software. This approach was selected to eliminate errors while completing the questionnaire and allow exporting of the data immediately for further analysis, thus cutting down on time required for data entry, editing and cleaning. Data analysis was conducted through MS Excel, as the size of sample and data is considered small, therefore, MS Excel is suitable for processing and analysis due to its simplicity and user-friendly interface. Excel is also used for checking, validating, editing and correcting data.

Survey tools and guidelines

Previous questionnaires were developed by UNHCR for respective categories of respondents. These were sent to consulting team for comments. After finalization, the questionnaire (available in both English/Arabic) was revised adding few questions and re-ordering the sections. During pre-testing, process testing of sampling frame preparation, household identification, sampling technique, CATI process, and so on was also piloted for better understanding of the sampling procedure.

Training

Formal training of survey team (call agents and supervisor) was arranged for proper understanding of all the survey questionnaire and survey procedures. All call agents and supervisor were trained and provided with a detailed instructions for interviews and CATI. The training included both classroom session as well as practical training; it consisted of sessions on interviewing techniques and rapport building with respondents; how to identify selected households; how to present the medical terminology; a thorough explanation of all questions; how to fill the questionnaires; how to handle non-response; how to check questionnaires for errors; and how to handle their daily schedules.

Data Collection

The validity and quality of the data collected was ensured via committing to the following responsibilities:

- Survey Manager: oversaw and documented all required quality checks. Furthermore the survey manager verified that the supervisor did validate and verify the data.
- Supervisor: participated and assisted the interviewers where needed. Moreover, the supervisor verified data entries and attended a sample of the interviews for each the call agents.
- Call agents: with the assistance of their supervisor, they ensured consistency of the data collected and corrected any errors in the skip patterns.

Quality Assurance

Quality assurance was accurately and strictly followed, as this is an integral role of the consulting team. Especially at the stage of research designing, data collection and analysis, the uppermost quality at all

levels was maintained. Employing call agents with adequate experience is one of the norms of the operational policy. Adequate records were kept in a computerized database to preserve confidentiality and privacy of respondents. Moreover, checking procedure was very strict and unbiased. The quality assurance practices covered the following stages:

i- Team selection and mobilization:

As for the selection and recruitment of supervisor and call agents; it was carefully done by the survey manager. The recruitment was made from the existing panel of call agents, where the assigned supervisor must have a minimum qualification of graduation and adequate experience in the same field. Call agents must have previous experience in similar projects for households, particularly refugees. The health and medical terminology aspect was provided by specialized UNHCR representative during training and piloting.

ii- Execution phase:

The questionnaire was pre-tested in the piloting exercise for flow of questions, clarity and translation errors if any. The piloting was conducted on a small sample of Syrian refugees (10 households) similar in demographics to the original sample of the survey. One team of five call agents accompanied with one supervisor conducted the piloting. Following the piloting, all trained call agents and supervisor participated the CATI with the target sample. Each call agent managed to complete an average of 15 successful interviews per day.

iii- Quality control:

Quality control measures were taken during each step of the project. In all stages of the survey, double check method was practiced and inspection of different outputs.

iv- Data cleaning:

Using CATI technology for data entry, a set of quality checks was ensured that does not accept any illogical answers. Accordingly, the data entered to the system were cleaned automatically, as the entry program shows an error alert in case there is something wrong with the data entered or contradiction between any answers. After completing the data collection, an extra validation check was done through matching and logical check to identify any further errors that might be missed.

Research limitations

The main limitation was the invalid contact information of the households, which was overcome by oversampling, as the unreachable cases in the sample provided by UNHCR reached more than 40%. In addition, some refusal to participate was recorded among the unreachable refugee households.

There is also the recall error, as the head of the household was interviewed on behalf of all family members, and in some cases the respondent was not the head of the household. This challenge was overcome by confirming the response to avoid doubts and presumption.

In some questions, there is a limitation due to sensitivity of the question related to some female conditions or income determination, therefore, all of the call agents were females, assisted by male survey supervisor.

Finally, the call agents faced some cases where Syrian refugees expect quick incentive or assistance as a result of participating in the survey, which was resolved by insisting on the role of the survey to update refugees stats and understand their pressing needs.

2.Sample Structure

2.1 Syrian refugees profile

Arrival of the first refugee in Jordan - The very first arrival of a family member to Jordan has been reported to be more than 2 years by (97.8%) of the respondents where such a figure is supported by last year's findings (97% reported to arrive more than two years in 2017).

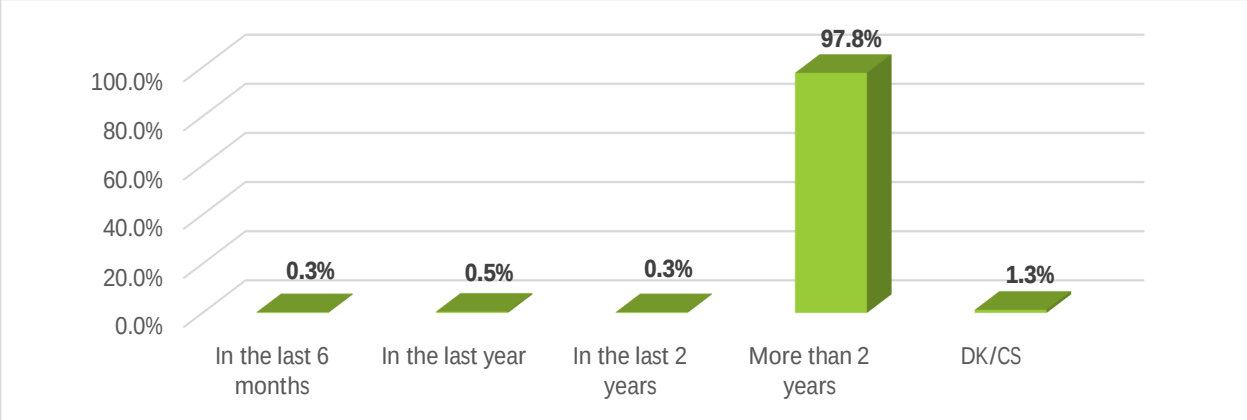

Figure 2. 1 Arrival of the first refugee in Jordan - All Syrians respondents (n=400)

Residing Governorate – Presently refugees host communities mostly dwell in Amman (35%). In comparison of the last year findings there has been a decrease in the percentage of refugees who live in Irbid by 2% where 27% of the Syrian refugees interviewed live in Irbid.

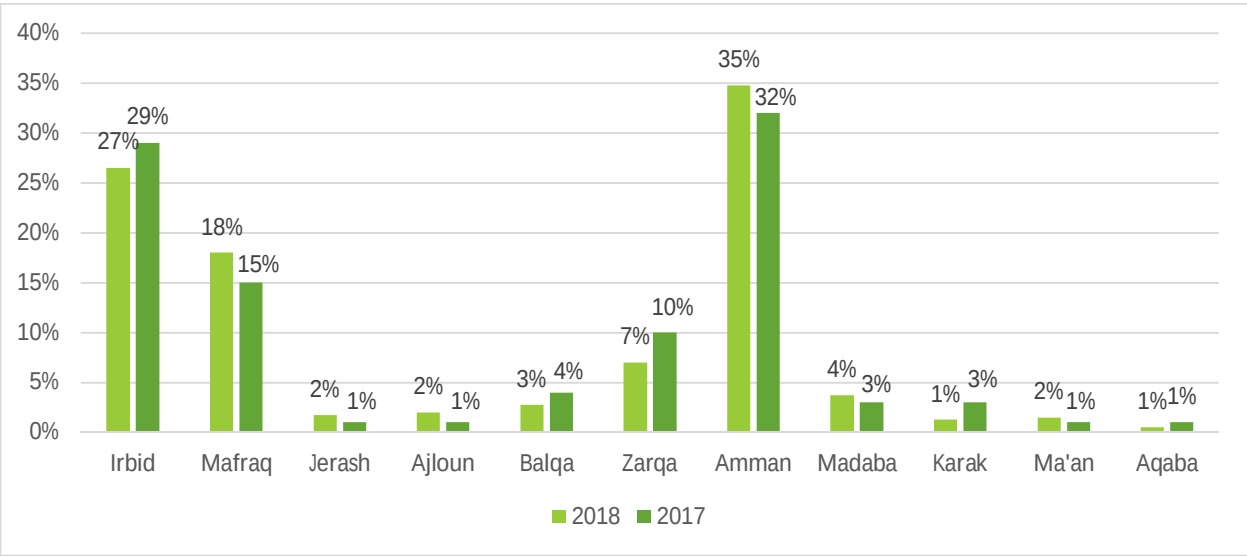

Figure 2. 2 Residing governorate - All Syrians respondents (n=400)

Table 1: Residing Governorate

City	2018	2017
Irbid	27%	29%
Mafraq	18%	15%
Jerash	2%	1%
Ajloun	2%	1%
Balqa	3%	4%
Zarqa	7%	10%
Amman	35%	32%
Madaba	4%	3%
Karak	1%	3%
Ma'an	2%	1%
Aqaba	1%	1%

Syrians place of birth – Among the (400) interviewed Syrian refugees (35%) of the Syrian households originated from Dara'a followed by Homs (19%) and Aleppo (12%).

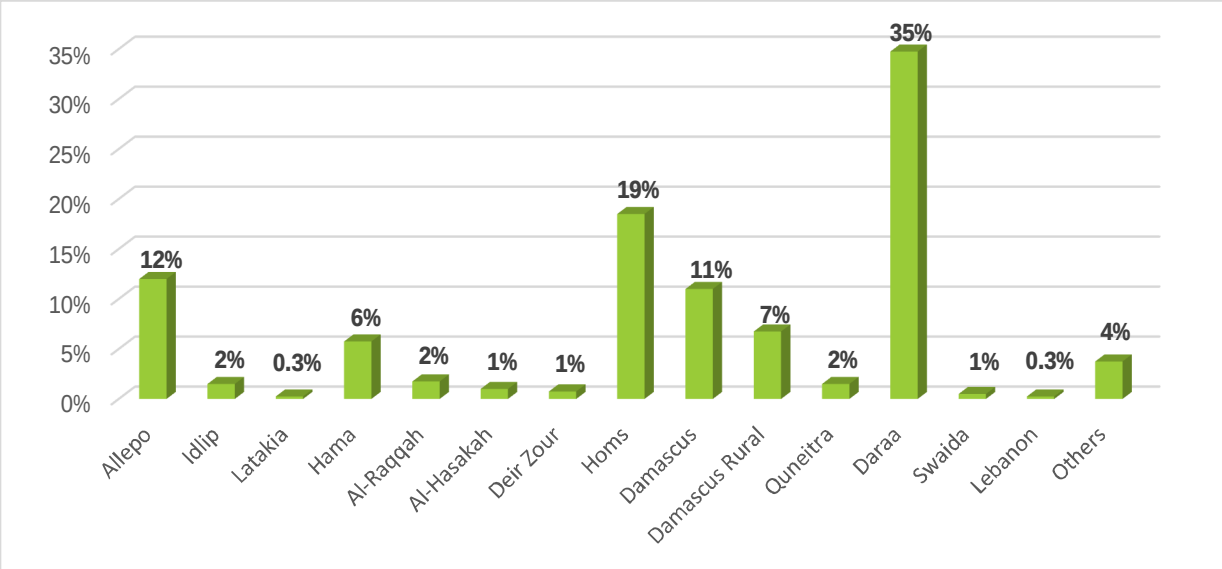

Figure 2. 3 Place of birth - Syrians (n=400)

2.2 Head of household profile

80.5% of respondents interviewed were the head of household. For those who were not interviewed, 65.8% of them were males .The majority fell into the age group of 18-35 years old by 48.4% and only 7.8% of them were illiterate. English comes as the secondary language (7.4%) as compared to Arabic which is the primary language of 92% of the household heads. More details presented in the following table:

Table 2: Head of household profile

Household head profile	2018 (n=400)
% of Household Head	**80.5%**
Gender	
Male	65.8%
Female	34.2%
Age	
Less than 18 years	0.0%
18-35 years	48.4%
36-59 years	41.6%
More than 59 years	9.9%
Education	
Knows how to read & write	2.5%
Primary school	28.6%
Intermediate/ complementary school	36.0%
Secondary school	12.7%
2 years Diploma	5.6%
University	6.8%
None	7.8%
Language spoken	
Arabic	92%
Kurdish	0.3%
Turkish	0.3%
English	7.4%

2.3 Household Profile

8% of all Syrian household members have been recorded as disabled and needed the assistance of others to perform daily activities.

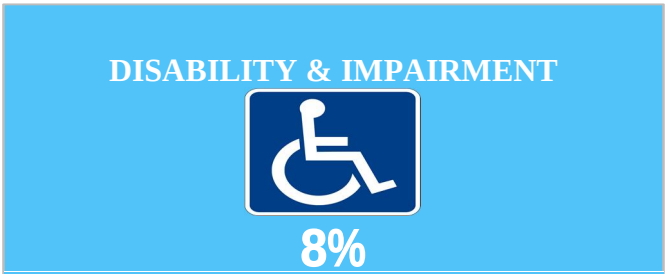

*Figure 1: **Disability & impairment - All household members (n= 2075)***

The share of females among interviewed households were higher by 2% than males.

