HEALTH ACCESS AND UTILIZATION SURVEY

ACCESS TO HEALTH SERVICES IN JORDAN AMONG SYRIAN REFUGEES

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FOR:

United Nations High Commissioner for Refugees

UNHCR
The UN Refugee Agency

BY:

nielsen

DOCUMENT CONTENTS

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Executive summary

Approximately 80% of the more than 727,000 refugees in Jordan live in major urban centres. More and more, UNHCR and partners recognize the link between robust support of non-camp refugees and local host communities, and the preservation of existing protection space. Compared to camp refugees, reliable data on the health service needs of non-camp refugees is more difficult to collect on a routine basis. In an effort to develop a cost-effective and efficient mechanism for regularly monitoring the health access and utilization of non-camp refugees, UNHCR in collaboration with Nielsen have carried out a household telephone survey. The main objectives of the survey were to evaluate access to and utilization of key health services and challenges faced by registered non-camp refugees.

The health access & utilization survey is a tool used by UNHCR on annual basis to monitor non-camp refugees' access and utilization behaviors over time and it assess each of the following attributes:

Sample structure

- Syrian refugees living in non-camp settings are predominantly concentrated in Amman (37%) followed by Irbid (24%) in 2016
- Among the 400 interviewed Syrian households, 2334 members were reported living within these households given an average of 6 members per household.
- An average of 2 children were reported living among the 400 interviewed Syrian households

Health services access & awareness

- Although 97% of the respondents are MOI security cardholders, only 70% of them were actually aware of the subsidized access to governmental facilities provided by the card.
- Majority of the respondents (93%) issued the security card in their residing governorate, yet few of them (7%) reported otherwise.

Childhood vaccination

- 9 in 10 of the households who had children less than 5 years old were aware and had access to children vaccination care, yet there is room for minor improvements
- From the households who had children less than 5 years old, 9 in 10 of them had their children vaccinated for both MMR & Polio where governmental facilities were the main source of vaccination.

Antenatal care

- From those who needed antenatal care (40%), 2 in 10 of them didn't receive the needed care.

- Governmental & private hospitals were the main places of delivery scoring 43% and 41% respectively.
- 4 in 10 of the deliveries were free of charge as a result that 41% of them were delivered in a governmental facility.

Chronic diseases

- Hypertension is predominantly the most reported disease followed by Diabetes among household members who had a chronic disease
- 34% and 37% were unable to access medicine and health services respectively. Inability to afford user fees was the most reported reason for not accessing medicine and health services scoring 75% and 74% respectively.

Disability & impairment

- Half of the impaired/disabled households reported natural reason as cause of disability while 2 in 10 reported that violence/war was the cause of their disability
- Rehabilitation (44%) followed by Surgical (31%) treatments were the main types of treatment received by the disabled/impaired household members.
- Inability to afford user fees (50%) is predominantly the main barrier to proper care followed by the respondent's personal sentiment that the treatment is unnecessary (21%)

Monthly health access assessment

- 3 in 10 household members sought health care during the last month of the interview
- Governmental & private hospitals were the first sought facility scoring 28% and 25% respectively
- 81% of the interviewed households spent an average of 105.3 JDs on health care during the last month of the interview although their combined monthly income is 233.0 JDs

1. INTRODUCTION

1.1 Background & Objective

The increase in the number of refugees from the Syrian Arab Republic (Syria) across the region in 2016 continued and the need remains for a large-scale response to address the needs of both refugees already present in the host community and those who arrived recently. As of end of 2016, 655,455 Syrian refugees were registered with UNHCR, including refugees hosted in Za'atari, Azraq camps, Cyber City 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 2016 60,875 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. Until the security situation in Iraq improves, and/or durable solutions are found, these Iraqi refugees require protection and assistance including the provision of essential and life-saving health services.

Apart from the Iraqi refugees, UNHCR also assists refugees of other nationalities including Sudanese, Somalis, Yemenis and others and had registered 10,889 non-Iraqi non-Syrian refugees by the end of December 2016.

1.2 Overview of Health Services Available to UNHCR PoCs in Jordan

In 2016 UNHCR will continue supporting the provision of health service to its PoCs through implementing partners and affiliated hospitals and other partners if needed. UNHCR will work to encourage Iraqis and Syrian refugees to increasingly utilize the governmental health services especially at the Primary Health Care level.

1.3 Research context

The Government of Jordan had allowed Syrians registered with UNHCR to access health care 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 are now required to pay the non-insured Jordanian rate when they use all types of health services provided by the Ministry of Health. This is a subsidized rate that is used for Jordanians who don't have government health insurance and is about 35 – 60 % of what non-Jordanians (foreigners) are paying. Though the non-insured Jordanian rate is normally affordable for non-vulnerable individuals this is expected to cause considerable hardship for many refugees.

There are important exceptions 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 HIV 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 police. This administrative procedure has been implemented effectively but imposes some challenges on health services accessibility for refugees. Refugees can only access the public health center that falls under the area of registration of the security card and if the refugee relocates, he finds difficulties accessing health services.

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

- Syrian 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.

1.5.5 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.

1.6.6 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.

1.6.7 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 four 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 Survey was also limited to only refugees who are have registered with UNHCR and have a telephone number on the database. Even though almost all registered refugees (99%) had a phone number on the database, a lot of the contacts sampled (40%) had invalid phone numbers or could not be reached. However, if excluded non-camp refugees are systemically different from those we interviewed, then findings may not be generalizable to the excluded population.

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 (95%) of the respondents where such a figure is supported by last year's findings where most of the first arrivals happened during the year 2013-2014 amid the intensity of the civil war in Syria.

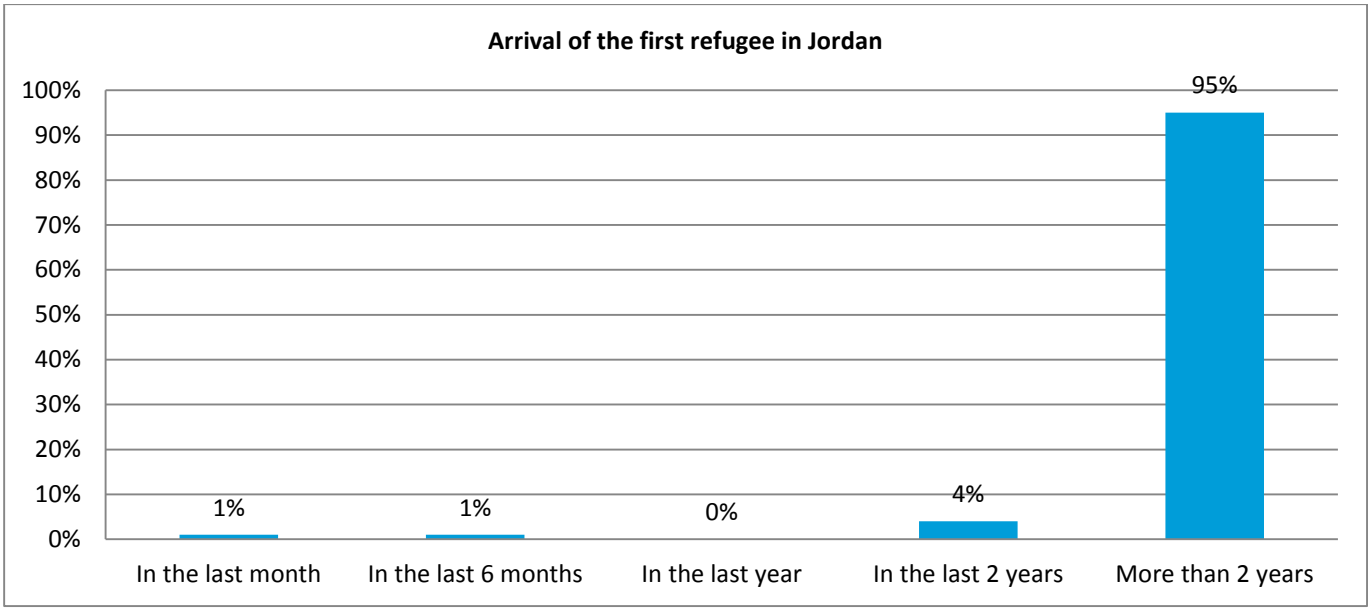
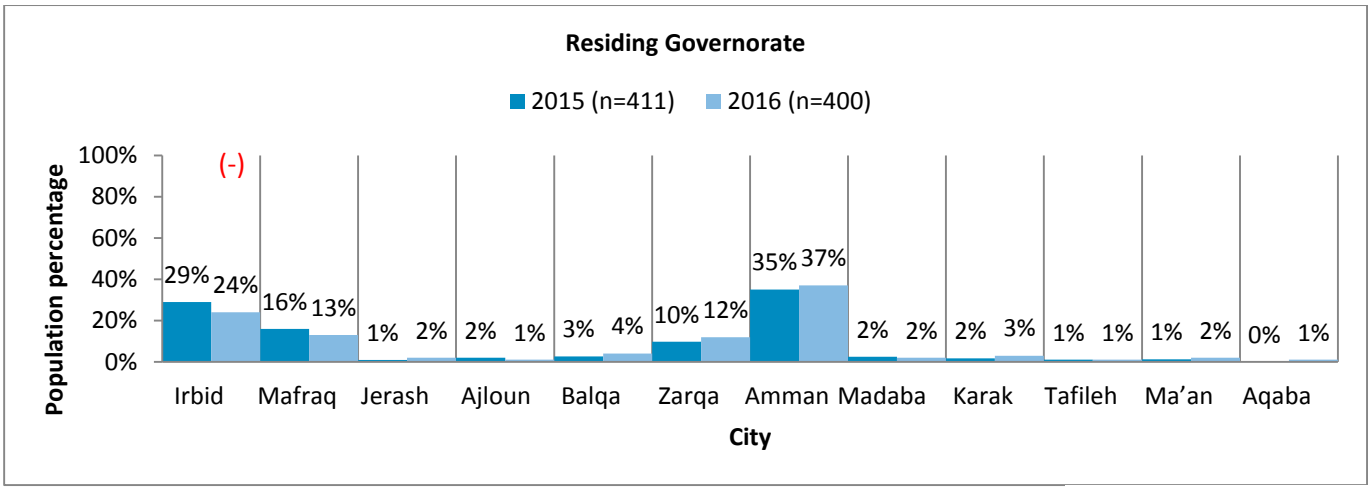


Figure 1: Arrival of the first refugee – All Syrian respondents (n=400)

Residing governorate – Presently refugees host communities mostly dwell in Amman (37%). In comparison of the last year findings there has been a deflation in the percentage of refugees who live in Irbid by 6% where only 23% of the Syrian refugees interviewed live in Irbid.



