HEALTH ACCESS AND UTILIZATION SURVEY

ACCESS TO HEALTH SERVICES IN JORDAN AMONG SYRIAN REFUGEES

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BY:

nielsen

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FAMILY COMPOSITION


HEALTH SERVICES AWARENESS


CHILD VACCINATION


ANTENATAL CARE


CHRONIC DISEASE


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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; Syrian refugee's ability to access health services impacted. Currently 79% of the more than 655,000 Syrian refugees in Jordan live in major urban centers[1]. 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

- Syrian refugees living in non-camp settings are concentrated in Amman (32%) followed by Irbid (29%) in 2017
- Among the 400 interviewed Syrian households, 2422 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 and awareness

- Although 97% of the respondents are MOI security card holders, only 65% (5% less than last year) were actually aware of the subsidized access to governmental facilities provided by the card.
- Majority of the respondents (92%) issued the security card in their residing governorate.

Childhood vaccination

- The awareness of free child vaccination has increased in 2017 compared to the results of 2016 where 96% are aware of the free access to vaccination compared to 93% last year.
- The access to MMR and polio vaccination shows a decrease in 2017 where 90% of households reported that their children had the MMR vaccination and 93% reported that their children had the polio vaccination compared to 93% and 94% respectively in 2016.
- Governmental health centers in Jordan were the main source of vaccination among Syrian refugees.

[1] UNHCR statistical report, December 2017.

Antenatal care

- An increase in the percentage of pregnant females who received antenatal care (88% vs. 85% last year)
- There is a significant increase in the percentage of pregnant women who had difficulty accessing ANC, as well as an increase in those who can't afford fees or transport compared to 2016.
- A decrease in the deliveries free of cost is recognized in 2017 results.
- Majority of child deliveries took place mainly in governmental hospitals (53%) and private clinics/hospitals (40%).

Chronic diseases

- Hypertension is predominantly the most reported disease followed by Diabetes among household members who had a chronic disease
- From those who needed medicine for their chronic condition, 55% of them were unable to access medicine mainly due to the cost of medicine (76%).
- There is a considerable increase in the number of cases where the medicine was not available in facility (30% in 2017, up 20% from 2016)
- From those who needed to access medical services for their chronic condition, 39% (increased 2% from 2016) of them were unable to access medical services mainly due to the inability to afford the cost (80% - increased 6% from 2016).

Disability & impairment

- Physical impairment scores the highest among types of disability/impairment where it has witnessed an increase of 20% in 2017 compared to the findings of the previous year.
- Most of the disabilities were reported to be due to natural reasons followed by violence war related.
- In 2016 Jordan had the lead on the place of first treatment for disability and impairment therapy, yet this year both treatment in Syria and Jordan are in parity as a place for first treatment.
- Access to rehabilitation, assistive devices and surgical treatment shows a decline as compared to 2016, in contrast to psychosocial treatment which increases by 12%.
- Only 38% reported to have proper treatment for their impairment.

Monthly health access assessment

- Health care services were needed by 37% of household members in the last year where 29% of them actively sought health services
- From those who sought the services the majority initially reached either a government hospital (27%) followed by private clinic/hospital (23%) or private pharmacy (22%) and paid an average 30.5 JDs in the first facility.
- The mean of the combined income of interviewed households is 243.0 JDs where they spend an average of 99.8 JDs on health care which is 41% of their total income.

1. INTRODUCTION

1.1 Background and 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 camp resident and vulnerable Syrian in urban setting through implementing partners and affiliated hospitals. While UNHCR maintain essential health services for vulnerable Syrian refugees, it will continue work to encourage Syrian refugees increasingly utilize the governmental health services at the Primary and Secondary Health Care levels.

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 were important exceptions made to this as all expanded program on immunization (EPI) vaccinations are provided free of charge to children and pregnant women. Furthermore, treatment for communicable diseases such as Leishmaniosis, TB and 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 and 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 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 and 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 Syrian refugees profile

Arrival of the first refugee in Jordan - The very first arrival of a family member to Jordan has been reported to be more than 2 years by (97%) of the respondents where such a figure is supported by last year's findings (95% reported to arrive more than two years in 2016) where most of the first arrivals happened during the year 2013-2014 amid the intensity of the civil war in Syria.

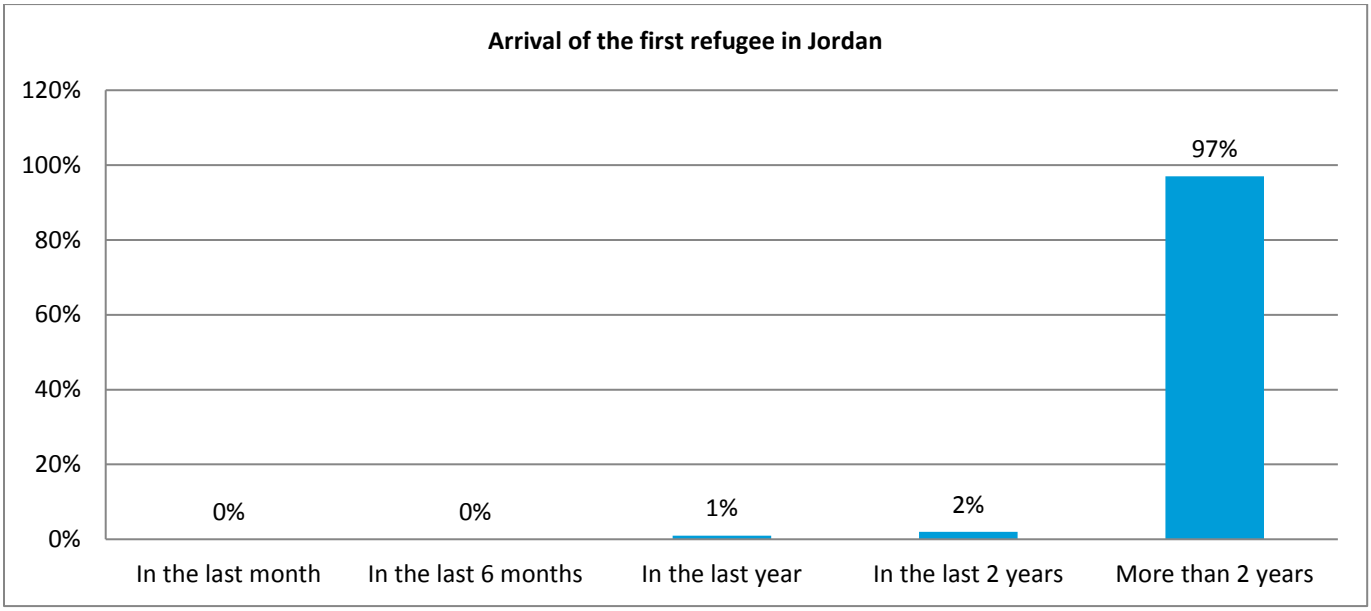
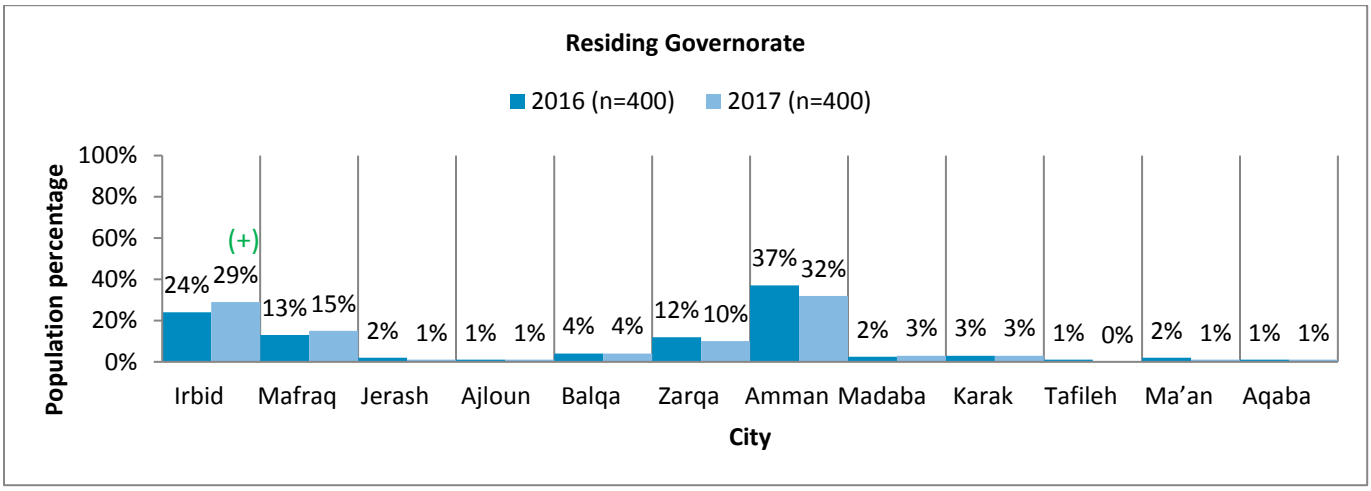


Figure 1: Arrival of the first refugee – All Syrian respondents (n=400)

Residing governorate – Presently refugees host communities mostly dwell in Amman (32%). In comparison of the last year findings there has been an increase in the percentage of refugees who live in Irbid by 5% where 29% 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 (39%) of the Syrian households originated from Daraa followed by Homs (17%) and Damascus (15%).

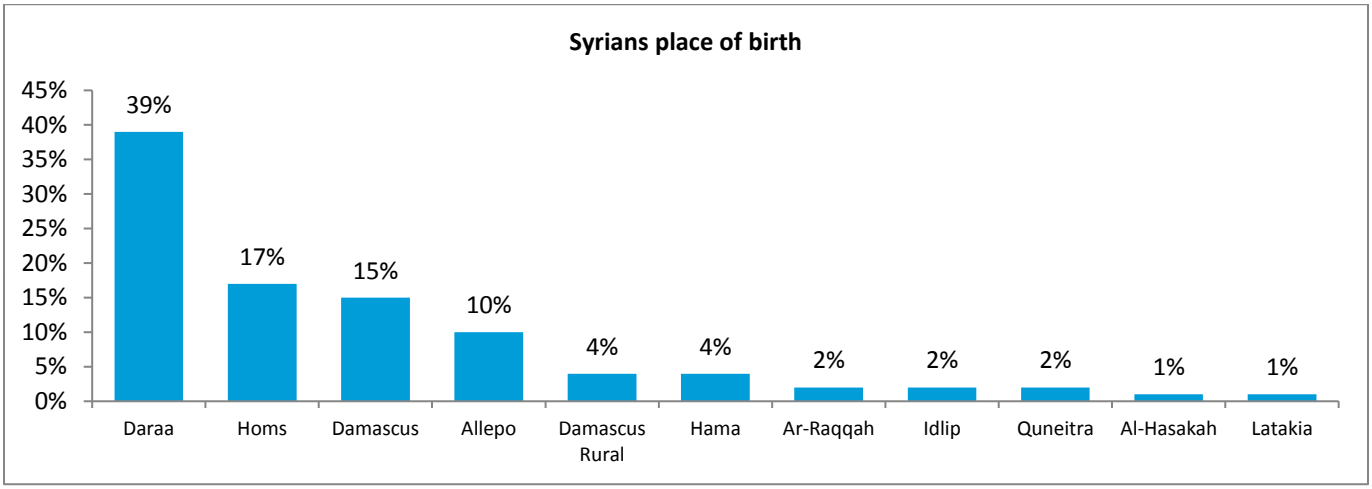


Figure 3: Place of birth - Syrians (n=400)

2.2 Household head profile

Household head profile: Only 81% of respondents interviewed were the head of household. For those who were not interviewed themselves, 87% of them were males .The majority fell into the age group of 36-55 years old by 51% and only 16% of them were illiterate. English comes as the secondary language (6%) as compared to Arabic which is the primary language of 100% of the household heads.

