ACCESS TO HEALTH CARE AND TENSIONS IN JORDANIAN COMMUNITIES HOSTING SYRIAN REFUGEES

THEMATIC ASSESSMENT REPORT

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British Embassy Amman

REACH Informing more effective humanitarian action

SUMMARY

With the protracted Syrian crisis extending into its fourth year, the conflict continues to force millions of Syrians to seek refuge in the neighbouring countries of Jordan, Iraq, Lebanon and Turkey. These host countries are bearing the brunt of the crisis, which represents the largest refugee exodus in recent history with a total of 2,863,595 registered refugees now living outside of Syria.[1] Since 2011, approximately 600,000 Syrians have crossed the border into Jordan, putting immense strain on already scarce resources, and intensifying competition for basic services. The vast majority of these refugees do not reside in camps, but in Jordan's host communities,[2] where limited opportunities, a lack of resources and inadequate living space present a challenge to social cohesion and community resilience.

In Jordan, few comprehensive studies have been conducted to provide an in-depth understanding of the key drivers of host community tensions. To address this information gap, this multi-sectoral REACH assessment aimed at identifying where tensions have emerged across northern Jordan as a result of the Syrian refugee crisis, and how they could be mitigated through social cohesion and resilience programming. In the shift from humanitarian relief to long-term development, the assessment aims to promote and inform the mainstreaming of a 'Do No Harm' approach in the response provided to conflict-affected populations residing in Jordanian host communities. Sectors assessed included: education, external support, healthcare, livelihoods, municipal services, shelter and water.

With support from the British Embassy in Amman, REACH carried out the assessment between August 2013 and March 2014 across the six northern Jordanian governorates of Ajloun, Balqa, Irbid, Jarash, Al Mafraq and Zarqa. The main coordination mechanism for the assessment was a steering committee comprised of government officials and representatives from the Ministry of Planning and International Cooperation (MoPIC), the Ministry of Interior (MoI), and the Ministry of Municipal Affairs (MoMA). In addition to these government ministries, key stakeholders included the British Foreign and Commonwealth Office (FCO), UN agencies, and other humanitarian and development actors from the international community.

REACH found health care to be a major source of tension in Jordanian host communities that were estimated to be at relatively high risk of tension at the time of assessment. Key findings include:

- More Syrians (66%) than Jordanians (57%) reported adequate access to health care services in their community.
- When asked to rate challenges confronting health care in the community, both Jordanian and Syrian respondents expressed heightened perceptions of urgency, with 'Very Urgent' the most commonly cited response.
- 64% of Jordanians and 56% of Syrians perceived access to health care as a cause of tension in their community.
- The majority of Jordanians (60%) indicated overcrowded health care centres as a driver of health-care related tension. This was also the most commonly cited reason among Syrians (39%).
- More Jordanians (26%) than Syrians (21%) cited uneven access to health care as a reason for tension.

Meeting the health care needs of both Jordanians and Syrians living in the host communities presents Jordan's health sector with a definitive challenge. Currently the national health system is encumbered with overcrowded health care facilities, a lack of qualified medical staff and shortages in supply.[3] Furthermore, outbreaks of communicable diseases such as polio and measles have posed a threat to the health of host community populations, despite being stymied by emergency vaccination campaigns.[4] Findings in this report suggest that overstretched health care services are likely to be contributing to heightened levels of tension and negative perceptions between Jordanian and Syrian groups in host communities. Additionally, these findings call attention to a range of issues obstructing even and adequate access to health care across the northern governorates.

[1] UNHCR, <www.data.unhcr.org>, [last checked 10 July 2014].
[2] UNHCR, UNICEF and WFP, Joint Assessment Review of the Syrian Refugee Response in Jordan, (January 2014).
[3] Host Community Support Platform, Needs Assessment Review of the Impact of the Syrian Crisis on Jordan: Executive Summary, (November 2013).
[4] UNHCR, 2014 Syria Regional Response Plan, (November 2013).

CONTENTS

Abbreviations and Acronyms

CBOs Community-Based Organisations
FCO British Foreign and Commonwealth Office
FGD Focus Group Discussion
GoJ Government of Jordan
HCSP Host Community Support Platform
ILO International Labour Organisation
MoH Ministry of Health
MoI Ministry of Interior
MoMA Ministry of Municipal Affairs
MoPIC Ministry of Planning and International Cooperation
NGO Non-Governmental Organisation
ODK Open Data Kit
UN United Nations

Geographical Classifications

Governorate	In Jordan this is the highest administrative boundary below the national level.
District	Governorates are divided into districts.
Municipality	Districts are divided into municipalities.
Sub-Municipality	Municipalities are divided into sub-municipalities.
Community	Sub-municipalities are divided into communities.

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INTRODUCTION

Jordan's health care services have been hard hit by the rapid influx of Syrian refugees. Despite being reinforced by external support, the sector continues to suffer from depleting access to health care facilities, medical staff, and supplies.[5] Prior to the protracted Syrian refugee crisis, Jordan's national health care system had reached an advanced stage of capacity building, with the country's total expenditure on health care representing 9.8% GDP in 2012.[6] However, the extra burden placed on health care services by an unprecedented increase in demand for medical assistance has since undermined progress. For this reason, the Government of Jordan (GoJ) has expressed acute concerns that the deteriorating absorptive capacity of health care services compounded by additional financial pressures has led to a projected reversal in some of the most important health indicators anchored in the Millennium Development Goals.[7]

Jordan's Ministry of Health (MoH) has guaranteed free access to primary and secondary care in national health care centres for registered Syrian refugees living in the host communities.[8] Yet for those who remain unregistered, accessing adequate health care is more problematic. Syrian refugees living outside of camps who do not possess official documentation are unable to benefit from national health care services, and are instead served by a network of non-governmental organisation (NGO) clinics located in Jordanian host communities.[9] In terms of obstacles to access, a lack of awareness surrounding available health care services, particularly among women, presents an additional challenge.[10] What is more, according to the 2014 Syria Regional Response Plan (RRP6) significant information gaps remain regarding access to health care and the health status and needs of those residing in host communities.[11]

