

# HEALTH ACCESS AND UTILIZATION SURVEY

ACCESS TO HEALTH SERVICES IN JORDAN AMONG  
REFUGEES FROM OTHER NATIONALITIES

Follow up Survey

December 2017

FOR:

United Nations High Commissioner for Refugees



BY:

nielsen  
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# DOCUMENT CONTENTS



BACKGROUND, OBJECTIVES & DESIGN



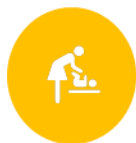
FAMILY COMPOSITION



HEALTH SERVICES AWARENESS



CHILD VACCINATION



ANTENATAL CARE



CHRONIC DISEASE



DISABILITY & IMPAIRMENT



MONTHLY HEALTH ACCESS ASSESMENT

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# Executive summary

Monitoring the health access and utilization behaviors among non-camps refugees has been regular practice since 2014. With increase burden on health system, economic crisis and policy changes; Non Syrian/ Non Iraqi refugee's (Yemini, Sudanese, Somalis etc.) ability to access health services impacted. Currently all Non Syrian/ Non Iraqi refugees in Jordan live in major urban centers<sup>1</sup>, where more than 84% living in Amman. UNHCR recognize that the availability of reliable data is essential to understand health services needs among urban refugees.

In an effort to develop a cost-effective and efficient mechanism for regularly monitoring the health access and utilization of non-camp refugees hence the health access and utilization survey was conducted on behalf of the UNHCR to assess each of the following attributes:

## Sample structure

- ❖ Other nationalities refugees living in non-camp settings are predominantly concentrated in Amman (84%).
- ❖ Among the 314 interviewed households, 1117 members were reported living within these households given an average of 4 members per household.
- ❖ An average of 1 child were reported living among the 314 interviewed households

## Health services access & awareness

- ❖ Awareness among other nationalities scored 66 on the fact that they have free access to UNHCR facilities; decreasing 3% compared to last year.
- ❖ People are becoming less aware about the location of the nearest clinic as a drop by 7% compared to last year is seen.

## Childhood vaccination

- ❖ Awareness about free access to vaccination is 71% as compared to 74% last year and 81% of other nationalities refugees have a vaccination card.
- ❖ The percentage of households who reported that their children received MMR and Polio vaccinations remains almost stable at 83% and 87% respectively among households who had children less than 5 years old compared to last year.

## Antenatal care

- ❖ Out of those females who needed antenatal care 88% received the care needed, while 31% had difficulties while receiving the care which shows a significant as compared to last year.

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<sup>1</sup> UNHCR statistical report, December 2017.

- ❖ Governmental hospitals increases significantly as a place for delivery and remains to be the most common place.
- ❖ For the delivery cost, delivering free of cost increased compared to 2016 results (69% vs. 64%)

### **Chronic diseases**

- ❖ From all household members who had a chronic condition, Hypertension becomes the top reported disease when compared to 2016, seeing a large increase (12%), followed by Diabetes
- ❖ From those who needed medicine for their chronic condition, 52% of them were unable to access medicine mainly due to the cost of medicine (59%), showing an increase of inability to access medicine when compared to 2016 (45%).
- ❖ From those who needed to access medical services for their chronic condition, 41% of them were unable to access health services with inability to afford the fees (67%) seeing a significant rise as a reason when compared to 2016 (57%).

### **Disability & impairment**

- ❖ Physical impairment scores the highest among types of disability/impairment (54%) followed by sensory (23%) and mental (15%) impairments.
- ❖ In 2017 most of the cases received their first treatment outside of country of origin. The treatment is mainly started in other countries than their country of origin (70%) nonetheless 30% of them received the first treatment in Jordan.
- ❖ Inability to afford user fees was the main barrier to proper care reported by 32% of households who had a disabled member. Being unable to afford the fees comes as the top mentioned barrier to proper care.

### **Monthly health access assessment**

- ❖ Health care services were needed by 32% of household members in the last month, with nearly three quarters of the individuals in need (72%) actively seeking health services – showing a significant increase when compared to 2016 (30%).
- ❖ From those who sought the services it is clear that – consistent with 2016's findings - the majority initially reached JHAS clinic (31%) followed by private clinic/hospital (23%) and private pharmacy (19%).
- ❖ The mean of the combined income of interviewed households dropped to 263.43 JDs from 273.4 JDs where they spend an average of 80.26 JDs - more than 30 JDs less than 2016 (116.9 JDs) on health care which is 30% of their total income



# 1. INTRODUCTION

## 1.1 Background & Objective

The increase in the number of refugees from the Syrian Arab Republic (Syria) across the region in 2017 continued and the need remains for a large-scale response to address the needs of refugees already present in the host community. As of end of 2017, 655,624 Syrian refugees were registered with UNHCR, including refugees hosted in Za'atari, Azraq camps, Emirati Jordanian (EJC) camp and King Abdullah Park.

Additionally, the continuous violence and insecurity in Iraq, after the 2003 military intervention, led to the displacement of Iraqis to the neighboring countries. The Jordanian government estimates that there are some 450,000 to 500,000 Iraqis hosted in Jordan. At the end of December 2017 65,922 Iraqis are registered with UNHCR in Jordan. Due to the escalating violence in Iraq, it is expected to see an increase the number of Iraqis seeking asylum.

Apart from the Iraqi refugees, UNHCR also assists refugees of other nationalities including Sudanese, Somalis, Yemenis and others and had registered 15,897 non-Iraqi non-Syrian refugees by the end of December 2017.

## 1.2 Overview of Health Services Available to UNHCR PoCs in Jordan

In 2017 UNHCR continue supporting the provision of health service to all registered non-Syrian/non-Iraqi refugees through implementing partners and affiliated hospitals network. While UNHCR maintain essential health services for refugees it will continue encouraging them increasingly utilize the governmental health services.

## 1.3 Research context

All refugees from other nationalities including Yemeni, Sudanese, Somalis and others have to pay the foreigners rate when accessing any level of health care at Ministry of Health facilities. This rate considered very high and not affordable for most of the refugees.

## 1.4 Research design & methodology

### 1.4.1 Methodology

Quantitative Interviews were carried out among target respondents through telephonic Interviews. Representativeness was ensured throughout the interviewing process beginning with the starting points which were chosen randomly from the provided database by UNHCR, in case more than one respondent was eligible for answering any part of the questionnaire, the classification grid/random function concept was applied to select who will continue answering the interview.

### 1.4.2 Target respondents

- Other nationalities refugees who live in non-camp settings.
- The study will be carried out with one adult household member (18 years or more)

### 1.4.3 Data analysis

Data was collected using CATI (Computer Aided Telephonic Interviews) through QPSMR 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 editing, punching and cleaning. Data analysis and significance testing (t-test with 2 tails) was conducted through Quantum IBM software, a highly sophisticated and very flexible computer language designed to simplify the process of obtaining useful information from a set of questionnaires. Quantum is also used for checking, validating, editing and correcting data.

#### 1.4.4 Survey tools and guidelines

Draft questionnaires were developed for respective categories of respondents in consultation with partners. Previous questionnaires were reviewed to develop the draft questionnaires. These were sent to partners for comment. After finalization, the questionnaire (available in both English/Arabic); the questionnaires were pretested by a team of expert researchers and finalized in consultation with partners.

Pretesting plan and finalization of questionnaires:

Process testing

During pre-testing, process testing of cluster identification/mapping, sampling frame preparation, household identification, sampling technique, CATI process, and so on was also piloted for better understanding of the sampling procedure.

#### 1.4.5 Training

Formal training of survey teams was arranged for proper understanding of all the survey tools and survey procedures. All investigators and supervisors were trained and provided with a detailed field instruction manual.

The training included both classroom session as well as field practice; it consisted of sessions on interviewing techniques and rapport building with respondents; how to identify selected households; 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.

#### 1.4.6 Fieldwork

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

- Study Manager: oversaw and documented all required quality checks. Furthermore the study 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 interviewers.
- Interviewers with the assistance of their supervisor's ensured consistency of the data collected and corrected any skip patterns.

#### 1.4.7 Quality Assurance

Quality assurance was assiduously sought, and as a guiding principle 'Quality Control at all levels' is the basic policy of the survey company (Nielsen). Especially at the stage of research designing, data collection and analysis, the uppermost quality at all levels was maintained. The ESOMAR (Europe) code of conduct is used as a basic guideline in all the aspects of marketing and social research. Only

employing interviewers with adequate experience is one of the norms of the operational policy. Adequate records were kept in a computerized database about each individual to track him or her for maintaining field management standards. Moreover, checking procedure was even more rigid.

#### **Team selection and mobilization:**

As for the selection and recruitment of supervisors and interviewers; it was carefully done by the field manager. The recruitment was made from the existing panel of field supervisors and interviewers, where all supervisors must have a minimum qualifications of graduation and fluent in both English and Arabic. Interviewers had previous experience on similar projects where final selection was based on interviewer's performance during the pre-training sessions.

#### **Execution phase:**

Pretesting: The questionnaire was pre-tested before conducting the pilot interviews and fieldwork for flow of questions, clarity and translation errors if any. The pre-testing was conducted in an area similar in demographics to the original area of the survey. One team of 4 interviewers accompanied with one supervisor conducted the pre-test.

#### **Pilot phase:**

Following the training, all trained interviewers participated in the pilot. They were organized in teams and accompanied with 1 supervisor

#### **Quality control:**

The diagram below illustrates the total quality management (TQM) control process that was in place for this survey.



Quality control measures were taken during each step of the project. The pre-field control was explained in pre-testing section, during field and post field are explained in the next section.

#### **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 a warning message 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 Error Check Report to identify any further errors that might be missed during the punching stage.

## 1.5 Research limitations

The study aims to evaluate the access of Syrian and non-Syrian refugees to health services & utilization in Jordan; although the study achieved its goals it had various limitations in which were inevitable.

First of all the study was absolutely dependent on the respondent to disclose the requested information on every household individual which in this case is combined with the second limitation of this study that is the respondents ability to recall the requested information.

Inadequacy to recall the information on the household members leaves a possibility to favoritism and preference to bias the information disclosed by the respondent regardless of all assorted preventative measures applied.

In addition, the interviews were conducted exclusively with refugees registered in UNHCR data base thus the inability of the findings to consolidate all of the refugees inhabited within the Jordanian borders.