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

Figure 2: Residing governorate – All Syrian respondents (n=400)

Syrians place of birth – Among the (400) interviewed Syrian refugees (37%) of the Syrian households originated from Daraa followed by (21%) and (13%) for Homs and Damascus respectively.

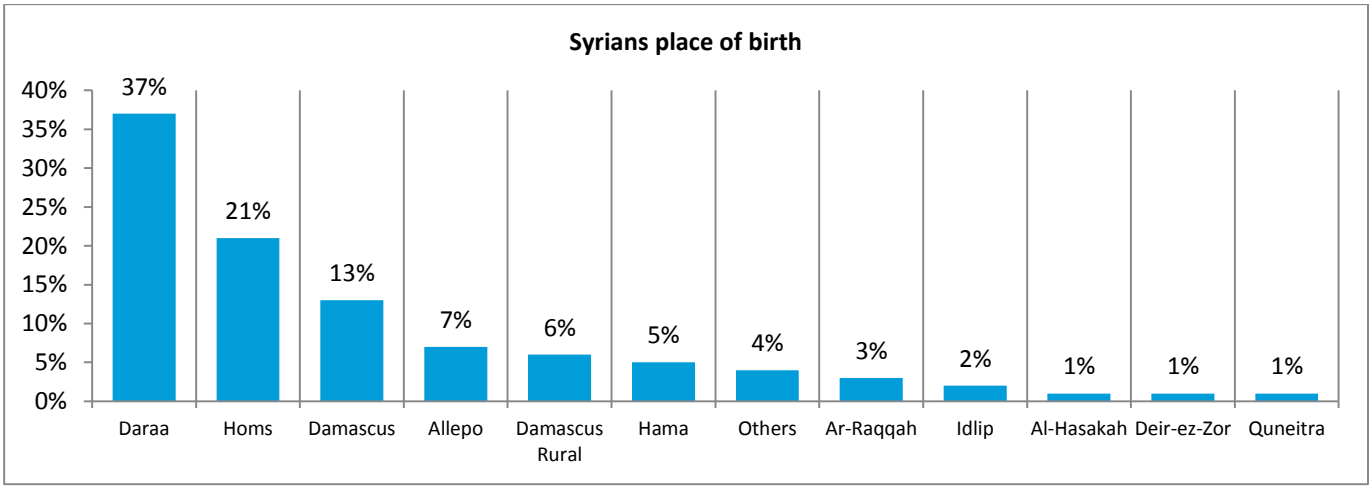


Figure 3: Place of birth - Syrians (n=400)

2.2 Household head profile

- **Household head profile:** On the base of 92 (23%) who were the head of households yet were not interviewed by themselves (89%) of them were males as compared to (11%) females. The majority fell into the age group of 36-55 years old by (52%) and (67%) reported that they have abandoned Secondary schooling however only (7%) of them were illiterate. English comes as the secondary language (8%) as compared to Arabic which is the primary language of (100%) of the household heads.

Household head profile	2016 (n=400)
% of Household head	**77%**
Gender	
Male	89
Female	11
Age	
Less than 18 years	0
18-35 years	32
36-55 years	52
More than 55 years	16
Education	
Knows how to read and write	8
Primary School	26
Intermediate/complementary school	33
Secondary school	15
2 years Diploma	4
University	8
None	7
Language spoken	
Arabic	100
Kurdish	0
Turkish	0

English	8
French	0
Somali	0
Other	2

All Figures are in % except n

2. 3 Household Profile

Disability & Impairment
For all household members who are 2334 member (7%) of them has been recorded as disabled and needed the assistance of others to perform daily activities.

Figure 4: Disability & impairment - All household members (n=2334)

Gender
The share of females among interviewed households were marginally higher than males by 6%

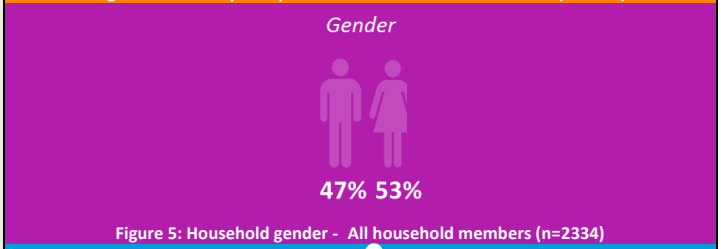


Figure 5: Household gender - All household members (n=2334)

Pregnant women who needed antenatal care
Among females who are at reproductive age, 40% were pregnant in Jordan during the last 2 years and needed antenatal/maternal care

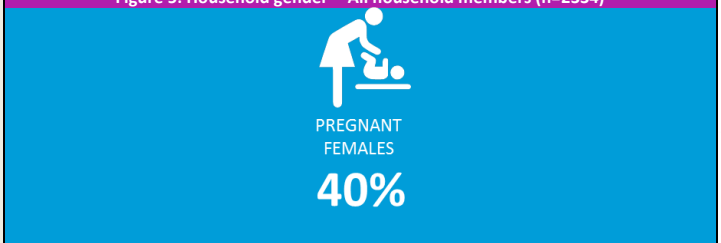


Figure 6: Pregnant women in Jordan during the last 2 years - Females at reproductive age (n=493)

Mean of household members
2334 household members has been reported to be living under the same roof and eating from the same pot in 400 households, the mean number of the members has been reported to be 6 members per household

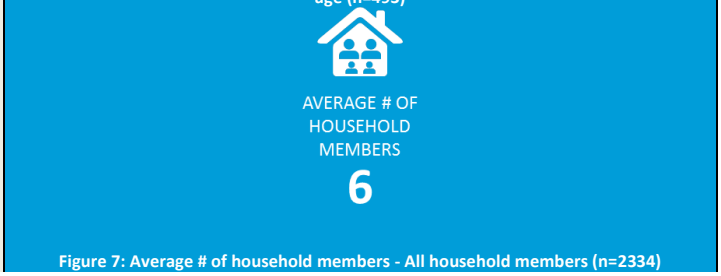


Figure 7: Average # of household members - All household members (n=2334)

Age groups

From all household members (81%) of them were youth less than the age of 35 where (49%) of them where less than the age of 18.

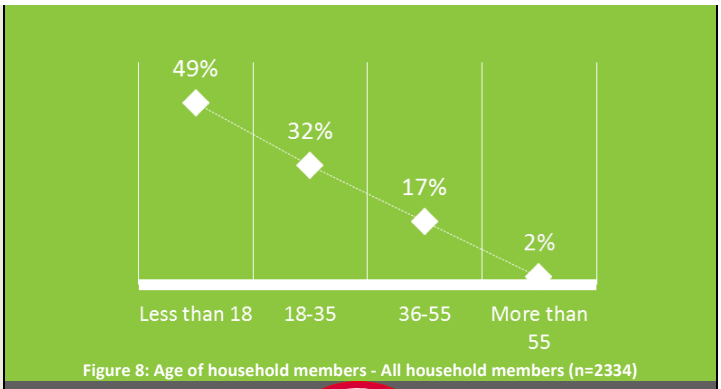


Figure 8: Age of household members - All household members (n=2334)

Chronic condition

Approximately 5 out 10 households have at least one member reported to have a chronic condition

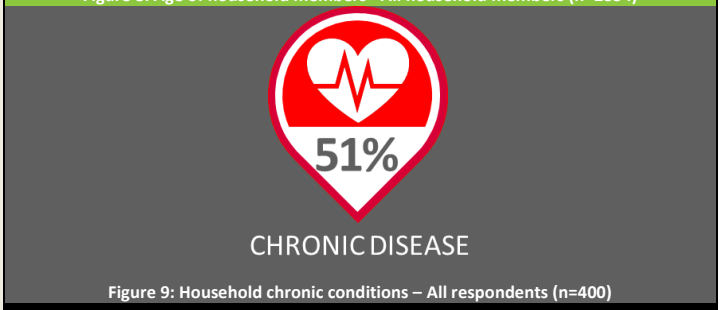


Figure 9: Household chronic conditions – All respondents (n=400)

Marital status

Most of the household members were single (58%) mainly as a result that (81%) of them were less than the age of 35

Figure 10: Marital status - All household members (n=2334)

Mean number of children <5 years

Each interviewed household had a mean score of 2 children that were in the age of 12 to 59 months

Figure 11: Children <5 years - All household members (n=2334)

2.4 Sample structure summary

Sample structure summary – The family composition among interviewed Syrian households remains the same as compared to last year findings.

	2015 (n=411)	2016 (n=400)
# of household members	2,489	2,334
Average # of household members	6	6
% of female household members	51%	53%
% of household members less than 18 years	52%	49%

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

3. HEALTH SERVICES AWARENESS

Awareness of health services provided by Ministry of health and UNHCR

Although (97%) of Syrians had a security card only (70%) were aware of the subsidized access to governmental health services.