A rise in communicable diseases perpetuated by the large-scale deterioration of Syria's public health system represents a pressing health concern for host community populations.[12] Reported cases of imported tuberculosis, leishmaniasis and hepatitis A have become more common, and a measles outbreak in Jordan in April 2013 was followed by an outbreak of polio in November of the same year, prior to which the country had been polio free since 1995.[13] Outbreaks of disease have been mitigated through the implementation of widespread vaccination campaigns.[14] However, routine immunization coverage remains uneven across the Jordanian host communities. Furthermore, long distances between health centres; the high cost of transportation to medical centres for those in rural areas; and long waiting lists contribute to deteriorating access to health care.[15] Inadequate access to health care services has forced Jordanians and Syrians living in host communities to resort to a range of coping strategies such as selling personal belongings to cover medical costs; relying on NGO-funded health care centres; and attending costly private clinics.[16]

This study is part of a series of thematic reports, following two previously released papers, based on assessment findings where sector-specific needs of self-settled Syrian refugees living in northern Jordan were mapped and identified.[17] The overall assessment, conducted from August 2013 to March 2014, concentrated on the dynamics of refugee-host community relations and explored factors influencing tension and destabilization. This report has a special focus on tensions relating to health care in 160 host communities assessed across the governorates of Ajloun, Balqa, Irbid, Jarash, Al Mafraq, and Zarqa in northern Jordan. Quantitative and qualitative findings included in this report provide evidence to suggest that negative perceptions of health care may be escalating community tension and eroding social cohesion in Jordanian host communities.

[5] HCSP, Needs Assessment Review of the Impact of the Syrian Crisis on Jordan: Executive Summary, (November 2013).
[6] WHO, <http://www.who.int/countries/jor/en/>, [Last checked 2 July 2014].
[7] Government of Jordan, Ministry of Planning and International Cooperation, National Resilience Plan 2014, (2014).
[8] UNHCR, 2014 Syria Regional Response Plan (RRP6), (November 2013).
[9] Ibid.
[10] WHO, <http://www.who.int/countries/jor/en/>, [Last checked 2 July 2014].
[11] UNHCR, 2014 Syria Regional Response Plan (RRP6), (November 2013).
[12] Ibid.
[13] HCSP, Needs Assessment Review of the Impact of the Syrian Crisis on Jordan: Executive Summary, (November 2013).
[14] Ibid.
[15] UNDP, Municipal Needs Assessment Report, (April 2014).
[16] CARE, Lives Unseen: Urban Syrian Refugees and Jordanian Host Communities Three Years Into the Syria Crisis, (April 2014).
[17] REACH, Syrian Refugees in Host Communities – Key Informant Interviews/District Profiling, (January 2014), and, Evaluating the Effect of the Syrian Refugee Crisis on Stability and Resilience in Jordanian Host Communities, (January 2014).

METHODOLOGY

REACH, with support from the British Embassy in Amman, undertook a large assessment in Jordanian host communities focusing on prioritization of needs, vulnerabilities and tensions that have emerged as a result of the Syrian refugee crisis. The assessment was undertaken over a six month time period between August and March 2014 and included a series of data collection and analysis exercises. First, a desk review was conducted to outline the broad challenges, needs and priorities in Jordan as a result of the Syrian refugee crisis. The findings from this desk review informed the methodology for a **key informant assessment** in 446 communities in the six northern governorates of Ajloun, Balqa, Irbid, Jarash, Al Mafraq and Zarqa.[18]

Findings from the key informant assessment were then used to select the 160 host communities most at risk of high tension and insecurity, which were identified based on having the lowest level of resilience.[19] REACH then undertook a **community-level assessment** of Jordanians and Syrians living in these 160 communities from December 2013 until early March 2014. Administration of questionnaires and eight focus group discussions (FGDs) with on average 6 participants per group were undertaken in each of these communities. During the targeted assessment phase 7,158 individual questionnaires were completed and 1,280 FGDs with Jordanians and Syrians.

In addition, REACH hosted six **participatory workshops with local government representatives** from the six sampled governorates during January and February 2014. The aim of these workshops was to gain a better understanding of perceptions, challenges and needs of local government institutions in providing support to host communities and incoming refugees. In particular, these workshops sought to identify the priority sectors in each governorate to inform programming around social cohesion and resilience. They thereby complemented the community-level data collection to illustrate a comprehensive and nuanced perspective of vulnerabilities and challenges to resilience in Jordanian host communities.

FOCUS GROUP DISCUSSION METHODOLOGY

In each of the 160 communities a FGD was held with each of the following demographic groups: Jordanian women, Jordanian men, young Jordanian women, young Jordanian men, Syrian women, Syrian men, young Syrian women, and young Syrian men. The upper-age threshold determining whether individuals were placed in the younger FGD was 30 years of age. The groups were divided in this manner to allow for different types of discussions to surface in the FGD setting. Previous assessments had already indicated the importance of separating Jordanian and Syrian FGDs[20] but it was also deemed necessary to separate according to sex and age groups to allow for a more nuanced discussion.

Prior to each FGD, participants were asked to fill out a survey questionnaire using Open Data Kit (ODK) which was uploaded onto smart phones. The questionnaires were filled out individually with the enumerators' guidance, and served the purpose of gauging the individual challenges, priorities, and perceptions held by participants in the FGDs. The ODK survey was completed before the FGDs so as not to have the group dynamics of the FGD influence the responses.

