Factors influencing Syrian refugees' access to NCD Care services in the Hashemite Kingdom of Jordan

Review and analysis of factors that influence the Syrian Refugees access to NCD care services in Jordan, and what is the way forward!

Dr Abdul Jamil Faqirzai

AFGHANISTAN

55th Master of Science in Public Health/International Course in Health Development
KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam (VU)

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health by

Dr Abdul Jamil Faqirzai

AFGHANISTAN

Declaration:
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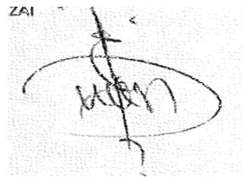
Signature: 

55th Master of Science in Public Health/International Course in Health Development
17 September 2018 – 6 September 2019
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam
Amsterdam, The Netherlands
September 2019

Organised by:
KIT (Royal Tropical Institute)
Amsterdam, The Netherlands
In co-operation with:
Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)
Amsterdam, The Netherlands

Table of Contents:

I. List of Tables and Figures **5**
II. List of Abbreviation: **6**
III. Terminologies and definitions: **7**
IV. Introduction: **8**
Chapter 1: Background and Context 10
1.1. The Syria Arab Republic before and after the Crisis 10
1.2. The Kingdom of Jordan and the refugee crisis 11
Chapter 2: Problem statement, Study Objective, and Methodology 12
2.1. Problem statement 12
2.2. Research objectives 13
2.2.1. General objective 13
2.2.1.1. Specific objective 1 13
2.2.1.2. Specific objective 2 13
2.2.1.3. Specific Objective 3 14
2.2.1.4. Specific Objective 4 14
2.3. Research Methodology 14
2.3.1. Study design: 14
2.3.2. Search strategy 14
2.3.3. Keyword and terms 15
2.3.4. Conceptual Framework 15
2.3.5. Study limitations 16
Chapter 3: Findings 17
3.1. Jordan's refugee policy and refugees' access to health care 17
3.1.1. An overview of Jordan's refugee policy 17
3.1.2. Factors driving policy changes on health care for refugees in Jordan 18
3.1.2.1. Financial and Health system capacity strains 18
3.1.2.2. Socio-political pressure from Jordanian society on Jordan's Government 18
3.1.2.3. The shortfall in the commitment of international funding agencies 19
3.1.3. Policy changes impacts on Syrian refugees' access to Health care 19
3.1.3.1. Rendered access to Medical care 19
3.1.3.2. Procedural barriers affecting Access 21
3.1.3.2.1. "Urban verification exercise" (UVE) 21
3.1.3.2.2. Suspending the "bailout" mechanism and restriction on movements 22
3.2. Jordan Health delivery system and Refugees access to health care 23
3.2.1. Jordan health care system: an overview 23

3.2.1.1. Health system organisation and governance 23
3.2.1.2. Health system structure 24
3.2.1.2.1. Primary Care services 24
3.2.1.2.2. Secondary and Tertiary Care services 25
3.2.1.2.3. Health Insurance Coverage 25
3.2.2. The burden of non-communicable disease in Jordan 26
3.2.3. Impact of the refugee crisis on Jordan’s health care system 26
3.2.4. Health system’s barriers affecting access of Syrians to NCD care: 28
3.3. Syrian Refugees' characteristics and access to health care 31
3.3.1. The Burden of NCD among non-camp Syrian refugees 31
3.3.2. Social determinants of health for Syrians refugees living in urban areas 32
3.3.3. Economic obstacles influencing access to NCD care for refugees: 33
3.3.4. Rendered access to health care to bureaucratic procedures 36
3.3.4.1. Registered Syrian refugees 36
3.3.4.2. Unregistered Syrian refugees 37
Chapter 4: Discussion 38
4.1. Policy changes implication on access **........ 38**
4.2. Health system’s and refugees’ characteristics and their impact on access 40
Chapter 5: Conclusion and Recommendations 42
5.1. Conclusion 42
5.2. Recommendations 43
5.2.1. To the Government of Jordan 43
5.2.2. To Jordanian MOH : 43
5.2.3. To the international community, including donors Agencies: 43
6. References **........ 45**
7. Appendixes **........ 50**
7.1. Appendix A: Adapted version of Aday Andersen model of access in a refugee setting 50

I. List of Tables and Figures

List of Figures:

Figure 1: Geographical distribution of Syrian refugees in the Middle East (9) 11
Figure 2: Aday Andersen Model of Access (29: p.212) 16
Figure 3: Trend of Syrian refugees Outpatient consultation and Hospital admission in public facilities between Jan 2012 to March 2013 (37: p.35). 18
Figure 4: Trend in the Utilization of Health care services by Syrian refugees in Jordan 2012-2016(44: p12) 20
Figure 5: Jordan's Health care system's structure and organisation (50: p.9) 23
Figure 6: Number and Type of health facilities providing Primary care services in Jordan, 2013* 25
Figure 7: Insurance Coverage in Jordan, geographical distribution, 2015 (50: p.33) 26
Figure 8: Service utilisation of public health facilities by Syrian refugees under Free care policy (50: p.49) 27
Figure 9: Household out-of-pocket Payment (USD) for recent health care visit of adults (n=1043 households) (53: p.9) 28
Figure 10: perceived accessibility barriers by type of services among refugees (54: p.8) 29
Figure 11: Burden of NCD among Syrian refugees (26: p.10) 31
Figure 12: Reasons for not seeking health care services among 200 patients with NCD (20: p.6) 34
Figure 13: Inability to access medical services for Chronic condition 2017 versus 2018 (58: p.31) 36
Figure 14: Reasons for not accessing Chronic care 2017 versus 2018 (58: p.31) 36

List of Tables:

Table 1: Keywords and Terms 15
Table 2: Chronology health Policy changes 2011-2019 (34: p17) 17
Table 3: Jordan's national health account indicators 2008-2013 (50: p.31) 24
Table 4: Hospital's beds capacity distributions in Jordan 2013** 25
Table 5: Health Indicators affected by Refugees crisis in Jordan 2014 (50: p.51) 27
Table 6: annual incidence rate of communicable diseases in Jordan (Syrian refugees versus Jordanian) in 2013 (36: P.71) 28
Table 7: Studies assessing NCD burden among Syrians in Jordan 32
Table 8: Health seeking behaviour association with Household income among 964 NCD patients (24: p.10) 35
Table 9: Reason for not seeking Health services among 260 NCD patients, last time when needed (22: p.8) 35

II. List of Abbreviation:

ASC:	Asylum Seeker Certificate
CHC:	Comprehensive Health Centre
CVDs:	Cardiovascular Diseases
COPD:	Chronic Obstructive Pulmonary Disease
DC:	Dental Clinics
DM:	Diabetes Miletus
GDP:	Gross Domestic Product
GoJ:	Government of Jordan
JFDA	Jordan Drug and Food Administration
HHC:	High Health Council
ICRC:	International Committee of Red Cross
IMC:	International Medical Corps
INGO:	Non-Governmental Organization
IPD:	In-Patients Dept
ISIS:	Islamic State of Iraq and Syria
JAFPP:	Jordanian Association for Family Planning and Protection
JOD:	Jordanian Dinar
MCH:	Mother and Child Health Centres
MDG	Millennium Development Goal
MHI	Military Health Insurance
MMR:	Maternal Mortality Ratio
MOH:	Ministry of Health
MoI:	Ministry of Interior affairs
MSF:	Médecins Sans Frontières
NCD:	Non-Communicable Disease
NRC:	Norwegian Refugee Council
PHC:	Primary Health Centres
RMC:	Royal Medical Services
SDG:	Sustainable Development Goal
THE:	Total Health Expenditure
UN:	United Nation
UNFPA:	United Nations Population Fund
UNHCR:	United Nations High Commissioner for Refugees
UNICEF:	United Nations Children’s Fund
UNRWA:	United Nations Relief and work Agency for Palestine
UVE:	Urban Verification Exercise
VHC:	Village Health Centres
WFP:	World Food Programme
WHO:	World Health Organisation