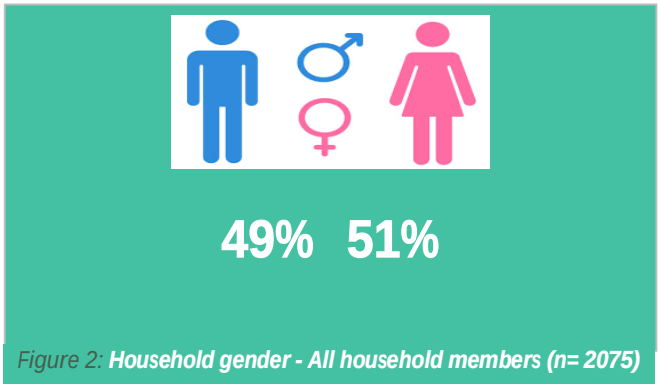

*Figure 2: **Household gender - All household members (n= 2075)***

2,075 Syrian household members has been reported to be living under the same roof and eating from the same pot in 400 households. The average number of households members has been reported to be 5.2 member.

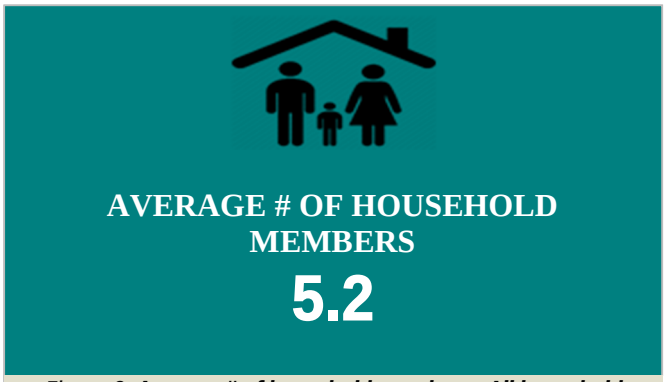

*Figure 3: **Average # of household members - All household members (n=2075)***

Among females who are at reproductive age, 17% were pregnant in Jordan during the last 2 years and needed antenatal/maternal care.

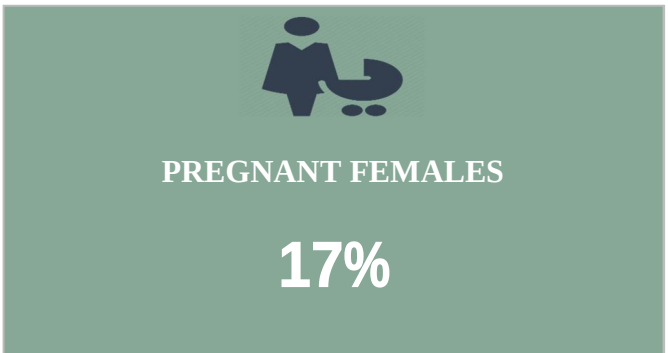

*Figure 4**: Pregnant females in Jordan during the last 2 years - Females at reproductive age (n=923)***

From all household members (49%) of them were youth less than the age of 18 years, where only (5%) of them where elderly more than 59 years.

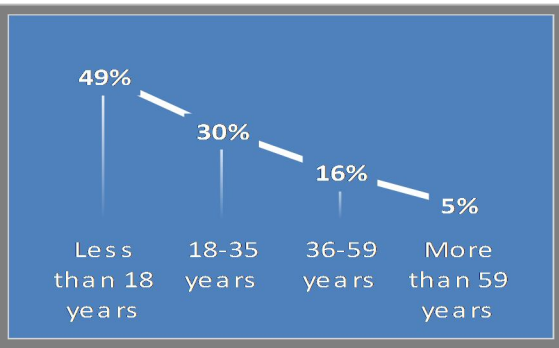

Figure 8: Age of household members - All household members (n=2075)

From all household members, 15% reported to have chronic disease.

15%

Figure 5: ***Households chronic conditions - All household members (n=2075)***

Regarding marital status, 60% of household members are single and 35% are married.

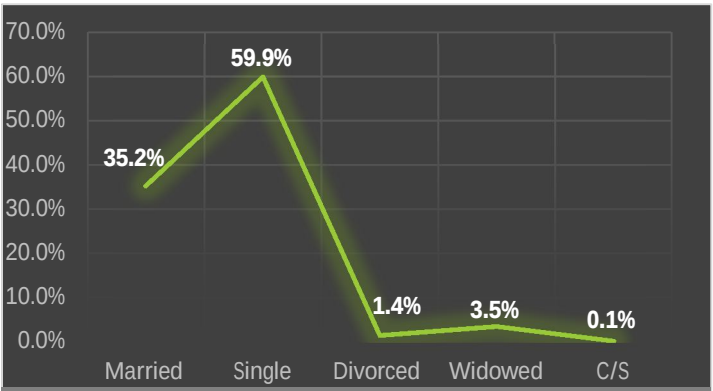

Figure 6: ***Marital status - All household members (n=2075)***

Each interviewed household had an average of two children that were in the age of 12 to 59 months.

AVERAGE # OF CHILDREN ELIGIBLE FOR VACCINATION

2

Figure 7: ***Children ≤5 years - All household members (n=2075)***

2.4 Sample structure summary

Table 3: sample structure summary

Characteristic	2017 (n=400)	2018 (n=400)
# of household members	2,422	2,075
Average # of household members	6	5.2
% of female household members	51%	51%
% of household members less than 18 years	51%	49%

3.Health Services Awareness and Cost

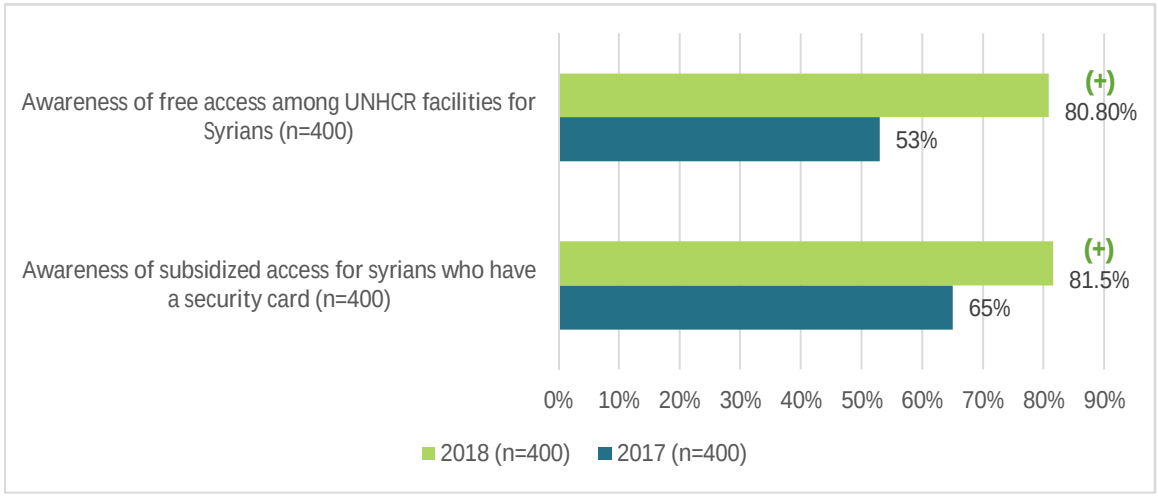

Figure 3. 1 Knowledge of available health services - All respondents

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

There is an increase in the percentage of Syrian households who are aware of the subsidized access to governmental healthcare services in 2018 compared to 2017; where 81.5 % of interviewed Syrian households were aware compared to 65% in 2017. Within the same context, 2018 shows an increase in the percentage of Syrian households aware of free access to UNHCR facilities (80% vs. 53%).

The penetration of security card among Syrian refugees is slightly less than 2017. However, regarding the ability to issue the card in the residing governorate there is a slight decrease of 1% than in 2017 as shown in the following table and figure.

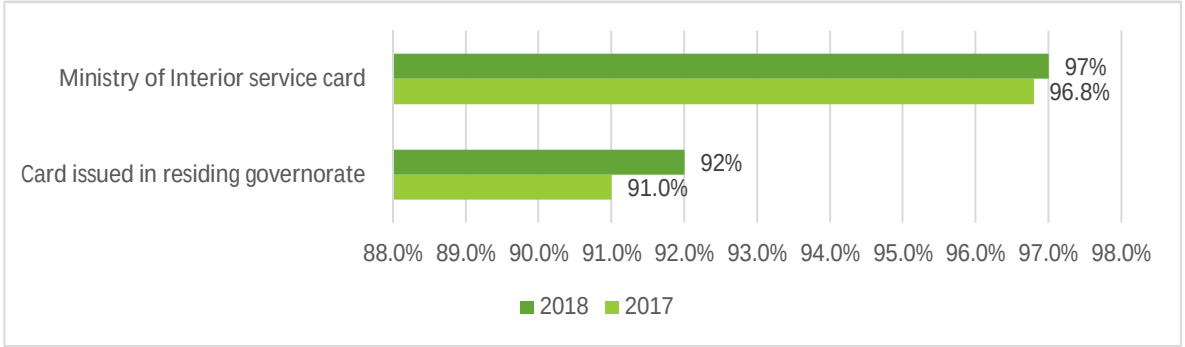

Figure 3. 2 Possession of ministry of Interior security card

The main reason for not being able to issue the MoI security card by Syrian refugees was lack of ID documents (30%). On the other hand, many Syrian refugees households (61.5%) mentioned other reasons.

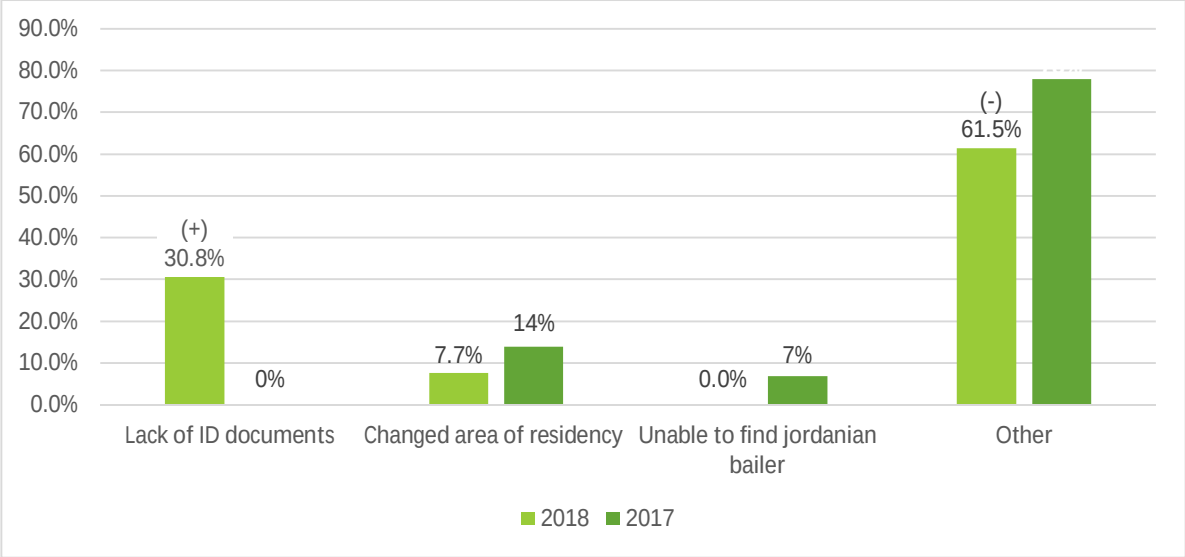

*Figure 3. 3 Reasons for not having security card (n=13)**

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%
(*) Insufficient base for analysis

Table 4: Reasons for not having security card

Reasons	2018	2017
Lack of ID documents	30.8%	0%
Changed area of residency	7.7%	14%
Unable to find Jordanian bailer	0.0%	7%
Other	61.5%	78%

Table 5: Summary for MoI security card

	2017 (n=400)	2018 (n=400)
# of households that didn't obtain security card	11	13
% of households that had a security card	97%	96.8%

The majority of Syrian refugees households (57%) confirmed that there was no any increase in the cost of healthcare services over the last 6 months. On the other hand, for those who stated that there was an increase in the healthcare cost, 42% of them had an impact on the affordability of the required medication.