## 2. SAMPLE STRUCTURE

### 2.1 Other nationalities 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 81% of the respondents

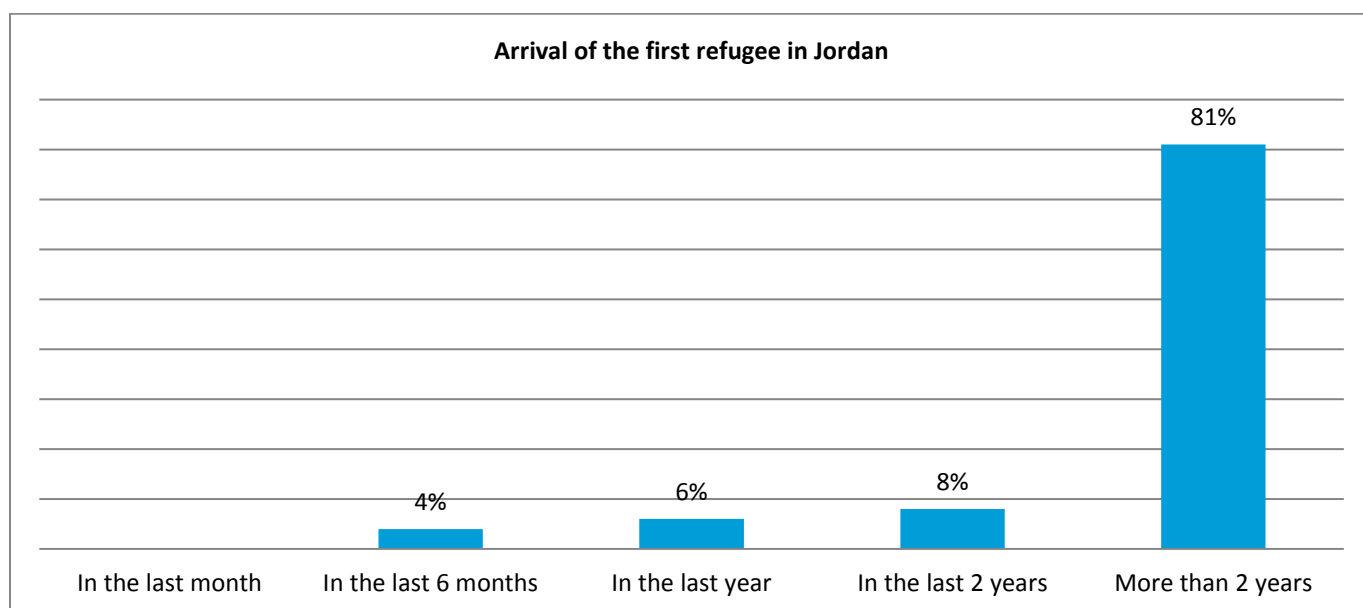


Figure 1: Arrival of the first refugee – All respondents (n=314)

**Residing governorate** – Presently other nationalities refugees host communities are highly concentrated in Amman (84%)

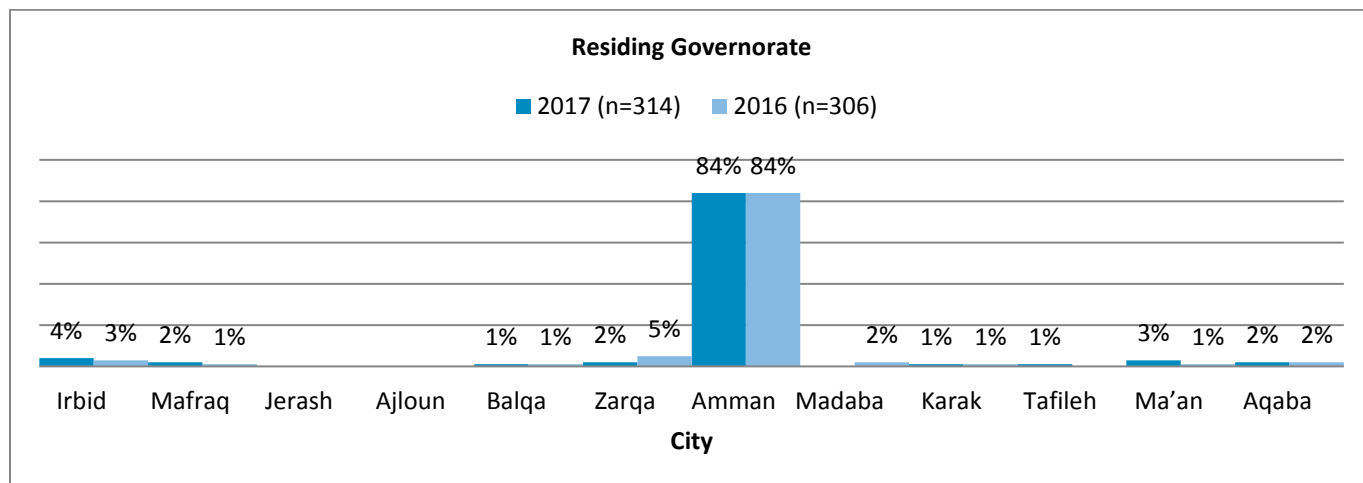


Figure 2: Residing governorate – All respondents

**Place of birth for other nationalities** – Yemen is the highest reported place of birth for interviewed respondents from other nationalities

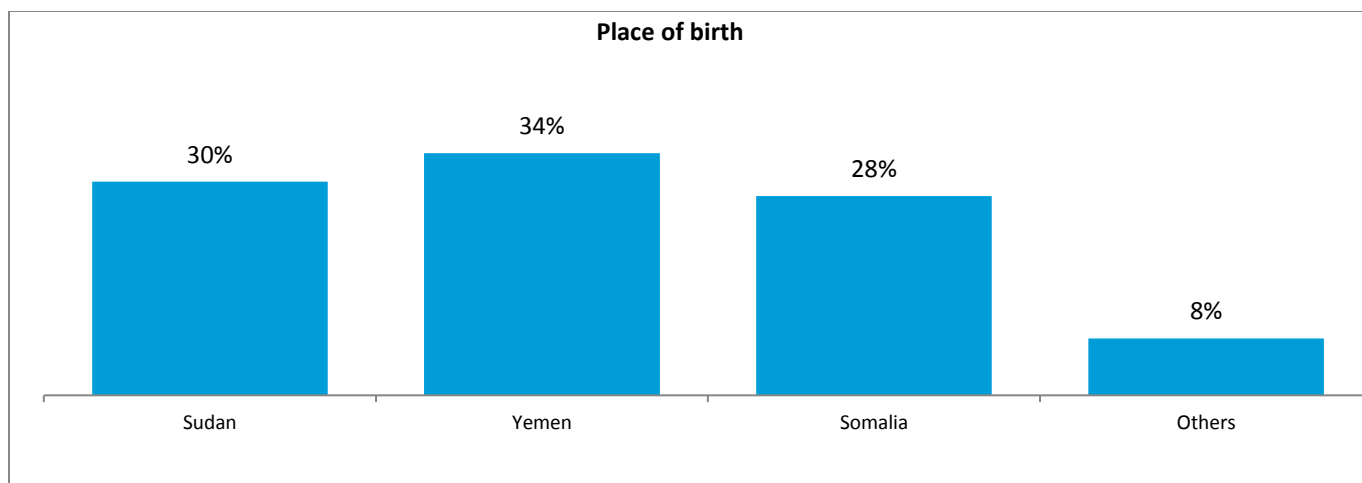


Figure 3: Place of birth – All respondents (n=314)

## 2.2 Household head profile

**Household head profile:** Only 78% of the respondents interviewed were the head of households. For those who were not interviewed themselves, 75% of them were males as compared to 25% females. The majority fell into the age group of 18-55 years old by 86% and 29% reported that they have Secondary schooling however only 12% of them were illiterate. 90% of the head of households speak Arabic and 41% speak Somali.

Household head profile	2017 (n=314)
% of Household head	78%
Gender	
Male	75
Female	25
Age	
Less than 18 years	0
18-35 years	43
36-55 years	43
More than 55 years	15
Education	
Knows how to read and write	10
Primary School	19
Intermediate/complementary school	12
Secondary school	29
2 years Diploma	4
University	13
None	12
Language spoken	
Arabic	90
English	18
Somali	41
Other	3

All Figures are in % except n



## 2.3 Household Profile

### Disability & Impairment

For all household members who are 1117 members, 6% of them has been recorded as disabled and needed the assistance of others to perform daily activities.

### Gender

The percentage of males among other nationalities respondents are more dominant than females scoring 58% of household members

### Pregnant females who needed antenatal care

Among females who are at reproductive age, 33% were pregnant in Jordan during the last 2 years and needed antenatal/maternal care

### Mean of household members

1117 household members has been reported to be living under the same roof and eating from the same pot in 314 households, where the mean number of the members has been reported to be 4 members per household

### Age groups

From all household members, 81% of them were youth less than the age of 35 where 27% of them were less than the age of 18.

### Chronic condition

12% of the household members reported that they have at least one member suffering from a chronic disease



DISABILITY & IMPAIRMENT

6%

Figure 4: Disability & impairment - All household members (n=1117)



58% 42%

Figure 5: Household gender - All household members (n=1117)



PREGNANT FEMALES

33%

Figure 6: Pregnant females in Jordan during the last 2 years - Females at reproductive age (n=183)



AVERAGE # OF HOUSEHOLD MEMBERS

4

Figure 7: Average # of household members - All household members (n=1117)

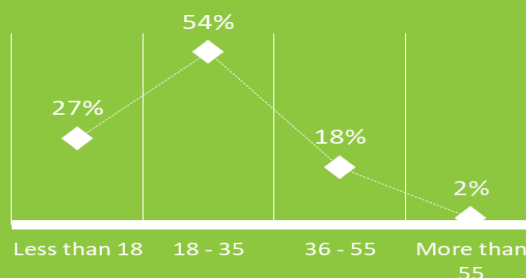


Figure 8: Age of household members - All household members (n=1117)



12%

Figure 9: Household chronic conditions - All household members (n=1117)

**Marital status**

Most of the household members were single (58%)

**Mean number of children <5 years**

Each interviewed household had a mean score of 1 child that is in the age of 12 to 59 months

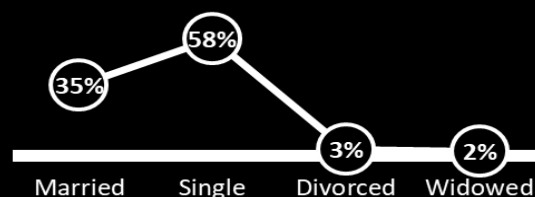


Figure 10: Marital status - All household members (n=1117)

AVERAGE # OF  
CHILDREN  
ELIGIBLE FOR  
VACCINATION

1



Figure 11: Children <5 years - All household members (n=1117)

## 2.4 Sample structure summary

**Sample structure summary** – From 314 interviewed households; an average of 4 members lived in the same household (1,117 member). 42% of the household members were females, and most of them were youth less than 35 years (81%).

	2017 (n=314)	2016 (n=306)
# of household members	1,117	1,074
Average # of household members	4	4
% of female household members	42%	38%
% of household members less than 18 years	27%	23%

### 3. HEALTH SERVICES AWARENESS

#### Awareness of health services provided by Ministry of health and UNHCR

Awareness among other nationalities scored 66 on the fact that they have free access to UNHCR facilities; decreasing 3% compared to last year. Out of those who are aware of the free access to UNHCR facilities only 51% knew the location of the nearest clinic; people are becoming less aware about the location of the nearest clinic as a drop by 7% compared to last year is seen.