CHALLENGES AND LIMITATIONS

A purposive sampling approach was adopted for the community-level assessment to clarify the specific challenges to social cohesion and resilience within different demographic groups in Jordanian host communities. Furthermore, the selection of respondents and participants in these communities was also purposive, and the sampling approach therefore is not intended to generate statistically significant findings, generalisable to the assessed communities or to northern Jordan. Instead, it allows for a more nuanced thematic understanding of the challenges to social cohesion and resilience facing people living in tension-prone Jordanian host

[18] REACH, 'Syrian Refugees in Host Communities – Key Informant Interviews/District Profiling', (January 2014).
[19] REACH, Evaluating the Effect of the Syrian Refugee Crisis on Stability and Resilience in Jordanian Host Communities: Preliminary Impact Assessment, (January 2014).
[20] Mercy Corps, Mapping of Host Community – Refugee Tensions in Al Mafraq and Ramtha, Jordan, (May 2013).

communities.

In some communities, there were occasions when both Jordanians and Syrians were reluctant to participate in the assessment. On the whole, this was not a major challenge, but it complicated operational planning as certain FGDs had to be rescheduled and moved around in order to achieve an acceptable level of participation in the assessment. Furthermore, in some communities it highlighted growing assessment fatigue; some Jordanians and Syrians felt that too many assessments are being conducted without being followed by action.

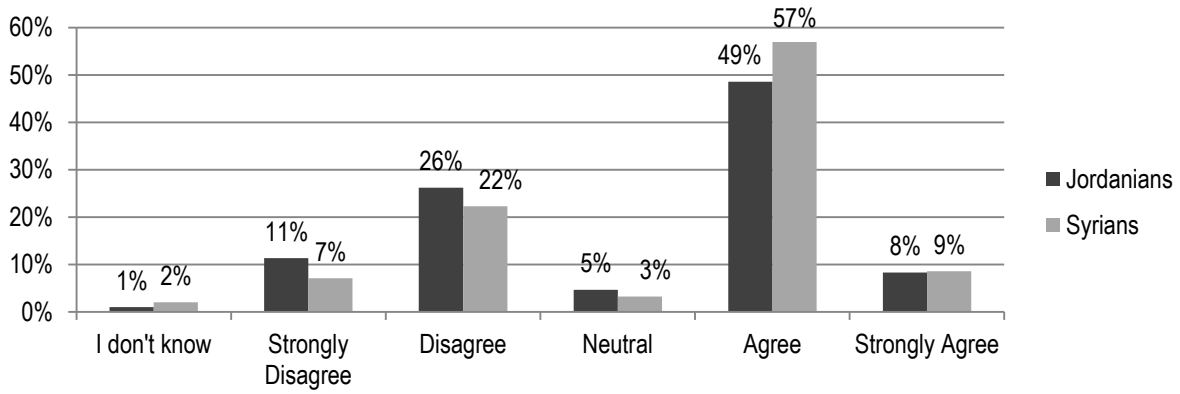
FINDINGS

This section of the report presents the main findings related to health care that were generated through the assessment of Jordanian host communities. It outlines perceptions of access to health care; challenges to health care; tensions and health care in the Jordanian host communities assessed.

PERCEPTIONS OF ACCESS TO HEALTH CARE

In order to gauge Jordanian and Syrian perceptions of access to health care, respondents were asked if there was adequate access to health care in their community. Findings showed that a large proportion of Jordanian and Syrian respondents perceived access to health care to be adequate in their community at the time of assessment, with 'Agree' the most commonly selected response for both groups. When disaggregated by nationality there was some variation in responses. **Overall more Syrians than Jordanians indicated adequate access to health care, with 66% of Syrian respondents selecting either 'Agree' or 'Strongly Agree', as opposed to 57% of Jordanians.** Meanwhile, 37% of Jordanians considered that access to health care was inadequate, compared to 29% of Syrians. This disparity may be attributable to Jordanian respondents comparing current demand for health care assistance with their experience during previous years, a reference point in time not used by recently arrived Syrian refugees. Additionally, Syrian respondents may perceive better access to health care services as they are able to benefit from free access to both national health services and NGO-funded field hospitals, while their Jordanian counterparts are limited to national health care centres and costly private clinics.

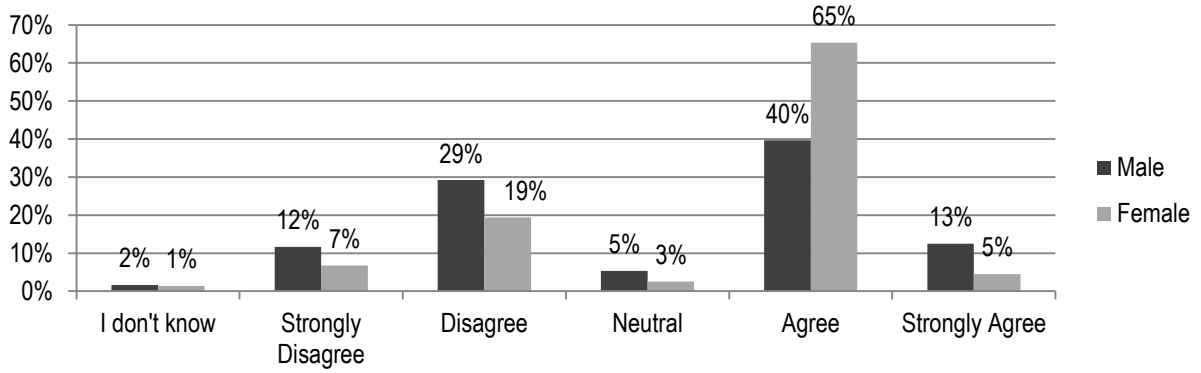
Figure 1: There is adequate access to health care services in this community (by nationality)



FGD findings gave a strong impression that Jordanians and Syrians participating in the assessment perceived access to health care to be inadequate. **During FGDs negative perceptions were expressed by participants across the six northern governorates, with reports that residents were resorting to various coping strategies to overcome challenges in accessing health care.** For instance, FGD participants in Halawah, Ajloon mentioned that Jordanians and Syrians were seeking medical care in private clinics due to a shortage of medical staff and limited health services, adding that health centres remained closed most of the time. In Dair Alla, Balqa FGD participants described lodging complaints with health care services asking for more healthcare centres to be built, complaints which to date had remained unaddressed.