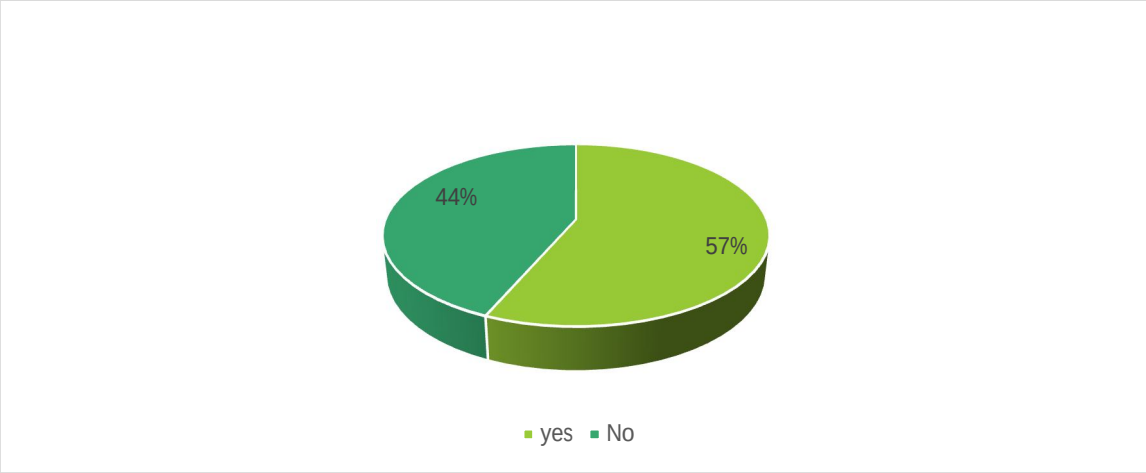

Figure 3. 4 Increase in health care costs

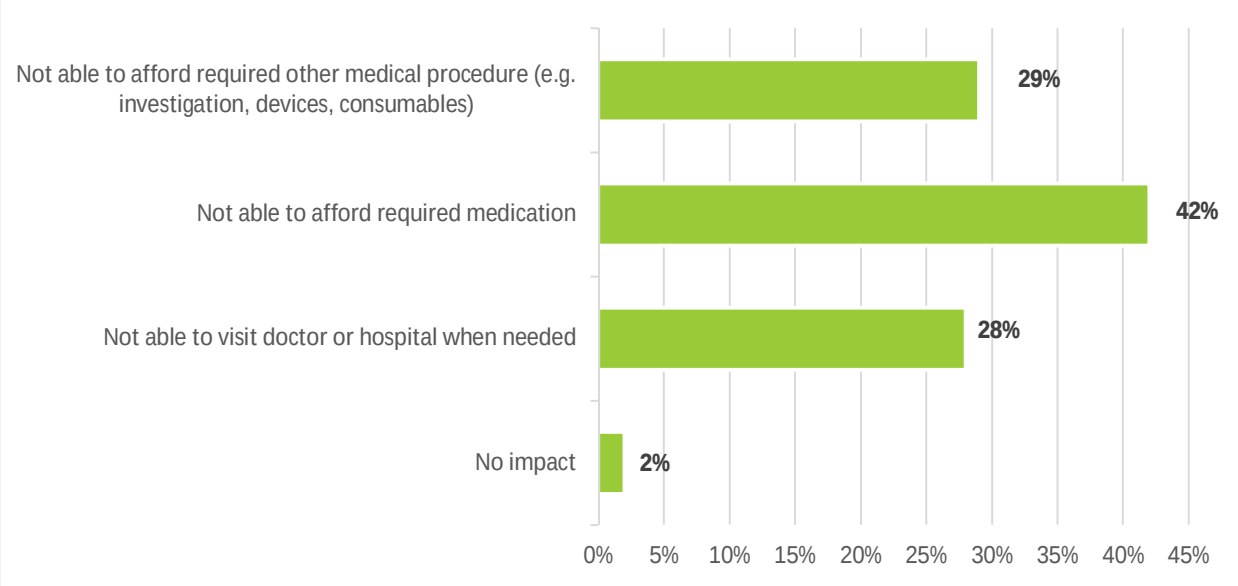

Figure 3. 5 Impact of healthcare costs increase (n=397)

Table 6: Impact of healthcare increase

Impact of healthcare costs increase	2018 (n=397)
No impact	2%
Not able to visit doctor or hospital when needed	28%
Not able to afford required medication	42%
Not able to afford required other medical procedure (e.g. investigation, devices, consumables)	29%

The Syrian refugees households used several adaptation strategies to meet the healthcare needs in 2018, mainly as reducing number of visits to the healthcare providers (27%) and seeking NGO free services (21%). However, about one quarter of them (26%) did not adopted any coping strategies.

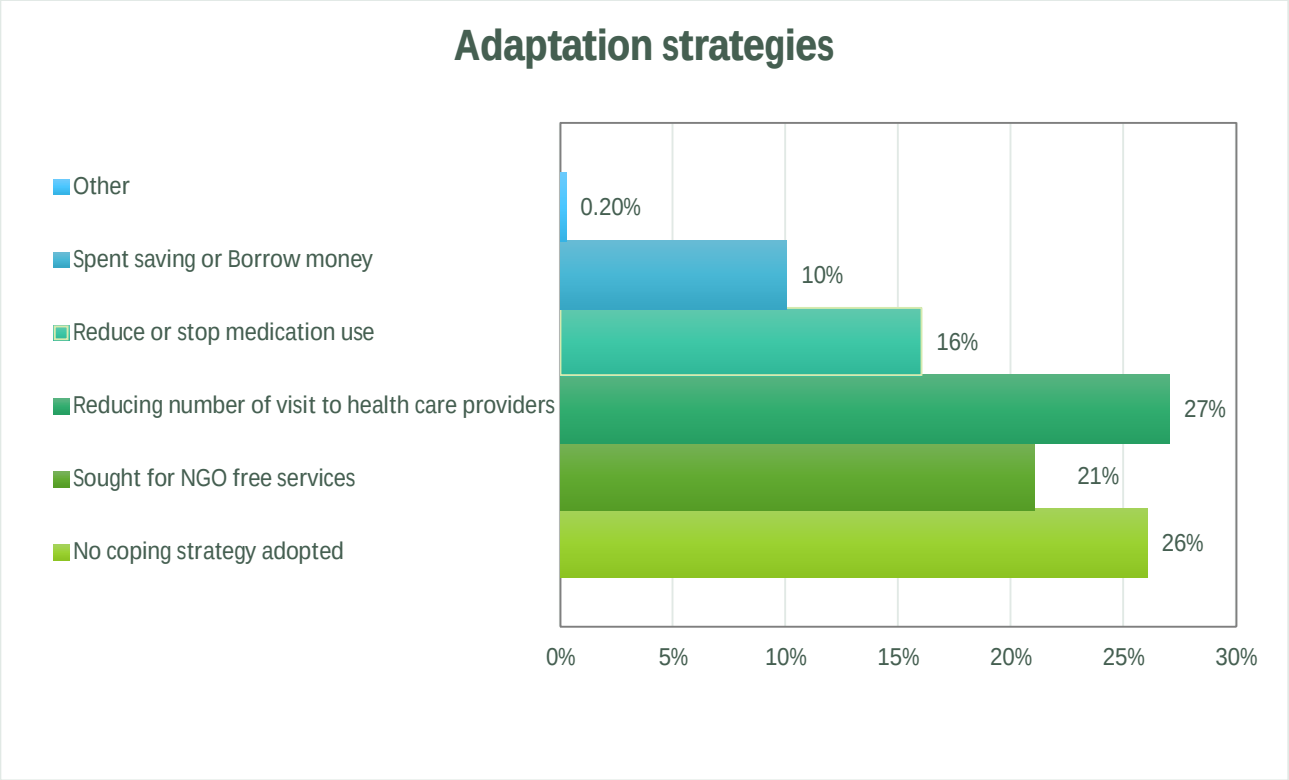

Figure 3. 6 Adaptation strategies

Adaptation strategies	2018 (n=563)
No coping strategy adopted	26%
Sought for NGO free services	21%
Reducing number of visit to health care providers	27%
Reduce or stop medication use	16%
Spent saving or Borrow money	10%
Other	0.20%

4.Child Vaccination

The awareness of free child vaccination has increased in 2018 compared to the results of 2017, where 97% are aware of the free access to vaccination compared to 93% in 2017.

The percentage of children who obtained vaccination card improved in 2018, where 97% reported to have a vaccination card compared to 90% in 2017.

The access to MMR and polio vaccination shows an increase in 2018 where 96% of households reported that their children had the MMR vaccination and 97% reported that their children had the polio vaccination compared to 90% and 93% respectively in 2017.

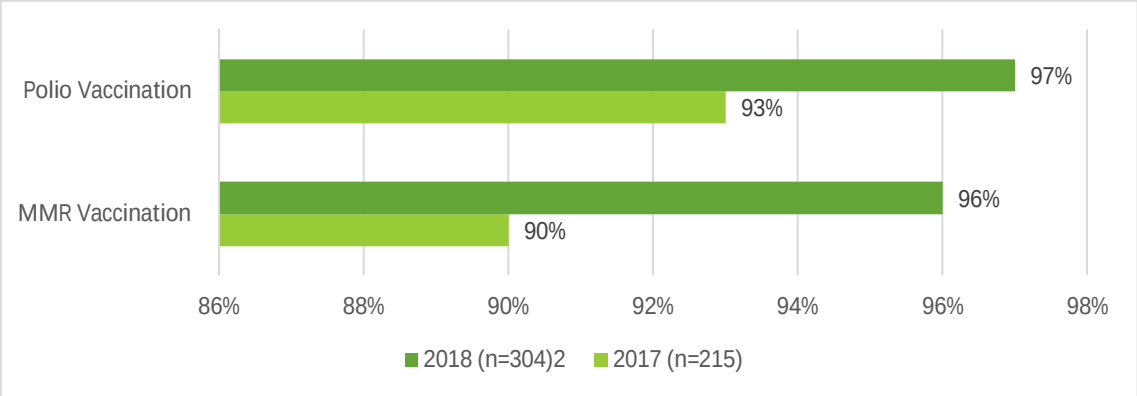

Figure 4. 1 Access to vaccination - Household that have children ≤ 5 years

In 2018 Syrian refugees encountered no difficulties in obtaining vaccination.

There is a slight increase in the percentage of those who had the Polio vaccination in governmental health centers in Jordan in 2018 by 1% compared to 2017 results. The provided MMR vaccination on the other hand stayed constant in 2018.

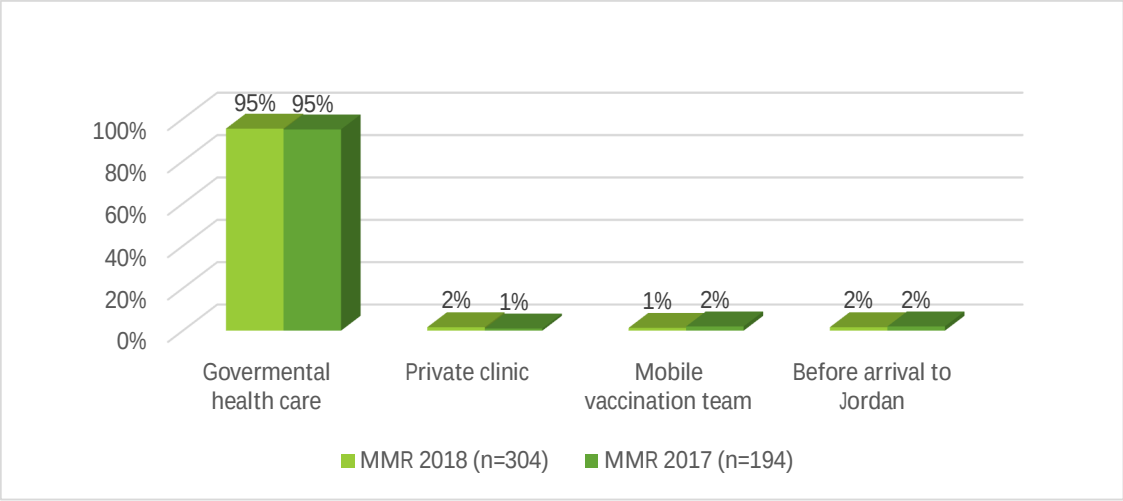

Figure 4. 2 Vaccination facility - Those who obtained vaccination (MMR)

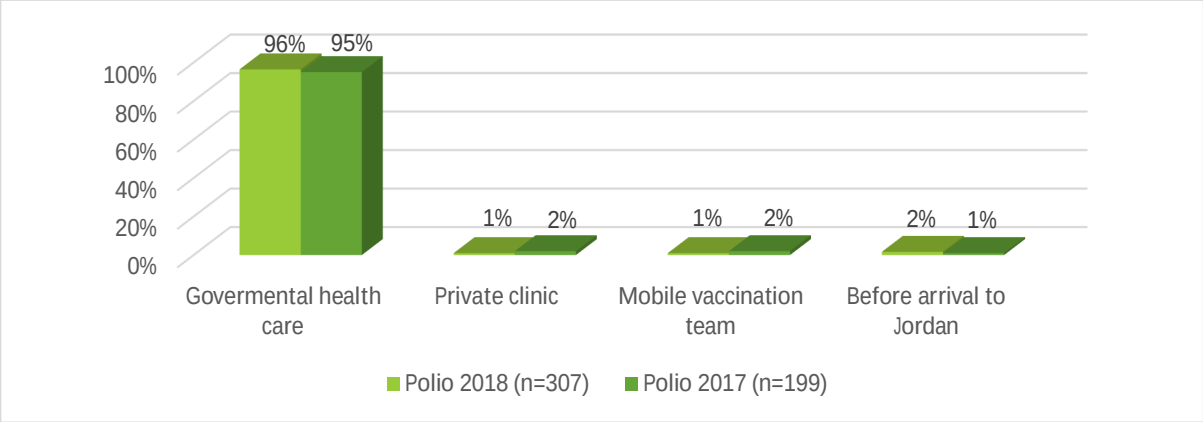

Figure 4. 3 Vaccination facility - Those who obtained vaccination (Polio)

Following is a summary of child vaccination indicators for Syrian refugees.