#### Nearest reported clinic

Among those aware of the nearest clinic, Amman continues to be the highest (91%)

#### Knowledge of available health services

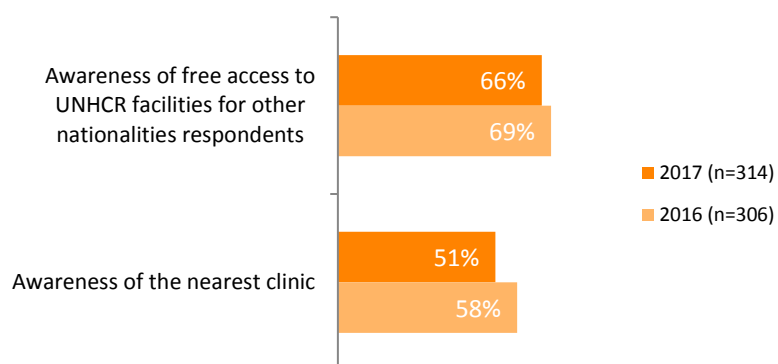


Figure 12: Knowledge of available health services - All respondents

#### Top 3 locations of the nearest clinic mentioned

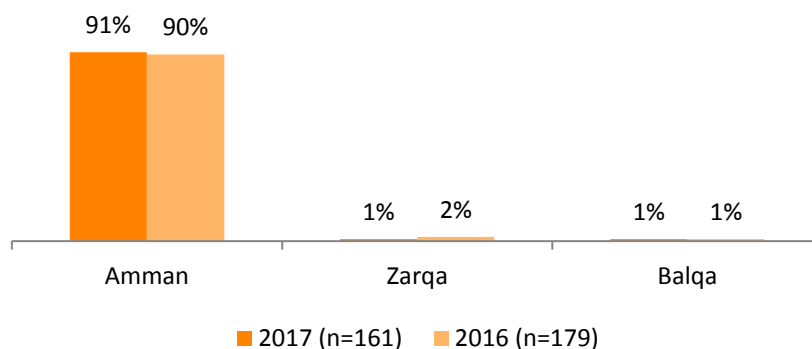


Figure 13: Awareness of the nearest clinic - Those who know the location of the nearest clinic

### 3.1 Health services awareness summary

**Health services awareness summary** – Awareness of free access to UNHCR facilities slightly decreased to 66% in 2017

	2016 (n=306)	2017 (n=314)
% of households who were aware of free access to UNHCR facilities	69%	66%
% of households who knew the location of the nearest clinic	58%	51%

## 4. CHILD VACCINATION

### Awareness and access to vaccination card

Awareness about free access to vaccination is 71% as compared to 74% last year and 81% of other nationalities refugees have a vaccination card.

### Access to MMR and Polio Vaccination

The percentage of households who reported that their children received MMR & Polio vaccinations remains almost stable at 83% and 87% respectively.

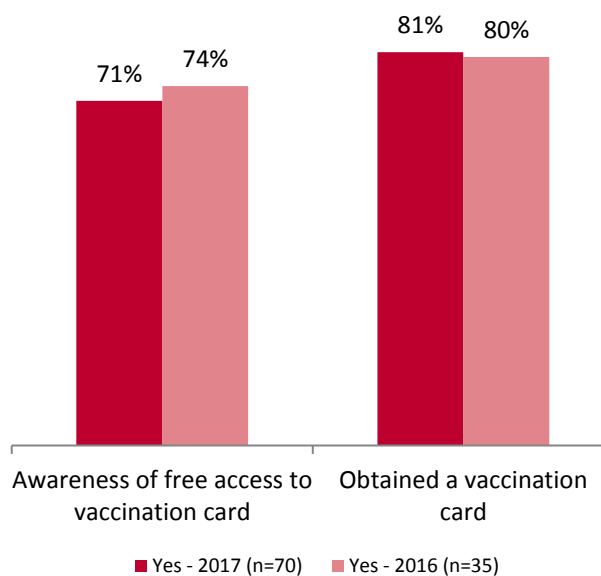


Figure 14: Awareness and possession of free access vaccination card - Households that have children <5 years

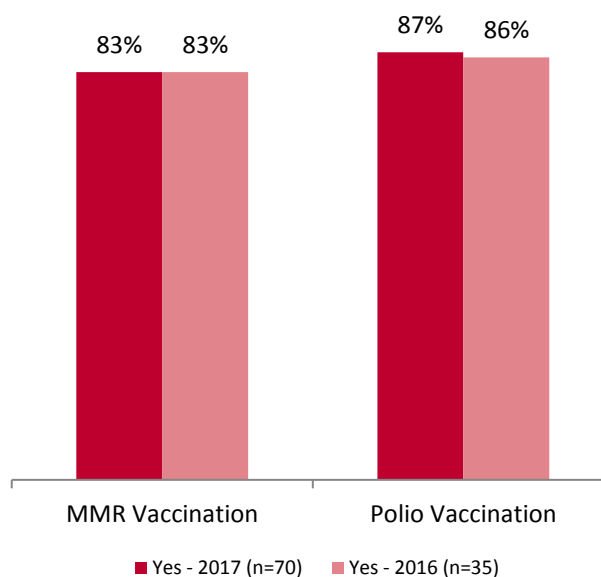


Figure 15: Access to vaccination - Households that have children <5 years

(+) Revaluation by more than 4%

(-) Devaluation by more than 4%

### Difficulties to obtain vaccination

Only 3% of the interviewed households had a difficulty to obtain MMR vaccination while for Polio vaccination 5% of households interviewed mentioned that it is difficult to get Polio vaccination to their children.

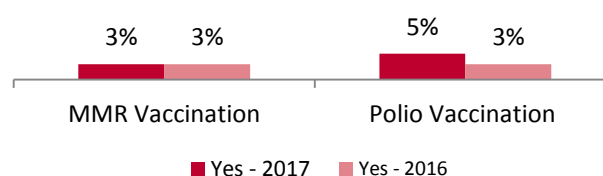


Figure 16: Difficulties to obtain vaccination - Those who obtained vaccination

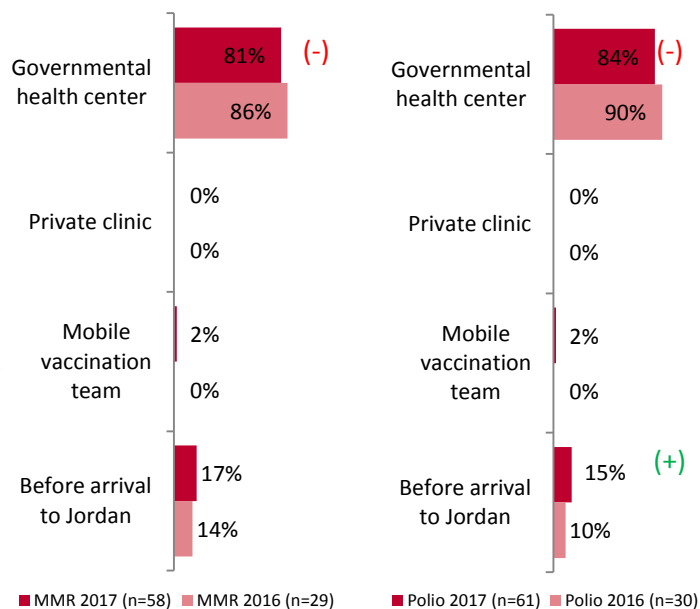


Figure 17: Vaccination facility - Those who obtained vaccination

### Vaccination Facility

Governmental health center is the most facility visited for children's MMR & Polio vaccination although receiving vaccination before arrival to Jordan and through mobile vaccination team are increasing in percentages.

(+) Revaluation by more than 4%

(-) Devaluation by more than 4%

### Encountered difficulties

Among those who had children in the vaccination age group only 2 households had a difficulty to obtain the access for MMR as for the reason of long waiting time and transportation affordability and for Polio only 3 households had a difficulty to obtain the access for the reasons of long waiting time, transportation affordability and lack of information about where to go.

\*The base is insufficient for analysis

(\*) = Insufficient base for analysis

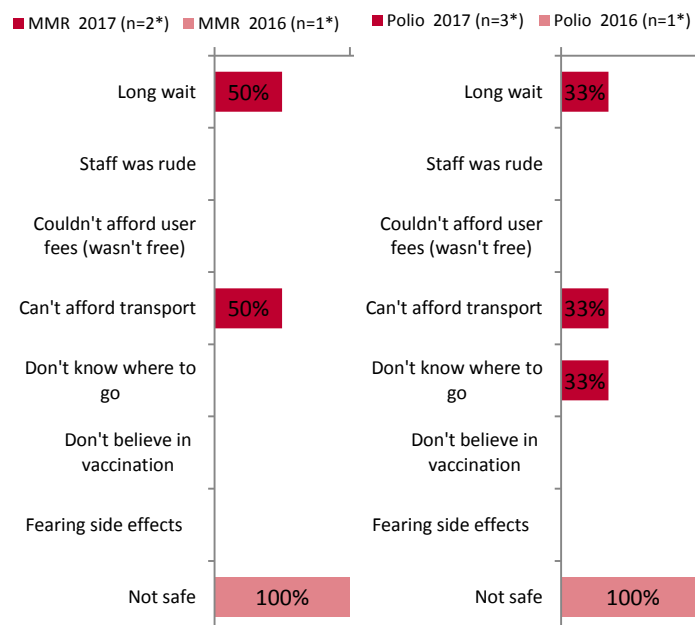


Figure 18: Difficulties while obtaining the vaccine - Those who encountered difficulties while obtaining the vaccine

#### 4.1 Child vaccination summary

**Child vaccination summary** – A decrease in the percentage of households that received MMR & Polio at Jordanian governmental health care center dropped compared to last year while percentage of those who receive vaccination before coming to Jordan increased.

	2017 (n=70)	2016 (n=35)
% that had an vaccination card	81%	80%
% that faced difficulties obtaining vaccine	4%	3%
% that received MMR vaccine at Jordanian government primary health care centre	81%	86%
% that received polio vaccine at Jordanian government primary health care centre	84%	90%
% that received MMR vaccine before coming to Jordan	17%	14%
% that received polio vaccine before coming to Jordan	15%	10%



## 5. Antenatal care

### 5.1 Access to antenatal care

#### Access to antenatal care

Out of those females who needed antenatal care 88% received the care needed, while 31% had difficulties while receiving the care which shows a significant increase as compared to last year.

(+) Revaluation by more than 4% (-) Devaluation by more than 4%

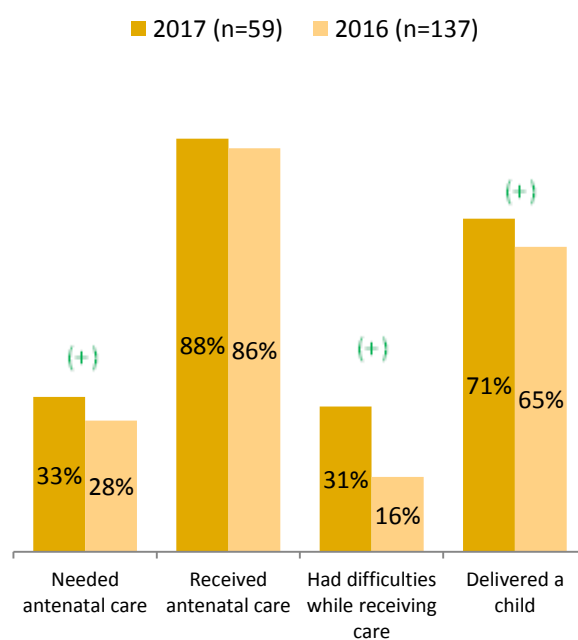


Figure 19 - Access to antenatal care - Pregnant females in Jordan during the last 2 years

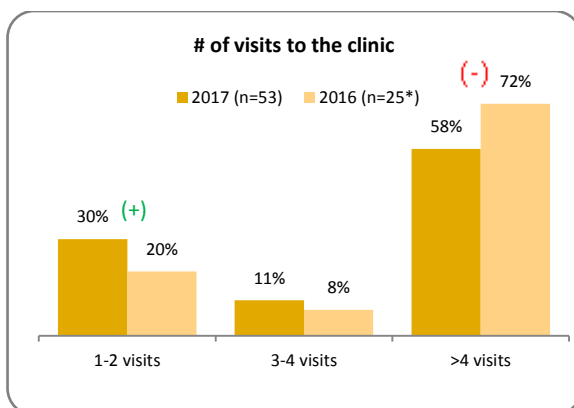


Figure 20: Number of visits to the clinic - Households that had females who received antenatal care