Location of the nearest clinic

Among the (47%) of refugees who are aware of the nearest clinic, Amman scored the highest by (24%) followed by (22%) and (19%) for Irbid and Mafraq respectively

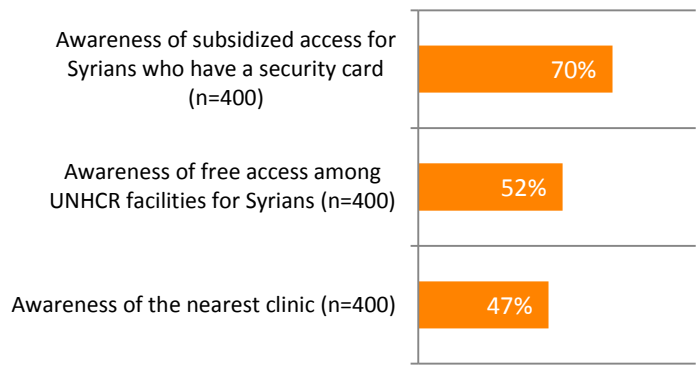


Figure 12: Knowledge of available health services - All respondents (n=400)

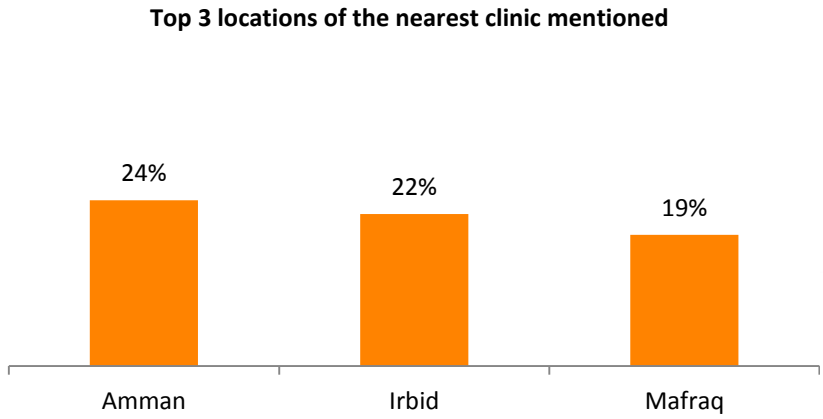


Figure 13: Awareness of the nearest clinic - Those who know the location of the nearest clinic (n=189)

Access to security card

Of all of the Syrian respondents interviewed (97%) of them already have the Ministry of Interior service card (security card) that has been issued in the residing governorate by (93%) of the card holders

(*) Insufficient base for analysis

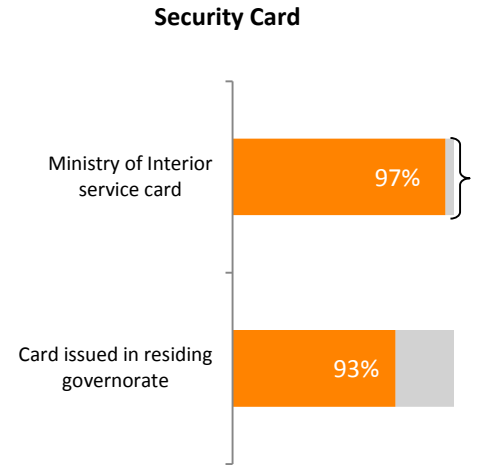


Figure 14: Possession of ministry of interior security card - Syrians (n=400)

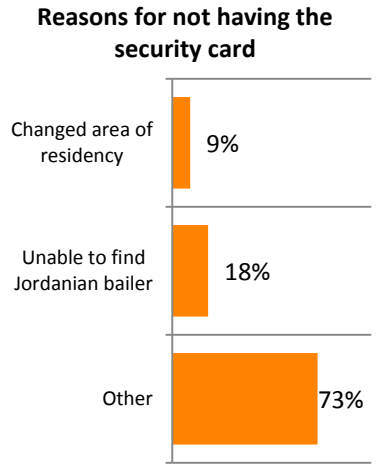
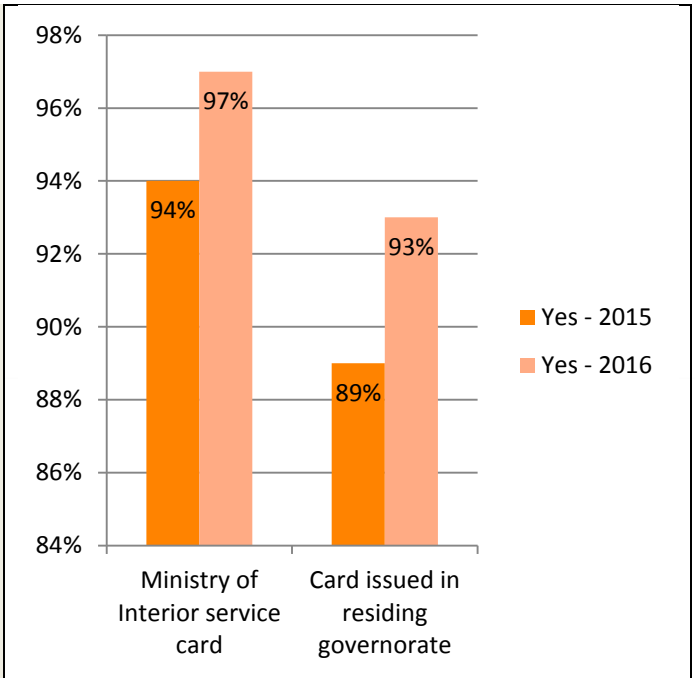


Figure 15: Reasons for not having the security card - Those who are Syrians and don't have a security (n=11)*

Access to security card

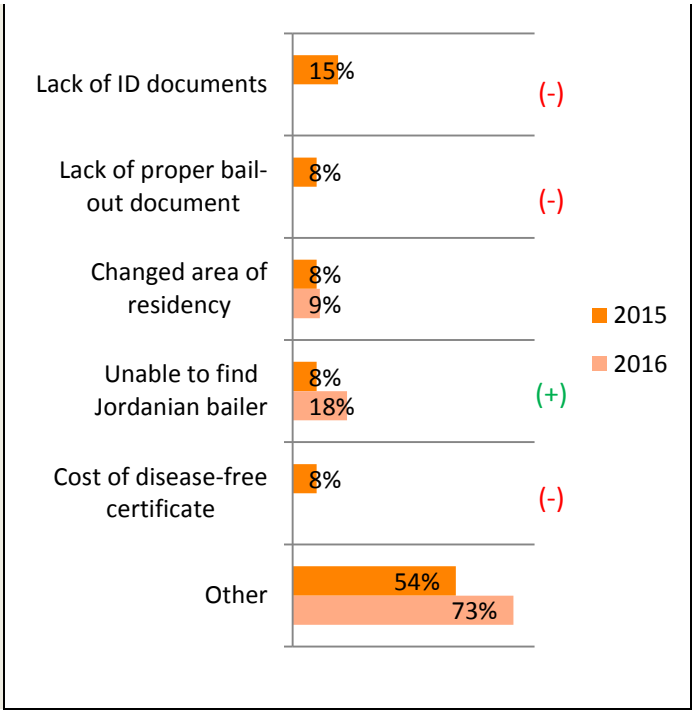
The penetration of security card among Syrian refugees reported an improvement by (3%) as compared to the last year of 2015, regarding the ability to issue the card in the residing governorate an improvement of (4%) has been recorded to stand at a (93%) in 2016

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



Reasons for not having the security card
Lack of documents has diminished as a reason for not having the security card in 2016; however, most of the respondents were unable to obtain the card due to changing the area of residence or the inability to find a Jordanian bailer.

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



3.1 Health services awareness summary

Health services awareness summary – The number of households who did not have a security card witnessed a (58%) drop. For awareness of free vaccination access to children <5 years the % of awareness improved by 11% in 2016

	2015 (n=411)	2016 (n=400)
# of households that didn't obtain security card	26	11 (-)
% of households that had a security card	94%	97%
% of households that knew children <5 years have free vaccination access	82%	93% (+)

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

4. CHILD VACCINATION

Awareness and access to vaccination card

Both awareness and access to child vaccination card has immensely improved in 2016 where the awareness improved by (11%) and access improved by (14%) to stand at a total level of (93%) and (90%) respectively

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

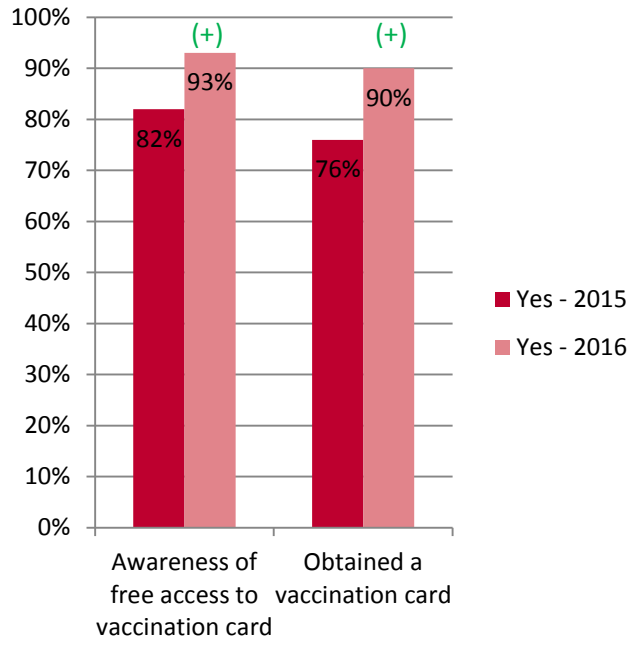


Figure 16: Awareness and possession of free access vaccination card - Households that have children <5 years (n=199)

Access to MMR and Polio Vaccination

The access to MMR vaccination improved by 5% compared to 2015 to stand at (93%) where access to Polio vaccine is marginally higher than MMR vaccination by (1%) in 2016

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

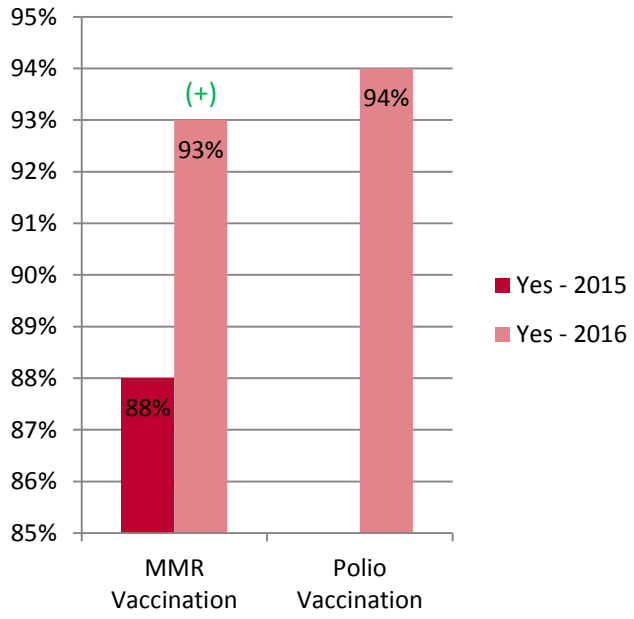


Figure 17: Access to vaccination - Households that have children <5 years (n=199)

Difficulties to obtain vaccination

In 2016 less difficulties to obtain vaccination were encountered by refugees where the % of those who had difficulties is relatively the same for both MMR and Polio vaccines