Table 7: Summary of child vaccination

Child vaccination indicator	2018 (n=304)	2017 (n=215)
% that had an vaccination card	97%	90%
% that faced difficulties obtaining vaccine	0%	1%
% that received vaccine at Jordanian government primary health care center	96%	95%
% that received vaccine before coming to Jordan (in Syria)	2%	2%
% that received vaccine at a mobile medical unit in Jordan	2%	2%

5.Antenatal Care

5.1 Access to antenatal care

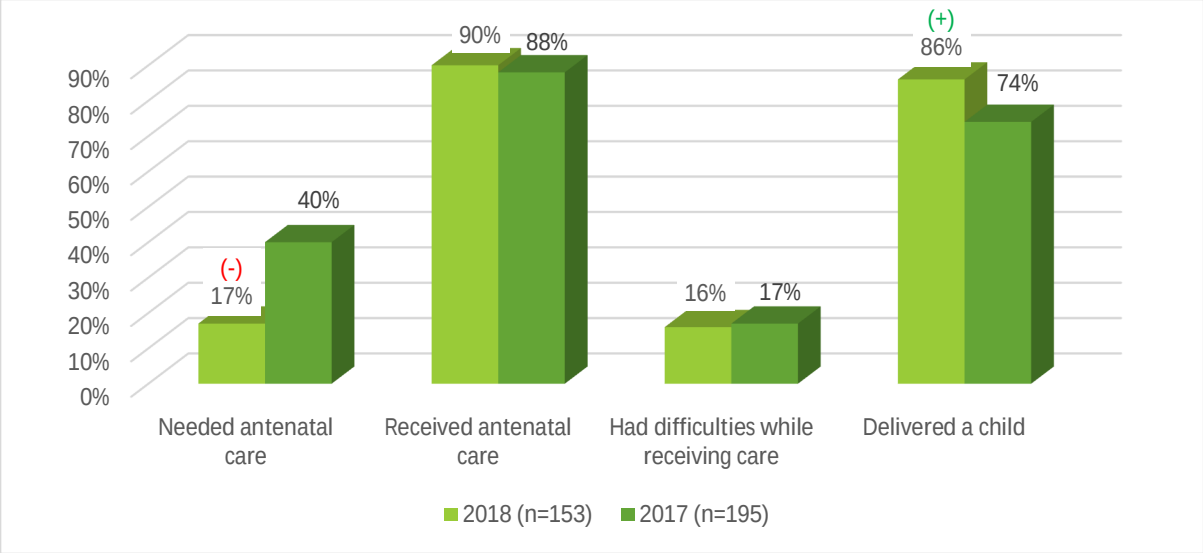

Figure 5. 1 Access to Antenatal care - Pregnant females in Jordan during the last two years

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

The results show a significant decrease in the percentage of pregnant females among Syrian refugees who needed antenatal care (17% vs. 40% in 2017). However, the pregnant women who received antenatal care were 90% in 2018 compared to 88% in 2017. More interesting facts are shown below.

Table 8: Access to Antenatal care

Access to Antenatal care	2018 (n=153)	2017 (n=195)
Needed antenatal care	17%	40%
Received antenatal care	90%	88%
Had difficulties while receiving care	16%	17%
Delivered a child	86%	74%

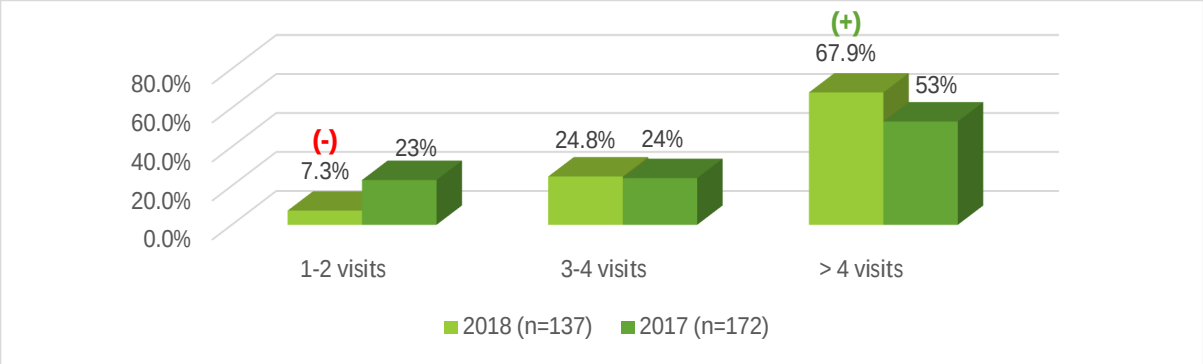

Figure 5. 2 Number of visits to the clinic - Households that had females who received antenatal care.

Table 9: Number of visits

# of visits	2018 (n=137)	2017 (n=172)
1-2 visits	7.3%	23%
3-4 visits	24.8%	24%
> 4 visits	67.9%	53%

69% of pregnant females delivered a child through normal vaginal delivery while 29% delivered in the Caesarian section. In terms of place of delivery, most of pregnant females delivered in the government hospitals (53%).

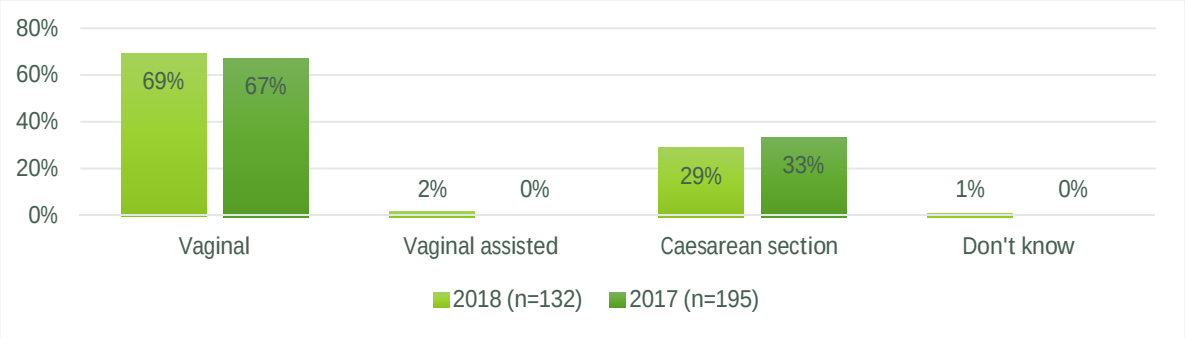

Figure 5. 3 Type of delivery - Households that had females who received antenatal care

Table 10: Type of delivery

Type of delivery	2018 (n=132)	2017 (n=195)
Vaginal	69%	67%
Vaginal assisted	2%	0%
Caesarean section	29%	33%
Don't know	1%	0%

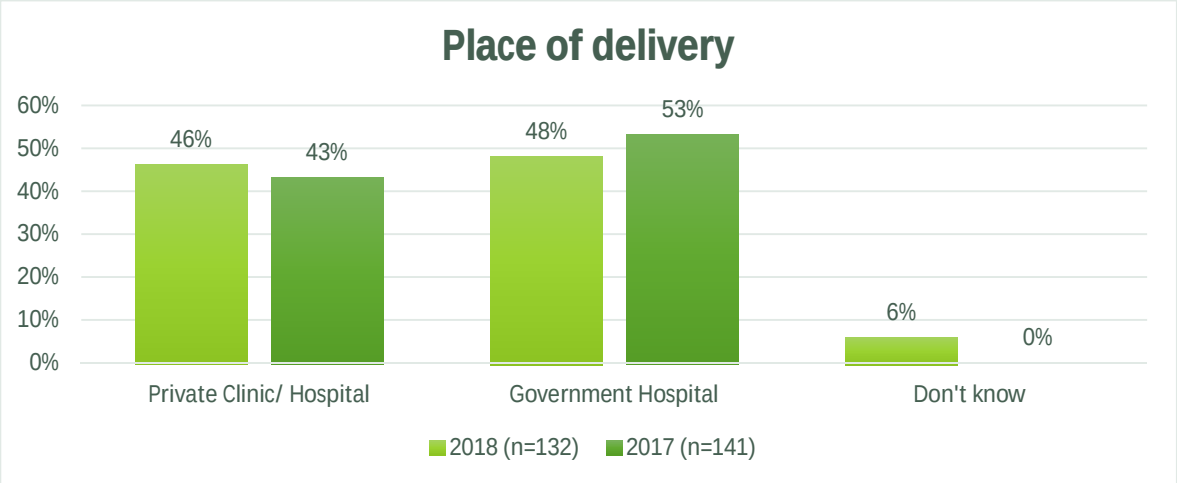

Figure 5. 4 Place of delivery - Those who delivered a child.

Table 11: Place of delivery

Place of delivery	2018 (n=132)	2017 (n=141)
Private Clinic/ Hospital	46%	43%
Government Hospital	48%	53%
Don't know	6%	0%

Regarding the cost of the delivery, 27% of them had the delivery for free, yet the majority of those who paid the cost of delivery (61%) were in the range of 100-750 JDs due to private hospitals and governmental hospitals charges.

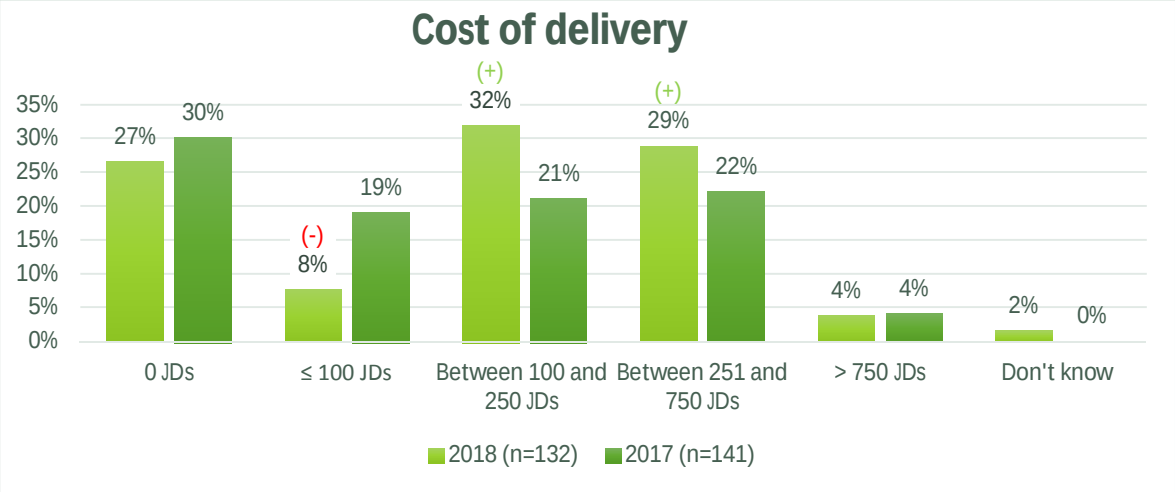

Figure 5. 5 Cost of delivery - Those who delivered a child.

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 13: Cost of delivery

Cost of delivery	2018 (n=132)	2017 (n=141)
0 JDs	27%	30%
≤ 100 JDs	8%	19%
Between 100 and 250 JDs	32%	21%
Between 251 and 750 JDs	29%	22%
> 750 JDs	4%	4%
Don't know	2%	0%

Difficulties occurred while receiving care - Inability to afford service fees (55%) and transport cost (23%) were reported as the main difficulties while receiving antenatal care.

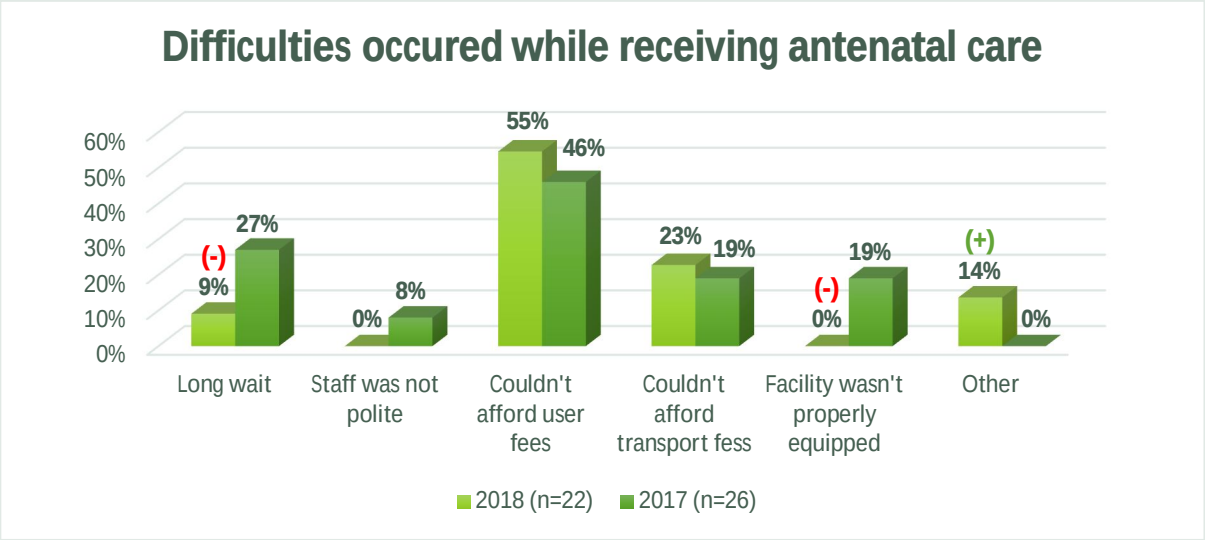

*Figure 5. 6 Difficulties occurred while receiving care - Those who encountered difficulties**

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%
(*) Insufficient base for analysis

Table 14: Difficulties occurred while receiving antenatal care

Difficulties	2018 (n=22)	2017 (n=26)
Long wait	9%	27%
Staff was not polite	0%	8%
Couldn't afford user fees	55%	46%
Couldn't afford transport fess	23%	19%
Facility wasn't properly equipped	0%	19%
Other	14%	0%

Reasons for a private facility – The main reason for accessing care in a private facility is the preference of females (62%), followed by ineligibility to access governmental facility at subsidized rate (16%).