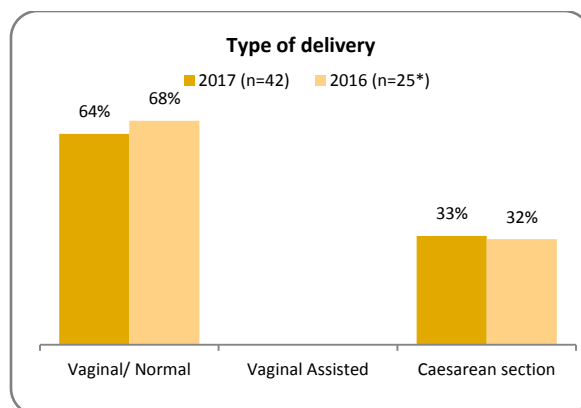


Figure 21: Type of delivery - Pregnant females in Jordan during the last 2 years

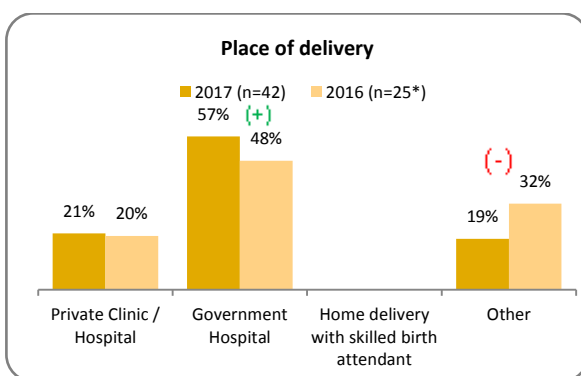


Figure 22: Place of delivery - Those who delivered a child

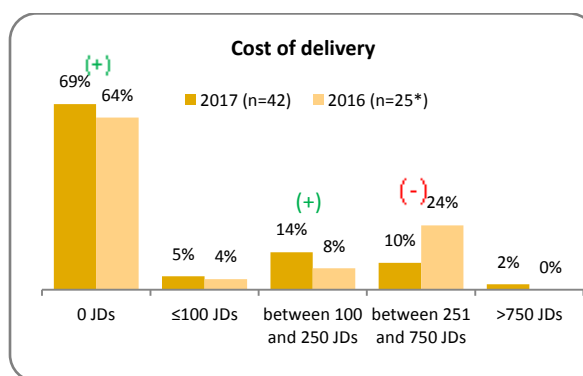
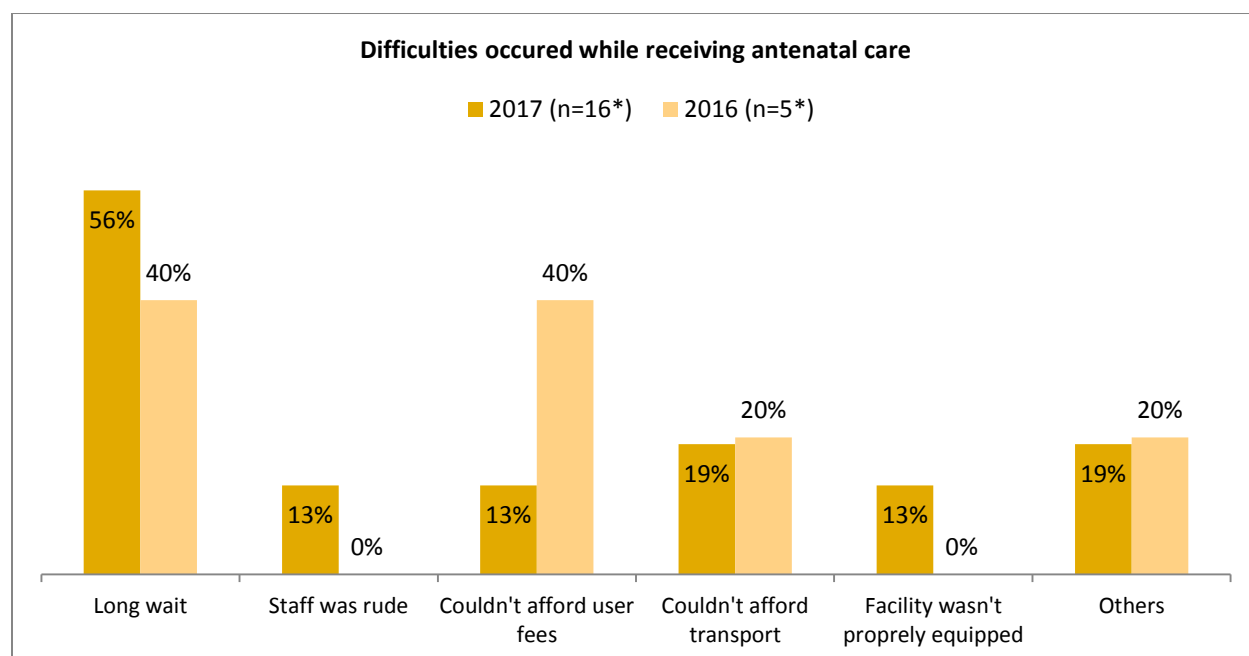


Figure 23: Cost of delivery - Those who delivered a child

Pregnant females had antenatal care coverage at 88% in 2017 given that 58% of them had full coverage. Normal vaginal delivery continues to be the most common delivery type (64%) followed by Caesarian section (33%). Governmental hospitals increases significantly as a place for delivery and remains to be the most common place. For the delivery cost, delivering free of cost increased compared to 2016 results (69% vs. 64%)

**Difficulties occurred while receiving care** – Long waiting time is the top reason among those who faced difficulties while receiving antenatal (56%). *Insufficient base for analysis (\*)*



**Figure 24: Difficulties occurred while receiving care - Those who encountered difficulties (n=5)\***

**Reasons for a private facility** – 33% of respondents access care in a private facility as birth costs covered by the commission and 22% access care in a private facility as they receive transfer from commissioner.

*Insufficient base for analysis (\*)*

Reasons accessing care in a private hospital/clinic	2017 (n=9*)	2016 (n=5)*
Not eligible to access Ministry of Health facility at subsidized rate	11%	60%
Eligible to access Ministry of Health facility at subsidized rate but could not access	0%	0%
The birth costs covered by the Commission	33%	0%
Transfer from commissioner	22%	0%
Prefer to go to a private facility	0%	40%
Others	33%	40%

## 5.2 Family planning

In all households who had a pregnant female eligible to antenatal care they were reporting that 33% of the households were aware of family planning and only 22% acquired knowledge on family planning mainly through health care center staff (44%) as the main source of knowledge. *Insufficient base for analysis (\*)*

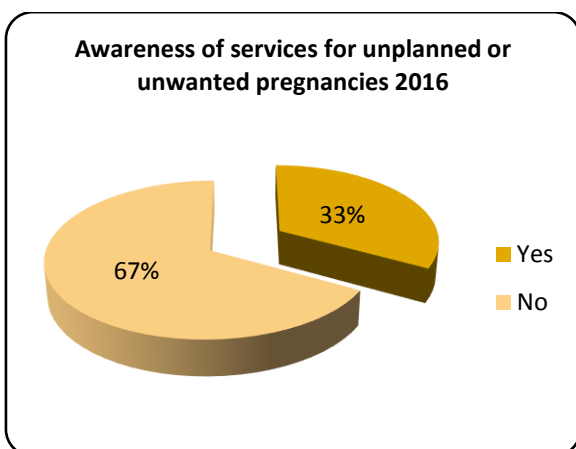


Figure 25: Awareness of services for unplanned pregnancies - Households that had pregnant females (n=24)\*

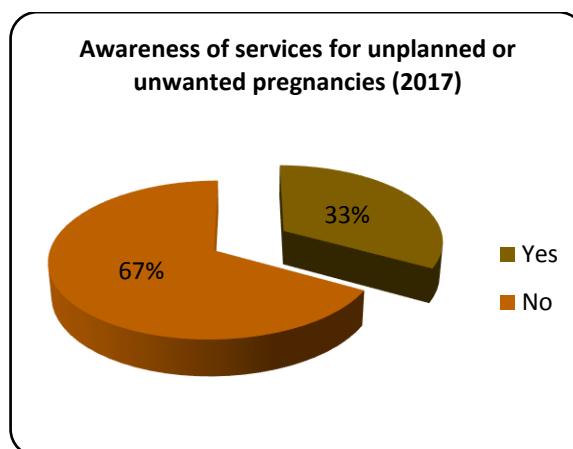


Figure 27: Awareness of services for unplanned pregnancies - Households that had pregnant females (n=18\*)

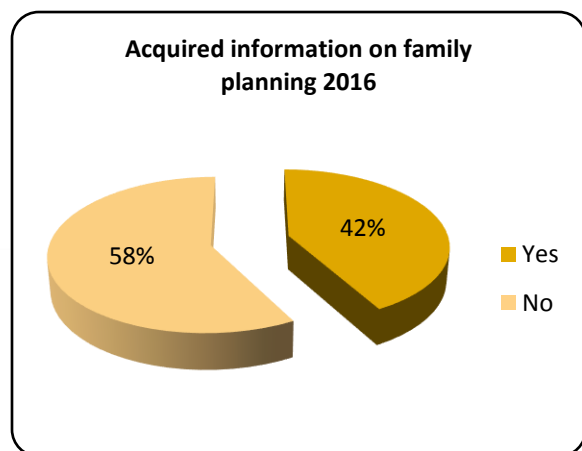


Figure 26: Acquired information on family planning - Households that had pregnant females (n=24)\*

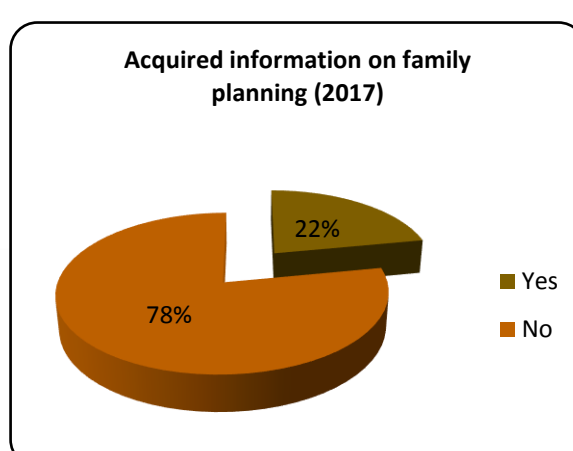
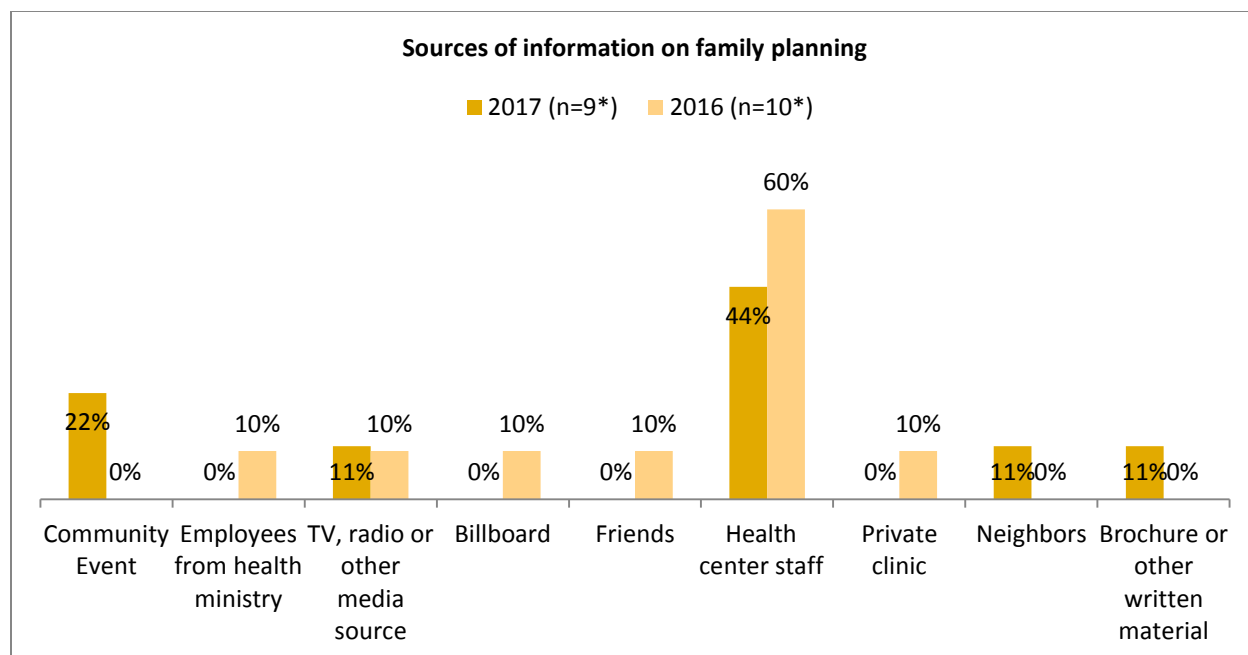