Similarly, in Azraq Shamali, Zarqa, FGD participants explained that there was no health care centre serving the community, forcing many people to seek medical attention in a neighbouring area approximately 15km away. Overall, concerns regarding inadequate access to health care in host communities were a recurring theme in FGDs.

Figure 2: There is adequate access to health care services in this community (by sex)

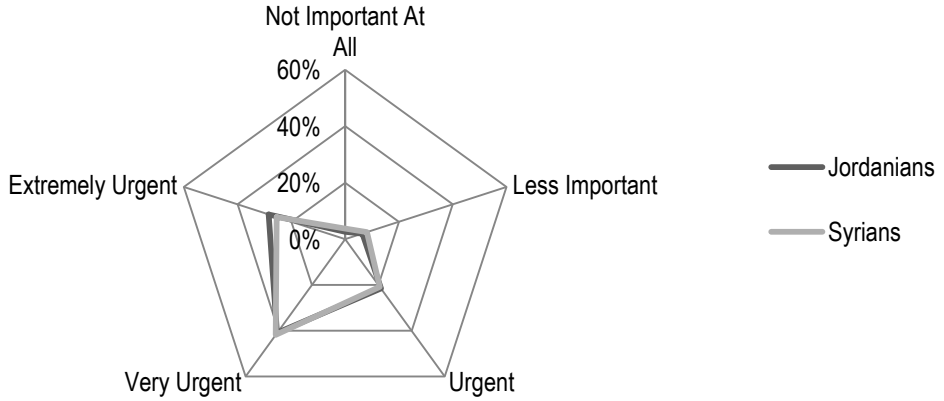


When disaggregated by sex, findings indicated different perceptions of access to health care among men and women (see Figure 2). **More female than male respondents considered access to health care services to be adequate in their community, with a total of 70% of females selecting the responses 'Agree' or 'Strongly Agree', compared to 53% of males.** Strikingly, 41% of male respondents perceived access to health care to be inadequate compared to 26% of females. This gender disparity implies that men may have more difficulties than women in accessing the health care services that they need in the assessed host communities.

CHALLENGES TO HEALTH CARE

At the time of assessment, Jordanian and Syrian respondents registered heightened perceptions of urgency in relation to challenges confronting health care in their community (see Figure 3). Notably, **the most commonly cited response for both groups was 'Very Urgent', with 41% of Jordanians and 42% of Syrians choosing this rating.** Jordanian perceptions of urgency were more acute than those of Syrians assessed, with 28% of Jordanian respondents selecting the response 'Extremely Urgent' compared to 25% of Syrians. A minority of respondents considered that challenges to health care in their community were not important at all. These findings conflict with the large proportion of Jordanians and Syrians recorded above as indicating that access to health care was adequate in their community. This disparity may be due to respondents attributing urgency to challenges confronting health care that are unrelated to access, such as the quality of services being provided, or general health risks, including the spread of communicable diseases; notably, **in 15% of all FGDs the spread of diseases was identified as a safety threat by participants.** Alternatively, it may be commonly perceived that health care provision will not keep pace with the continued influx of refugees.

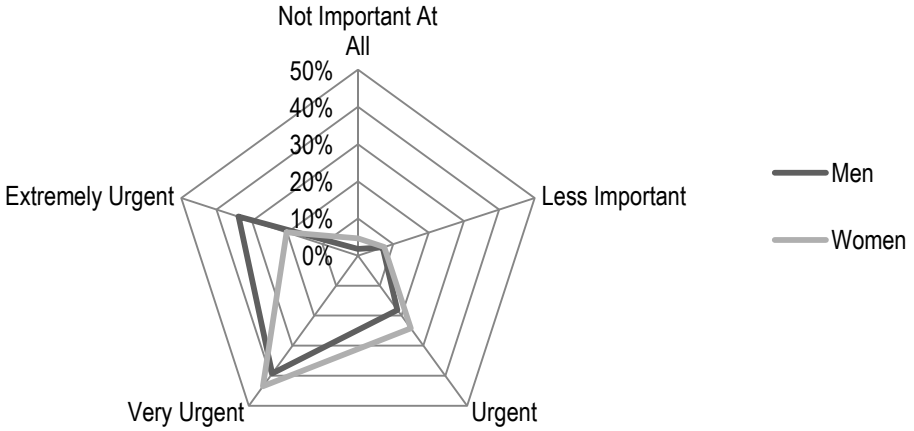
Figure 3: Rate challenges to health care in your community (by nationality)



A breakdown by sex showed some discrepancy between male and female responses, with 34% of male respondents selecting the response 'Extremely Urgent' compared to 20% of females (see Figure 4). This indicates that **Jordanian and Syrian males assessed perceived more acute challenges to health care in their community than their female counterparts.** The most commonly cited response for both male and female respondents was 'Very Urgent', with 43% of female respondents and 39% of male respondents indicating this response. This breakdown by sex corroborates earlier findings that a higher percentage of male than female

respondents perceived access to health care in their community to be inadequate, underlining a pronounced gender disparity in perceptions of access to health care.