Table 15: Reasons accessing care in a private hospital/ clinic

Reasons accessing care in a private hospital / clinic	2018 (n=61)	2017 (n=57)
Not eligible to access Ministry of health facility at subsidized rate	16%	7%
Eligible to access Ministry of health facility at subsidized rate but could not access	7%	11%
prefer to go to a private facility	62%	30%
Others	15%	60%

5.2 Family panning

In all households who had a pregnant female eligible to antenatal care reported that 57% of the households were aware of family planning compared to 48% in 2017. On the hand, 70% acquired knowledge on family planning mainly through health care center staff (29%) and community events (28%) as the main sources of knowledge.

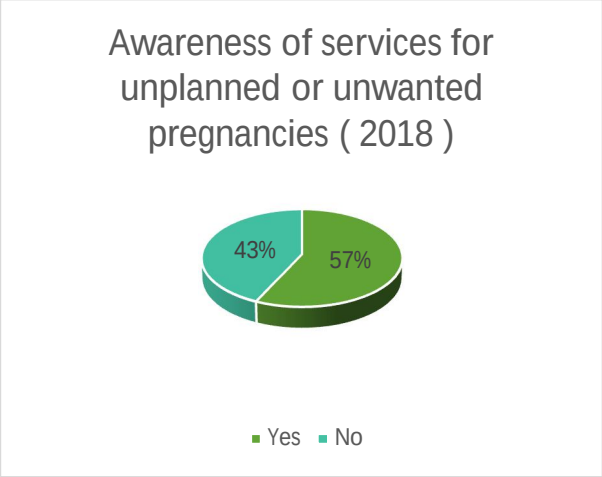

Figure 5. 8 Awareness of services for unplanned pregnancies - Households that had pregnant females (n=132

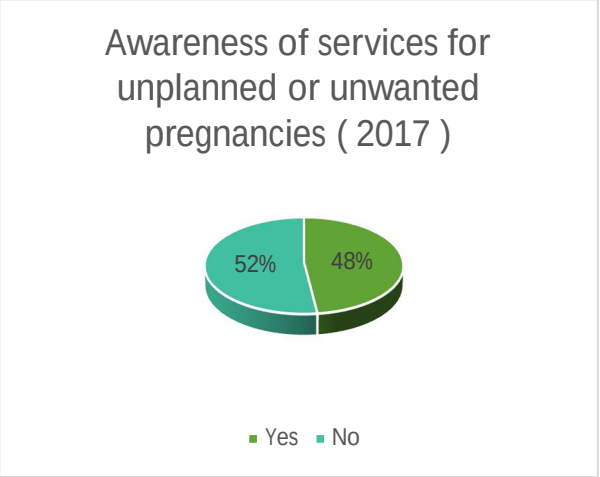

Figure 5. 7 Awareness of services for unplanned pregnancies - Households that had pregnant females (n=132)

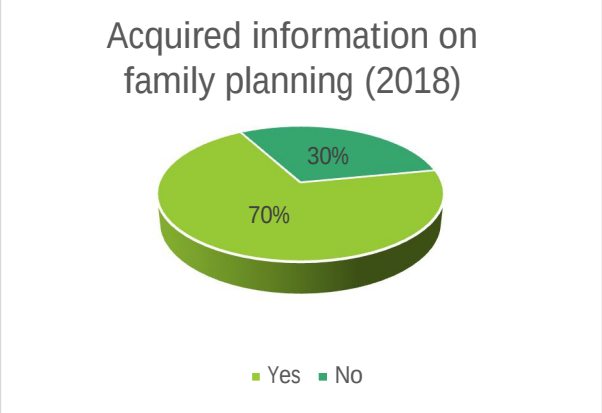

Figure 5. 10 Acquired information on family planning - Households that had pregnant females (n=132)

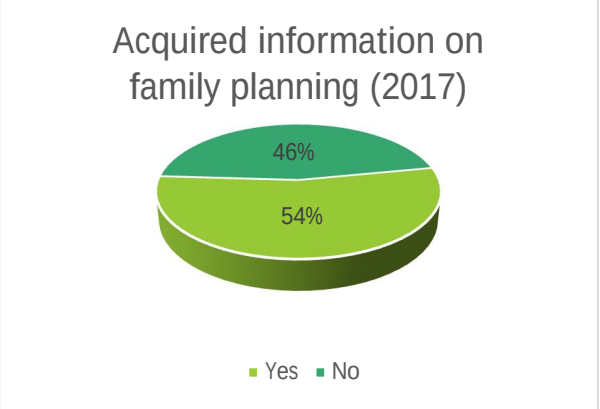

Figure 5. 9 Acquired information on family planning - Households that had pregnant females (n=132)

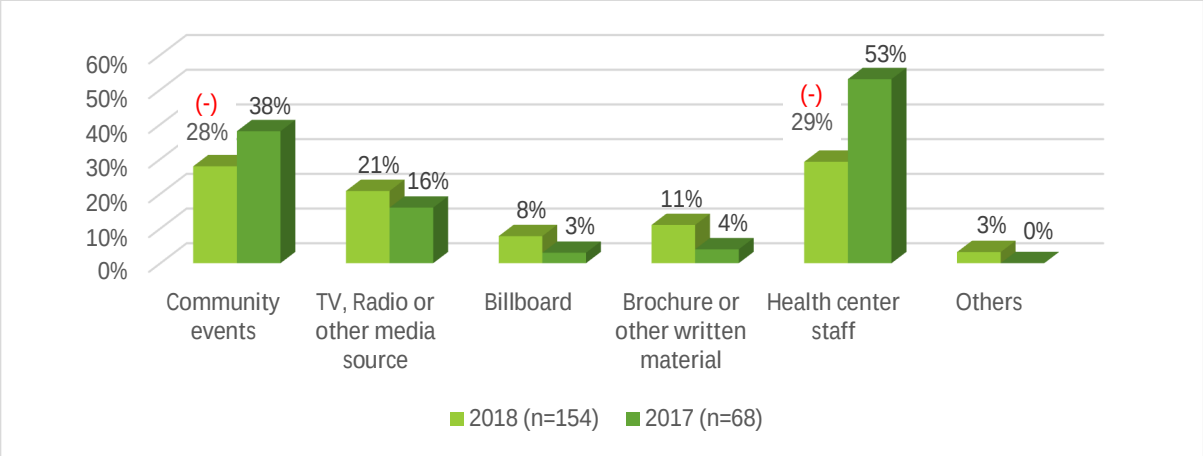

Figure 5. 11 Sources of information on family planning - Households that had pregnant females

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 16: sources of information on family planning

Sources of information on family planning	2018 (n=154)	2017 (n=68)
Community events	28%	38%
TV, Radio or other media source	21%	16%
Billboard	8%	3%
Brochure or other written material	11%	4%
Healthcare center staff	29%	53%
Others	3%	0%

5.3 Contraceptives

Only 17% of households who had a female eligible to antenatal care had a household member who tried to obtain contraceptives, where the main sought facility was Ministry of Health center (36%), with more people attempting to seek contraceptives from other sources (36%).

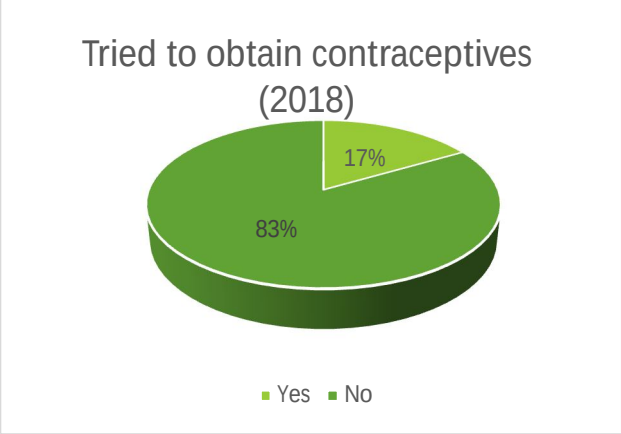

Figure 5. 13 Trial to obtain contraceptives - Households that had pregnant females (n=132)

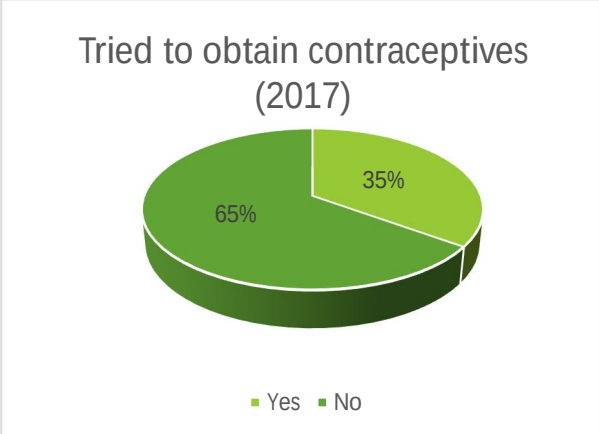

Figure 5. 12 Trial to obtain contraceptives - Households that had pregnant females (n=132)

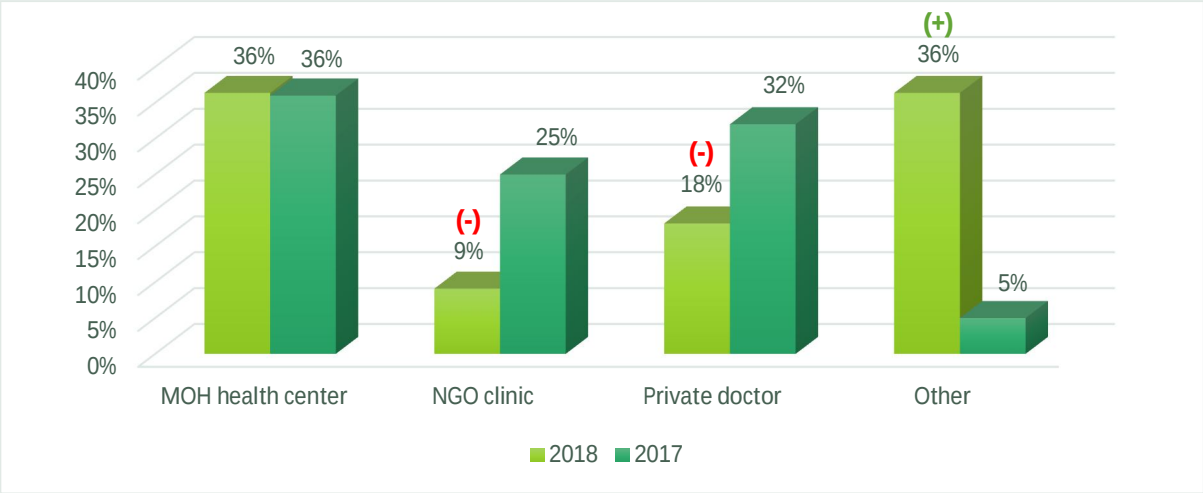

Figure 5. 14 places sought for contraceptives - Households who had a family member trying to obtain contraceptives

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 17: Places sought for contraceptives

Places sought for contraceptives	2018	2017
MoH healthcare center	36%	36%
NGO clinic	9%	25%
Private doctor	18%	32%
Other	36%	5%

5.4 Antenatal care summary

Table 18: Antenatal care summary

Antenatal care summary	2018 (n=153)	2017 (n=195)
% of pregnant women who had at least one NC visit	100%	88%
% of pregnant women who had difficulty accessing ANC	16%	17%
% of those who couldn't afford fees or transport	78%	65%
% of those who encountered Long wait and/or not polite staff	9%	35%
% of deliveries by caesarean section	29%	32%
% of deliveries in private facilities	46%	40%
% of deliveries in government facilities	48%	53%
% of deliveries free of cost	27%	30%

6. Chronic Diseases

6.1 Type of disease

From all household members who had a chronic condition, 27% members suffer from Hypertension followed by 19% who were reported diabetic. The other main types of chronic illnesses among Syrian refugees include heart disease (9%) and Asthma (14%).