Figure 28: Acquired information on family planning - Households that had pregnant females (n=18\*)



**Figure 29: Sources of information on family planning - Households that had pregnant females (n=10)\***

### 5.3 Contraceptives

38% of households who had a female eligible to antenatal care had a household member who tried to obtain contraceptives where 38% sought of Ministry of Health medical center as a place for contraceptives followed by pharmacy (25%). *Insufficient base for analysis (\*)*

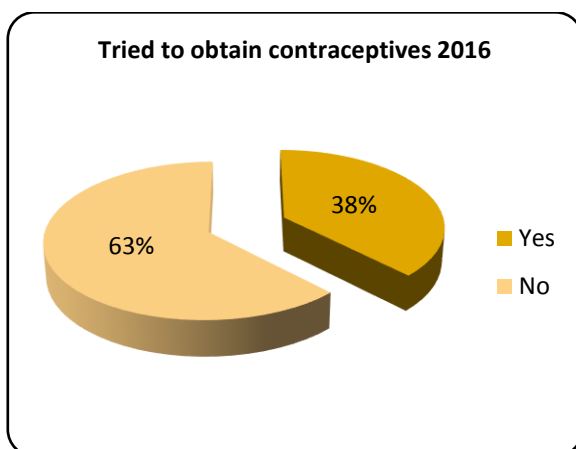


Figure 30: Trial to obtain contraceptives - Households that had pregnant females (n=24)\*

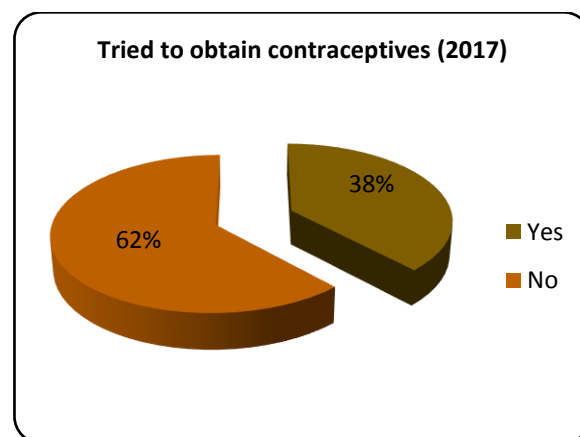


Figure 32: Trial to obtain contraceptives - Households that had pregnant females (n=42)

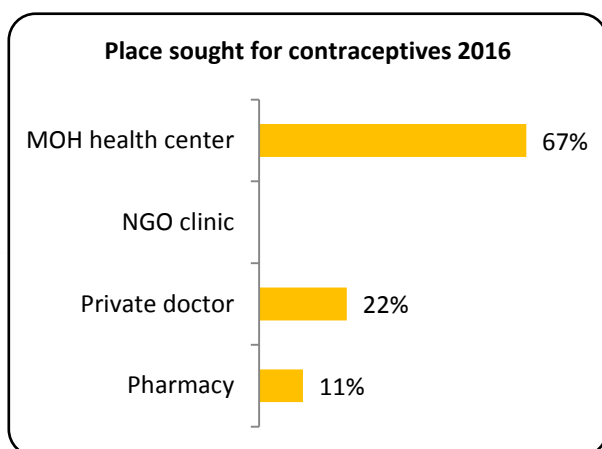


Figure 31: Place sought for contraceptives - Households that had pregnant females (n=9)\*



Figure 33: Place sought for contraceptives - Households that had pregnant females (n=16\*)

Insufficient base for analysis (\*)

## 5.4 Antenatal care summary

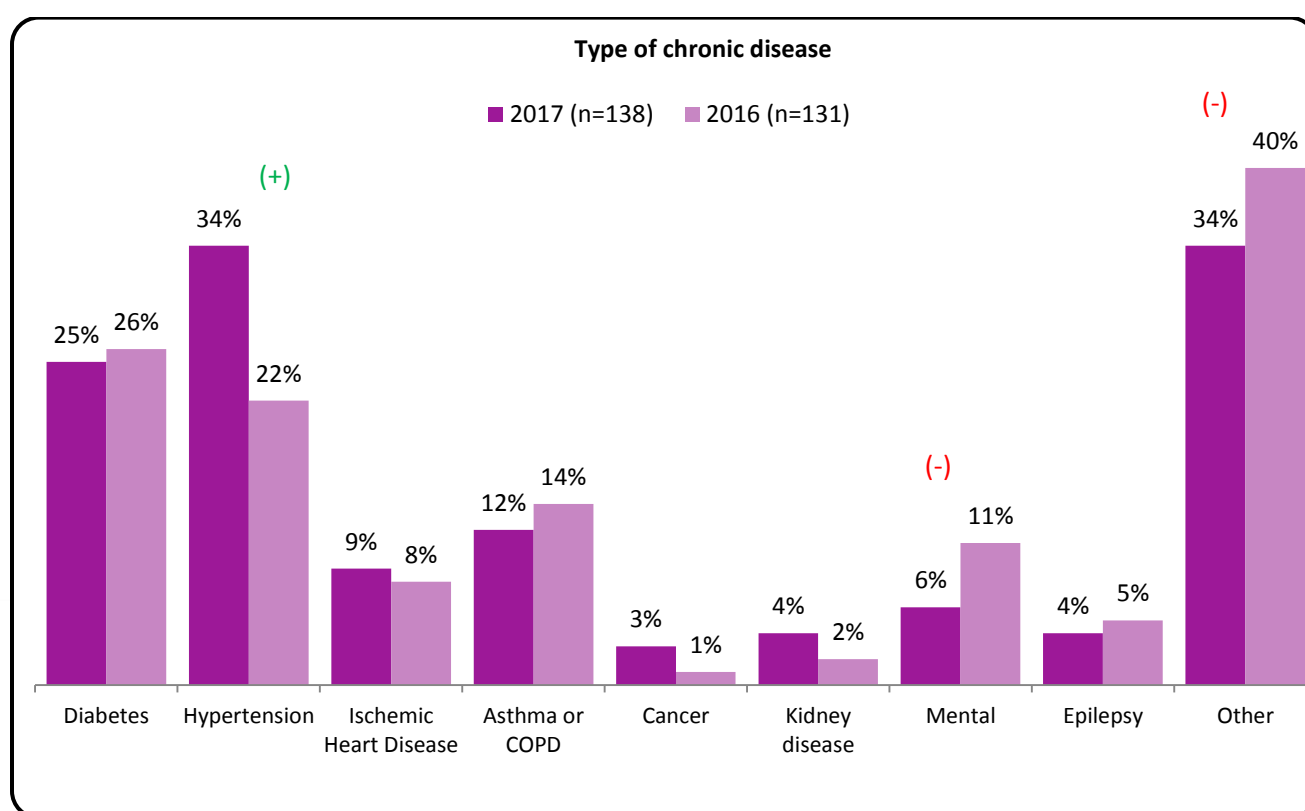
Deliveries in a governmental hospital continue to be the highest (88%) among all facilities. The percentage of women who faces difficulties increases as of the long waiting time. Governmental facilities is the top place for delivery and its gaining further increase as a place of delivery.

	2017 (n=59)	2016 (n=137)
% of pregnant women who had at least one ANC visit	88%	86%
% of pregnant women who had difficulty accessing ANC	31%	16%
% of those who couldn't afford fees or transport	32%	60%
% of those who encountered Long wait &/or rude staff	69%	40%
% of those who didn't know where to go	0%	0%
% of deliveries by caesarean section	33%	32%
% of deliveries in private facilities	21%	20%
% of deliveries in government facilities	57%	48%
% of deliveries free of cost	69%	64%

## 6. CHRONIC DISEASE

### 6.1 Type of disease

From all household members who had a chronic condition, Hypertension becomes the top reported disease when compared to 2016, seeing a large increase (12%), followed by Diabetes. A significant drop is seen among reports of mental conditions (5%).



**Figure 34: Type of chronic disease - Household members that have a chronic condition**

(+) Revaluation by more than 4%    (-) Devaluation by more than 4%



## 6.2 Access to medicine for chronic conditions

From those who needed medicine for their chronic condition, 52% of them were unable to access medicine mainly due to the cost of medicine (59%), showing an increase of inability to access medicine when compared to 2016 (45%).