Household head profile	2017 (n=400)
% of Household head	**81%**
Gender	
Male	87
Female	13
Age	
Less than 18 years	0
18-35 years	27
36-55 years	51
More than 55 years	22
Education	
Knows how to read and write	5
Primary School	23
Intermediate/complementary school	31
Secondary school	10
2 years Diploma	5
University	9
None	16
Language spoken	
Arabic	100
Kurdish	0
Turkish	3
English	6
French	0

2. 3 Household Profile

Disability & Impairment
7% of all Syrian household members have been recorded as disabled and needed the assistance of others to perform daily activities.

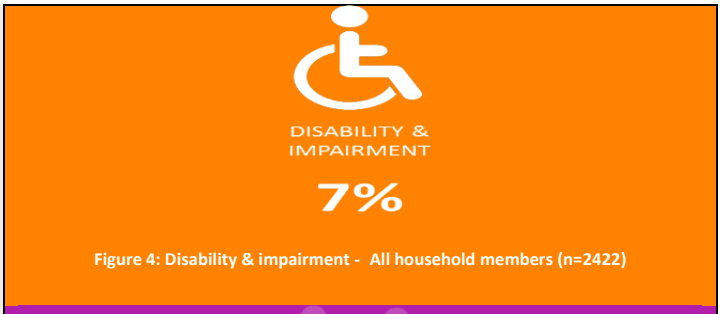


Figure 4: Disability & impairment - All household members (n=2422)

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

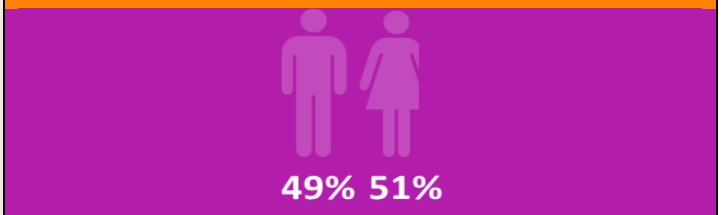


Figure 5: Household gender - All household members (n=2422)

Pregnant females 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 females in Jordan during the last 2 years - Females at reproductive age (n=494)

Mean of household members
2422 Syrian household members has been reported to be living under the same roof and eating from the same pot in 400 households, the average number of the members has been reported to be 6 members per household

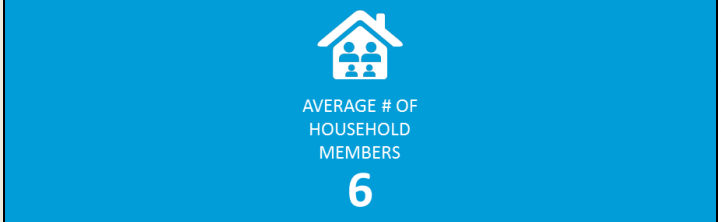


Figure 7: Average # of household members - All household members (n=2422)

Age groups
From all household members (79%) of them were youth less than the age of 35 where (51%) of them where less than the age of 18.

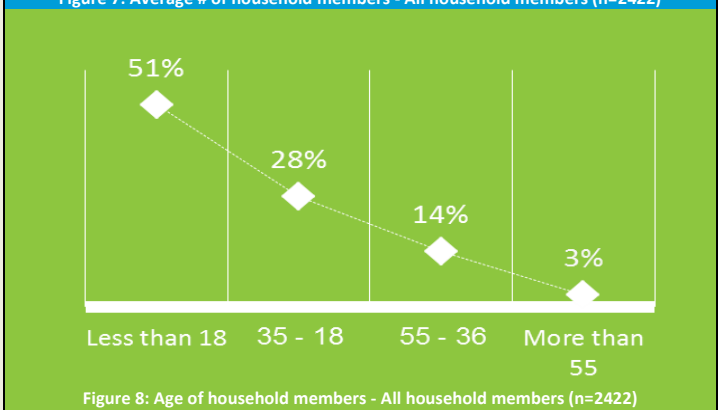


Figure 8: Age of household members - All household members (n=2422)

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

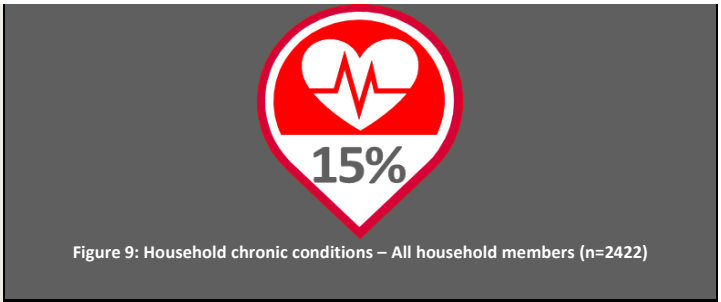


Figure 9: Household chronic conditions – All household members (n=2422)

Marital status
54% of household members are single and 37% are married.

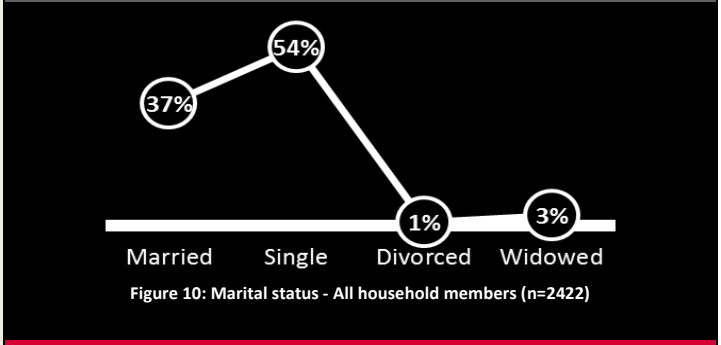


Figure 10: Marital status - All household members (n=2422)

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

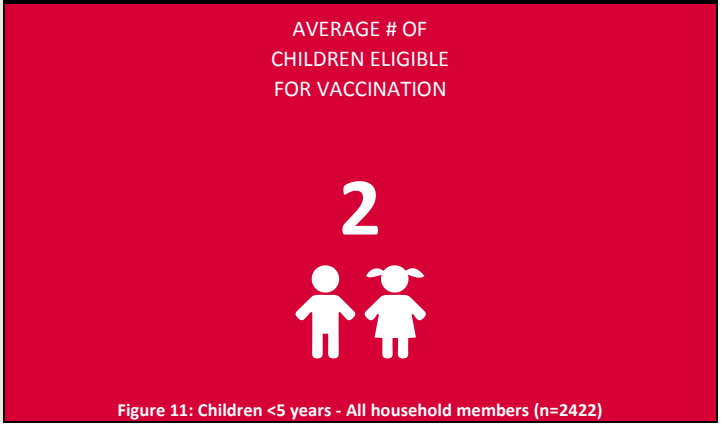


Figure 11: Children <5 years - All household members (n=2422)

2.4 Sample structure summary

Sample structure summary – The family composition among interviewed Syrian households shows a slight decrease in the percentage of female household members and a slight increase in the percentage of household members less than 18 years old.

	2016 (n=400)	2017 (n=400)
# of household members	2,334	2,422
Average # of household members	6	6
% of female household members	53%	51%
% of household members less than 18 years	49%	51%

(+) 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

A decrease in the percentage of Syrians who are aware of the subsidized access to governmental health services shows this year compared to last year's results; where 65% of Syrians interviewed were aware compared to 70% in 2016. This year shows an increase in the percentage of Syrians aware of free access to UNHCR facilities (53% vs. 52%) and those aware of the nearest clinic (52% vs. 47%)

Location of the nearest clinic

Among those aware of the nearest clinic, Irbid scored the highest by (28%) followed by Mafraq (25%) and Amman (22%).

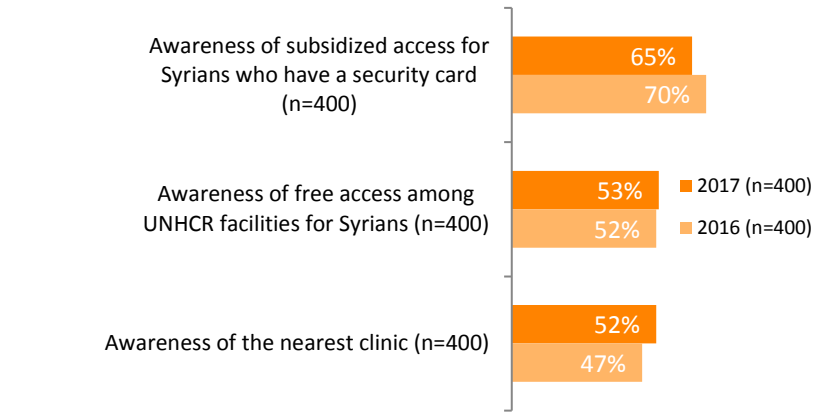


Figure 12: Knowledge of available health services - All respondents

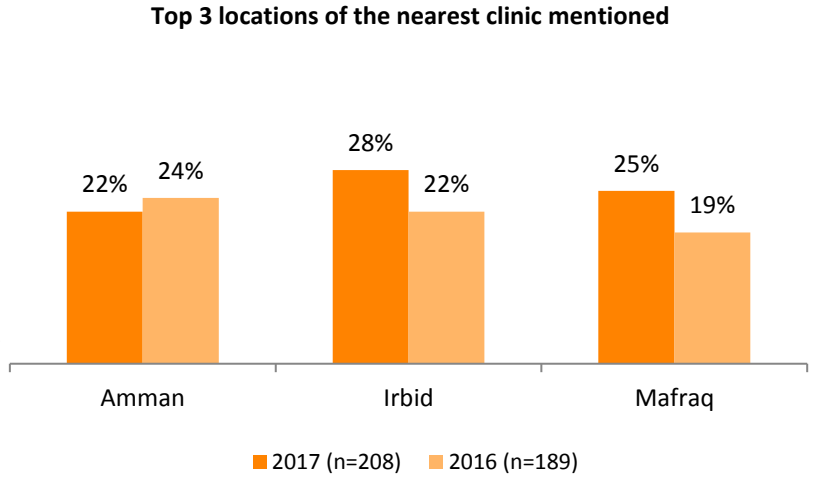


Figure 13: Awareness of the nearest clinic - Those who know the location of the nearest clinic

Access to security card

The penetration of security card among Syrian refugees shows to be the same as in last year. However, regarding the ability to issue the card in the residing governorate a slight decrease of 1% has been recorded to become 92% in 2017.

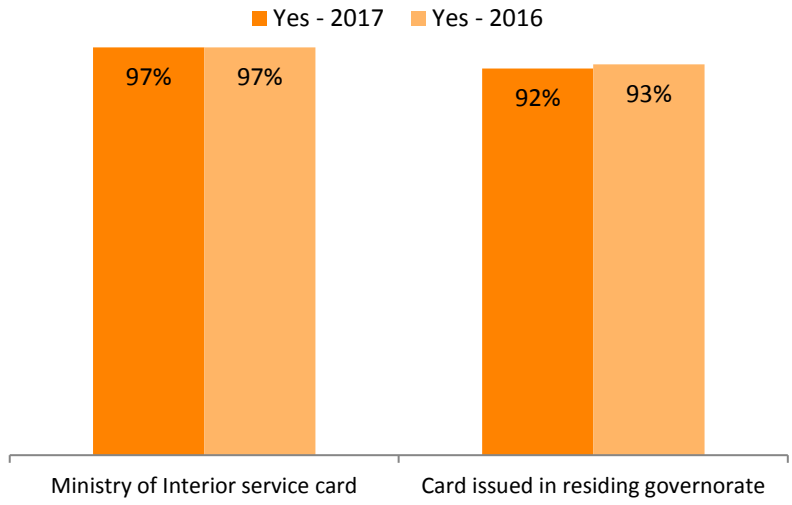


Figure 14: Possession of ministry of interior security card

Reasons for not having the security card

More respondents compared to last year were unable to obtain the card due to changing the area of residence (14% in 2017 vs. 9% in 2016). On the other hand, there is a considerable decrease in the inability to find a Jordanian bailer as a reason of not having security card.