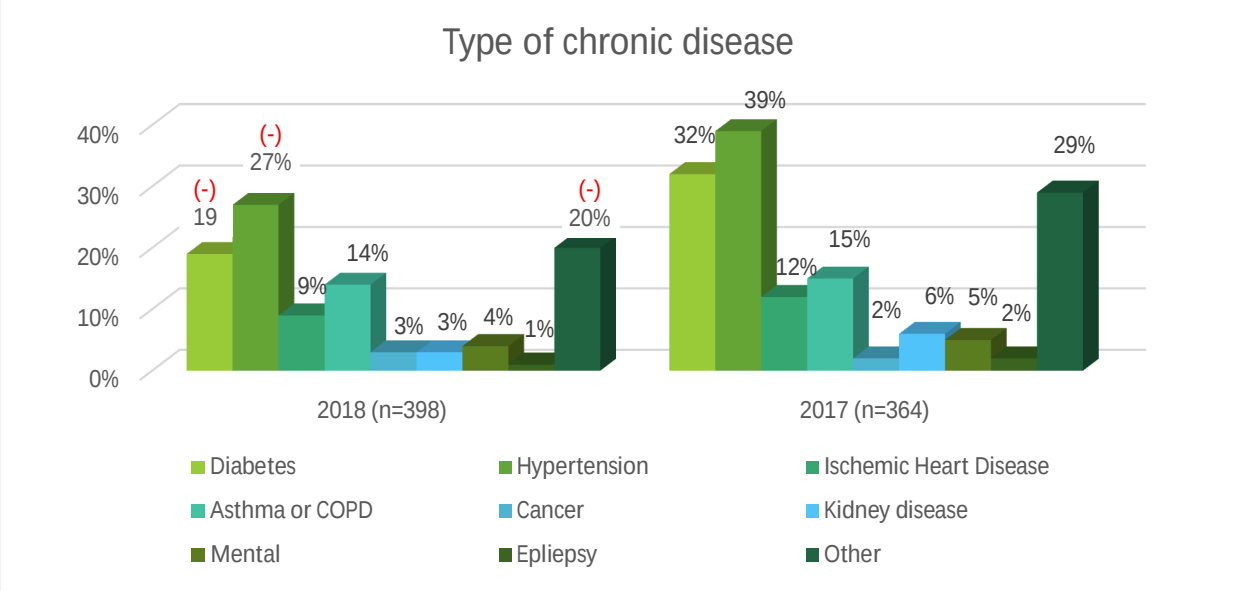

Figure 6. 1 Type of chronic disease - Household members that have a chronic condition

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 19: Type of chronic disease

Type of chronic disease	2018 (n=398)	2017 (n=364)
Diabetes	19%	32%
Hypertension	27%	39%
Ischemic Heart Disease	9%	12%
Asthma or COPD	14%	15%
Cancer	3%	2%
Kidney disease	3%	6%
Mental	4%	5%
Epilepsy	1%	2%
Other	20%	29%

6.2 Access to medicine for chronic conditions

From those who needed medicine for their chronic condition, 26% of them were unable to access medicine mainly due to the cost of medicine (52%). In addition, the medicine was not available in facility for a significant proportion of Syrian refugees (19%).

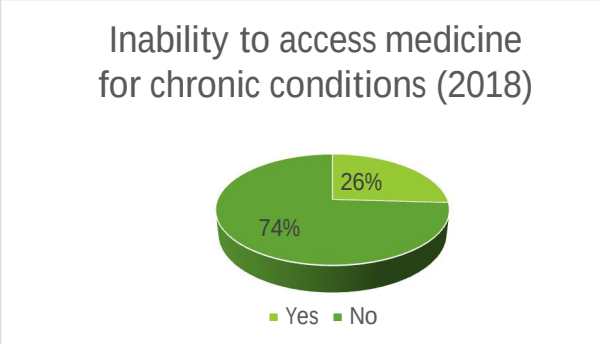

Figure 6. 2 Inability to access medicine - households that have a member with chronic condition (n=301)

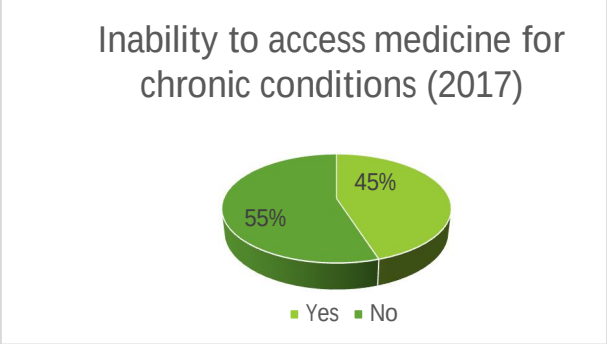

Figure 6. 3 Inability to access medicine - households that have a member with chronic condition (n=227)

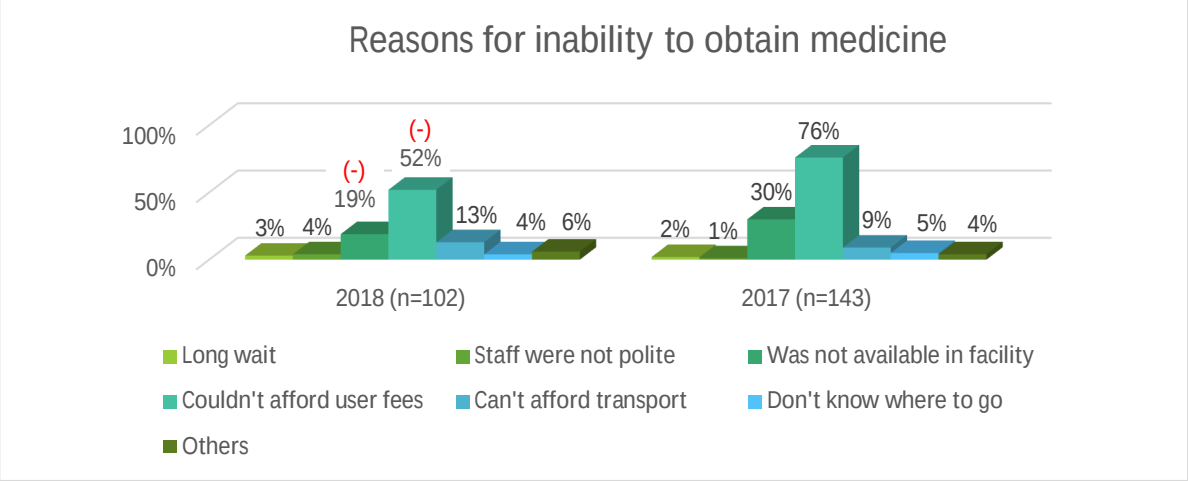

Figure 6. 4 Reasons for inability to access medicine - Those who were unable to obtain medicine

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 20: Reasons for inability to obtain medicine

Reasons for inability to obtain medicine	2018 (n=102)	2017 (n=143)
Long wait	3%	2%
Staff were not polite	4%	1%
Was not available in facility	19%	30%
Couldn't afford user fees	52%	76%
Can't afford transport	13%	9%
Don't know where to go	4%	5%
Others	6%	4%

6.3 Access to medical services for chronic conditions

From those who needed to access medical services for their chronic condition, 22% of them were unable to access medical services, mainly due to the inability to afford the cost (49%).

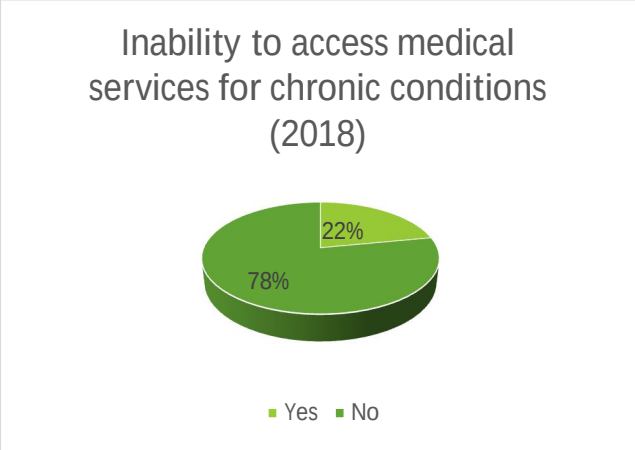

Figure 6. 5 Inability to access health services - households that have a member with chronic condition (n=301)

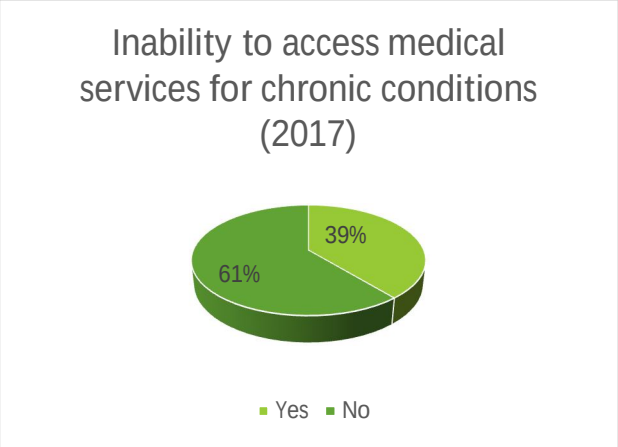

Figure 6. 6 Inability to access health services - households that have a member with chronic condition (n=227)

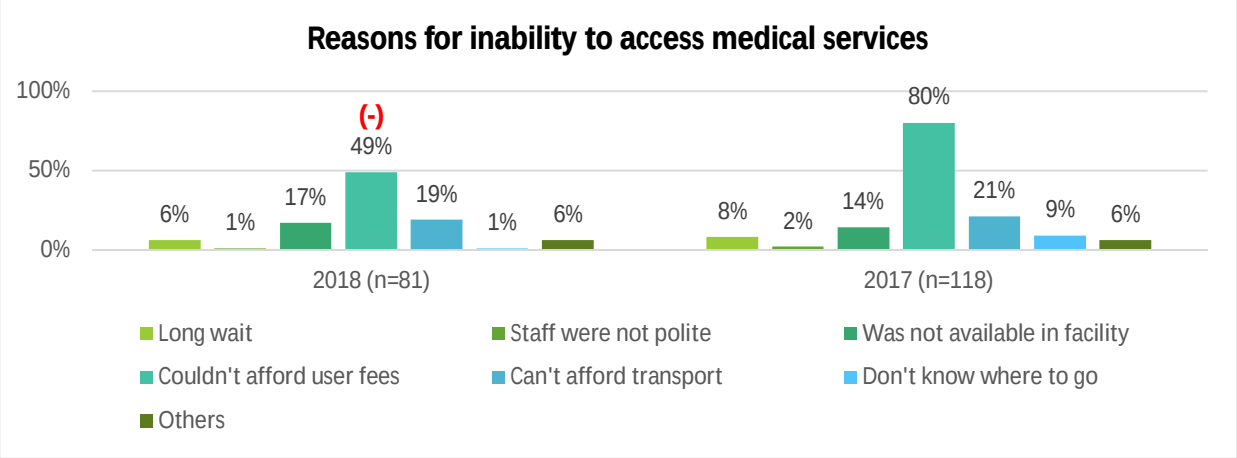

Figure 6. 7 Reasons for inability to access health services - Those who were unable to access health services

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 21: Reasons for inability to access medical services

Reasons for inability to access medical services	2018 (n=81)	2017 (n=118)
Long wait	6%	8%
Staff were not polite	1%	2%
Was not available in facility	17%	14%
Couldn't afford user fees	49%	80%
Can't afford transport	19%	21%
Don't know where to go	1%	9%
Others	6%	6%

6.4 Chronic diseases summary

Table 22: Chronic diseases summary

Chronic diseases indicator	2018 (n=319)	2017 (n=400)
% of households members with a chronic condition	15%	2%
% of adults with chronic conditions who weren't able to access medicine or other health services	48%	42%
% of those who couldn't afford fees of medicine	52%	76%
% of those who couldn't afford fees of medical service	49%	80%
% of service unavailable in local facility	17%	14%
% of those who didn't know where to access care	10%	9%

7.Disability and Impairment

7.1 Type of disability and impairment

Physical impairment was recorded as the highest among types of disability/impairment, where it reached 64% in 2018 compared to 50% in 2017. The second place went to sensory impairment with 19%.