III. Terminologies and definitions:

Terms	Descriptions/definitions
UN 1951 Convention on refugees and its 1967 protocol	The United nation of 1951 "Refugee Convention" and its 1967 protocol is an important legal document which forms the foundation for the UNHCR mandates and its activities. The convention is signed into law by 145 countries. It describes the term ' refugee ' and defines the rights of the refugees in a host country. It also contains the legal duty of the signatory states to safeguard the rights of the displaced in their territories. The basic concept is non-refoulment, which states that migrants should not be returned back to a country where they may encounter severe risks to their lives or liberty.
Asylum seeker certificate (ASC)	"ASC" is a Certificate provided by UNHCR to the Syrian refugees which entitle them for obtaining UNHCR support including cash and food assistance. ASC is also a prerequisite for obtaining the MoI Card.
Urban verification Exercise (UVE)	The urban verification exercise is a process, launched by GoJ in 2015; aimed to re-register all Syrians living outside camps. The process will entail refugees with new Biometric MoI card that is in turn a prerequisite for accessing public services.
Bailout process for refugees	The process in which Syrian refugees were allowed to leave camps for the urban area, provided they receive sponsorship from Jordanian citizens who fulfil the criteria. The GoJ suspended the process from Jan 2015
Refugees status determination	Refugee Status Determination or RSD is the legal or administrative mechanism by which states or the UNHCR evaluate whether an individual requesting international protection is eligible to obtain refugee status and its related rights under international, regional or domestic legislation.
Asylum seeker	An asylum seeker is someone whose application for refuge in another place yet to be handled. Around one million individuals try asylum every year.
Refugee	A refugee is an individual who has been compelled to evade his country of origin because of oppression, conflict or violence. A refugee fears of persecution based on his/her ethnicity, nationality, religious or political view or affiliation.

IV. Introduction:

I have been working for more than ten years in the humanitarian assistance field with a non-governmental Organization (NGO) called "Médecins Sans Frontières" (MSF) or "Doctor Without borders". These ten years of working in the humanitarian assistance field with MSF, mostly in leading positions, have been entirely enriching but also challenging experiences. Working in the humanitarian filed pose humanitarian workers to a variety of challenges that require them to seek carefully approaches that best fit the interest of the people in need.

Moreover, to be effective, leaders and managers engaged in humanitarian work need to take into account prudently countries socio-political context as well as the existing state policies as a prerequisite in their actions. Good understanding and analysis of the state policy will enable humanitarian field leaders to adapt effectively humanitarian aid approaches in a manner that in any given humanitarian context the beneficiaries would get the maximum of support with the minimum risk posed to the humanitarian workforce delivering that support.

Furthermore, advocacy is another practical approach used by the International Aid Agencies in a humanitarian context, aiming to encourage and bring about such positive changes that best fit the interests of the people in need; including the facilitation of their access to needed health care services. However, in order to formulate and, organise effective advocacy efforts, a comprehensive understanding of the socio-political context the of mission country as well as a good knowledge of the country existing policies are crucial.

My last assignment with MSF was in the Kingdom of Jordan, where MSF was running a vertical NCD project for Syrian refugees. Although NCD care was widely available across the country, it was costly and unaffordable, and hence, access to comprehensive NCD care was a big hurdle for a significant number of Syrian refugees who were suffering from a massive burden of NCDs.

Unfortunately, the efforts put by the International Aid Organisations were not sufficient to meet the NCD care needs of Syrian refugees. Most of the INGOs have been running short term projects due to lack of adequate resources; meanwhile, obtaining funds from the donor agencies were extraordinarily challenging and subject to lots of bureaucratic procedures. Furthermore, a series of recurrent policy changes by the GoJ since the start of the Syrian refugee crises made the situation more critical and challenging for the majority of Syrian refugees residing in the host communities across the country.

I found the topic of NCD care in the humanitarian context quite interesting. Taking the opportunity of my thesis assignment for the MPH/ICHD course at KIT Royal Tropical Institute, I decided to explore and examine more in depth the issue of NCDs care within the refugees' context in the kingdom of Jordan. In this study, which purely relies on the literature review, I have tried to look at the issue of the refugees' access to NCD care from the host country policy perspective and that how the needs of the clients (refugees) and the motive of the state authorities (GoJ) for policy changes have interacted and what have been the role of the International community in between; and lastly what else the international community can contribute in order to effectively tackle the health care needs of Syrian refugees in Jordan.

I want to thank my thesis advisor Dr Pierre Prately and my academic tutors, Mr Abu Zafarullah and Mr Hermen Ormal, who provided me with adequate support while preparing this paperwork.