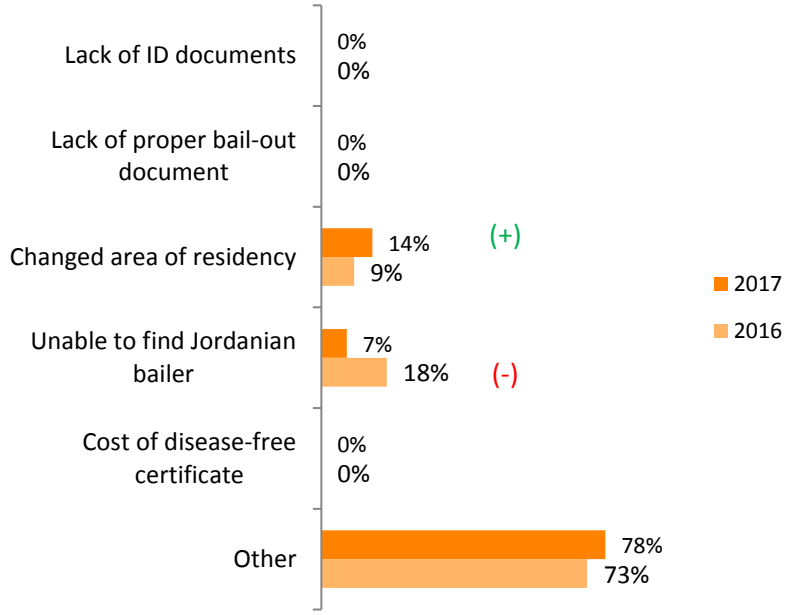


Figure 15: Reasons for not having security card (n=14*)

(*) = Insufficient base for analysis

(+) 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 have a security card shows no change in 2017.

	2016 (n=400)	2017 (n=400)
# of households that didn't obtain security card	11	11
% of households that had a security card	97%	97%

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

4. CHILD VACCINATION

Awareness and access to vaccination card
The awareness of free child vaccination has increased in 2017 compared to the results of 2016 where 96% are aware of the free access to vaccination compared to 93% last year.
The percentage of children who has vaccination card didn't improve where 90% reported to have a vaccination card in line with last year's results.

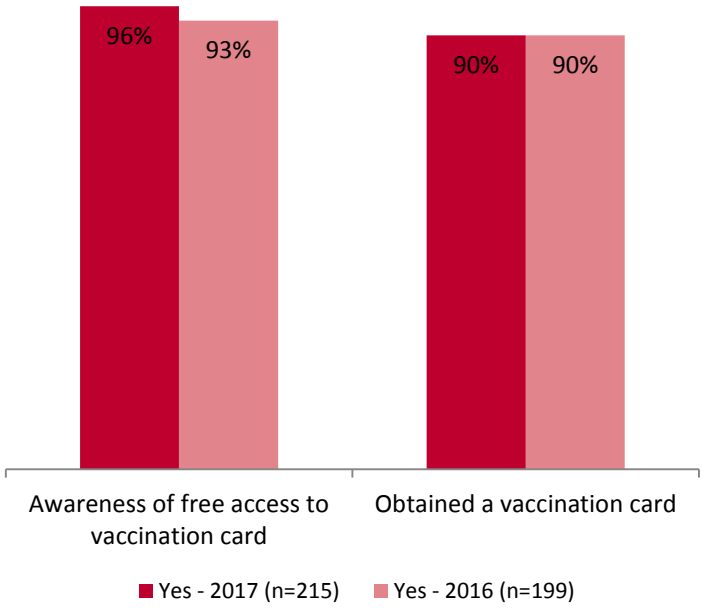


Figure 16: Awareness and possession of free access vaccination card - Households that have children <5 years

Access to MMR and Polio Vaccination
The access to MMR and polio vaccination shows a decrease in 2017 where 90% of households reported that their children had the MMR vaccination and 93% reported that their children had the polio vaccination compared to 93% and 94% respectively in 2016.

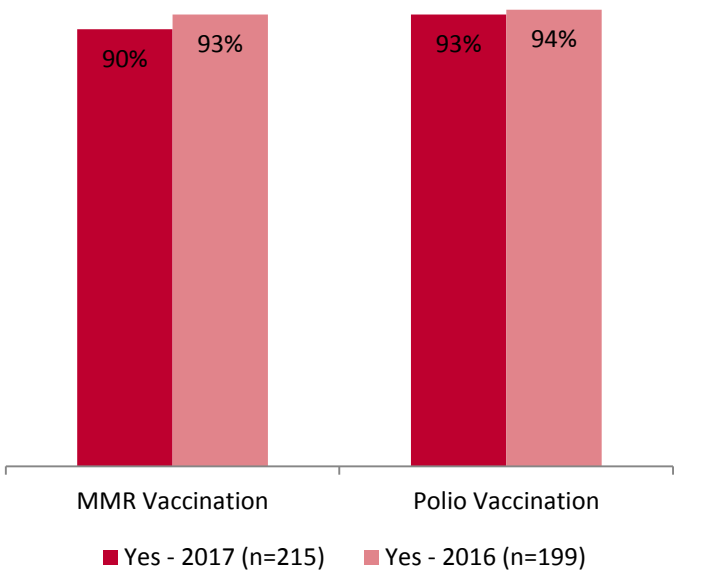


Figure 17: Access to vaccination - Households that have children <5 years

Difficulties to obtain vaccination

In 2017 fewer difficulties to obtain vaccination were encountered by refugees where the percentage of those who had difficulties in obtaining polio is 1%, while no one showed to had difficulties obtaining MMR.

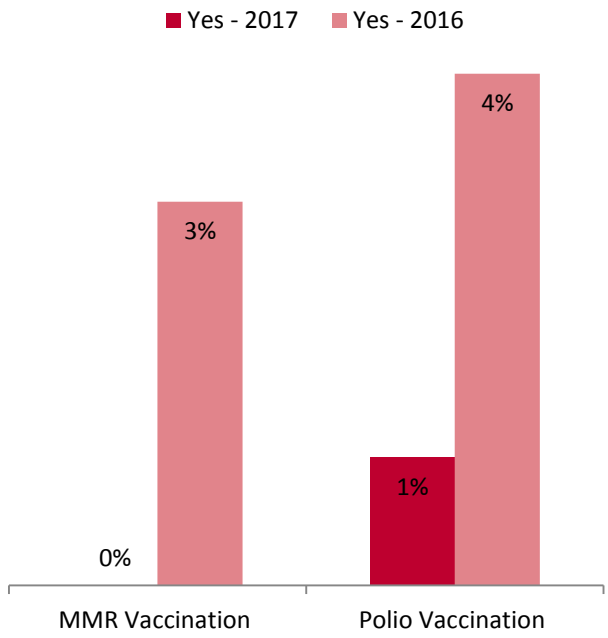


Figure 18: Difficulties to obtain vaccination - Those who obtained vaccination

Vaccination Facility

There is an increase in the percentage of those who had the MMR vaccination in governmental health centers in Jordan in 2017 by 2% compared to 2016 results.

The polio vaccination in governmental health centers witnessed a 1% increase as well compared to last year.

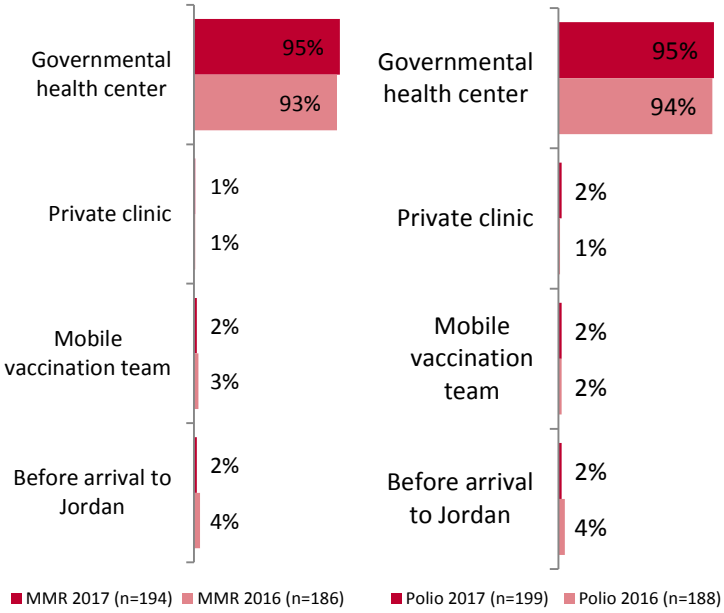


Figure 19: Vaccination facility - Those who obtained vaccination

Encountered difficulties
Only 2 reported they had difficulties obtaining polio vaccination this year. Main difficulties mentioned among them were the long wait, the transportation costs, and the unavailability of the vaccination.

(*) = Insufficient base for analysis

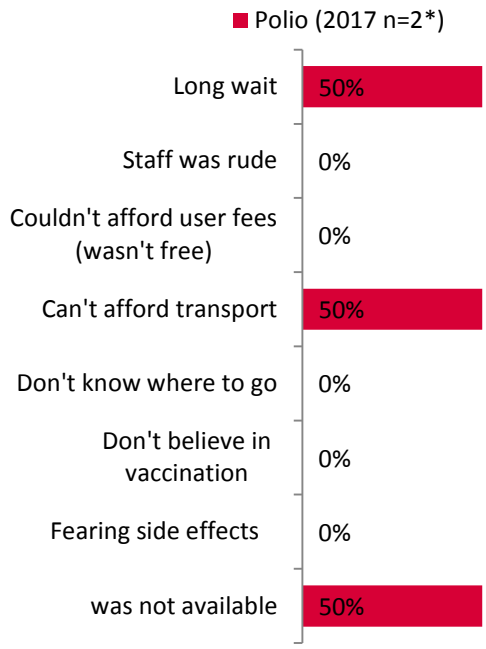


Figure 20: Difficulties while obtaining the vaccine - Those who encountered difficulties while obtaining the vaccine

4.1 Child vaccination summary

Child vaccination summary – The access to vaccination card doesn't show any increase compared to last year, yet the percentage of those who faced difficulties to receive vaccination decreased in 2017. Access to vaccination at governmental health care centers in Jordan has marginally improved by (1%).