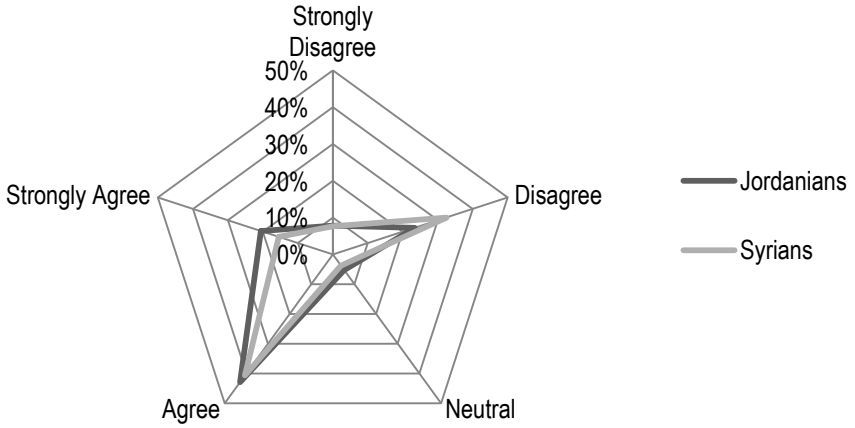
Figure 4: Rate challenges to health care in your community (by sex)



TENSIONS AND HEALTH CARE

To assess the impact of health care on social cohesion, respondents were asked to indicate if access to health care caused tension in their community (see Figure 5). **Findings revealed that a large proportion of Jordanian and Syrian respondents had heightened perceptions of tension at the time of assessment, with 57% of all respondents expressing that access to health care caused tension in their community.** When disaggregated by nationality 64% of Jordanians and 56% of Syrians indicated the responses 'Agree' or 'Strongly Agree' pointing to more acute perceptions of health care-related tension among Jordanian respondents.

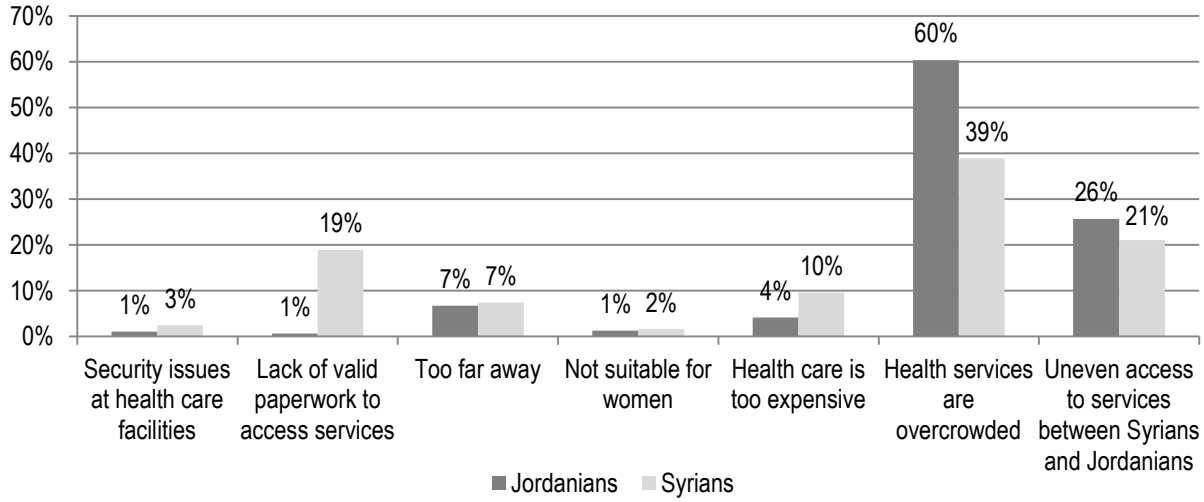
Figure 5: Access to health care causes tension in your community (by nationality)



When asked to identify reasons behind health care related tension, **considerably more Jordanians (60%) than Syrians (39%) felt that overcrowded health care services were generating tension** (see Figure 6). However, it should be noted that this was also the most commonly cited response among Syrians.

FGDs held in the six northern governorates reflected these findings, with a large proportion of participants citing overburdened health care centres as a priority issue. In Mokhayam Baq'ah, Balqa, Jordanian and Syrian FGD participants stated that there was only one healthcare centre in the area, which suffered from severe overcrowding. Meanwhile, Jordanians and Syrians participating in FGDs held in Ashrafiyyeh, Irbid highlighted that overcrowded healthcare centres were forcing families to travel long distances in order to access medical treatment.

Figure 6: Perceived reasons why access to health care causes tension in your community (by nationality)



Notably, more Jordanian (26%) than Syrian respondents (21%) indicated that uneven access to services between Jordanians and Syrians was a reason behind health-care related tension in the community. Uneven access to health care should be understood here as a lack of universal health coverage for both Jordanians and Syrians. This finding was reflected in FGDs held in Kharja, Irbid in which Jordanian participants stated that the influx of Syrian refugees had over-stretched medical services, leading to shortages of medical supplies, affecting both groups and fostering tension between them. In FGDs held in Hoson, Irbid, uneven access to health care was identified as key driver of tension by Syrians, who expressed frustrations that they were unable to access medical treatment in local healthcare centres if their security cards were not registered in the same community. It may be that Jordanian perceptions of uneven access are closely related to the fact that Syrians can access services from UN agencies and NGOs, while Jordanians cannot. Additionally, the findings shown in Figure 6 indicate that Syrian perceptions of uneven access are likely to be influenced by issues such as high health care costs and a lack of valid paperwork.