Word Count:12951 (including citations in the main text)

Abstract

Introduction: NCD's have been the leading cause of mortality in Syria. The recent conflict caused 671,579 Syrians to flee to Jordan. The increased health demands and high NCD's burden among refugees, placed an immense load on Jordan's health-system, resulting in recurring state policy changes that adversely affected the refugee's access to health care, including NCD care. This study aims to analyse factors affecting access to NCD care for Syrian refugees in Jordan and provide recommendations to the Jordanian authorities and other stakeholders to reduce NCD related morbidity and mortality among Syrian refugee's, through taking concerted actions in their health-policy and system.

Methodology: Literature-review conducted, and "Aday Andersen" model applied for the analysis of the findings.

Results: Financial, socio-cultural, and short-fall in the commitment of the international community were identified as the key driving factors, causing recurrent policy modifications on refugees by the Jordanian government. Increased health services cost and complexity in the refugees' enrolment process were the two main structural barriers, hampering Syrian refugees access to health care services, including NCD care in Jordan.

Discussion: Studies conducted previously In Jordan, mainly cross-sectional in type, have examined Syrian refugees' access to health care services purely from the clients' viewpoints. This research brought into the context the other two crucial elements of access, the health-system, and policy. This research calls for necessary policy adjustments and encourages the international community to support Jordan with adequate resources in order to enable effective policy adjustments and support further research.

Keywords: Policy, Noncommunicable diseases, Refugee, Access, Jordan

Chapter 1: Background and Context

1.1. The Syria Arab Republic before and after the Crisis

The republic of Syria is located in the Middle East; bordering Iraq in the east; Jordan, Israel, and Lebanon in the south and south-west, and Turkey in the North. It connects with the Mediterranean Sea through a coastline in the west. The country is divided into 14 administrative division called 'Muhafeza' (provinces) with Damascus (Capital city), Aleppo, and Homs, being the main cities. The country land is featuring a narrow coastal plain with double mountain belt in the west and a vast semiarid desert plateau in the east. It has mild, rainy winter from December to February and a hot, dry summer from June to August(1).

The country is home to a variety of ethnic and religious groups, including Arabs (90% of the population), Kurds, Armenians, Assyrians, Druze. Muslims predominate the country population (74 % are Arab Sunni, and 12% are Shias). Christian comprise 10% of the Syrian community, and 4% of the population practice other religions. The main spoken languages are Arabic (official), Kurdish, Armenian, and Aramaic, respectively.

Literacy rate for age 15 and above, as of the year 2015, was estimated to be 91.7% and 81% for male and female, respectively(2). As of 2016, Syria population was estimated to be around 18.4 million people with a growth rate of -1.6 and life expectancy of 59y for male and 69y female(3).

The modern state of Syria emerged in 1920 under the French mandate following the collapse of the Ottoman Empire. Syria obtained its independence from French administration in 1946 and became a member of the United Nations. Since 1970, the nation is [non-democratically] governed by Assad's family, who belong to the minority religious sect of Alawite Shia (4).

Before the eruption of conflict in 2011, Syria was a rapid-growing low-middle-income country with a gross domestic product (GDP) per Capita of 2032 USD(5). The average of 4.3% growth in the GDP per annum between the year 2000 and 2010 was almost purely driven by non-oil sector with the inflation rate kept at a reasonable level of 4.9% (6).

After the eruption of the unrest in 2011, the economic impact of the conflict in Syria has been devastating. The decline in GDP between 2011 and 2016 was amounted to be about four times the size of the Syrian GDP in 2010, with an estimated cumulative loss in GDP of about $226 billion over the courses of 5 years (6).

The Syrian unrest, like a branch of the 2010 Arab spring, was triggered in March 2011 by a small peaceful protest in the Daraa city of southern Syria. The regime's harsh punitive measures against the small-scale peaceful protest turned into a very complex humanitarian disaster in a short time. By June 2012, the rapidly growing conflict was declared as a civil war by the United nation (UN) (7).

In general, the conflict in Syria is delineated to be driven by a set of national, regional, and international factors. Authoritarian nature of Assad's regime; the long-lasting sectarian power imbalance within the Syrian society (Shiite minority versus Sunni majority) and corrupted state system are the leading internal drivers (8).