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

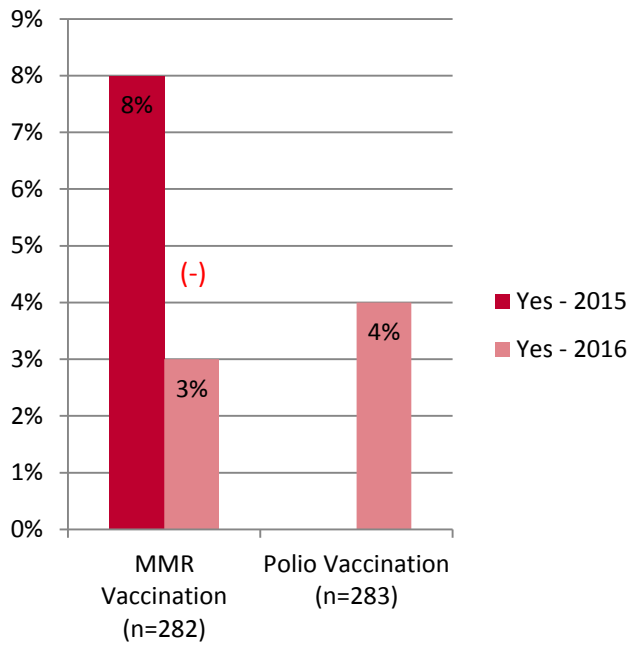


Figure 18: Difficulties to obtain vaccination - Those who obtained vaccination

Vaccination Facility

9 out of 10 from those who obtained vaccination had it in the governmental health center in Jordan. On the other hand few reported that they have been vaccinated before arriving to Jordan

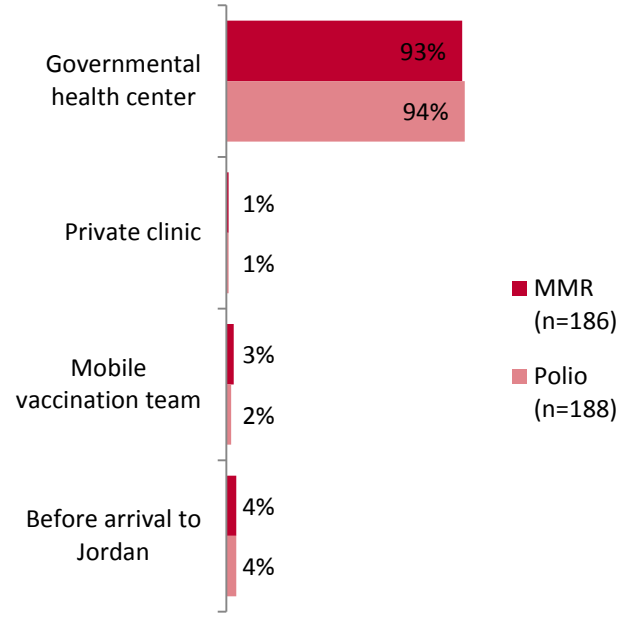


Figure 19: Vaccination facility - Those who obtained vaccination

Encountered difficulties
Rude staff scored higher among difficulties encountered by refugees while obtaining vaccination, where it's reported by (40%) and (43%) of those who had an MMR or Polio vaccine respectively.

(*) = Insufficient base for analysis

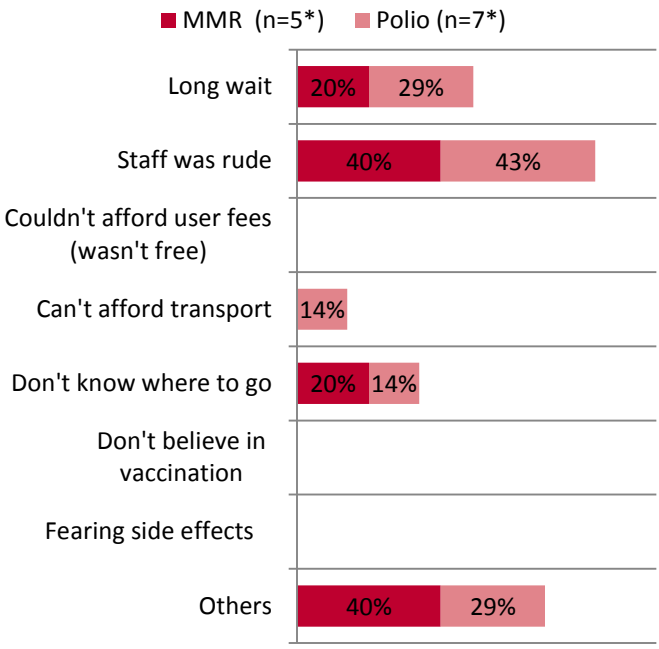


Figure 20: Difficulties while obtaining the vaccine - Those who encountered difficulties while obtaining the vaccine

4.1 Child vaccination summary

Child vaccination summary – At an overall level the access to child vaccination has improved significantly as compared to last year, the access to vaccination card extensively appreciated by (14%); Access to a measles containing vaccine and vaccination at governmental health care centers in Jordan has marginally improved by (5%) and (6%) respectively.

	2015 (n=238)	2016 (n=199)
% that had an vaccination card	76%	90% (+)
% that had received a measles containing vaccine	88%	93% (+)
% that faced difficulties obtaining vaccine	8%	4%
% that received vaccine at Jordanian government primary health care centre	88%	94% (+)
% that received vaccine before coming to Jordan (in Syria)	9%	4% (-)
% that received vaccine at a mobile medical unit in Jordan	3%	3%

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

5. Antenatal care

5.1 Access to antenatal care

Access to antenatal care
The proportion of those who needed antenatal care increased by (23%) in 2016 among Syrians. Less number of instances reporting encountered difficulties have dropped to 9% among them.

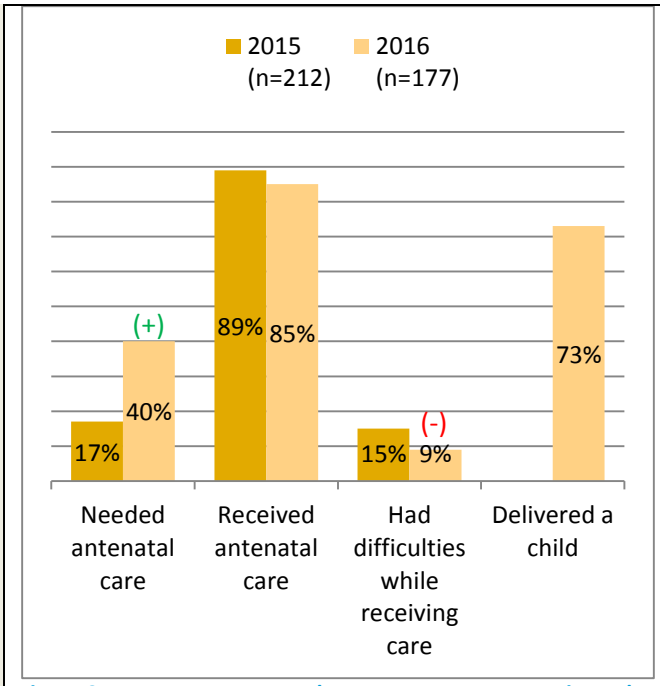


Figure 21 - Access to antenatal care - Pregnant women in Jordan during the last 2 years

85% pregnant females had received antenatal care in 2016 with 59% of them had 4 visits to the clinic. 73% of them delivered a child mostly through normal vaginal delivery (70%) followed by Caesarian section (25%). As for the cost 39% of them had the delivery for free, yet the majority of those who paid the cost of delivery was estimated to be in the range of 100~750 JDs mostly due to the high score of deliveries reported in a private hospital/clinic.

Child deliveries took place mainly in governmental hospitals (43%) and private clinics/hospitals (41%).

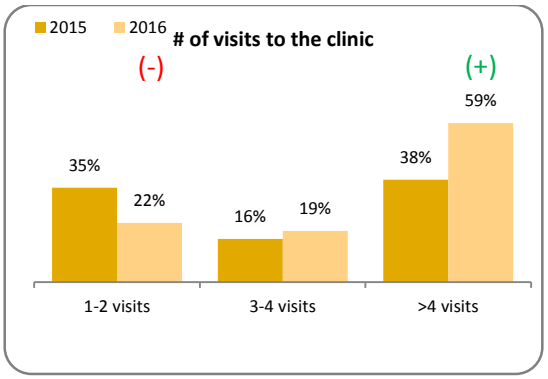


Figure 22: Number of visits to the clinic - Households that had females who received antenatal care (n=115)

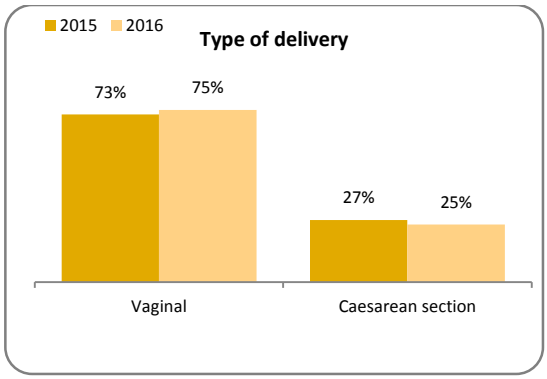


Figure 23: Type of delivery - Pregnant women in Jordan during the last 2 years (n=142)

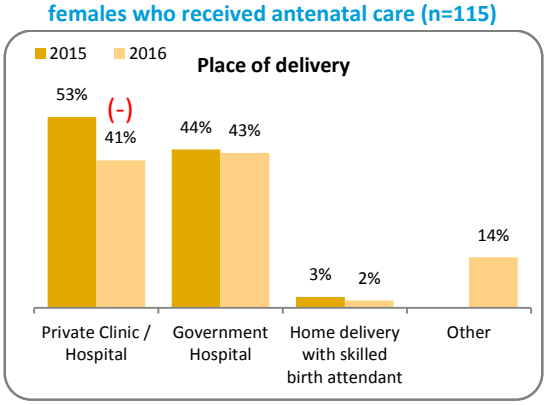


Figure 24: Place of delivery - Those who delivered a child (n=142)

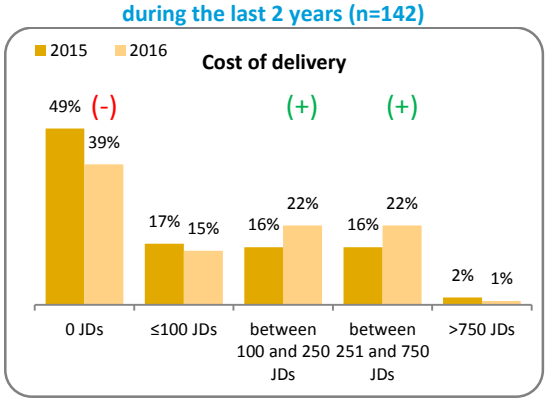


Figure 25: Cost of delivery - Those who delivered a child (n=142)

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

Difficulties occurred while receiving care - Long wait and inability to afford delivery fees were reported as the main difficulties while receiveing antenatal both scoring 46%