	2016 (n=199)	2017 (n=215)
% that had an vaccination card	90%	90%
% that faced difficulties obtaining vaccine	4%	1%
% that received vaccine at Jordanian government primary health care centre	94%	95%
% that received vaccine before coming to Jordan (in Syria)	4%	2%
% that received vaccine at a mobile medical unit in Jordan	3%	2%

5. Antenatal care

5.1 Access to antenatal care

Access to antenatal care

The results show an increase in the percentage of pregnant females who received antenatal care (88% vs. 85% last year). However, there is a considerable increase of pregnant women who had difficulties while receiving antenatal care in 2017 (17%) compared to last year results (9%)

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

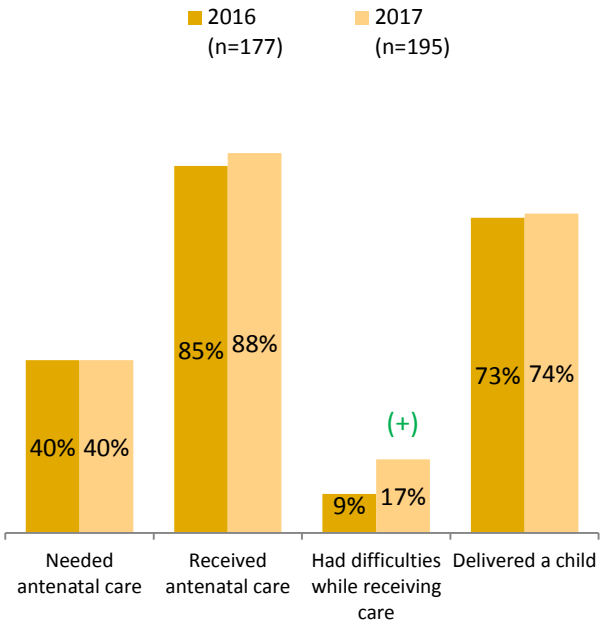


Figure 21 - Access to antenatal care - Pregnant females in Jordan during the last 2 years

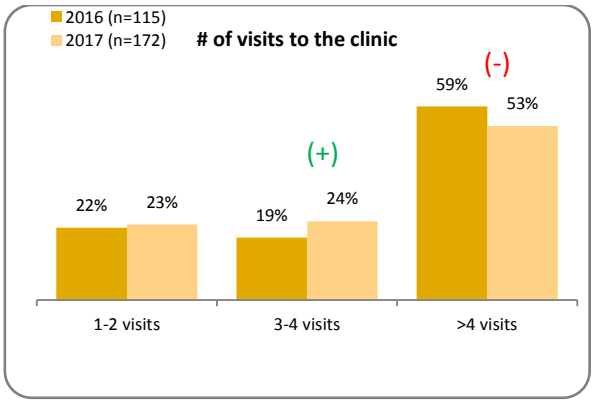


Figure 22: Number of visits to the clinic - Households that had females who received antenatal care

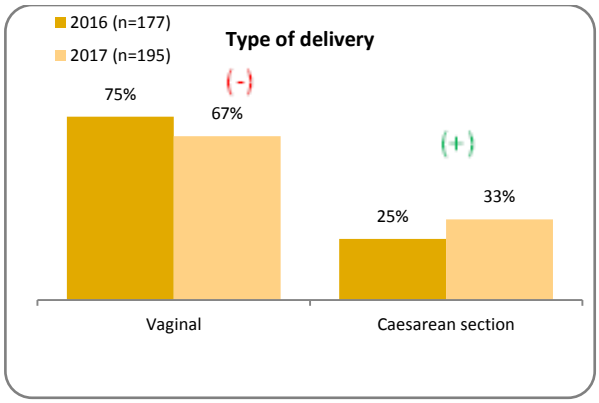


Figure 23: Type of delivery - Pregnant females in Jordan during the last 2 years

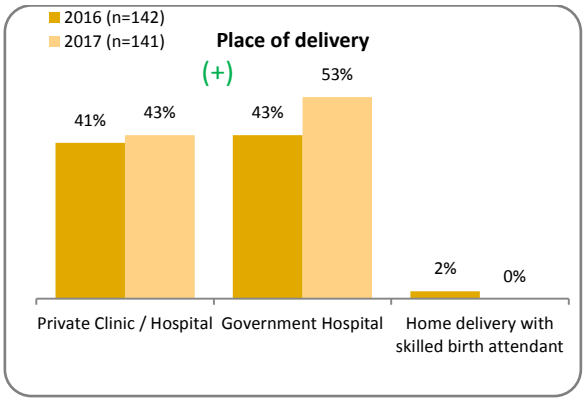


Figure 24: Place of delivery - Those who delivered a child

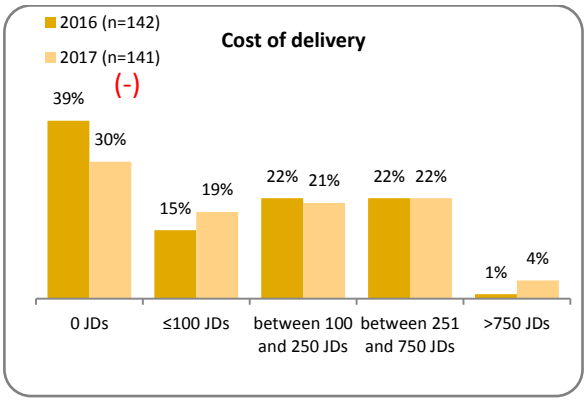


Figure 25: Cost of delivery - Those who delivered a child

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

67% of pregnant females delivered a child through normal vaginal delivery while 32% delivered in the Caesarian section. Regarding the cost of the delivery, 30 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 private hospitals and governmental hospitals charges.

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

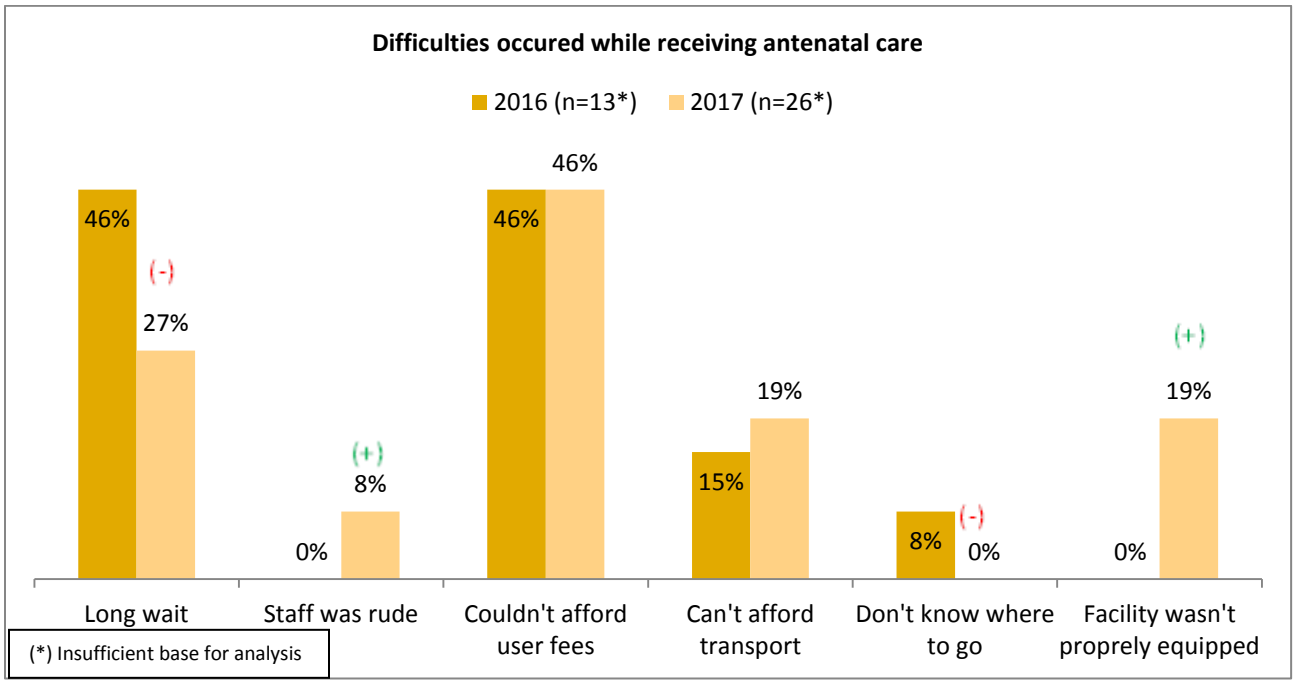


Figure 26: Difficulties occurred while receiving care - Those who encountered difficulties

Reasons for a private facility – The reason for accessing care in a private facility is based on the preference of respondents (30%) in addition to lack of access to eligible governmental facilities at a subsidized rate (11%), followed by ineligibility to the latter (7%).

On comparing the results of 2016 and 2017, an increase in those who are eligible to access MoH facilities but could not is witnessed.

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

Reasons accessing care in a private hospital/clinic	2016 (n=58)	2017 (n=57)
Not eligible to access Ministry of Health facility at subsidized rate	19%	7% (-)
Eligible to access Ministry of Health facility at subsidized rate but could not access	7%	11%
Prefer to go to a private facility	36%	30%
Others	41%	60%

5.2 Family planning

In all households who had a pregnant female eligible to antenatal care reported that 48% of the households were aware of family planning (down 4% from 2016) and 54% acquired knowledge on family planning mainly through health care center staff (53%) – up (12%) since 2016, followed by community events (38%) as the main sources of knowledge – up (10%) since 2016.

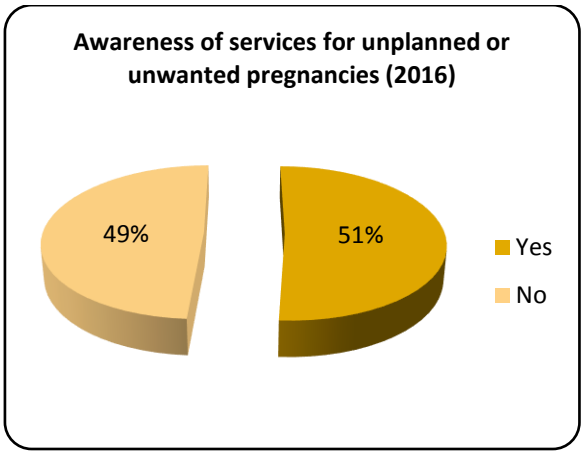


Figure 27: Awareness of services for unplanned pregnancies - Households that had pregnant females (n=129)

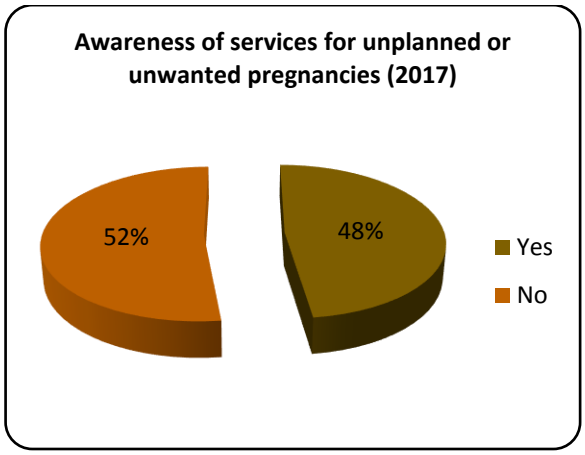


Figure 29: Awareness of services for unplanned pregnancies - Households that had pregnant females (n=129)

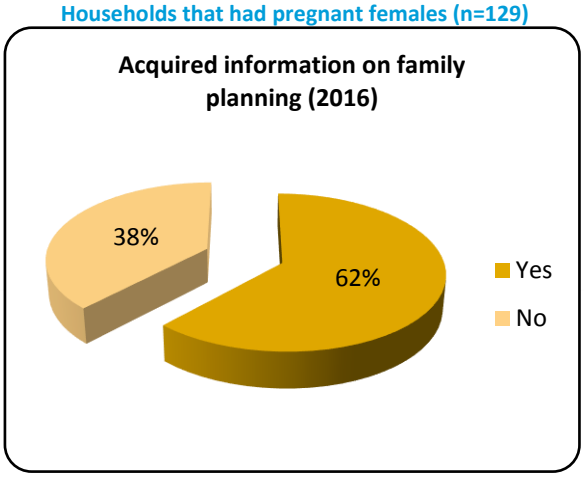


Figure 28: Acquired information on family planning - Households that had pregnant females (n=126)