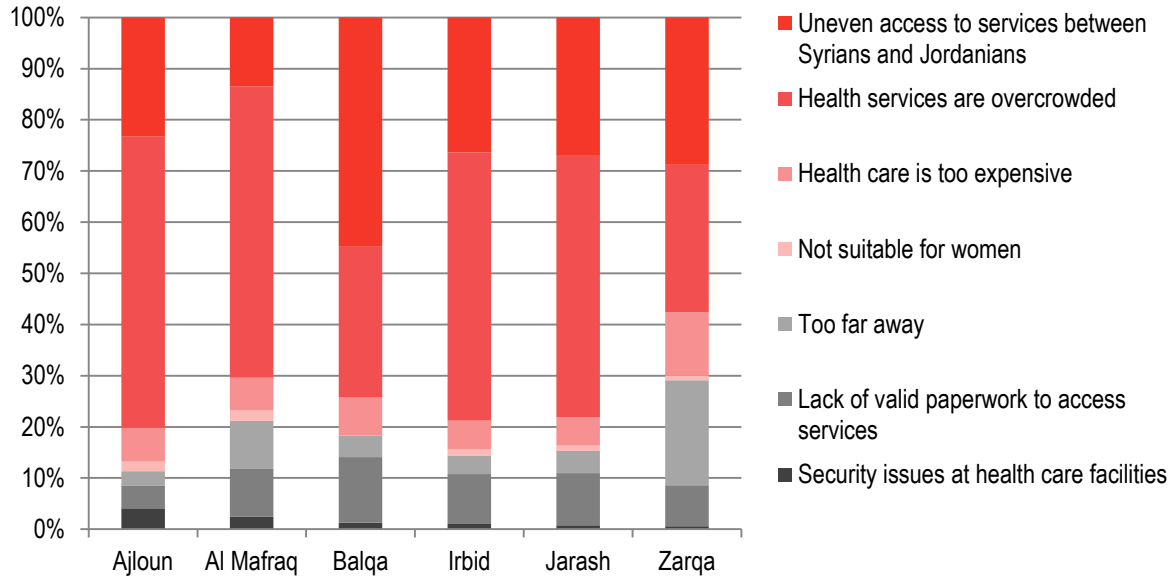
Predictably, a much larger proportion of Syrians (19%) than Jordanians (1%) pointed to a lack of valid paperwork as a reason for tension surrounding health care in their community. This is most likely attributable to the fact that only registered Syrian refugees are eligible to receive free health care services. FGDs held in Samt, Irbid echoed this finding, as Syrian participants reported that they lacked the correct documentation to access health care. Similarly, in Al-Jabal Al-Abyahd, Zarqa Syrians complained that when their UNHCR cards expired they were left unable to access public health services, forcing them to face long queues to receive medical attention at health care centres where admission is permitted without documentation. This issue was also reported in FGDs held in Wahadneh, Ajloon where Syrian respondents stated that they attended private healthcare clinics due to the expiry of their UNHCR documents. Remarkably, in Azraq Shamali-Mazare', Syrian FGD participants reported that they had resorted to using their relatives' identity cards to receive medical treatment illegally. A lack of valid paperwork may contribute to tension between Jordanians and Syrians, as Syrians without the correct documentation are likely to feel excluded from the health care access enjoyed by their Jordanian counterparts and may direct their dissatisfaction toward them. It may also lead to deteriorating social cohesion between Syrian refugees and Jordanian authorities, for those Syrians in need of medical assistance who are unable to obtain the necessary paperwork from officials in order to meet their needs.

Only 4% of Jordanians and 10% of Syrians indicated that a reason for health care related tension was excessive health care costs. On the contrary, FGD content highlighted that Jordanians and Syrians alike were being forced to pay out of pocket for their own medication and private health care appointments at exorbitant costs. In Jdaitta, Irbid for instance FGDs highlighted that Syrians were turning to charitable organisations and asking for help in covering medical costs, or visiting refugee camps to secure medicine for their children. In Balaooneh, Balqa Jordanian and Syrian FGD participants stated that obstacles to accessing basic services were forcing people to pay for expensive health care services despite barely being able to cope with the high cost of living. Health care costs could be seen as a source of tension between Jordanians and Syrians because Jordanians may feel forced to attend expensive private clinics in order to avoid queues, resource shortages and

overcrowding caused by the influx of refugees. Syrians, meanwhile, may feel excluded by high health care costs due to their disadvantaged situation; particularly in light of the challenges and legal restrictions that they face in sustaining livelihoods,[21] potentially sparking resentment towards Jordanians who are able afford access to better quality health care services.

Distance from health care services was identified as a driver of health care related tension by an equal proportion of Jordanians and Syrians, at 7%. This finding was reflected by Jordanian and Syrian FGD participants in Al Janubi and Downtown, Irbid, among others, who were commuting to distant hospitals to access medical attention. Distance to health care centres could represent a source of tension between the two groups because Jordanians and Syrians who are isolated from health care services and transportation links are likely to feel excluded from the health care benefits enjoyed by others in the community, which may prompt them to develop negative perceptions of those with enhanced access. Encouragingly, **only a very small proportion of Jordanians and Syrians considered that security issues at health care facilities and health care centres that were not suitable for women counted as reasons behind health care related tension.** Correspondingly, there was only one FGD in which a security issue was mentioned. Syrian participants in this FGD held in Kofor Jayez, Irbid, reported that they had been mistreated by medical staff in the community, which had sparked feelings of resentment towards the local community.

Figure 7: Perceived reasons why access to health care causes tension in your community (by governorate)



When disaggregated by governorate, findings indicated variation across the six northern governorates assessed (see Figure 7). **Balqa had the highest number of respondents citing uneven access to services between Syrians and Jordanians at 44%**, which may suggest that more acute perceptions of tension exist between the two groups in this area. By contrast, **only 13% of Jordanian and Syrian respondents in Al Mafraq perceived uneven access between Jordanians and Syrians as a reason for tension**, while the number of respondents citing this response ranged from some 23% in Ajloun, 26% in Irbid, 27% and Jarash to 29% in Zarqa.