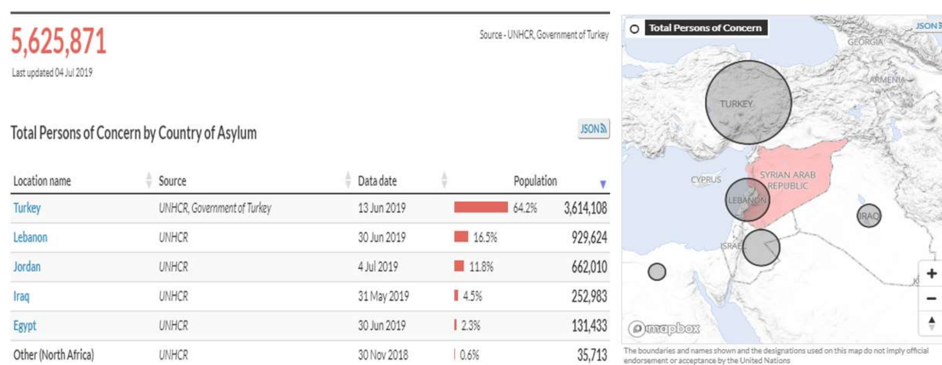
The eruption of the Jihadist organisation such as the Islamic State of Iraq and Syria (ISIS) and other Islamic extremist groups in Syria has been the additional desperate

consequences of the crisis. The Syria conflict is one of the worst humanitarian crises ever seen after the Second World War. Since its eruption in 2011, it has claimed more than 470,000 lives and has forcedly displaced more than half of Syria's total population either internally or to the neighbouring countries(7).

By December 2018, UNHCR registered about 5.6 million Syrian refugees in the middle-east of which 662,000 were enrolled in Jordan (Fig:1). Furthermore, an estimated 6.2 million Syrians have displaced internally with interrupted access to health care services, including NCD care(9).

Life expectancy in Syria has declined 15 years from 70.5y to 55.4y between the years 2010 and 2015(10). The crude mortality rate has increased from 4.4 deaths /1000 to 10.9 deaths /1000 per between 2010 and 2015(11). The impact of war on the Syrian health sector was overwhelming, as deliberated attacks on hospitals since five years, have left more than 700 doctors and medical workers killed and forced hundreds of them to flee overseas(12)

Figure 1: Geographical distribution of Syrian refugees in the Middle East (9)



5,625,871

Last updated 04 Jul 2019

Source - UNHCR, Government of Turkey

Total Persons of Concern by Country of Asylum

Location name	Source	Data date	Population	
Turkey	UNHCR, Government of Turkey	13 Jun 2019	64.2%	3,614,108
Lebanon	UNHCR	30 Jun 2019	16.5%	929,624
Jordan	UNHCR	4 Jul 2019	11.8%	662,010
Iraq	UNHCR	31 May 2019	4.5%	252,983
Egypt	UNHCR	30 Jun 2019	2.3%	131,433
Other (North Africa)	UNHCR	30 Nov 2018	0.6%	35,713

1.2. The Kingdom of Jordan and the refugee crisis

The Syrian refugee's crisis placed massive pressure on Jordan socio-economic structure and system, from depleting country's limited resources to depriving its local population of government-sponsored public services. These, in turn, created socio-political challenges for the GoJ and threatened the country political stability and steadiness(13).

Jordan is facing an extremely complicated refugee scenario, having the second-largest ratio of refugees per capita and the tenth-largest refugee population in absolute terms at the global level(14). Since the eruption of conflict in Syria, 671,579 Syrian refugees have taken shelter in Jordan. Of these, approximately 84% live in host communities, mainly in Aman, the capital and in the northern governorates bordering with Syria, namely the Irbid and Mafraq governorates. The three camps of Zaatari, Azraq, and the Emirati-Jordanian host the remaining 16% of Syrian refugees. (15). By the end of 2015, it was estimated that Syrian refugees comprise 15% of the Jordan total population(16). *(section 3.2 of Chapter 3 provides details of refugees crises impact on Jordan health care system)*

Chapter 2: Problem statement, Study Objective, and Methodology

2.1. Problem statement

Noncommunicable diseases (NCDs) have become the leading cause of mortality in middle-income countries like Syria. Moreover, NCDs are a matter of growing concern in middle-income settings where the trend towards political instability and the eruption of humanitarian crises is on the rise (17). Syria, Iraq, Libya, Ukraine, and the Balkans are examples of middle-income countries with a high burden of NCDs that have been inflicted by the humanitarian crisis in recent years (18).