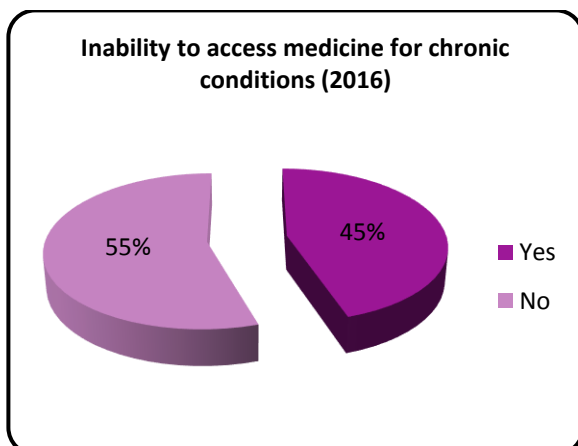


Figure 35: Inability to access medicine - households that have a member with chronic condition (n=92)

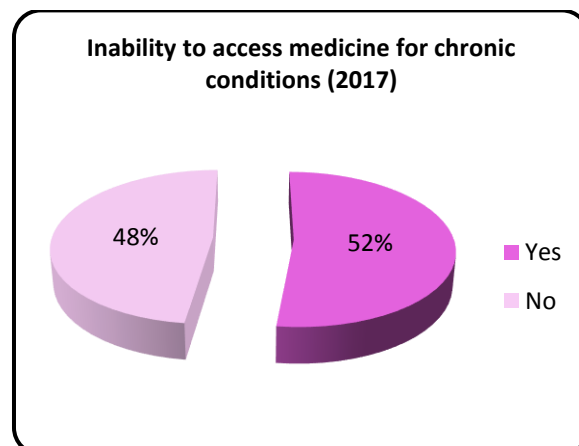


Figure 37: Inability to access medicine - households that have a member with chronic condition (n=102)

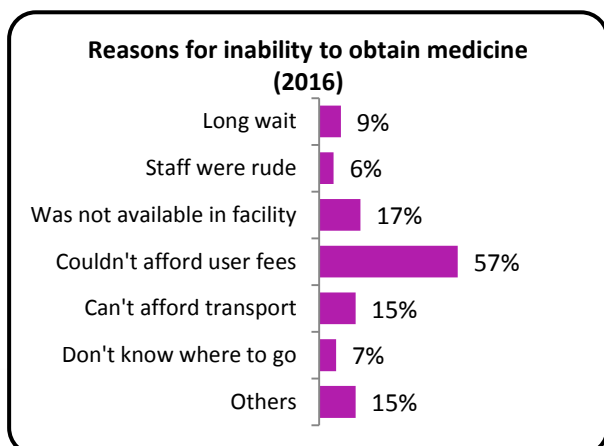


Figure 36: Reasons for inability to access medicine - Those who were unable to obtain medicine (n=54)

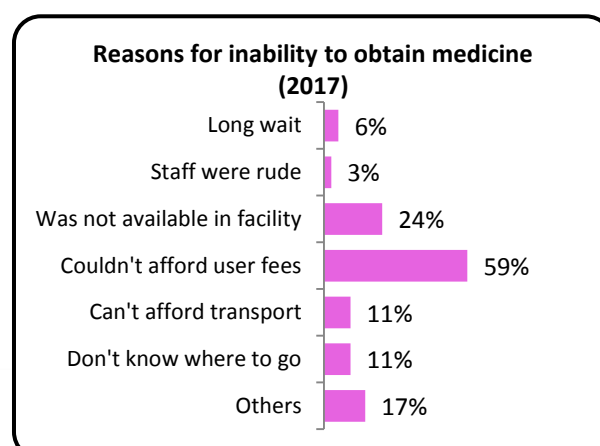


Figure 38: Reasons for inability to access medicine - Those who were unable to obtain medicine (n=63)

### 6.3 Access to medical services for chronic conditions

From those who needed to access medical services for their chronic condition, 41% of them were unable to access health services with inability to afford the fees (67%) seeing a significant rise as a reason when compared to 2016 (57%).

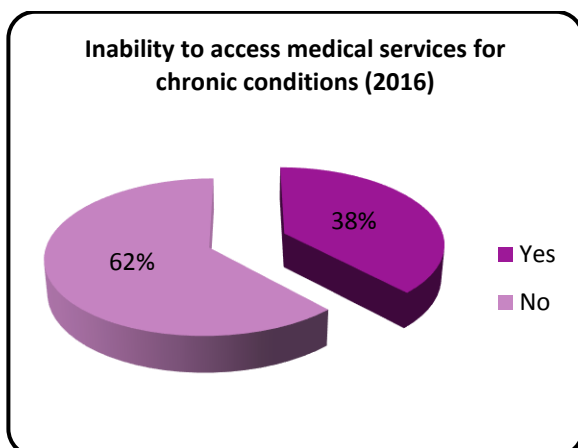


Figure 39: Inability to access health services - households that have a member with chronic condition (n=92)

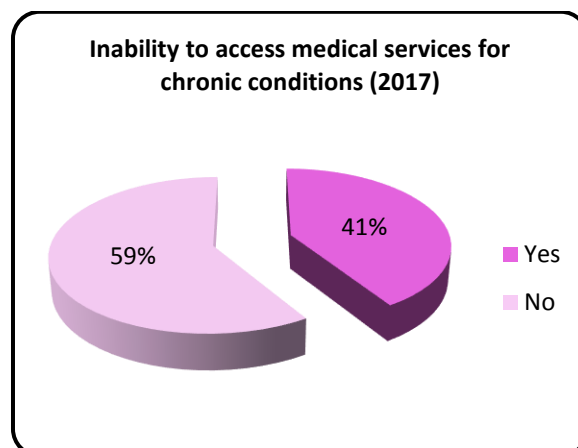


Figure 41: Inability to access health services - households members with chronic condition (n=102)

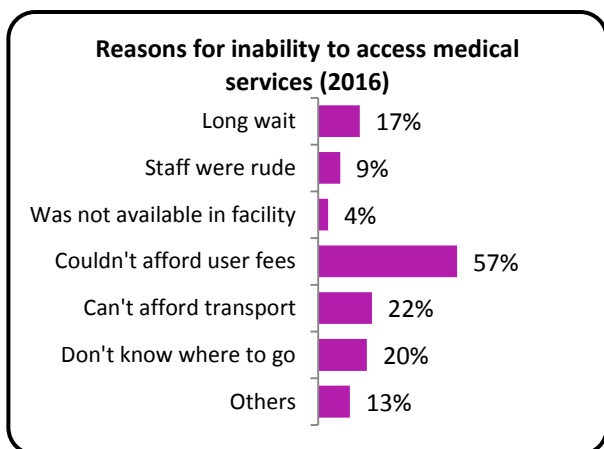


Figure 40: Reasons for inability to access health services - Those who were unable to access health services (n=46)

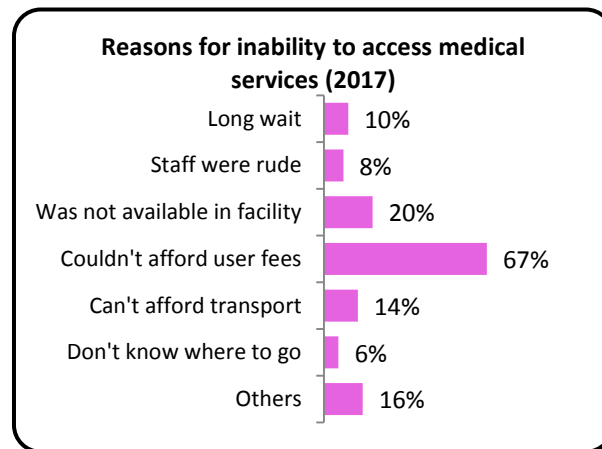


Figure 42: Reasons for inability to access health services - Those who were unable to access health services (n=51)

## 6.4 Chronic disease summary

The percentage of households reporting at least one adult with a chronic condition jumped to 44% since 2016 in which less than a third of households (30%) reported the same.

2017 also saw a rise- in adults being unable to access medicine or other health services when compared to the previous year. Affordability and unavailability of services saw significant rises as reasons for this lack of access (by 10% and 11% respectively). In 2017, respondents became more aware of where to access care showing a 5% drop when compared to the previous year.

	2017 (n=314)	2016 (n=306)
% of households with at least one adult with a chronic condition	44% (+)	30%
% of adults with chronic conditions who weren't able to access medicine or other health services	47% (+)	42%
% of those who couldn't afford fees	67% (+)	57%
% of service unavailable in local facility	22% (+)	11%
% of those who didn't know where to access care	9% (-)	14%

(+) Revaluation by more than 4%    (-) Devaluation by more than 4%

## 7. DISABILITY & IMPAIRMENT

### 7.1 Type of disability & impairment

Physical impairment scores the highest among types of disability/impairment (54%) followed by sensory (23%) and mental (15%) impairments.

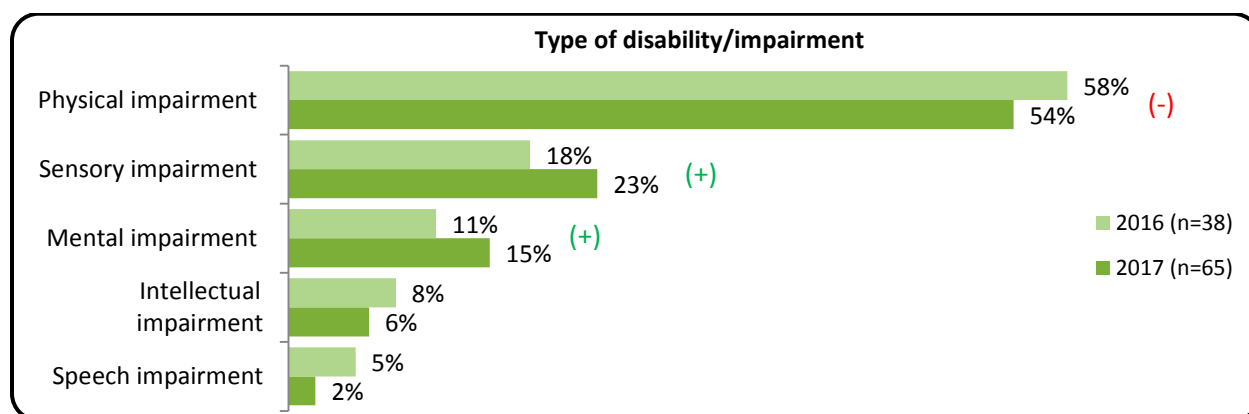


Figure 43: Type of disability/impairment - Household members who had a disability/impairment

In contrary with 2016 results, war related disabilities come second with 31% after natural impairment (42%)

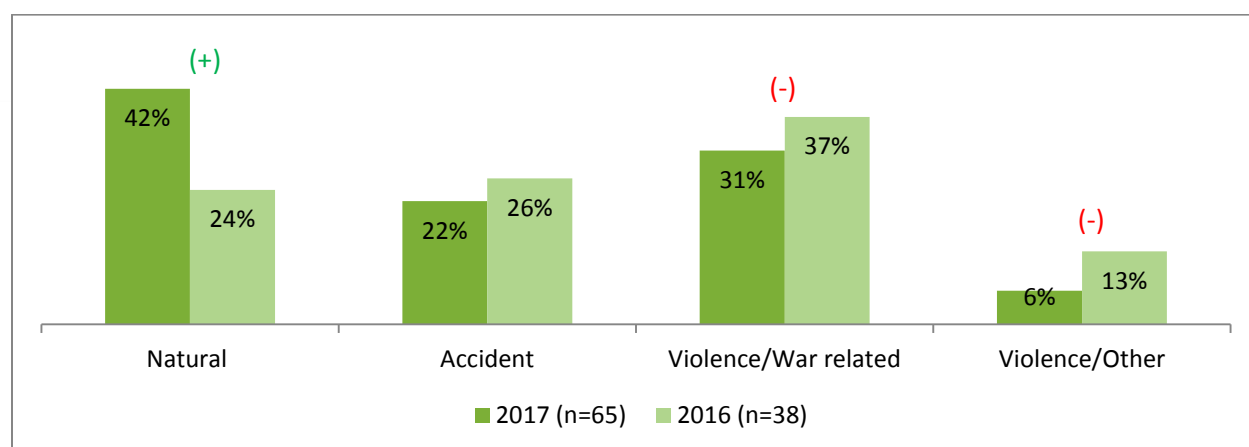


Figure 44: Cause of disability/impairment - Household members who are disabled/impaired

(+) Revaluation by more than 4% (-) Devaluation by more than 4%

## 7.2 Disability & impairment therapy

In 2017 most of the cases received their first treatment outside of country of origin. The treatment is mainly started in other countries than their country of origin (70%) nonetheless 30% of them received the first treatment in Jordan.