The most commonly cited reason for health care-related tension across the six governorates was overcrowded health care services. **A minority of respondents indicated that health care services were not suitable for women across the six governorates, although Ajloun and Al Mafraq had a marginally higher percentage of respondents selecting this reason for health care-related tension at 2% in each governorate.** Perceptions of security issues at health care facilities were low across the six governorates. However it is notable that a larger proportion of respondents indicated this response in Ajloun (4%) than in other governorates.

Additionally, there was a distinct disparity between the six governorates with regards to distance as a key driver of health-care related tension in the community. **Strikingly, some 20% of respondents in Zarqa indicated this reason for tension compared to considerably lower numbers across the remaining five governorates.**

[21] Syria Needs Analysis Project, Legal status of individuals fleeing Syria, (June 2013).

Zarqa also stood out as having the highest proportion of respondents indicating health care expenses as a reason behind health care-related tension, with some 12% selecting this response compared to only 6% in Irbid, Jarash and Al Mafraq, and 7% in Ajloun and Balqa.

CONCLUSION

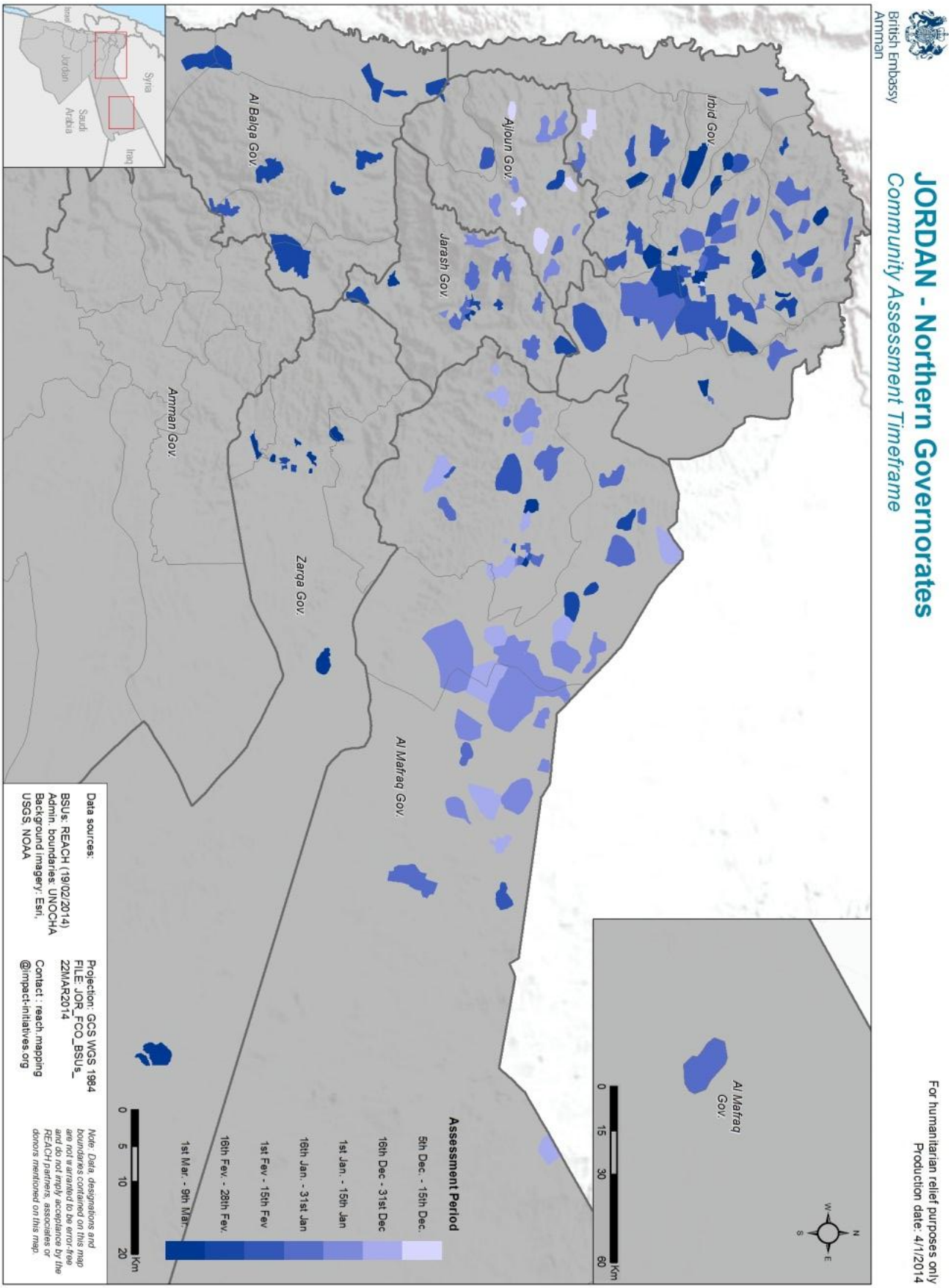
This report has outlined some of the core issues surrounding health care-related tension in the host communities of northern Jordan. The findings of this report suggest that for many of the Jordanians and Syrians participating in this assessment, health care represented a key driver of tension, linked to heightened perceptions of urgency regarding the challenges confronting health care in the community. Based in these findings, it is recommended that assistance should continue to be provided to Jordan's health sector in order to increase its absorptive capacity and enhance access to services, particularly for Syrian refugees who remain unregistered and consequently without access to public health services.

The most commonly cited reasons behind health care-related tension included; overcrowding of health care services, uneven access to health care between Jordanians and Syrians, a lack of valid paperwork to access services (for Syrians), distance from health centres, and high health care costs. These issues, which all allude to the absence of universal health coverage, could be contributing to tension between Jordanians and Syrians by exacerbating perceptions of inequality between the two groups, and escalating feelings of unfair exclusion from health care services, thereby fostering negative perceptions and deteriorating social cohesion. Overcrowding of health care services was the most commonly perceived reason for tension by Jordanian and Syrian respondents. This is likely attributable to the fact that overcrowding represents a very visible manifestation of competition for health services between Jordanians and Syrians, and may lead to hindrances such as long waiting lists and shortages in supply of staff and medicines which will affect both groups.