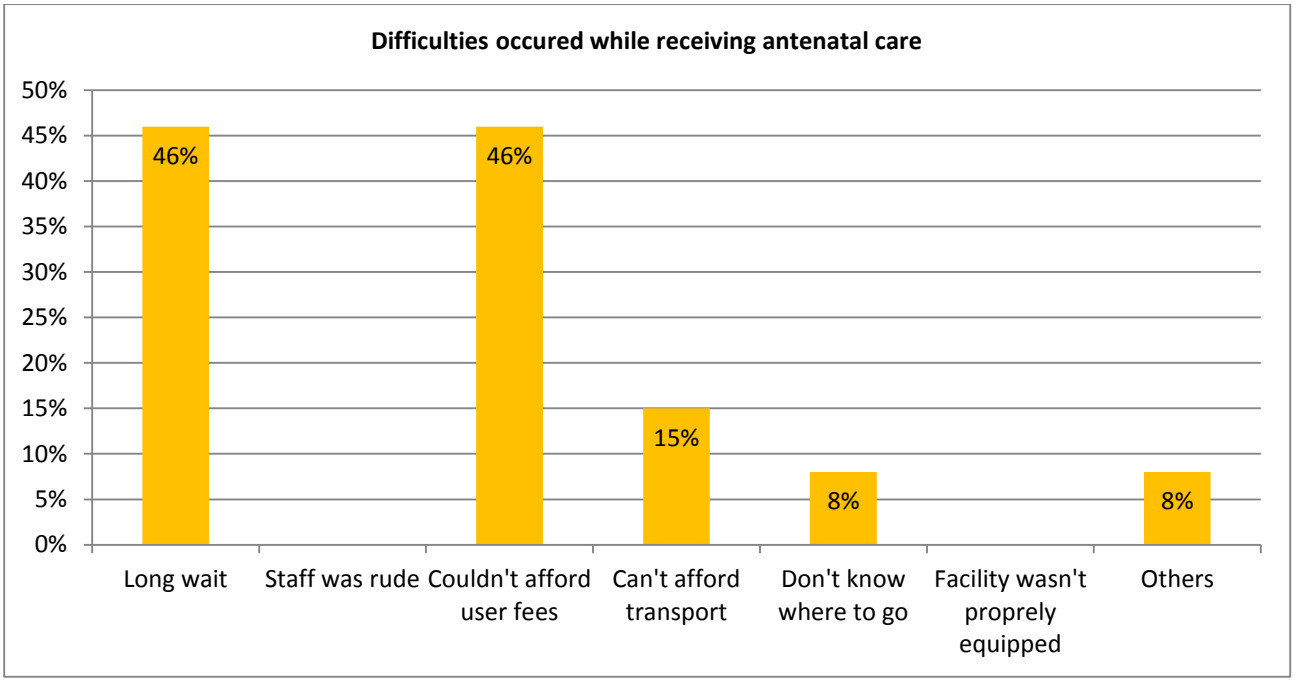


Figure 26: Difficulties occurred while receiving care - Those who encountered difficulties (n=13*)

Reasons for a private facility – The reason for accessing care in a private facility is based on the preference of respondents (36%) in addition to lack of eligibility to access governmental facilities at a subsidized rate (19%)

Reasons accessing care in a private hospital/clinic	2016 (n=58)
Not eligible to access Ministry of Health facility at subsidized rate	19%
Eligible to access Ministry of Health facility at subsidized rate but could not access	7%
Prefer to go to a private facility	36%
Others	41%

5.2 Family planning

In all households who had a pregnant female eligible to antenatal care they were reporting that 51% of the households were aware of family planning and 62% acquired knowledge on family planning mainly through health care center staff (41%) followed by community events (28%) as the main sources of knowledge

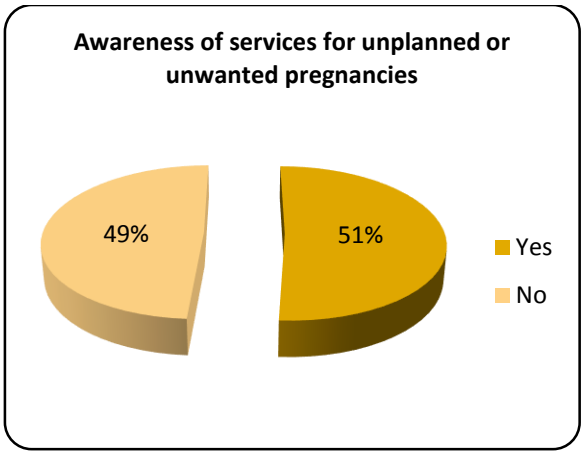


Figure 27: Awareness of services for unplanned pregnancies - Households that had pregnant women (n=129)

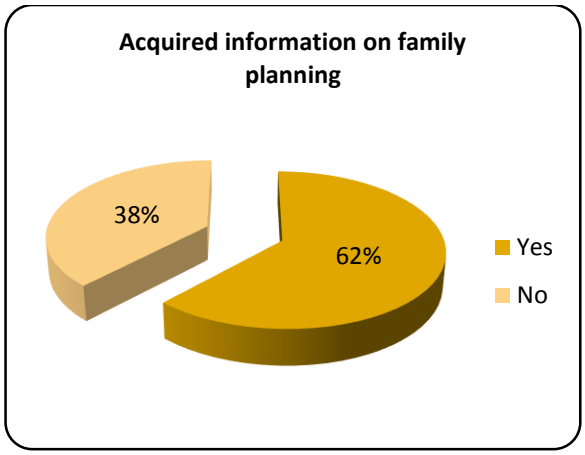


Figure 28: Acquired information on family planning - Households that had pregnant women (n=129)

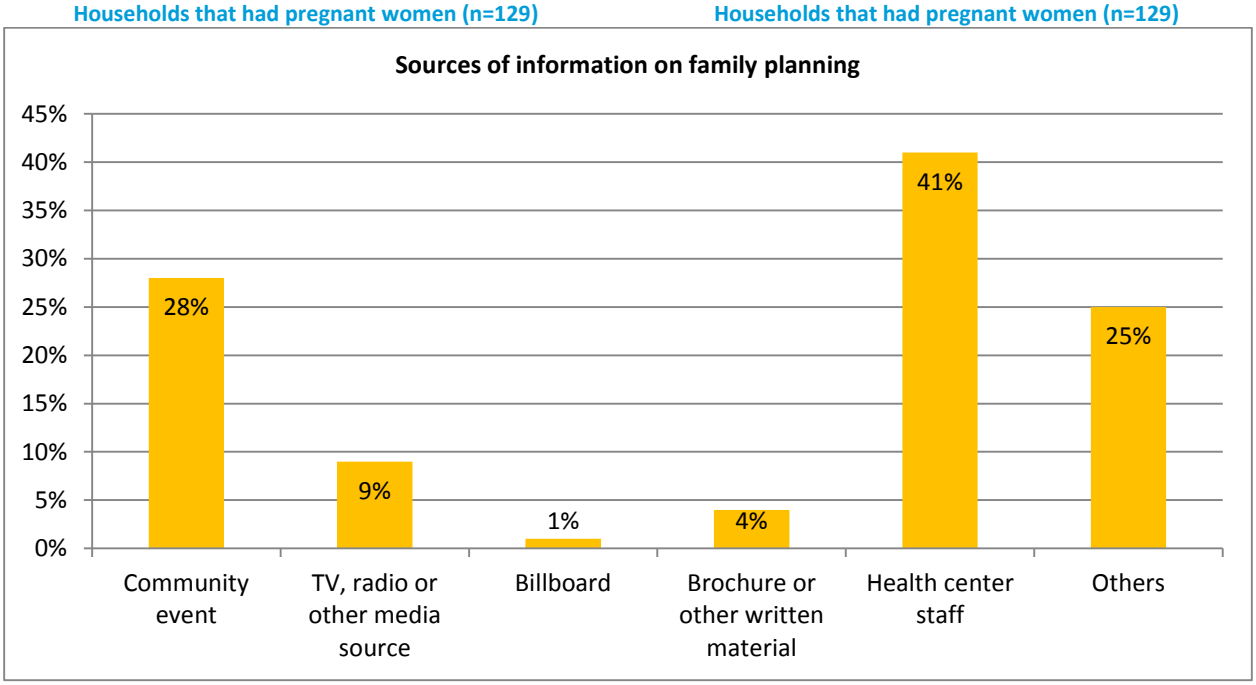


Figure 29: Sources of information on family planning - Households that had pregnant women (n=80)

5.3 Contraceptives

1 in 3 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 medical center (71%)

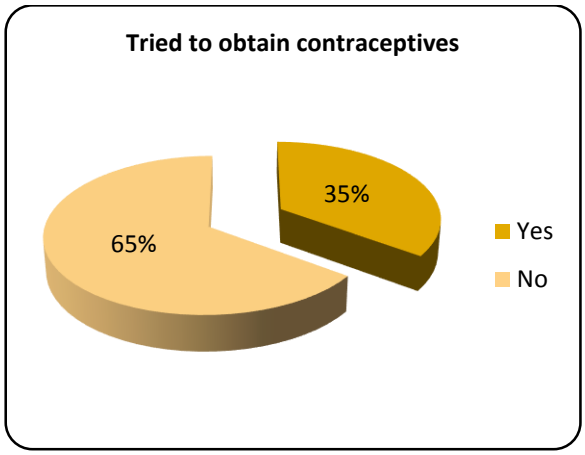


Figure 30: Trial to obtain contraceptives - Households that had pregnant women (n=181)

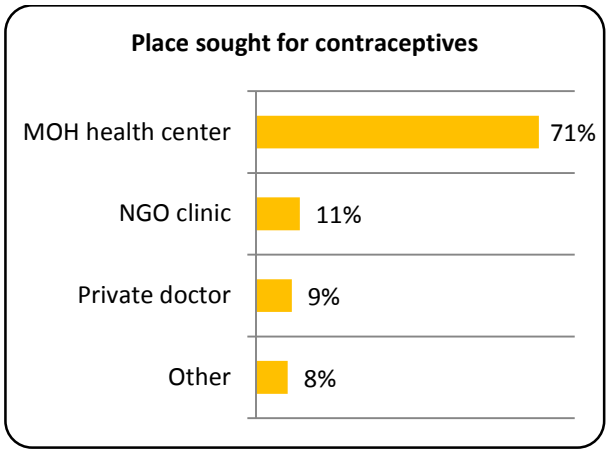


Figure 31: Place sought for contraceptives - Households that had pregnant women (n=181)

5.4 Antenatal care summary

Instances where long wait/rude staff encountered were widely reported in 2016, witnessing 27% surge in such reported instances in comparison with 2015 findings.