The armed conflict in Syria has led to a major humanitarian crisis of the decades, displacing more than half of the Syria total population. Around 5,6 million Syrian refugees have fled to neighbouring countries, with the majority of them (92%) residing in the host communities. The Kingdome of Jordan alone hosted 6.7 hundred thousand Syrians as registered refugees. The actual number of Syrian refugees residing in Jordan is estimated to be much higher and nearly the double of what is officially reported by UNHCR as registered refugees (9).

NCD was a leading public health problem in Syria before the eruption of the civil war. Mortality due to NCD was estimated to count for 77% of all annual deaths in Syria, ranking NCD as the first leading cause of death before the war(19). Following the displacement of Syrians to the neighbouring countries, the burden of disease travelled with them. The large scale households survey, conducted in 2014 by UNHCR among Syrian refugees living in urban areas of Jordan, concluded that half of the Syrian refugees' household surveyed (50.3%) reported at least one or more members of the family suffering from one of the five common NCDs, namely: Cardiovascular Diseases (CVD), Hypertension, Diabetes Miletus(DM), Chronic Obstructive Pulmonary Disease(COPD) and arthritis(20).

Humanitarian assistance activities in protracted emergencies like refugees' context are complex and costly; placing huge economic and workforce burden on the health care system of the host country as well as on the humanitarian aid organisations (21). In the context of Jordan, due to the scarcity of resources and the high burden of NCD among Jordanians citizens , the national health system and international aid organizations continued lacking the capacity to address the NCD care needs of Syrian refugees adequately, and hence access to NCD care remains a constant challenge for a significant number of refugees in Jordan(20)(22).

People in the humanitarian context of displacement are increasingly vulnerable in term of their ability and right to access essential services, including health care. The Government of Jordan (GoJ) recurring policy modifications on refugees have been a matter of great concern for the international aid agencies and human right organisations (23)(24)(25). The scoping review conducted in 2019, by Farah et al. indicates a high burden of NCD among Syrian refugees in the neighbouring host countries (Fig:11) and that their health care demands are mostly unmet due to the host countries health policies and the inadequate humanitarian responses by the International community (26).

The health element of humanitarian intervention in an emergency setting has traditionally been focusing on the management of acute medical conditions, such as trauma and infectious diseases(27). There is a lack of evidence on how to effectively address NCD care

needs in a humanitarian context (18). Effective NCD care involves regular patient's follow-up, constant supply of medications, and a good account of preventive measures. These objectives are hard to reach in an emergency context due to the diminished capacity of the health care system, scarcity of resources, and insecurity (28).

There is a paucity of research undertaken to assess the effectiveness of strategies for NCD care in an emergency context. The only systematic review conducted in the refugee setting by Alexander Ruby et al. in 2015, highlights the benefits of interventions that incorporate standardisation and patients' follow-up for the continuum of care. Furthermore, studies that aim to analyse the cost-effectiveness of various NCD intervention strategies in the context of emergency are lacking, and no research is conducted in this field yet (18).

This research examines factors affecting Syrian refugees' access to NCD care in the context of Jordan within the three interrelated aspects :

1) The Jordanian Government policy on refugees.

2) The Jordan's health care system setup (its structural and organisational features); and

3) The particular characteristics of the Syrian refugee population (socio-economic and cognitive factors).

This research aims to inform the Jordanian Ministry of Health (MOH) and other stakeholders on how to address the issue of NCDs among Syrian refugees by taking necessary actions to improve present health policy and addressing the existing structural gaps in the Jordanian health delivery system in order to contain preventable morbidity and mortality due to NCDs among Syrian refugees.

2.2. Research objectives

2.2.1. General objective

To make recommendations to the Jordanian MOH to prevent excess NCD morbidity and mortality among the non-camp Syrian refugee's population due to their inadequate access to NCD care, through taking concerted actions in its policy and health system. To this end, three sub-objectives have been identified that will look into Jordan's current policy on refugees and its implications on health access; Jordan's health system's characteristics, and the refugee's descriptors that affect access to, and utilisation of NCDs care services by Syrian refugees in Jordan.

2.2.1.1. Specific objective 1

To identify the drivers for the recurring changes in the refugee policy of Jordan's government, and to examine the policy changes impact on access of Syrian refugee to health care services, including NCD care.