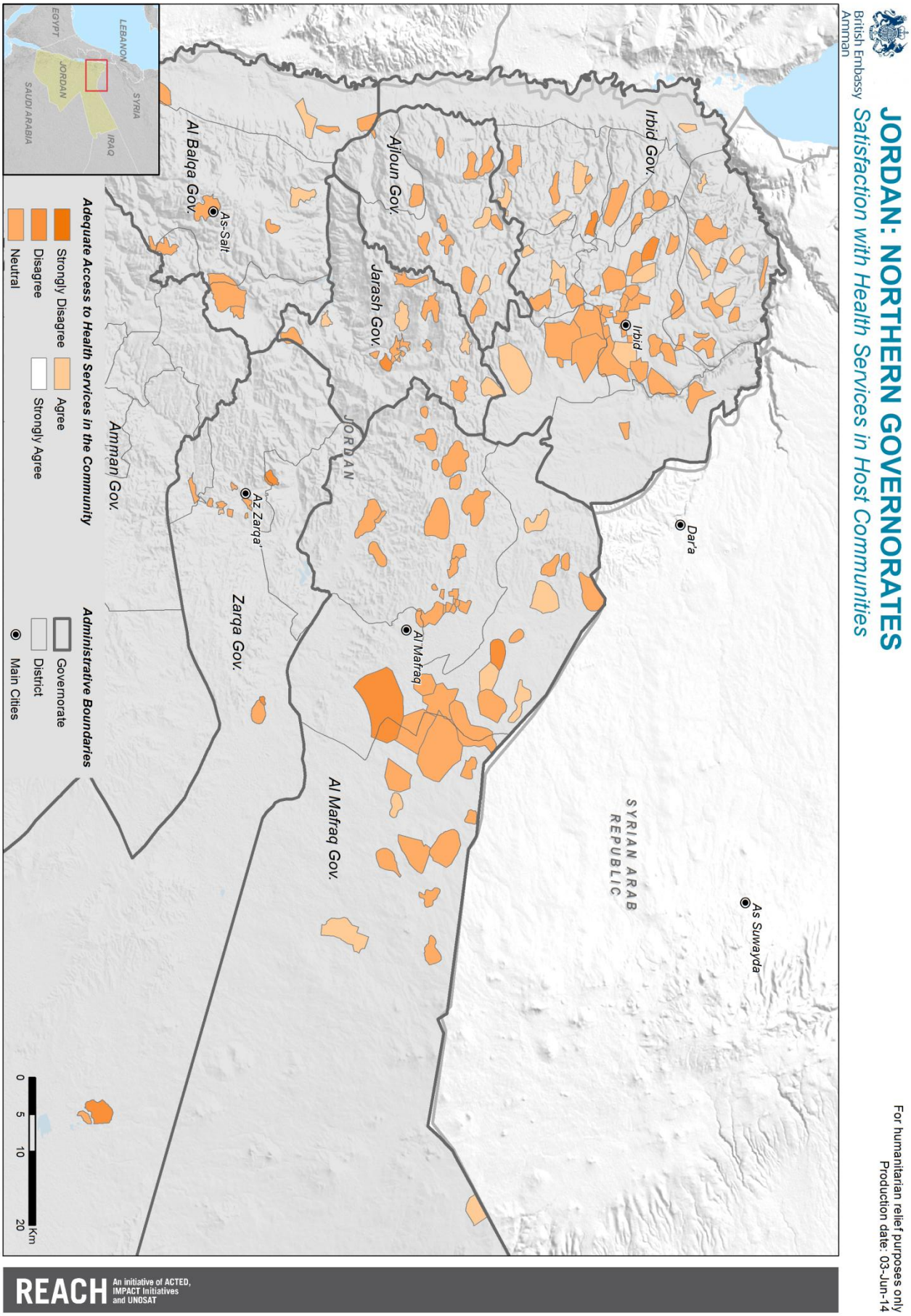
Considerably more Syrian than Jordanian respondents linked a lack of valid paperwork to health care related tension, most likely due unregistered refugees entering Jordan who are unable to obtain the correct documentation. Notably, anecdotal evidence gave a stronger impression than individual interviews that access to health care was inadequate, with a large proportion of FGD participants reporting that they were frequenting private clinics or travelling to other areas to reach medical centres due to a lack of adequate health care services in their community. One explanation for this discrepancy may be that FGDs can be dominated by one or two individuals with strong opinions. Alternatively, it may be that when asked to discuss access to health care in more depth, previously neglected challenges to access were given more attention by participants.

Qualitative and quantitative findings in this report provide evidence to support that negative perceptions of access to health care present a challenge to social cohesion and resilience in the Jordanian host communities assessed, and may spark resentment between Jordanian and Syrian groups. Strikingly, in 15% of all FDGs the spread of diseases was identified as safety threat. Thus, there may be a danger that a narrative of fear stemming from the spread of communicable diseases among host community populations may lead Jordanians and Syrians to reduce their level of interaction with one another. This issue also arose in FGD content on the topic of education, whereby a selection of FGD participants from both groups expressed that Syrian and Jordanian students should be segregated in schools to mitigate the spread of disease.

ANNEX I: MAP OF COMMUNITIES ASSESSED AND ASSESSMENT TIMEFRAME



ANNEX II: MAP OF SATISFACTION WITH HEALTH CARE SERVICES IN HOST COMMUNITIES



ANNEX III: MAP OF ACCESS TO HEALTH CARE AS A CHALLENGE TO SOCIAL COHESION