% of deliveries in private facilities has diminished by 12%, yet the free of cost deliveries were lessened by 10%

	2015 (n=212)	2016 (n=177)
% of pregnant women who had at least one ANC visit	89%	85%
% of pregnant women who had difficulty accessing ANC	15%	9% (-)
% of those who couldn't afford fees or transport	50%	61% (+)
% of those who encountered Long wait &/or rude staff	19%	46% (+)
% of those who didn't know where to go	6%	8%
% of deliveries by caesarean section	27%	25%
% of deliveries in private facilities	53%	41% (-)
% of deliveries in government facilities	44%	43%
% of deliveries free of cost	49%	39% (-)

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

6. CHRONIC DISEASE

6.1 Type of disease

From all household members who had a chronic condition, 4 out of 10 (42%) members suffer from Hypertension followed by 32% who were reported diabetic.

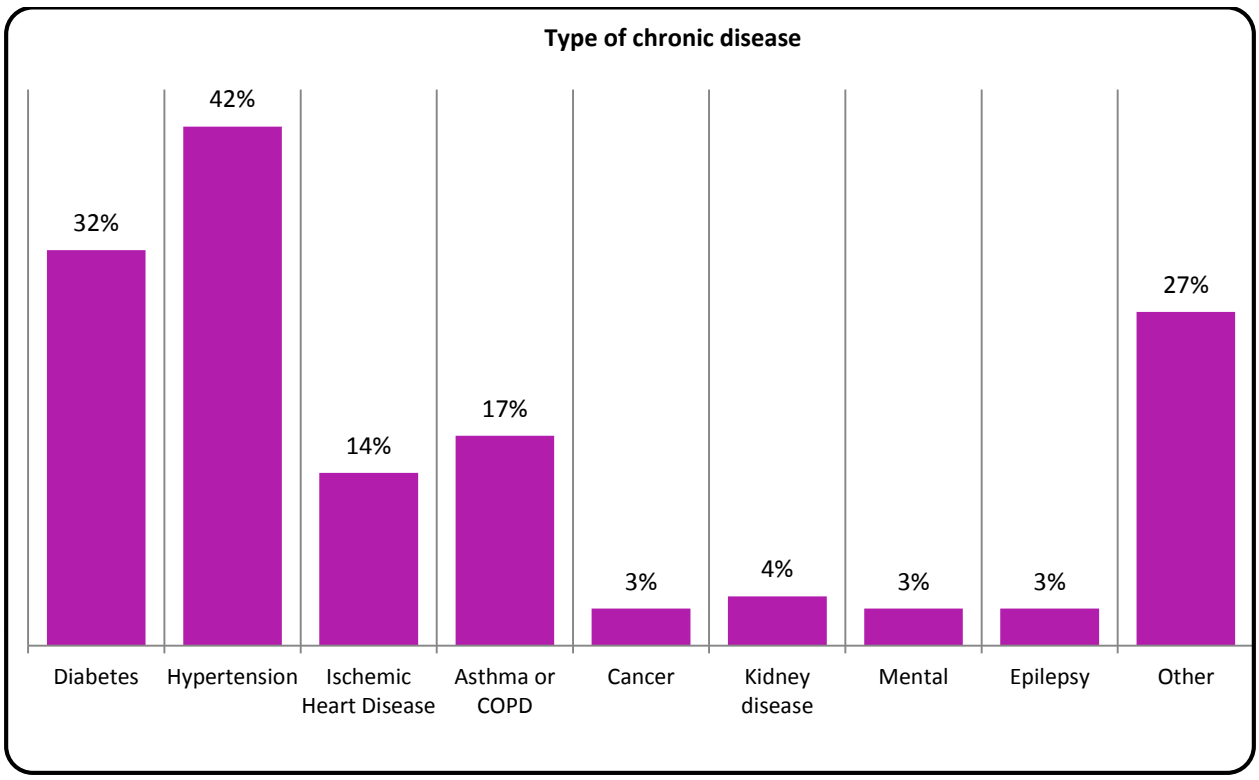


Figure 32: Type of chronic disease - Household members that have a chronic condition (n=320)

6.2 Access to medicine for chronic conditions

From those who needed medicine for their chronic condition, 34% of them were unable to access medicine mainly due to the cost of medicine (75%).

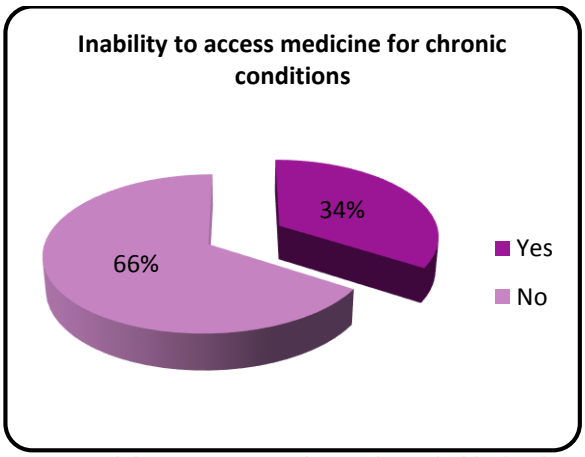


Figure 33: Inability to access medicine - households that have a member with chronic condition (n=204)

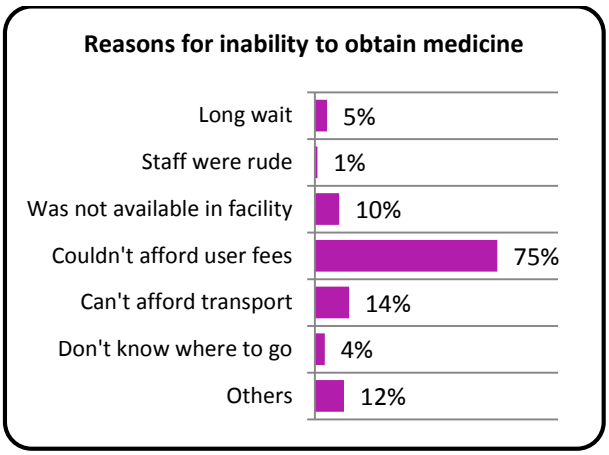


Figure 34: Reasons for inability to access medicine - Those who were unable to obtain medicine (n=101)

6.3 Access to medical services for chronic conditions

From those who needed to access medical services for their chronic condition, 37% of them were unable to access medical services mainly due to the inability to afford the cost (74%).

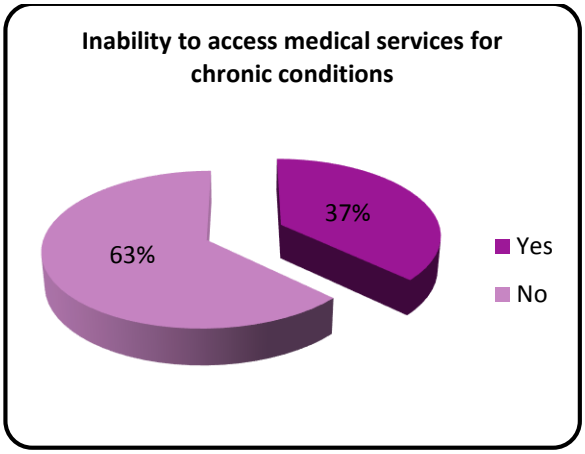


Figure 35: Inability to access health services - households that have a member with chronic condition (n=204)

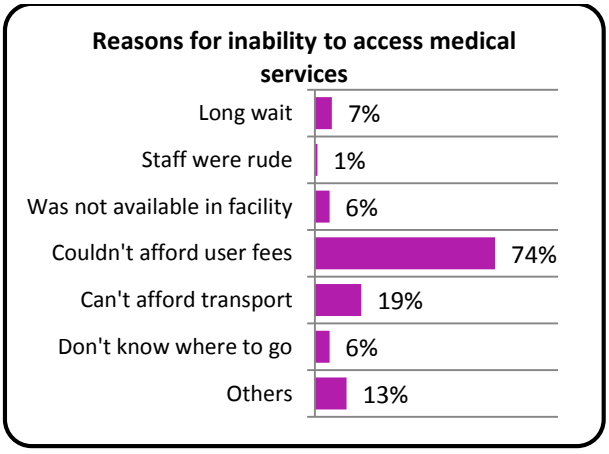


Figure 36: Reasons for inability to access health services - Those who were unable to access health services (n=109)

6.4 Chronic disease summary

Access to medicine and health services improved by 22% in 2016, yet inability to afford fees has been numerously reported where it appreciated by 18% to stand at (75%) of the reasons leading to inability to access medical and health services

	2015 (n=411)	2016 (n=400)
% of households with at least one adult with a chronic condition	48%	51% (+)
% of adults with chronic conditions who weren't able to access medicine or other health services	58%	36% (-)
% of those who couldn't afford fees	57%	75% (+)
% of service unavailable in local facility	10%	8%
% of those who didn't know where to access care	7%	5%

(+) 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 where it has witnessed an increase of 11% in 2016 compared to the findings of the previous year.

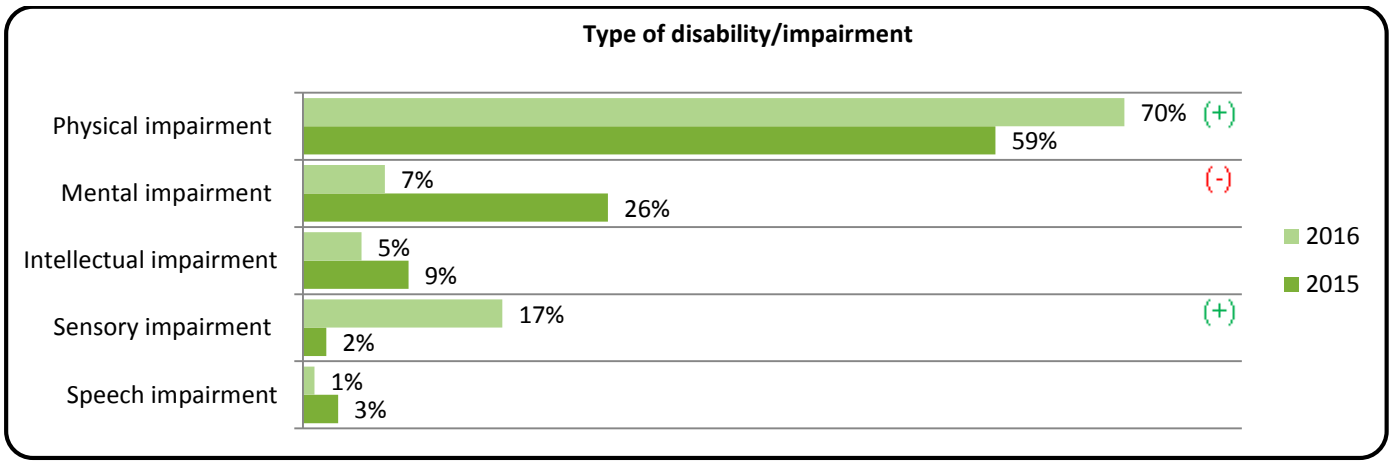


Figure 37: Type of disability/impairment - Household members who had a disability/impairment (n=166)

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

Most of the disabilities occurred due to natural reasons yet from those who had a disability/impairment 2 out of 10 of them had it due to violence and war in Syria.