2.2.1.2. Specific objective 2

To examine Jordan's current health delivery system and identify barriers related to its structural and organisational setup that may affect access to and utilisation of NCD care services by Syrian refugees; shall it be the refugees' first time-entry or the follow-up contacts for the continuum of care.

2.2.1.3. Specific Objective 3

To examine Syrian refugees' socioeconomic and behavioural characteristics and their role and impact on refugees' access to NCD care services.

2.2.1.4. Specific Objective 4

To inform and advise the Jordanian Ministry of Health and other stakeholders engaged in the provision of NCD care, on what to do in order to make NCD care services accessible for Syrian refugees and hence reduce NCD related morbidity and mortality among Syrian refugees in Jordan.

2.3. Research Methodology

2.3.1. Study design

A comprehensive literature review and desk survey were conducted in order to obtain a good insight into the various aspects of this research work by finding answers to the research objectives. The Aday Andersen conceptual framework on access is used to address and analyse all the issues of interest for this research work. This research first examines the concept of access in a broader portrayal of general care and then narrows the scope to NCD care.

2.3.2. Search strategy

The literature review is the primary methodology used for this research work. Related published and unpublished literature were searched, using the bibliographic databases such as the VU library platform, PubMed and Google scholar. Articles that are in English and published between the year 2011 and 2019 were searched and considered based on the Keyword used (Table: 1).

When needed, through snowballing, the cited papers in the index articles, were also searched and reviewed. The cited articles were searched via Google scholar first, and where no access granted, the UV library platform was used to access them. Search in PubMed was also conducted, using the Medical Subject Headings (MeSH) terms.

As part of the desk review, related grey literature and reports from the relevant website such as World Bank, World Health Organisation (WHO), United Nations High Commissioner for Refugees (UNHCR), Médecins Sans Frontières (MSF), International Committee of Red Cross (ICRC), United Nation Children Fund (UNICEF), Norwegian Refugee Council (NRC), Handicap International and other sites were also searched and accessed, using the google search engine. Moreover, websites of well-known news agencies were also used for the context-related information.

2.3.3. Keyword and terms

The Main Keywords used while performing a search are shown below in Table 1.

Table 1: Keywords and Terms

Objectives	Search engines	Key Terms & Words
Objective 1: Policy related	-Google Scholar (used for quick search and when an article was known) -VU Library Used when access to the article was not possible through Google scholar or PubMed (not open access)	Health Policy OR Refugee Policy AND Syrian Refugee OR Syrian Migrant AND Relief Work OR Rescue Work OR Humanitarian Aid AND Human Right AND Noncommunicable Diseases OR Chronic Disease OR Cardiovascular Diseases OR Diabetes Mellitus OR Cancer OR Chronic Obstructive Pulmonary Disease OR Asthma OR Hypertension AND Middle East OR Arab World OR Jordan OR Syria OR Lebanon OR Turkey OR Iraq AND Health Services Accessibility OR Health Access to NCD Care AND Access Survey OR Utilization Survey AND Bailout AND Camp AND Urban Verification Exercise AND UNHCR OR WHO OR NRC OR MSF OR AMNESTY INTERNATIONAL OR WORLD BANK OR MoH JORDAN OR UNICEF
Objective 2: health system-related	-PubMed (using MESH terms) -Google Search used for accessing websites, web pages, reports	Armed Conflicts OR Disaster OR Natural Disaster OR Emergencies AND Relief Work OR Rescue Work OR Emergency Medical Services OR Emergency Medicine OR Disaster Planning AND Noncommunicable Diseases OR Chronic Disease OR Cardiovascular Disease OR Diabetes Mellitus OR Neoplasm AND Pulmonary Disease, Chronic Obstructive AND Asthma OR Hypertension AND Middle East OR Arab World OR Syria OR Jordan OR Iraq OR Lebanon OR Turkey AND Refugees OR Transients and Migrants AND Health AND Health Policy AND Health Services Accessibility OR Patient Acceptance of Health Care AND Hospital AND Work Force
Objective 3: Clients related		

2.3.4. Conceptual Framework

The Aday Andersen framework of access(29) is applied to facilitate the analysis of the three interrelated access elements that this research work will examine for the Syrian refugees in the context of Jordan (Fig:2).