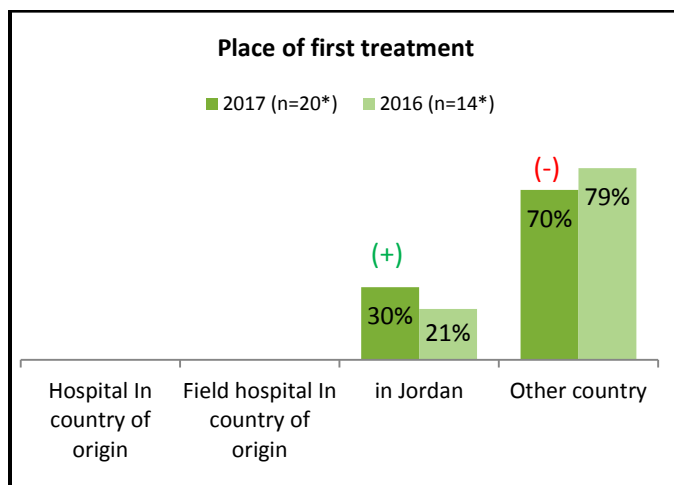


Figure 45: Place of first treatment - those who had a violence/war related disability/impairment

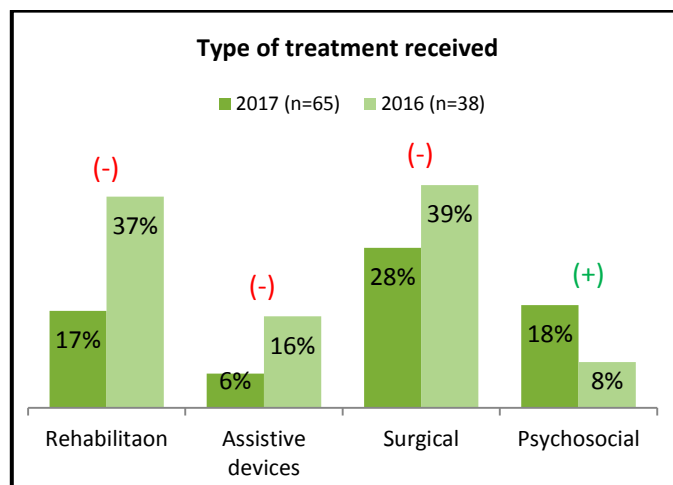


Figure 46: Type of treatment received - Household members who are disabled/impaird

(+) Revaluation by more than 4% (-) Devaluation by more than 4%

### 7.3 Barriers to proper care

Inability to afford user fees was the main barrier to proper care reported by 32% of households who had a disabled member. Being unable to afford the fees comes as the top mentioned barrier to proper care.

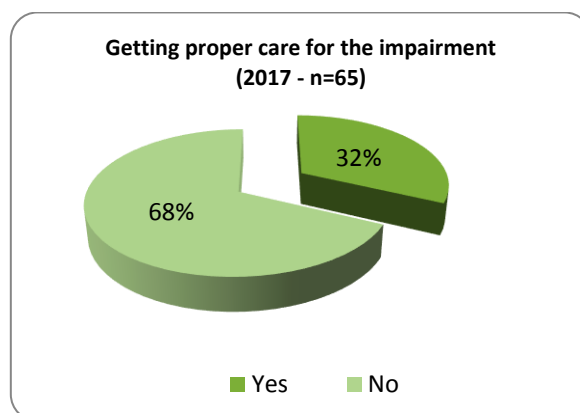


Figure 47: Getting proper care for the impairment (2017 -n=65)

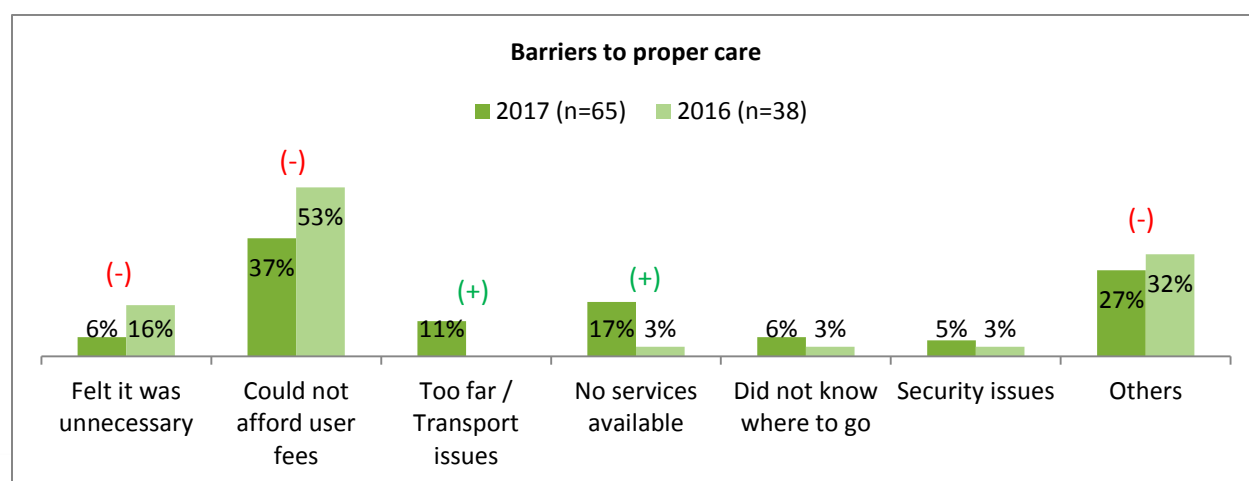


Figure 48: Barriers to proper care - Household members who are disabled / impaired

(+) Revaluation by more than 4% (-) Devaluation by more than 4%

## 7.4 Disability & impairment summary

Of all the disabled households members the inability to afford user fees was their main obstacle to have proper care for their disability.

	2017 (n=65)	2016 (n=38)
% who were reported to have a disability	6%	4%
% of impairments due to war related violence	31% (-)	37%
% of those who received care in Jordan	30% (+)	21%
% of those who received care in country of origin	0%	0%
% of those could not afford service fees and/or transport costs	37% (-)	53%
% of who did not know where to go	6%	3%

(+) Revaluation by more than 4%

(-) Devaluation by more than 4%

## 8. MONTHLY HEALTH ACCESS ASSESSMENT

### 8.1 First facility

Health care services were needed by 32% of household members in the last month, with nearly three quarters of the individuals in need (72%) actively seeking health services – showing a significant increase when compared to 2016 (30%).

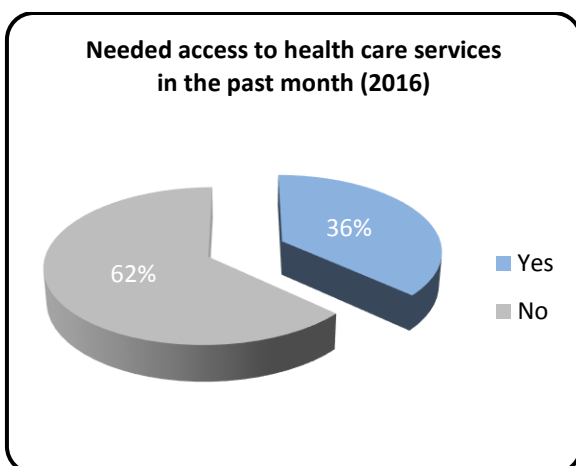


Figure 49: Need to access health care in the past month - All household members (n=1074)

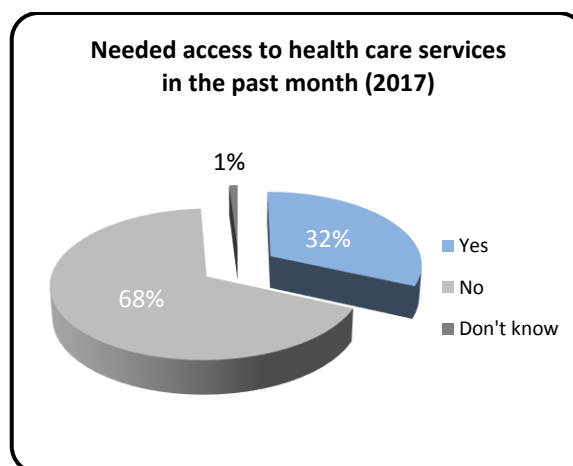


Figure 51: Need to access health care in the past month - All household members 2017 (n=1117)

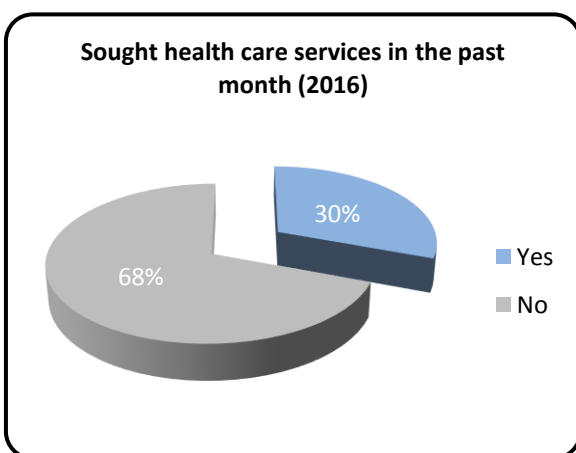


Figure 50: Sought health care services in the past month - All household members (n=1074)

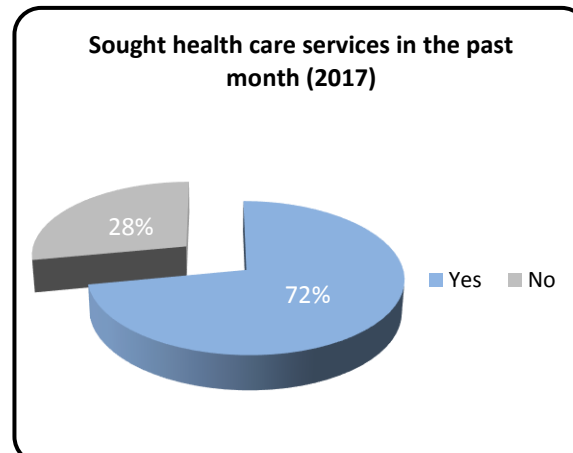
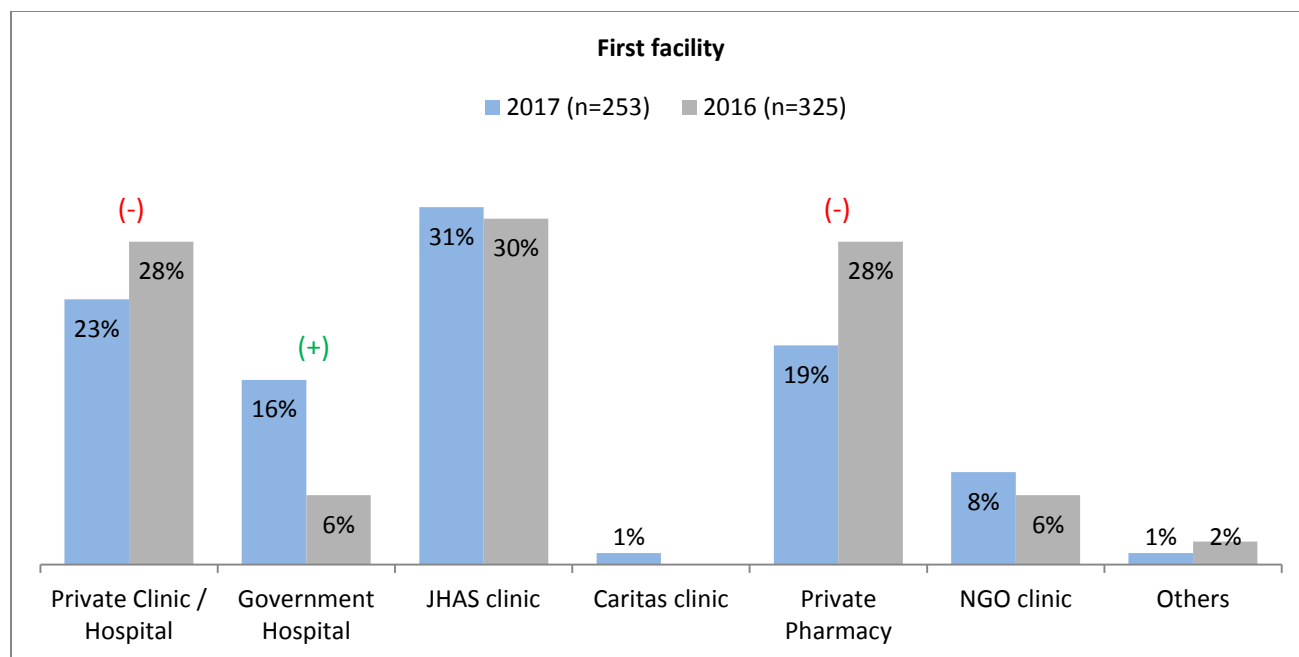