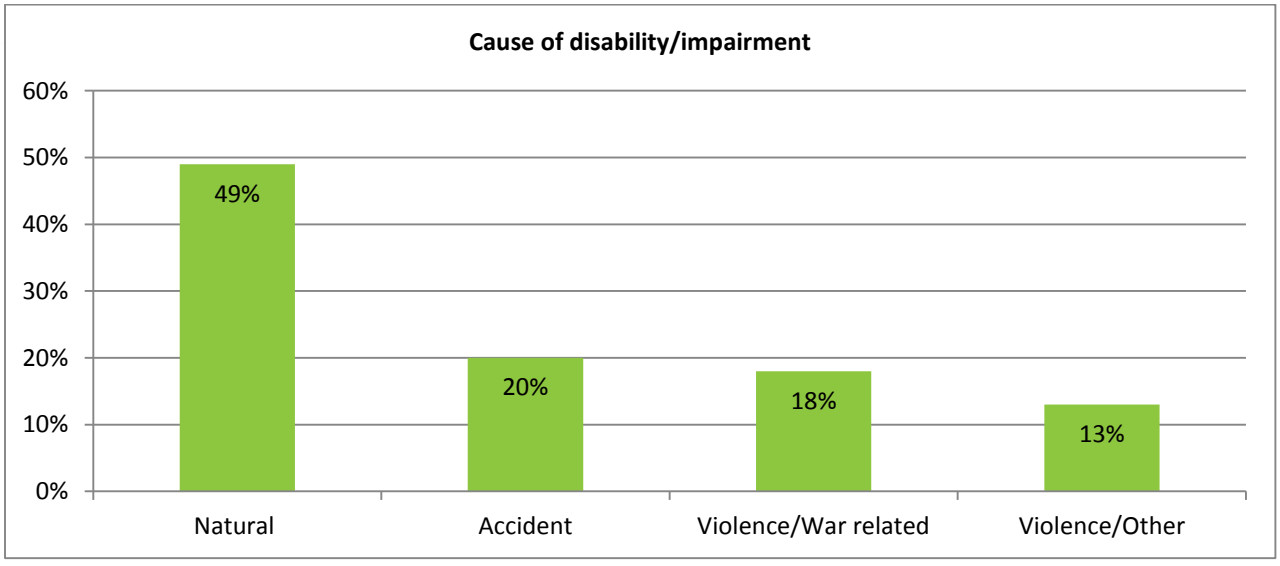


Figure 38: Cause of disability/impairment - Household members who are disabled/impaired (n=166)

7.2 Disability & impairment therapy

In 2015 most of the cases received their first treatment in Syria, however in 2016 such cases depreciated by 31% and Jordan has the lead on the place of first treatment in 2016 by 47%

Access to rehabilitation treatment is widely reported in 2016 exhibiting 20% incrimination. On the other hand assistive devices, surgical and psychosocial treatments are lessened in 2016.

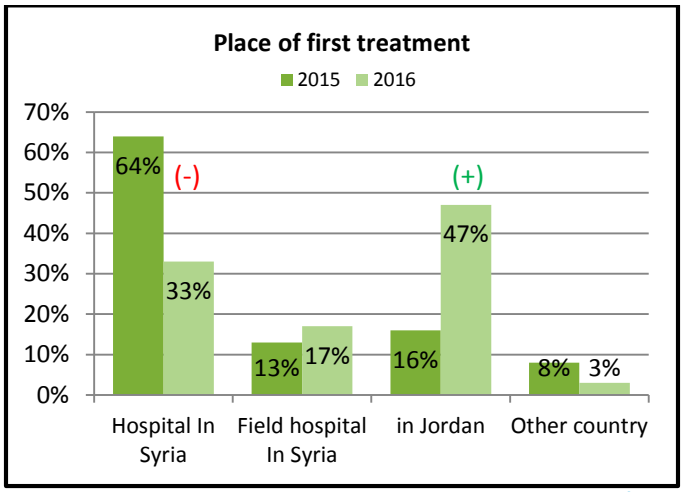


Figure 39: Place of first treatment - those who had a violence/war related disability/impairment (n=30)

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

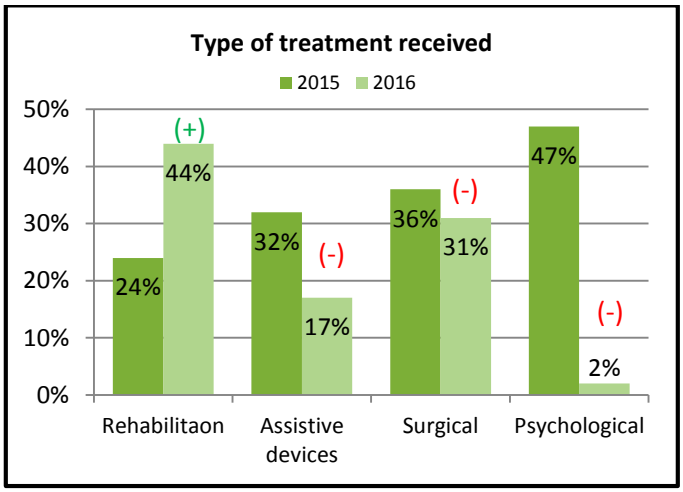


Figure 40: Type of treatment received - Household members who are disabled/impaired (n=166)

7.3 Barriers to proper care

Inability to afford user fees is the main barrier to proper care reported by 50% of households who had a disabled member

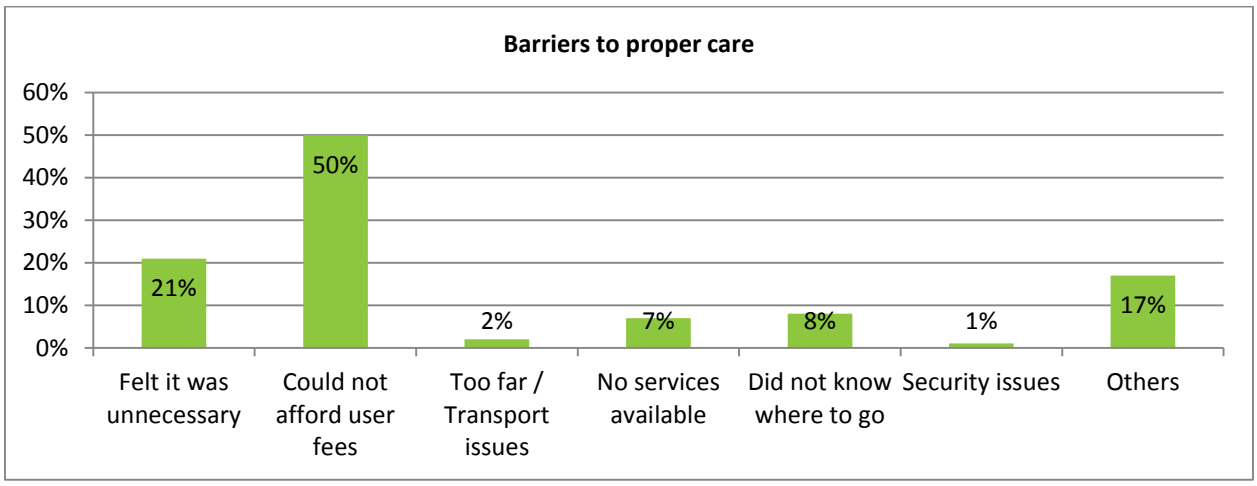


Figure 41: Barriers to proper care - Household members who are disabled / impaired (n=166)

7.4 Disability & impairment summary

Impairments due to violence and war were less reported in 2016 by 10%. The shift of the location of receiving the first treatment from Syria to Jordan in 2016 delineates that the impaired members either they recently developed this type of impairment or decided to seek health care for the first time in 2016.

More cases has been reported as unable to afford service fees or transport costs in 2016 by 25%

	2015 (n=212)	2016 (n=166)
% who were reported to have a disability	4%	7%
% of impairments due to war related violence	28%	18% (-)
% of those who received care in Jordan	8%	47% (+)
% of those who received care in Syria	76%	50% (-)
% of those could not afford service fees and/or transport costs	27%	52% (+)
% of who did not know where to go	20%	8% (-)

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

8. MONTHLY HEALTH ACCESS ASSESMENT

8.1 First facility

Health care services were needed by 39% of household members in the last month however only 30% of them actively sought health services.