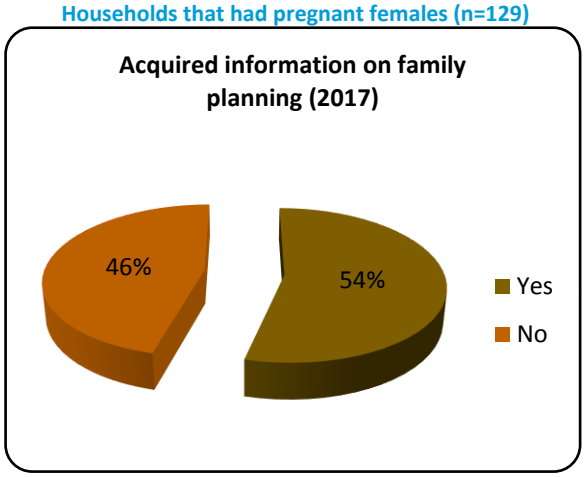


Figure 30: Acquired information on family planning - Households that had pregnant females (n=126)

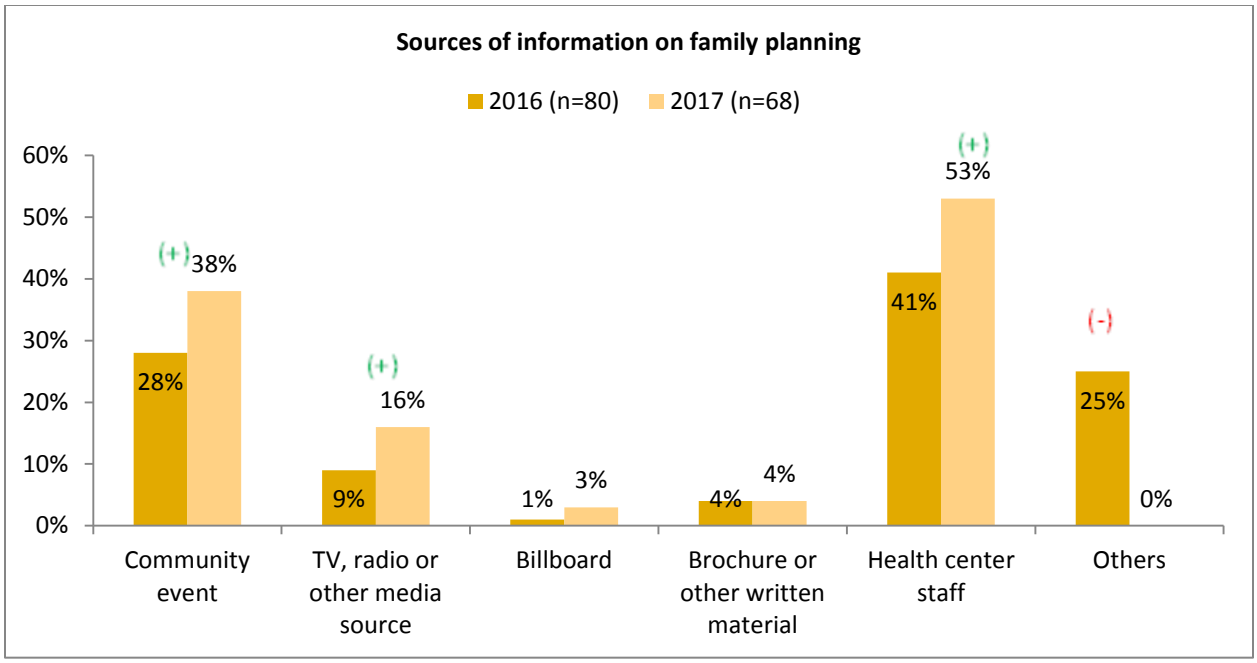


Figure 31: Sources of information on family planning - Households that had pregnant females

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

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 center (36%), with more people opting to seek contraceptives from Private Doctors (32%) increasing 23% from 2016.

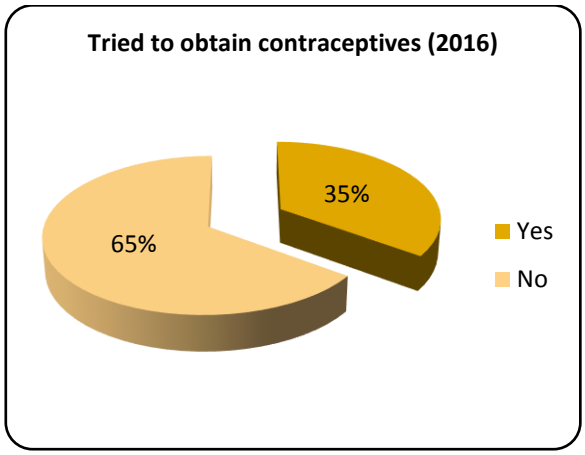


Figure 32: Trial to obtain contraceptives - Households that had pregnant females (n=129)

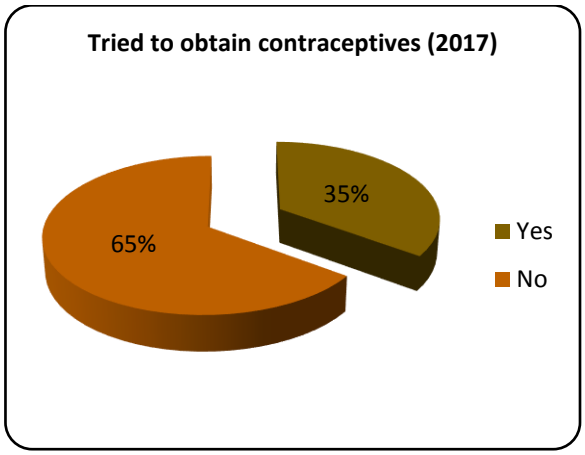


Figure 34: Trial to obtain contraceptives - Households that had pregnant females (n=126)

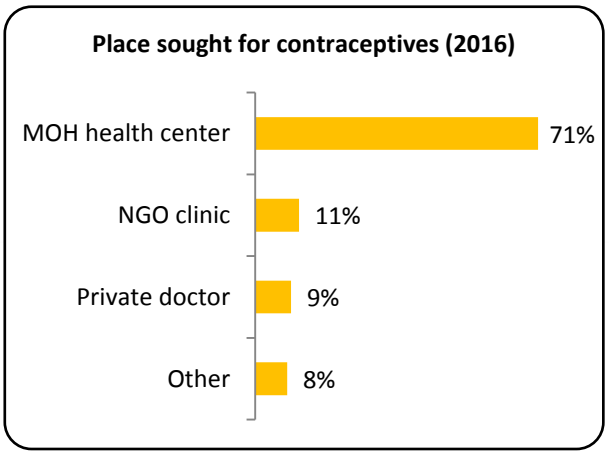


Figure 33: Place sought for contraceptives - Households who had a family member trying to obtain contraceptives (n=45)

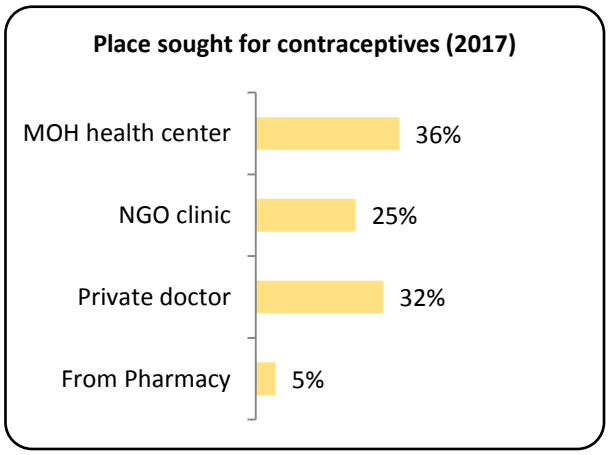


Figure 35: Place sought for contraceptives - Households who had a family member trying to obtain contraceptives (n=44)

5.4 Antenatal care summary

On overall level, the antenatal care shows a drop in the performance compared to last year on many attributes. There is a significant increase in the percentage of pregnant women who had difficulty accessing ANC, as well as an increase in those who can't afford fees or transport. Also a decrease in the deliveries free of cost is recognized in 2017 results.

On the other hand, instances where long wait was encountered and not knowing where to go for ANC fell significantly in 2017 in comparison with 2016 findings.

	2016 (n=177)	2017 (n=195)
% of pregnant women who had at least one ANC visit	85%	88%
% of pregnant women who had difficulty accessing ANC	9%	17% (+)
% of those who couldn't afford fees or transport	61%	65%
% of those who encountered Long wait and/or rude staff	46%	35% (-)
% of those who didn't know where to go	8%	0% (-)
% of deliveries by caesarean section	25%	32% (+)
% of deliveries in private facilities	41%	40%
% of deliveries in government facilities	43%	53% (+)
% of deliveries free of cost	39%	30% (-)

(+) 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 (39%) members suffer from Hypertension followed by 32% who were reported diabetic. The main types of chronic illnesses reported did not change much from 2016 over 2017, with most types seeing a decrease save for Kidney Disease and Mental Illness which both saw a (2%) increase in 2017.

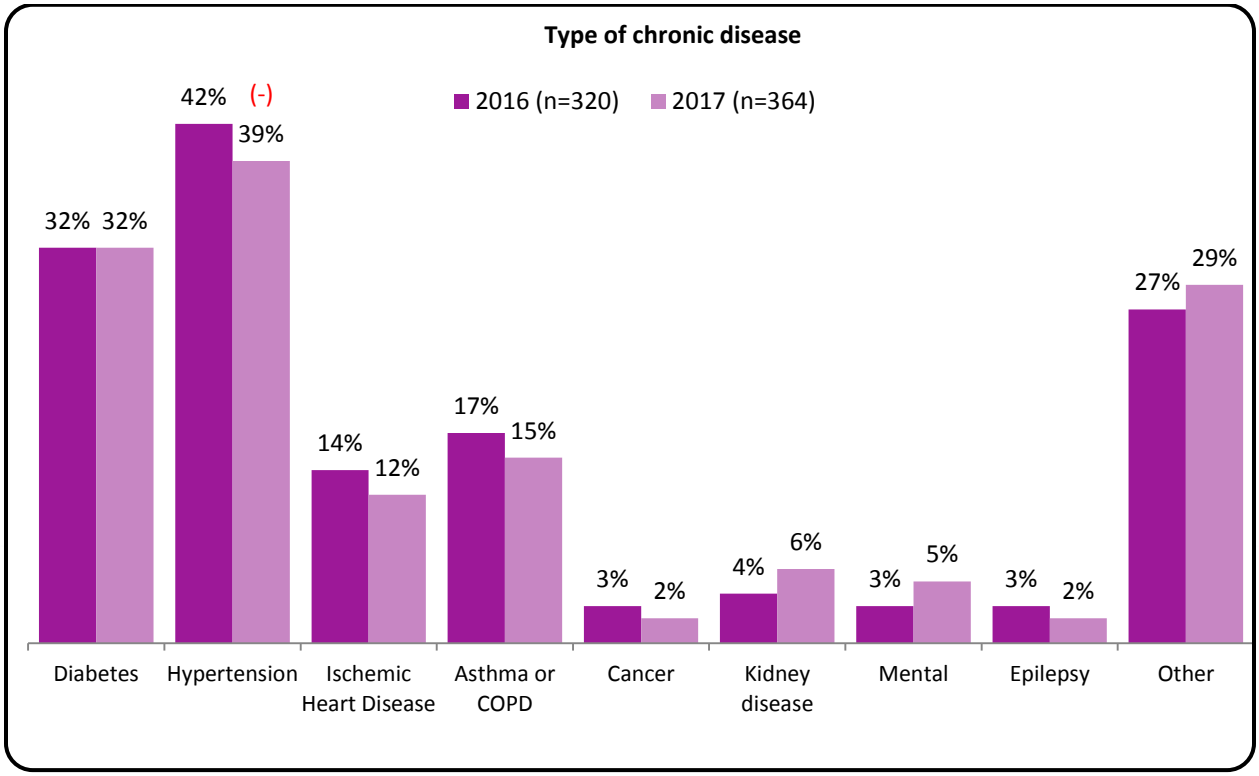


Figure 36: Type of chronic disease - Household members that have a chronic condition