Figure 52: Sought health care services in the past month - All household members (n=1117)





**Figure 53: First facility - Those who sought health care services (n=325)**

(+) Revaluation by more than 4% (-) Devaluation by more than 4%

From those who sought the services it is clear that – consistent with 2016’s findings - the majority initially reached JHAS clinic (31%) followed by private clinic/hospital (23%) and private pharmacy (19%). We see a shift in preference away from the two latter facilities with a combined drop of 14% when compared to 2016. An average amount of 32.68 JDs was paid in the first facility for those who sought care in the first facility – more than 10 JDs less in comparison to 2016 (42.8 JDs).

## 8.2 Second facility

As a result of inability to be served in the first facility 25% of household members – 6% more than 2016 – decided to seek an alternative facility.

From those who sought the second facility the primary destination remained a private clinic/hospital (38%), with a 5% increase when compared to 2016. NGO clinics/hospitals saw a significant increase, jumping up (by 15%) to the second most sought-after secondary facility with more than a quarter (28%) of respondents choosing them.

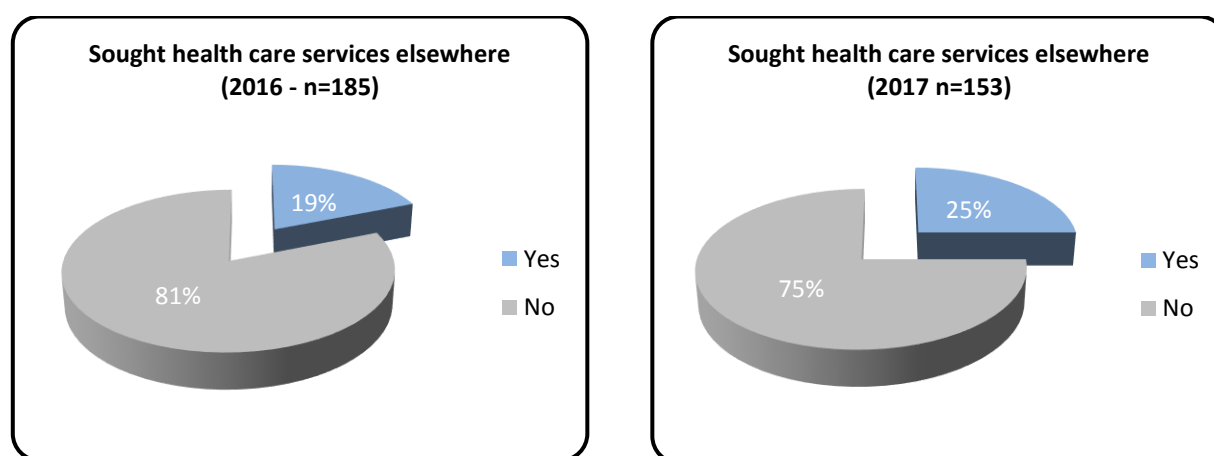


Figure 54: Sought healthcare elsewhere - Those who sought healthcare services

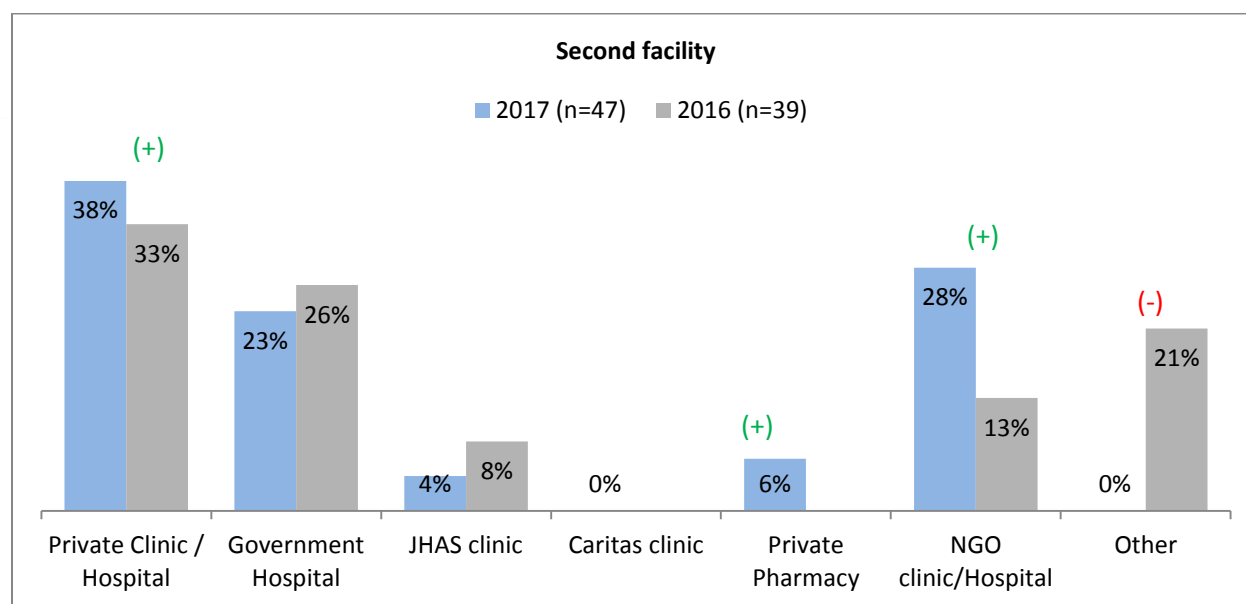


Figure 55: Second facility - Those who sought care elsewhere

(+) Revaluation by more than 4%    (-) Devaluation by more than 4%

### 8.3 Household spending

In terms of household spending on health care, half (50%) of interviewed households spent money on health care services during the last month – 6% more than in 2016. The mean of the combined income of interviewed households dropped to 263.43 JDs from 273.4 JDs where they spend an average of 80.26 JDs - more than 30 JDs less than 2016 (116.9 JDs) on health care which is 30% of their total income

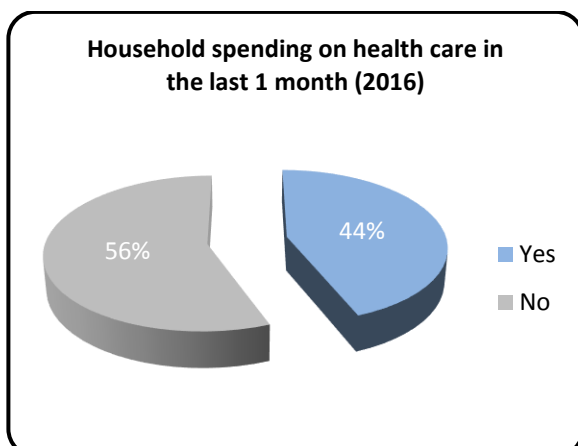


Figure 56: Household spending in the last month - All respondents (n=306)

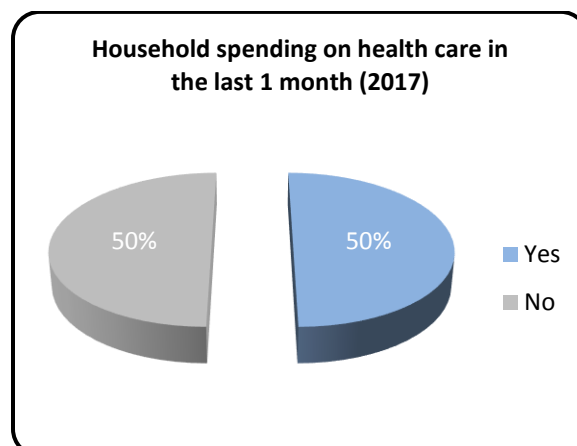


Figure 58: Household spending in the last month - All respondents (n=314)

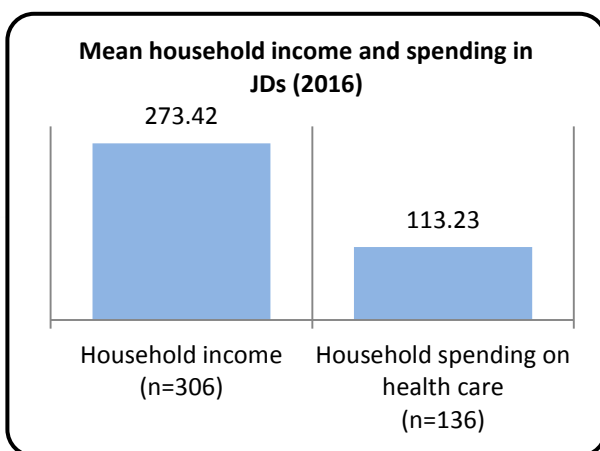


Figure 57: Mean household income & expenditure

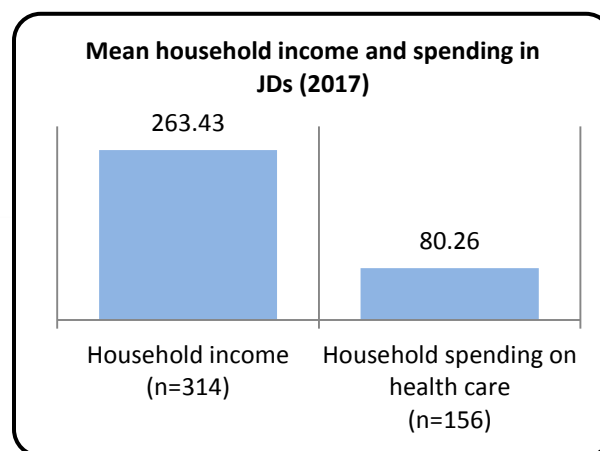


Figure 59: Mean household income & expenditure

## 8.4 Monthly household assesment summary

2017 saw a drop of 6% in ability to receive care in first facility when compared to 2016, as well as a shift in preference away from private clinics/hospitals (5% less). In 2017, the mean cost of care dropped by more than 10 JDs to 32.68 JDs when compared to last year.

	2017 (n=314)	2016 (n=306)
% of surveyed household members who needed health care in preceding month	32%	36%
% of those who were able to receive care in first health facility	75% (-)	81%
% of those initially seeking care in a private clinic or hospital	23% (-)	28%
Average cost for care in first facility	32.68 JDs	42.8 JDs

(+) Revaluation by more than 4%    (-) Devaluation by more than 4%