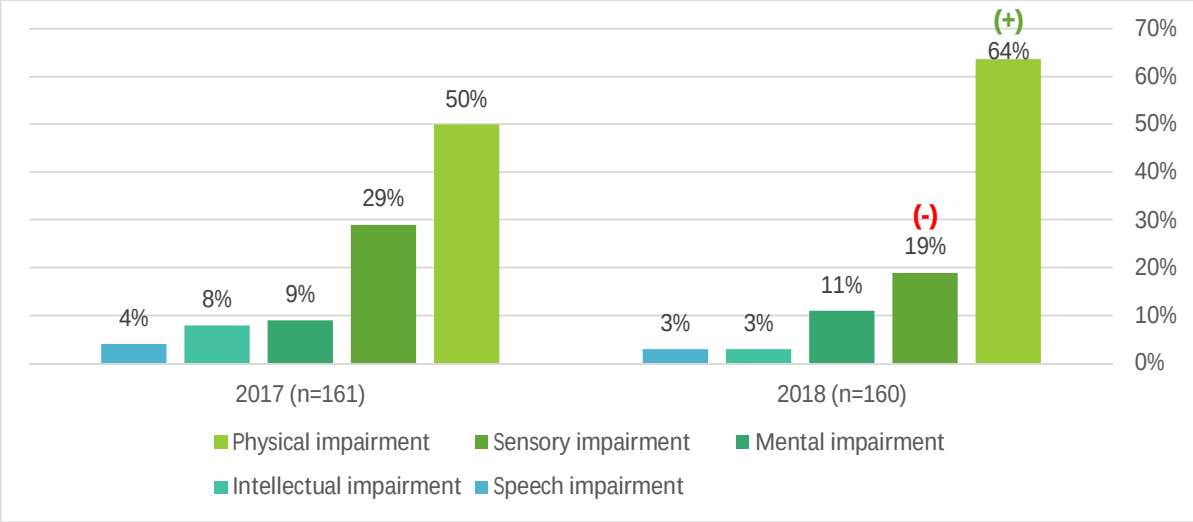

Figure 7. 1 Type of disability/ impairment - Household members who had a disability/ impairment

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 23: Types of disability / impairment

Types of disability / impairment	2018 (n=160)	2017 (n=161)
Physical impairment	64%	50%
Sensory impairment	19%	29%
Mental impairment	11%	9%
Intellectual impairment	3%	8%
Speech impairment	3%	4%

Most of the disabilities occurred due to natural reasons (49%) followed by accident (36%).

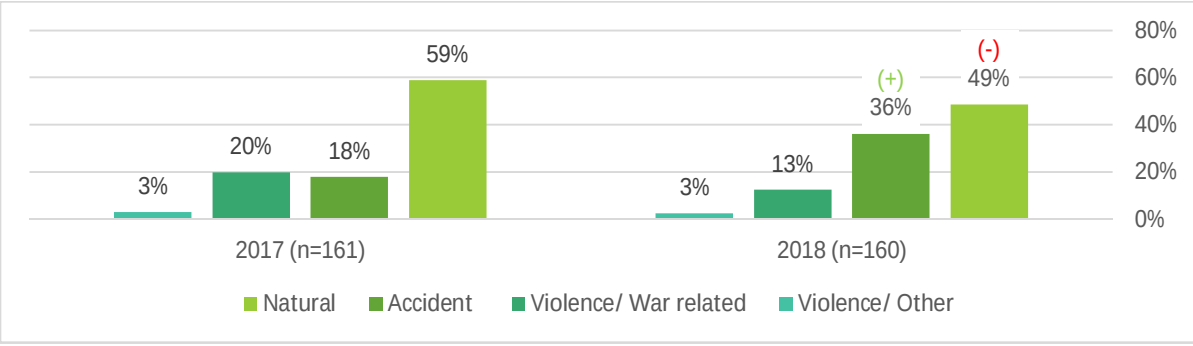

Figure 7. 2 Cause of disability/ impairment - Household members who are disabled/ impaired

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 24: Cause of disability

Cause of disability	2018 (n=160)	2017 (n=161)
Natural	49%	59%
Accident	36%	18%
Violence/ War related	13%	20%
Violence/ Other	3%	3%

7.2 Disability and impairment therapy

In 2018, Jordan had the lead on the place of first treatment with 47% of Syrian refugees households confirming this, unlike 2017 where both treatment in Syria and Jordan are equal as a place for first treatment. Access to psychological, assistive devices and surgical treatment shows an increase as compared to 2017, in contrast to rehabilitation treatment.

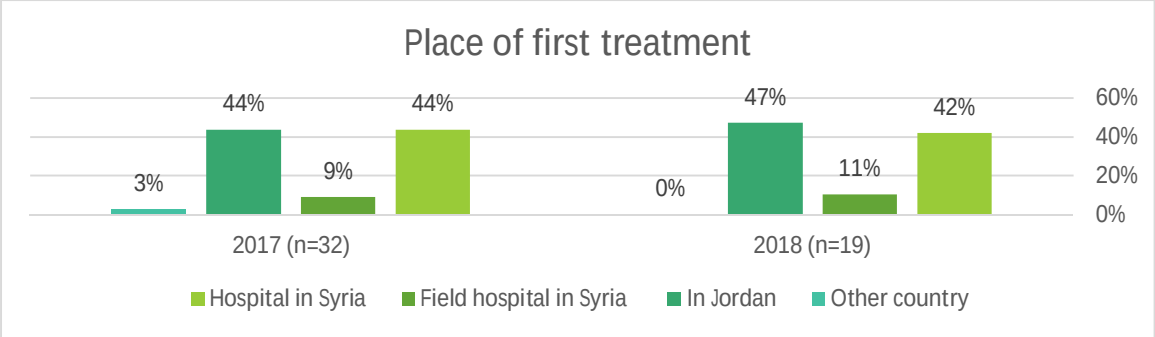

*Figure 7. 3 Place of first treatment - those who had a violence / war related disability/ impairment**

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%
(*) Insufficient base for analysis

Table 25: Place of first treatment

Place of first treatment	2018 (n=19)	2017 (n=32)
Hospital in Syria	42%	44%
Field hospital in Syria	11%	9%
In Jordan	47%	44%
Other country	0%	3%

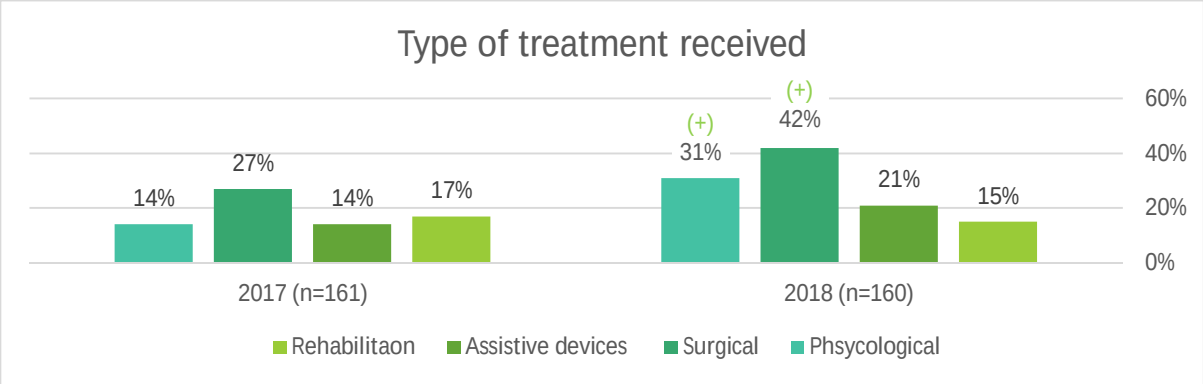

Figure 7. 4 Type of treatment received - Household members who are disabled/ impaired

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 26: Type of treatment received

Type of treatment received	2018 (n=160)	2017 (n=161)
Rehabilitation	15%	17%
Assistive devices	21%	14%
Surgical	42%	27%
Physiological	31%	14%

7.3 Getting proper care

Only 27% reported to get proper care for their impairment. Inability to afford user fees is the main barrier to proper care reported by 49% of households who had a disabled members.

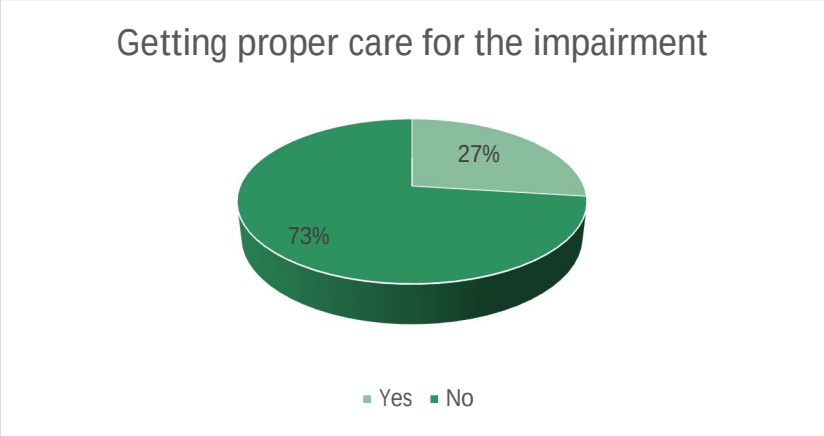

Figure 7. 5 Getting proper care - Household members who are disabled/ impaired

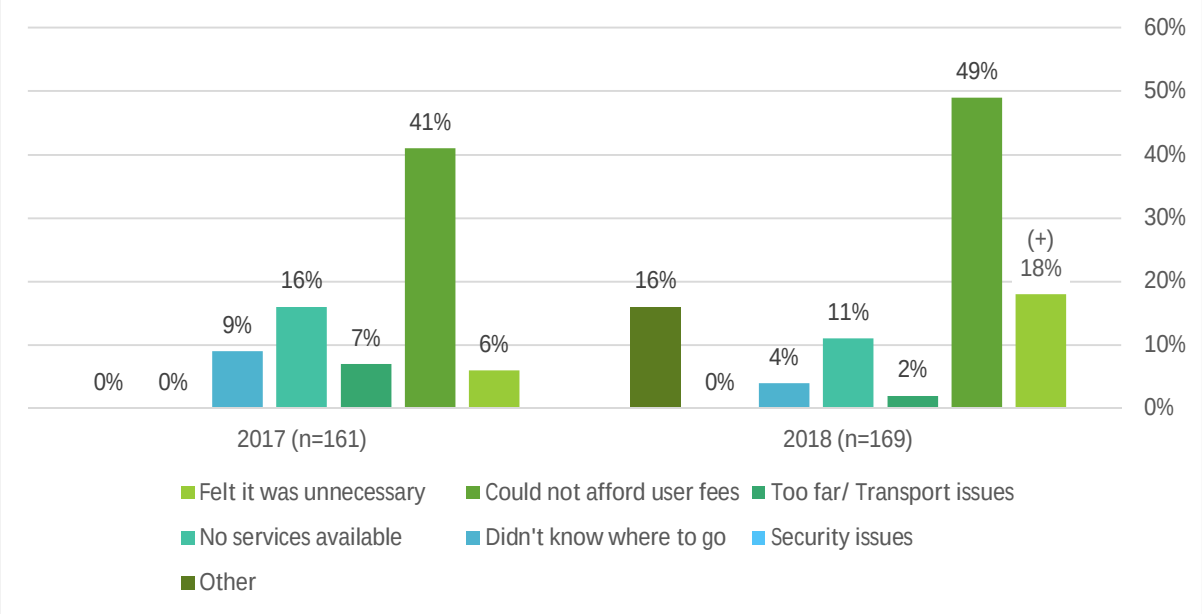

Figure 7. 6 Barriers to proper care - Household members who are disabled/ impaired

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

7.4 Disability and impairment summary

Table 27: Disability & impairment summary

Indicator	2018 (n=160)	2017 (n=161)
% who were reported to have a disability	8%	7%
% of impairments due to war related violence	13%	20%
% of those who received care in Jordan	47%	44%
% of those who received care in Syria	53%	53%
% of those could not afford services fees and/ or transport fees	51%	48%
% of who did not know where to go	4%	9%

8.Monthly Health Access Assessment

8.1 First facility

Health care services were needed by 49% of household members where 45% of them actively sought health services.

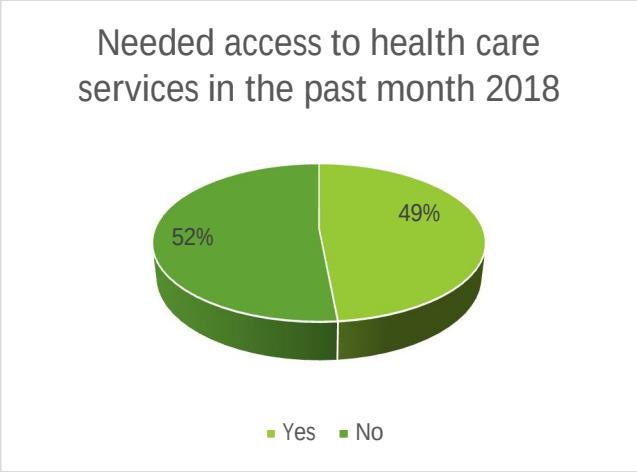

Figure 8. 1 Needed access to health care services in the past mon - All household members (n=2075)

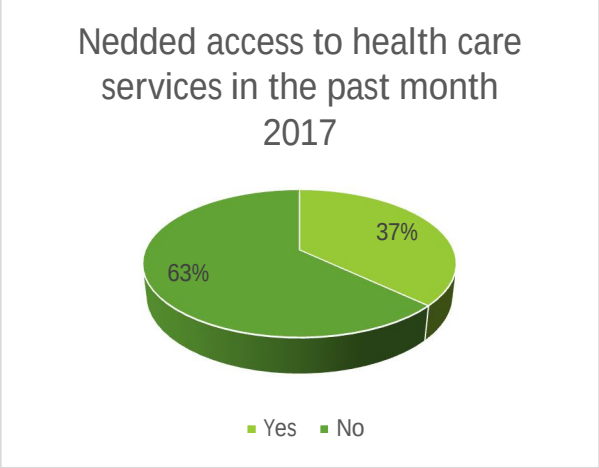

Figure 8. 2 Needed access to health care services in the past month - All household members (n=2422)