(+) 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, 45% of them (down 11% from 2016) were unable to access medicine mainly due to the cost of medicine (76%). We also witness a considerable increase in the number of cases where the medicine was not available in facility (30% in 2017, up 20% from 2016)

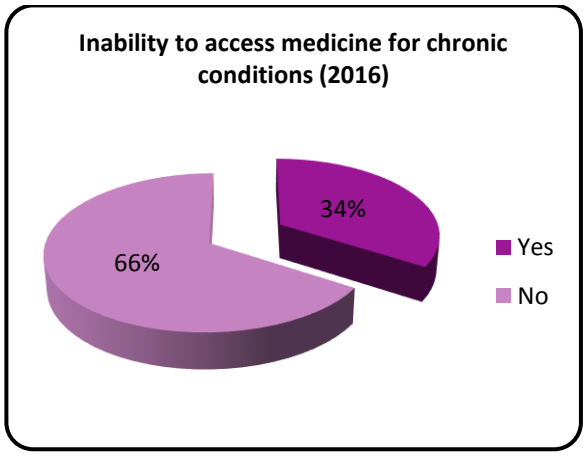


Figure 37: Inability to access medicine - households that have a member with chronic condition (n=204)

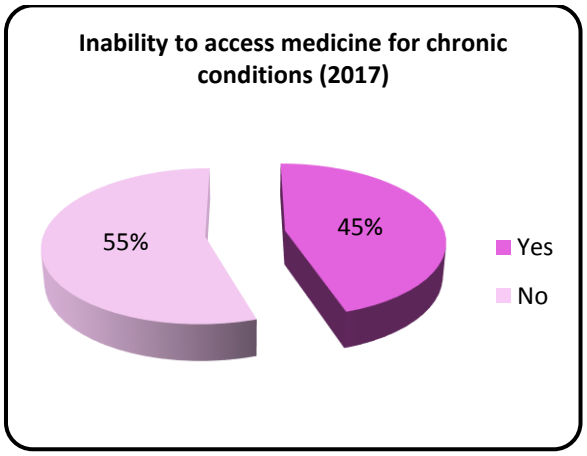


Figure 39: Inability to access medicine - households that have a member with chronic condition (n=227)

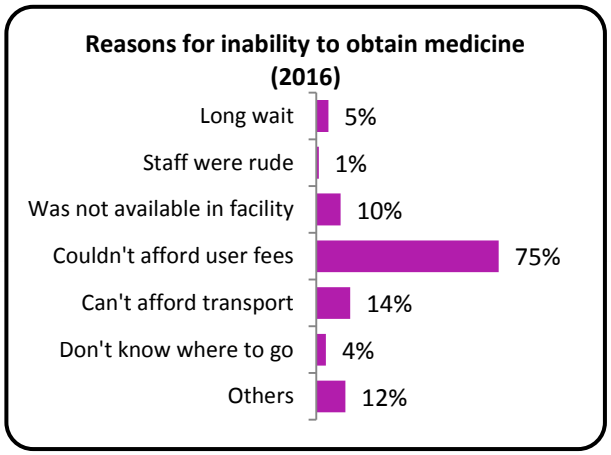


Figure 38: Reasons for inability to access medicine - Those who were unable to obtain medicine (n=101)

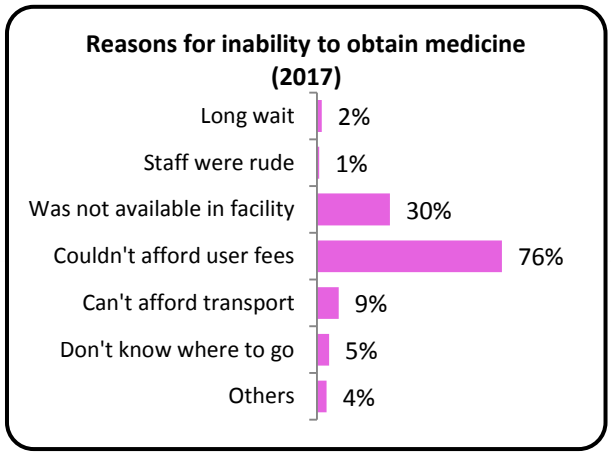


Figure 40: Reasons for inability to access medicine - Those who were unable to obtain medicine (n=143)

6.3 Access to medical services for chronic conditions

From those who needed to access medical services for their chronic condition, 39% (increased 2% from 2016) of them were unable to access medical services mainly due to the inability to afford the cost (80% - increased 6% from 2016).

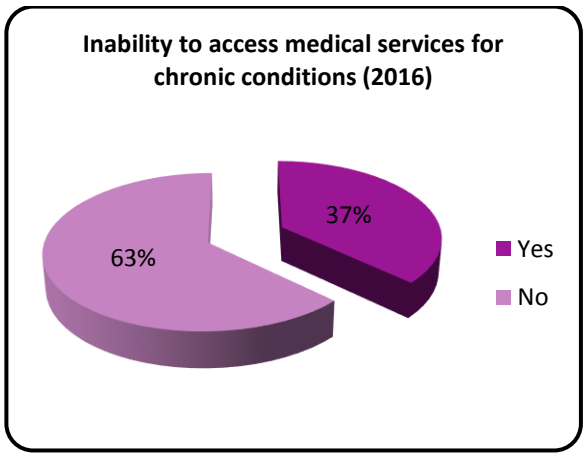


Figure 41: Inability to access health services - households that have a member with chronic condition (n=204)

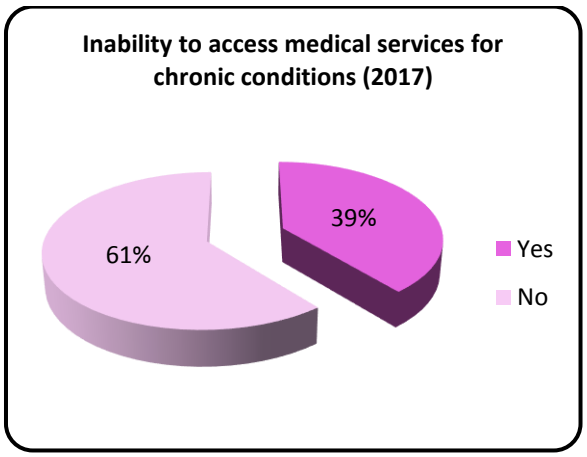


Figure 42: Inability to access health services - households that have a member with chronic condition (n=227)

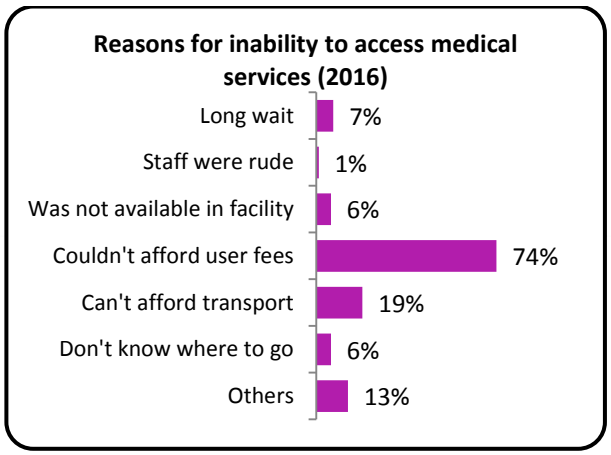


Figure 43: Reasons for inability to access health services - Those who were unable to access health services (n=109)

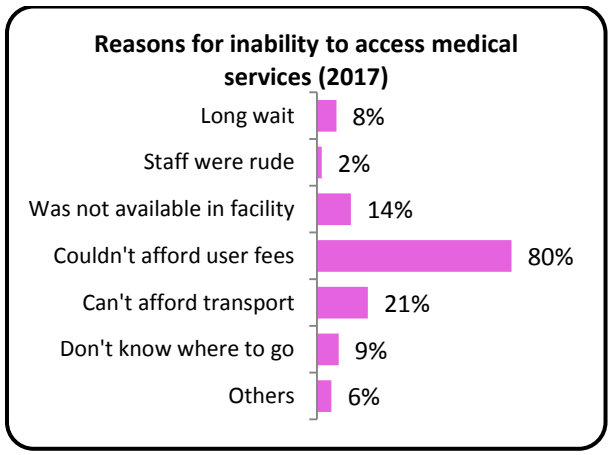


Figure 44: Reasons for inability to access health services - Those who were unable to access health services (n=118)

6.4 Chronic disease summary

Access to medicine and health services worsened by 6% in 2017, yet inability to afford fees has been numerously reported where it appreciated by 3% to stand at (78%) of the reasons leading to inability to access medical and health services. In addition, service unavailability saw a rise by (14%) in 2017.

	2016 (n=400)	2017 (n=400)
% of households members with a chronic condition	14%	15%
% of adults with chronic conditions who weren't able to access medicine or other health services	36%	42% (+)
% of those who couldn't afford fees of medicine	75%	76%
% of those who couldn't afford fees of medical service	74%	80% (+)
% of service unavailable in local facility	8%	14%(+)
% of those who didn't know where to access care	6%	9%

(+) 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 20% in 2017 compared to the findings of the previous year.

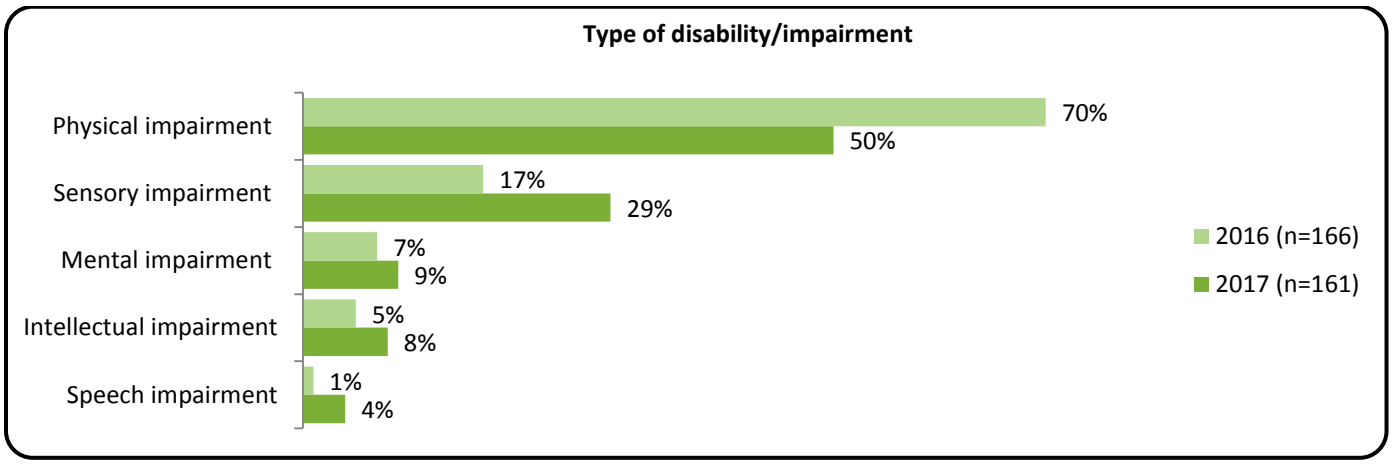


Figure 45: Type of disability/impairment - Household members who had a disability/impairment

Most of the disabilities occurred due to natural reasons followed by violence war related.