From those who sought the services the majority initially reached either governmental hospital (28%) or a private clinic/hospital (25%) and paid an average 57.1 JDs in the first facility

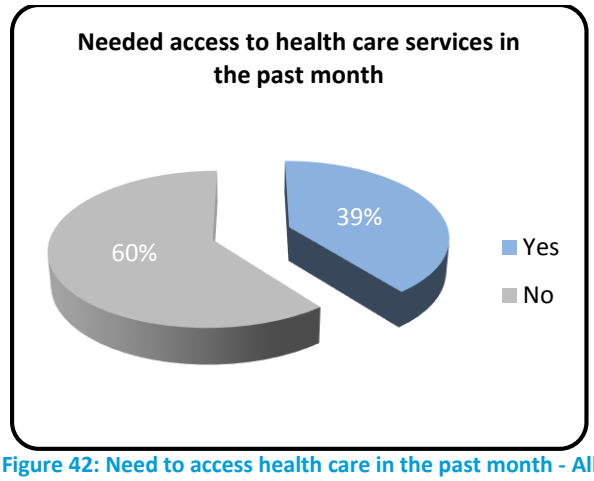


Figure 42: Need to access health care in the past month - All household members (n=2334)

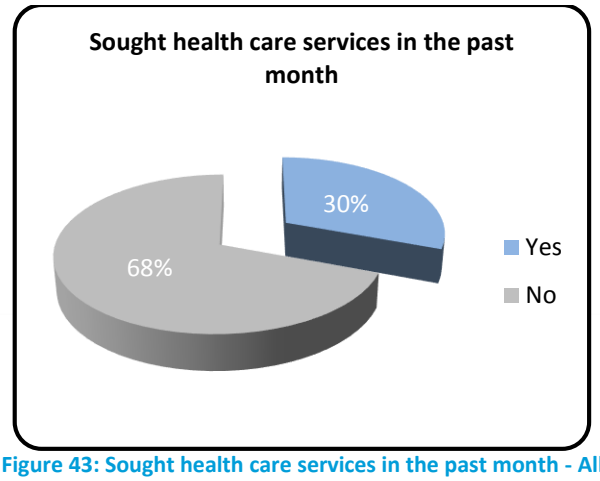


Figure 43: Sought health care services in the past month - All household members (n=2334)

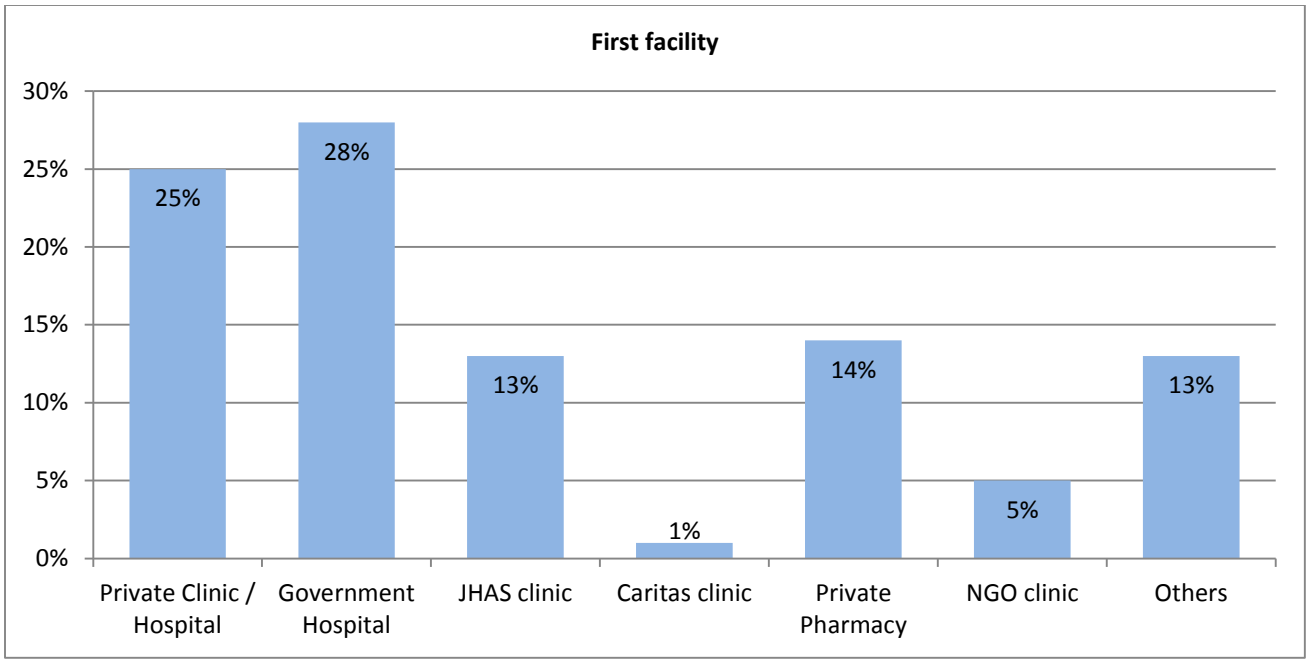


Figure 44: First facility - Those who sought health care services (n=707)

8.2 Second facility

As a result of inability to be served in the first facility 15% of household members decided to seek an alternative facility.

From those who sought the second facility the majority reached governmental hospital (57%) and paid an average 229.4 JDs in the second facility

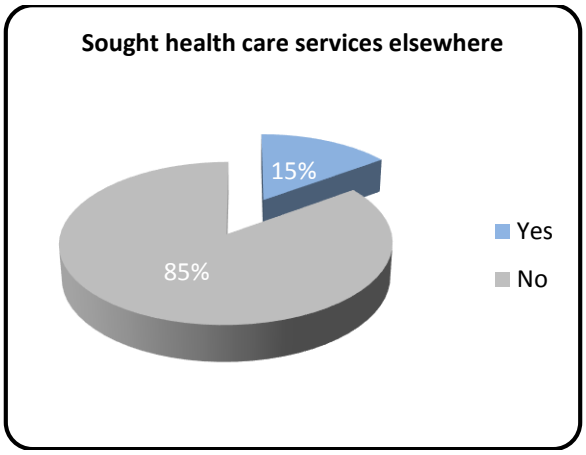


Figure 45: Sought healthcare elsewhere - Those who sought healthcare services (n=254)

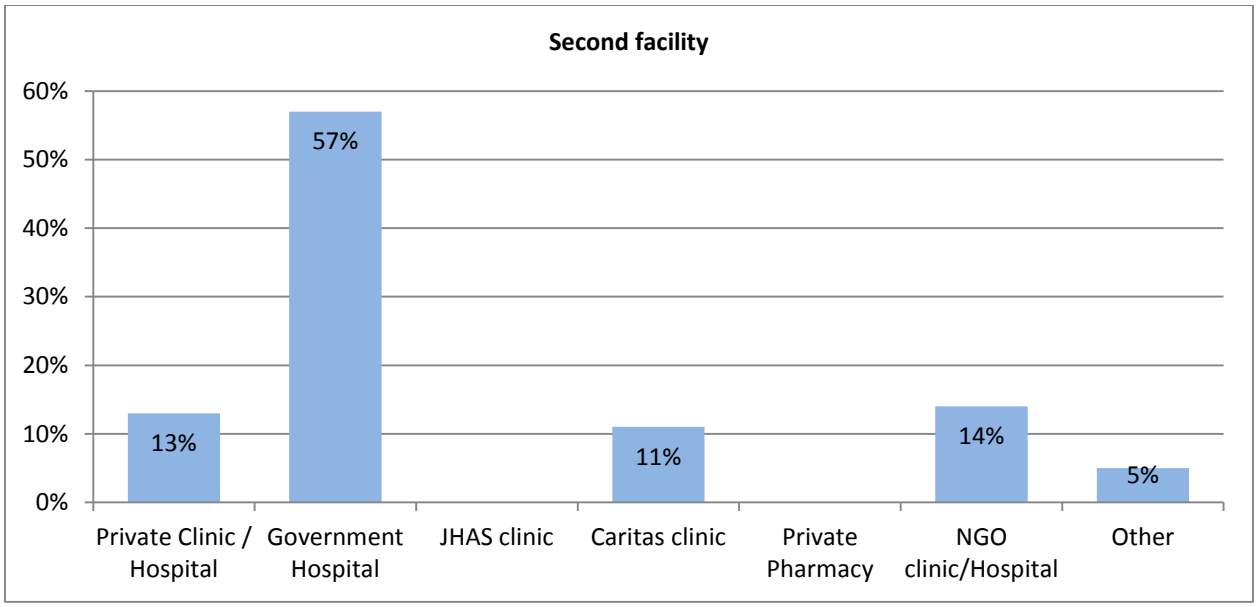


Figure 46: Second facility - Those who sought care elsewhere (n=56)

8.3 Household spending

In terms of household spending on health care 81% of interviewed households spent money on health care services during the last month, the mean of the combined income of interviewed households is 233.0 JDs where they spend an average of 105.3 JDs on health care which is 45% of their total income

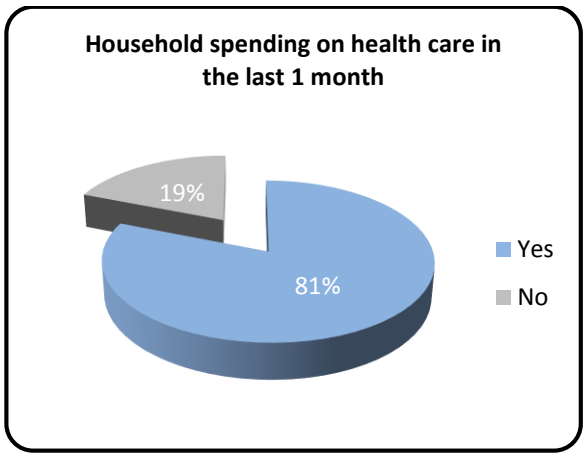


Figure 47: Household spending in the last month - All respondents (n=400)

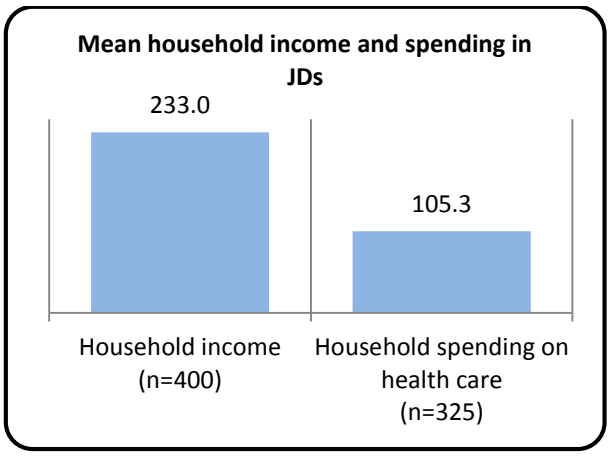


Figure 48: Mean household income & expenditure

8.4 Monthly household assesment summary

Evaluating the ability to access care in the first facility, 2016 reported a 4% decrease scoring 91% compared to 95% in 2015. Among those who initially sought health care in a private clinic/hospital such instances were recorded at a depreciation of 39% in 2016.

Although the % of those who initially sought a private clinic/hospitals reported were minor compared to 2015, yet the mean cost has been reported with an increase of 74%.

	2015 (n=411)	2016 (n=400)
% of surveyed household members who needed health care in preceding month	32%	39%
% of those who were able to receive care in first health facility	95%	91%
% of those initially seeking care in a private clinic or hospital	64%	25% (-)
Average cost for care in first facility	32.8 JD	57.1 JD (+)

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