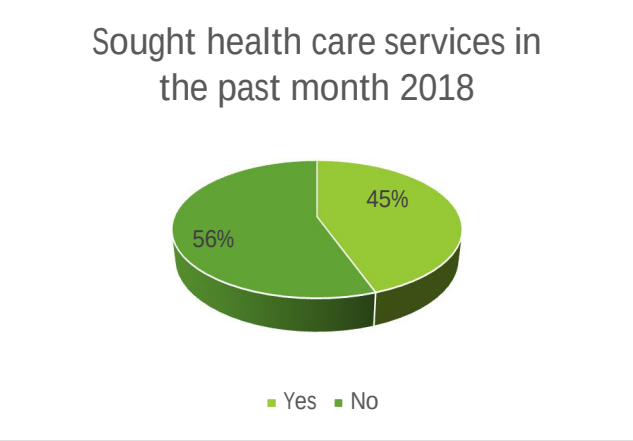

Figure 8. 3 Sought health care services in the past month - All household members who sought health care (n=923) 2018

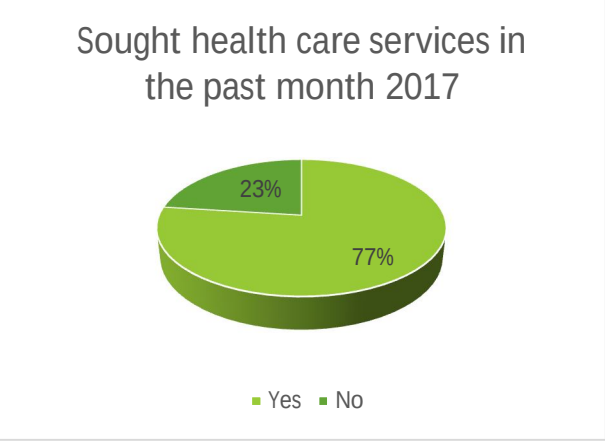

Figure 8. 4 Sought health care services in the past month - All household members who sought health care (n=905) 2017

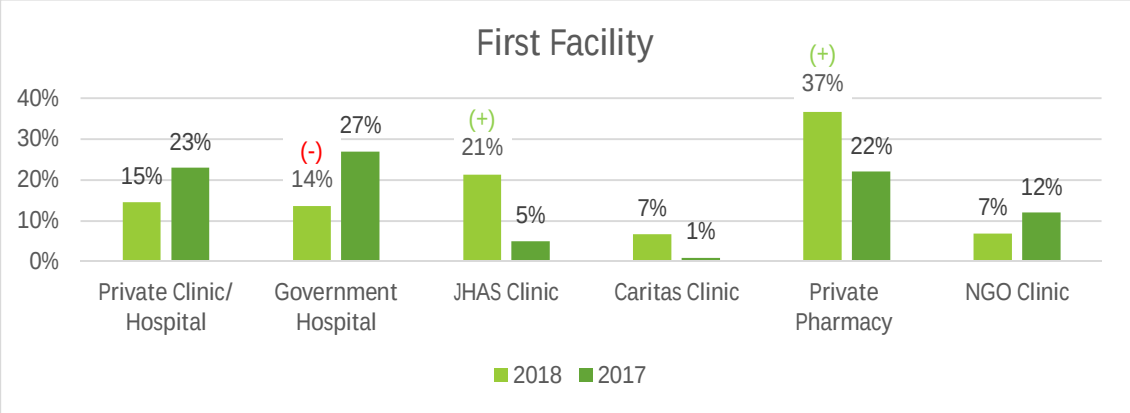

Figure 8. 5 Sought health care services in the past month - All household members who sought health care (n=905)

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 28: First Facility

First Facility	2018	2017
Private Clinic/ Hospital	15%	23%
Government Hospital	14%	27%
JHAS Clinic	21%	5%
Caritas Clinic	7%	1%
Private Pharmacy	37%	22%
NGO Clinic	7%	12%

From those who sought the services the majority initially reached private pharmacy (37%) followed by JHAS clinic (21%) and paid an average 47 JDs in the first facility, compared to 30.5 JDs in 2017.

8.2 Second facility

As a result of inability to be served in the first facility, 7% of household members decided to seek an alternative facility. Most of the Syrian refugees seeking a second facility went to JHAS clinic (26%) or private clinic (25%).

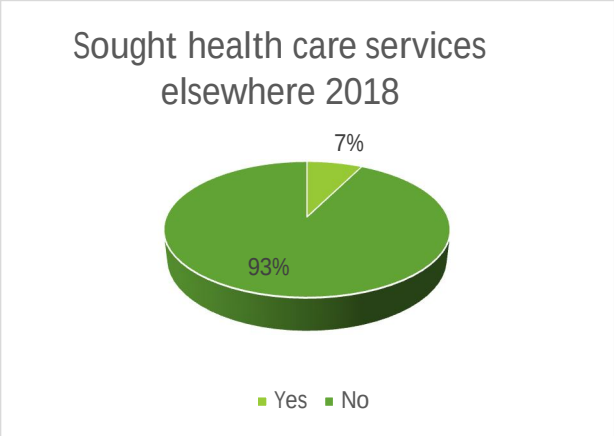

Figure 8. 6 Sought healthcare elsewhere - Those who sought healthcare services 2018 (n=923)

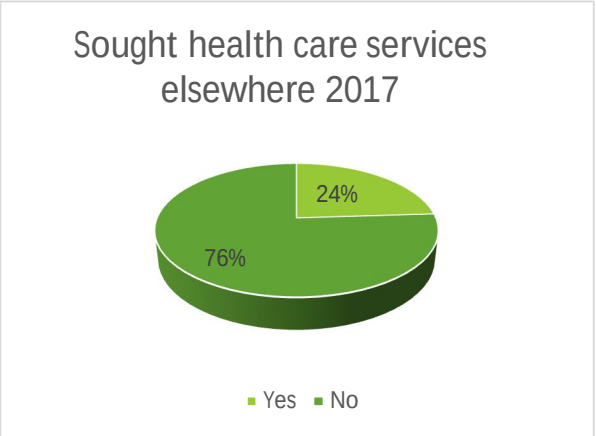

Figure 8. 7 Sought healthcare elsewhere - Those who sought healthcare services 207 (n=254)

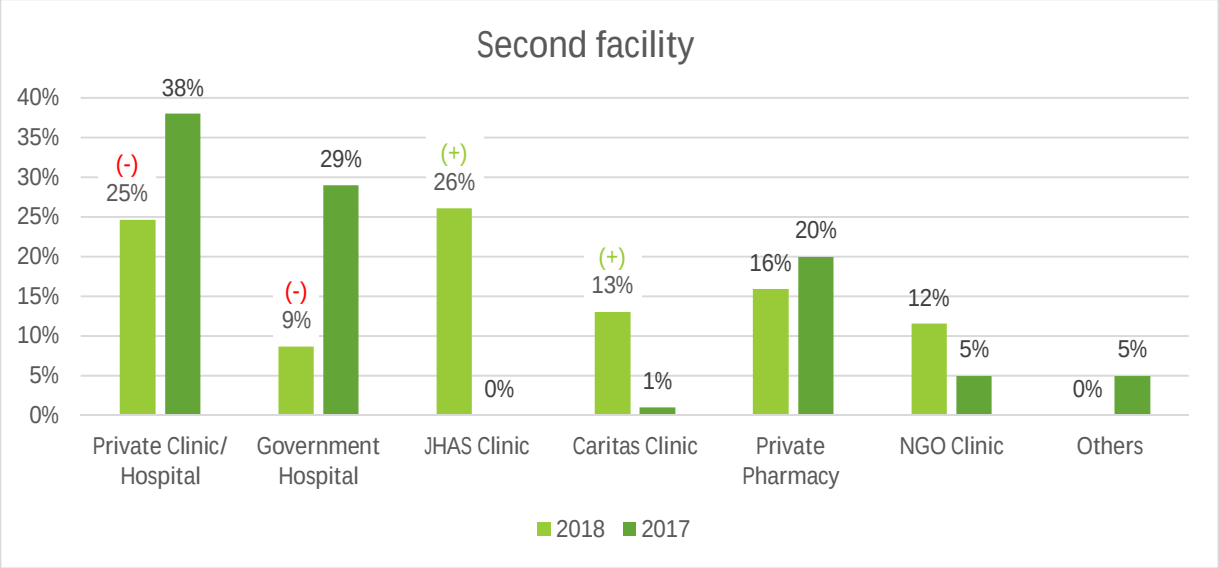

Figure 8. 8 Second facility - Those who sought care elsewhere

(+) Revaluation by more than 10%
(-) Devaluation by more than 10%

Table 29: Second facility

Second facility	2018	2017
Private Clinic/ Hospital	25%	38%
Government Hospital	9%	29%
JHAS Clinic	26%	0%
Caritas Clinic	13%	1%
Private Pharmacy	16%	20%
NGO Clinic	12%	5%
Others	0%	5%

8.3 Household spending

In terms of household spending on healthcare, 78% of interviewed households spent money on health care services during the last month; the mean of the combined income of interviewed households is 153 JDs, where they spend an average of 97.7 JDs on health care, which is 63.9% of their total income.

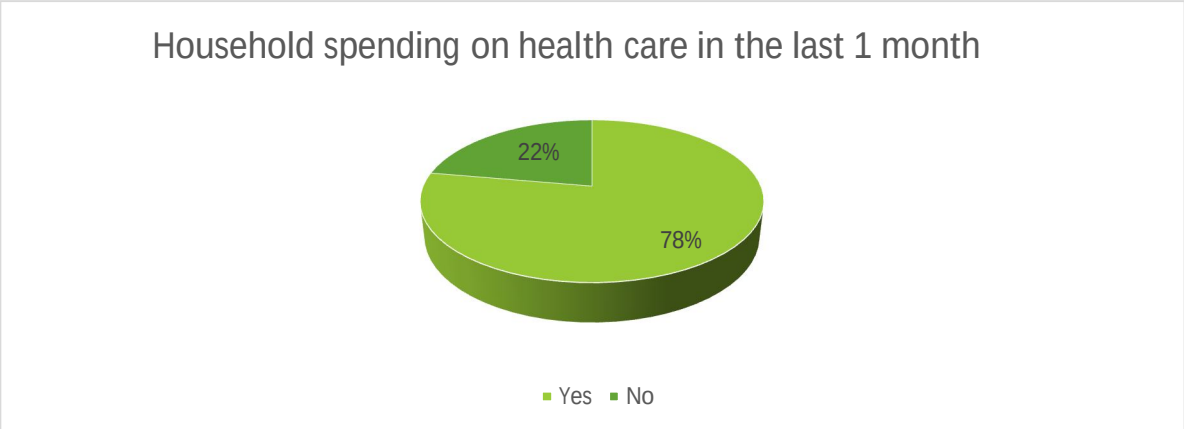

Figure 8. 9 Household spending in the last month - All respondents (n=400)

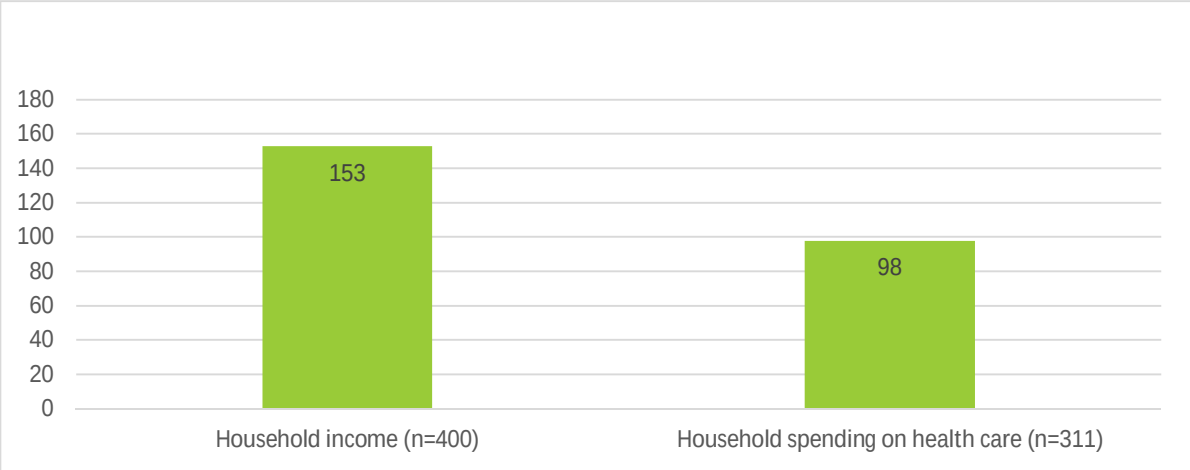

Figure 8. 10 Mean household income & expenditure (JDs)

8.4 Monthly household assessment summary

Table 30: Monthly household assessment summary

Monthly household assessment summary	2018 (n=400)	2017 (n=400)
% of surveyed household members who needed health care in preceding month	49%	37%
% of those who were able to receive care in first health facility	94%	91%
% of those initially seeking care in a private clinic or hospital	15%	23%
Average cost for care in first facility	47 JD	30.5 JD
Average cost for care in second facility	71 JD	NA