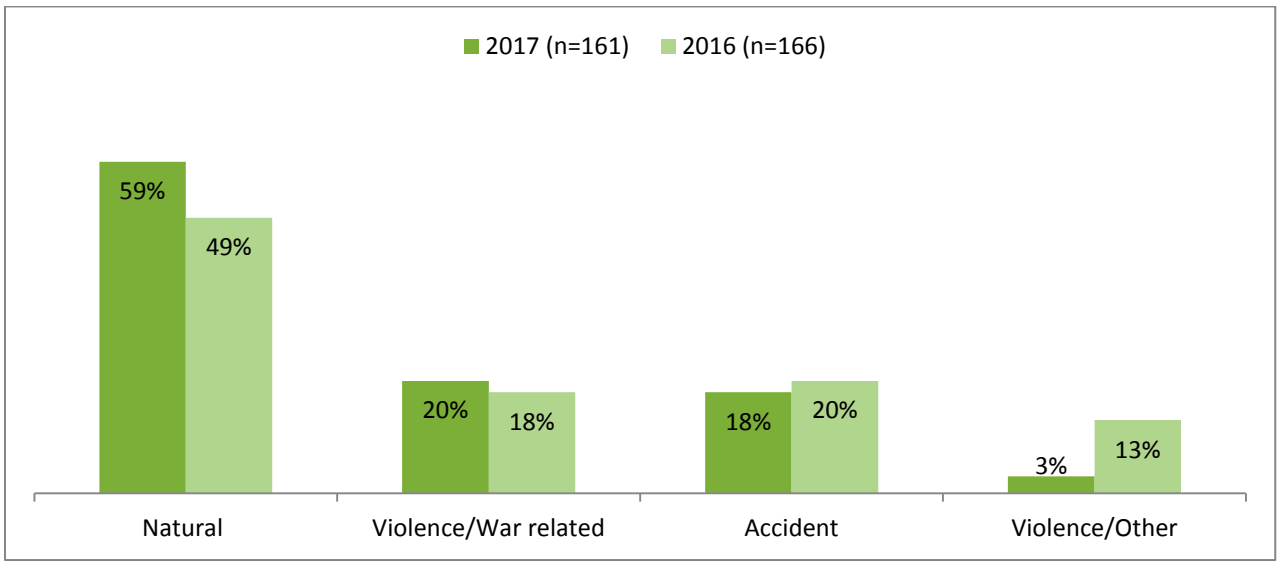


Figure 46: Cause of disability/impairment - Household members who are disabled/impaired

7.2 Disability & impairment therapy

In 2016 Jordan had the lead on the place of first treatment, yet this year both treatment in Syria and Jordan are in parity as a place for first treatment

Access to rehabilitation, assistive devices and surgical treatment shows a decline as compared to 2016, in contrast to psychosocial treatment which increases by 12%.

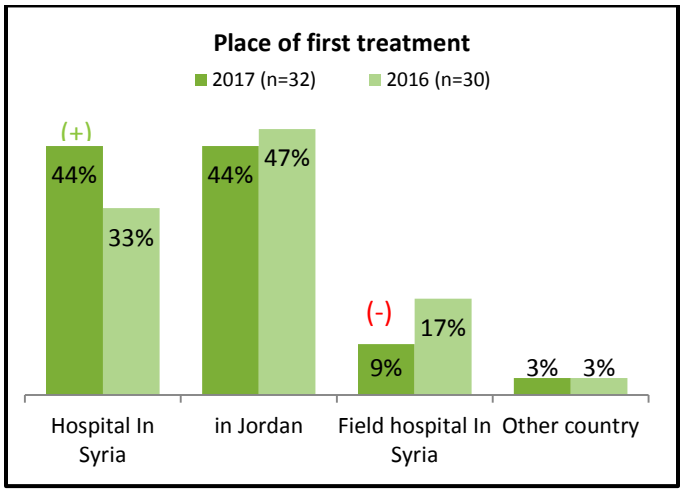


Figure 47: Place of first treatment - those who had a violence/war related disability/impairment

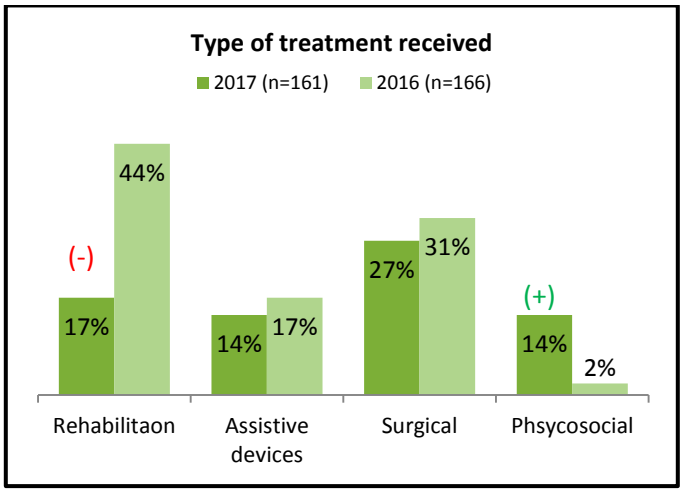
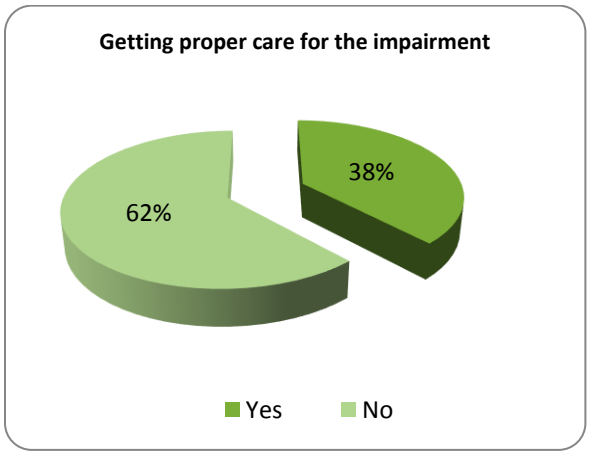


Figure 48: Type of treatment received - Household members who are disabled/impaired

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

7.3 Getting proper care

Only 38% reported to get proper care for their impairment. Inability to afford user fees is the main barrier to proper care reported by 41% of households who had a disabled member



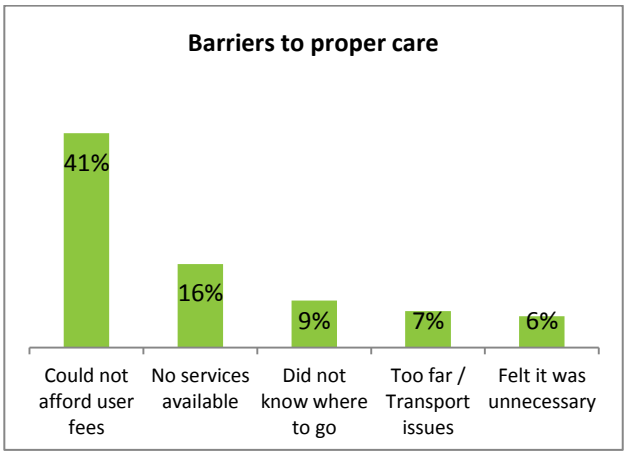


Figure 49: Getting proper care - Household members who are disabled / impaired (n=161)

7.4 Disability & impairment summary

44% of impaired members continue to receive health care from Jordan yet a shift to Syria for receiving first treatment by 3% of impaired members as compared to last year is witnessed.

	2016 (n=166)	2017 (n=161)
% who were reported to have a disability	7%	**7%**
% of impairments due to war related violence	18%	20%
% of those who received care in Jordan	47%	44%
% of those who received care in Syria	50%	53%
% of those could not afford service fees and/or transport costs	52%	48%
% of who did not know where to go	8%	9%

(+) 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 37% of household members where 77% of them actively sought health services.

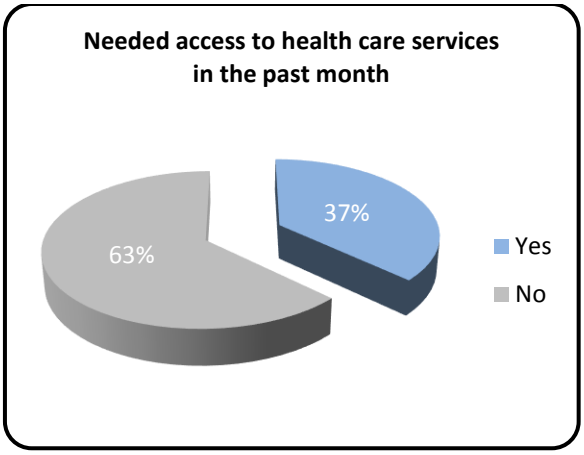


Figure 50: Need to access health care in the past month - All household members (n=2422) 2017

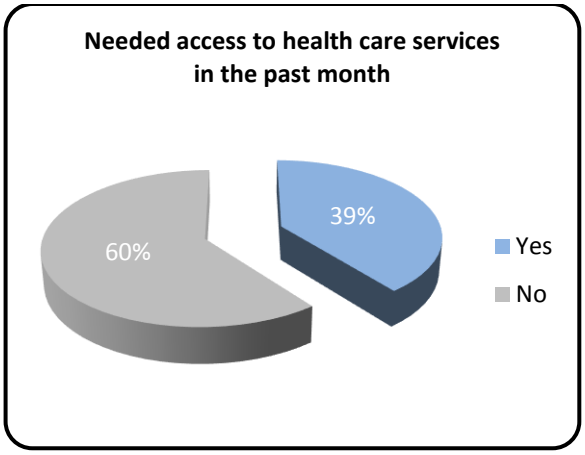


Figure 51: Need to access health care in the past month - All household members (n=2334) 2016

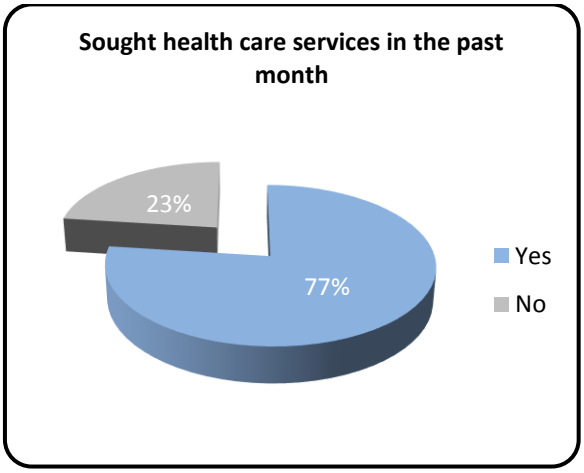


Figure 52: Sought health care services in the past month - All household members who sought health care (n=905) 2017

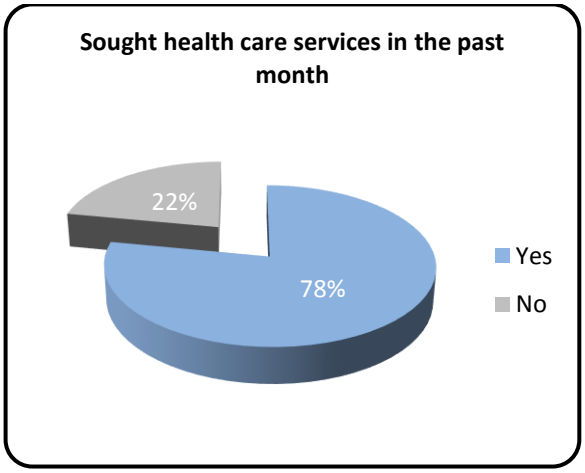


Figure 53: Sought health care services in the past month - All household members who sought health care(n=905) 2016

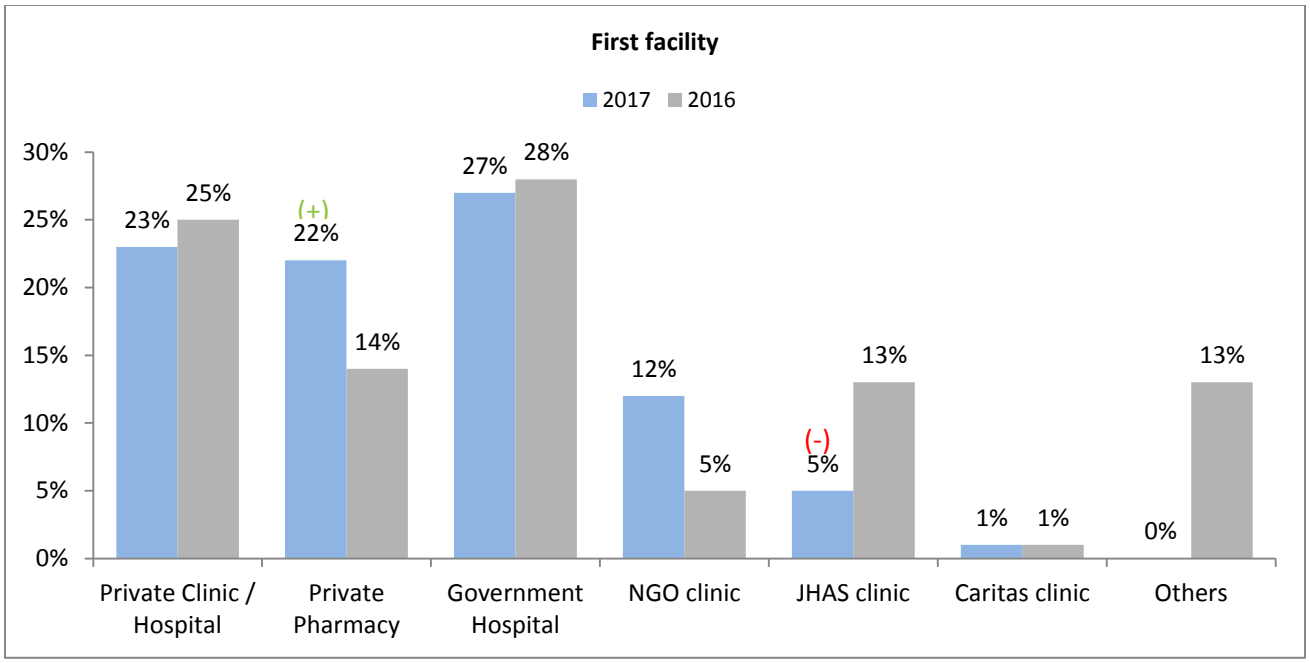


Figure 54: First facility - Those who sought health care services 2017 (n=696), 2016 (n=707)

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

From those who sought the services the majority initially reached either a government hospital (27%) followed by private clinic/hospital (23%) or private pharmacy (22%) and paid an average 30.5 JDs in the first facility.

8.2 Second facility

As a result of inability to be served in the first facility 24% of household members decided to seek an alternative facility. Last year the majority (57%) who sought of a second facility went to governmental hospital. However, in 2017 (38%) out of which went to private clinic followed by (29%) to governmental hospital. A drop in the percentage of those who seeks governmental hospitals in 2017 is seen.

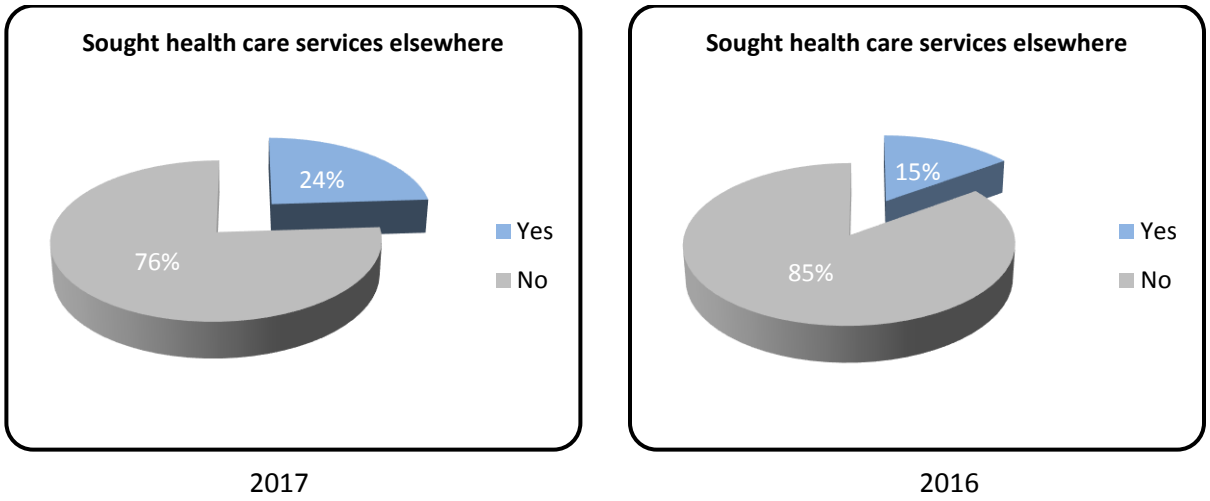


Figure 55: Sought healthcare elsewhere - Those who sought healthcare services 2017 & 2016 (n=254)

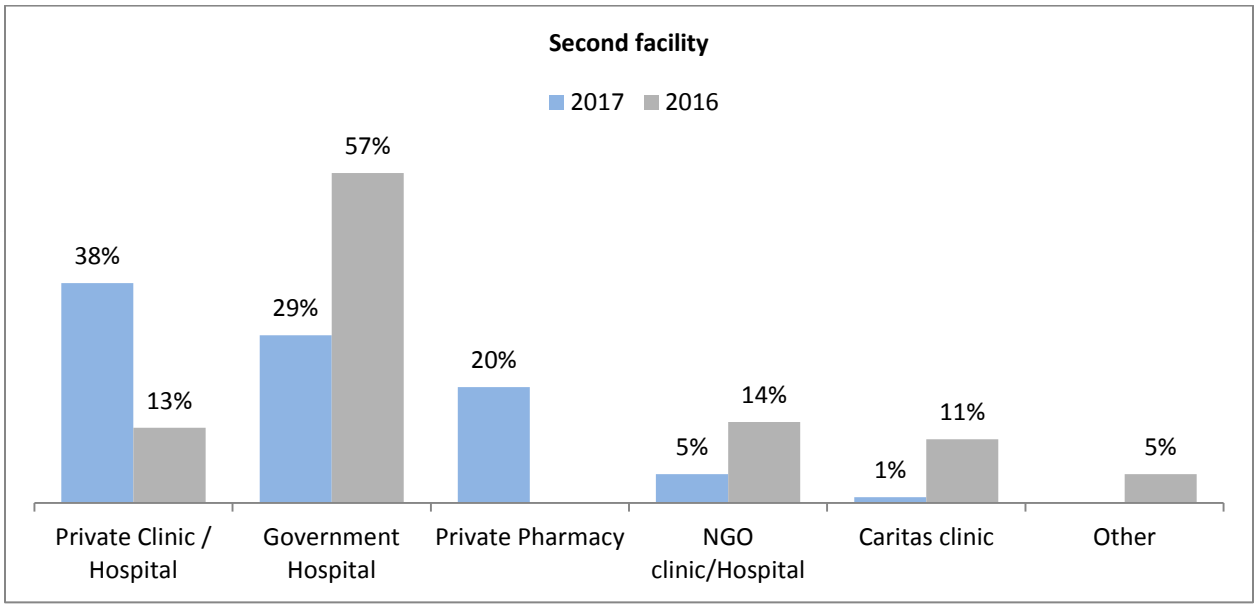


Figure 56: Second facility - Those who sought care elsewhere 2017 (n=84), 2016 (n=56)

8.3 Household spending

In terms of household spending on health care 79% of interviewed households spent money on health care services during the last month, the mean of the combined income of interviewed households is 243.0 JDs where they spend an average of 99.8 JDs on health care which is 41% of their total income

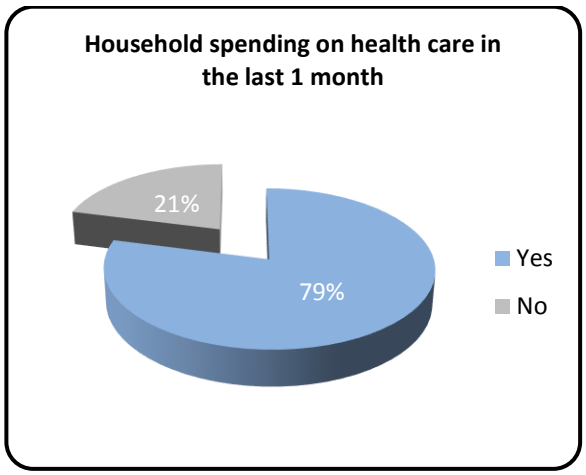


Figure 57: Household spending in the last month - All respondents (n=400)

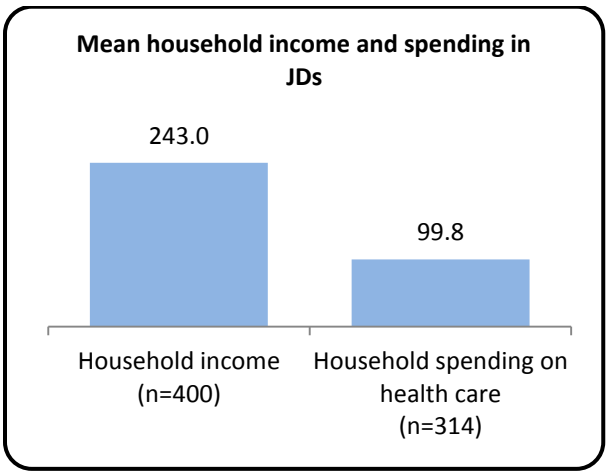


Figure 58: Mean household income & expenditure

8.4 Monthly household assesment summary

91% of the interviewed sample continues to have access for health care in the first facility and 23% out of those who sought of health care received it through a private clinic/hospital. The average spending in first health care facility decreased by 46.6% as compared to last year.

	2017 (n=400)	2016 (n=400)
% of surveyed household members who needed health care in preceding month	37%	39%
% of those who were able to receive care in first health facility	91%	91%
% of those initially seeking care in a private clinic or hospital	23%	25%
Average cost for care in first facility	30.5 JD (-)	57.1 JD

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