The Aday Andersen framework sees health policy as the overarching element in health access concept that can influences, the other two critical elements of access namely, the features of the health care system and the attributes of the target population. This study will assess the interactions between these three elements and will assess its impact on the Syrian refugees' access to health care services in the refugees' context of Jordan. The adaptation of the framework may be considered during analysis, as the framework is not primarily designed for evaluating access to health care in a displacement setting.

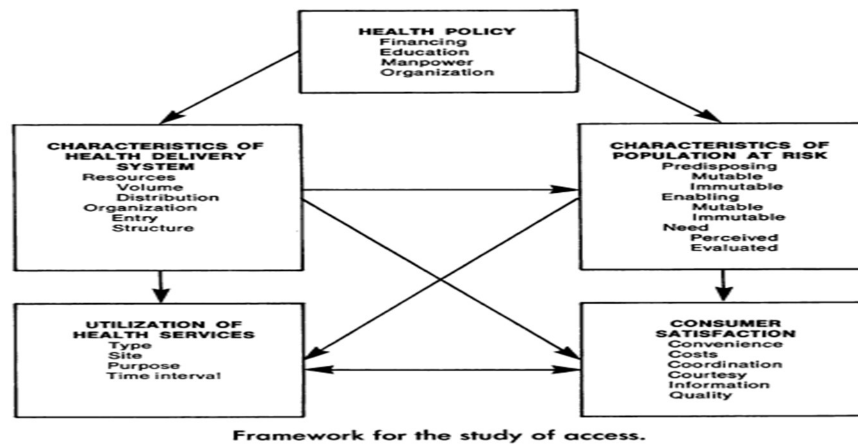
Following the Aday Andersen framework of access, and as outlined in the first specific objective, the study will describe the current refugee's policy of GoJ. It will define the main driving factors for the policy changes; and lastly, it will examine the impact of policy changes on Syrian refugees' access to health care. It is worth to note that this study aims not to propose alternative policy options.

Linked with the second specific objective, and following the framework outline, the research will examine the existing health system structural barriers and its effect on Syrian refugees' access to health care, including NCD care services. Furthermore, under specific objective three, Syrian refugees' specific attributes such as their socio-economic status (enablers), behavioural characteristics (predisposing factors) and their needs will be defined, and the role of these specific characteristics in the concept of access to NCD care will be examined.

Lastly, the study will generate some evidence-informed recommendations, to encourage Jordanian authorities and other stakeholders involved including international community to take concerted steps for policy improvement and strengthening of the health care

system in order to improve Syrian refugees' access to adequate NCD care services in Jordan.

Figure 2: Aday Andersen Model of Access (29: p.212)



2.3.5. Study limitations

Studies focusing on Syrian refugees' access to health care, including NCD care in Jordan have been mainly observational in type (household surveys) with the limitation of being highly subjected to bias and with weak methodology rigour. Among them, only the two studies; the study by Doocy et al. (30) and the study by Manuela Rehr et al. possessed better methodological rigours. No article or report was found to assess the impact of the 2018 Jordan's health policy change on refugees access; the UNHCR household survey on access for the year 2018 shows discordant results (25).

Since this research work relies solely on the findings of observational studies that present different levels of methodological rigours, and that some of the information and data analysed in this study are taken from secondary sources, hence, the likelihood of bias and other limitations might be high.

It is important to note that worldwide, there is a paucity of research done on NCD care in emergency settings. The systematic review by Alexander Ruby et al. (18) conducted in 2015, focusing on the effectiveness of NCD interventions in an emergency setting, found only eight studies eligible for review (studies conducted between 1997 to 2014). Ruby et al. concluded substantial research gaps in this field. Besides, no studies have yet been conducted to examine the cost-effectiveness of NCDs emergency response interventions in a humanitarian context (18).

The systematic review by El Arab et al.(30) conducted in 2018 on access to health care of Syrian refugees in Jordan (camp and not camp settings); found only nine articles eligible for review, of which six studies articles were scholarly peer-reviewed using cross-section method, and three studies used secondary data method (30).

The scoping review conducted by Farah Naja et al. (26) in 2019, found only 34 published articles after 2013, focusing on Syrian refugees health access in countries such as Jordan, Turkey, Iraq, and Lebanon. Majority of the articles reviewed used cross-sectional methods. For Jordan, this review captured the same studies articles already assessed by El Arab et al. (26).

Chapter 3: Findings

3.1. Jordan’s Government refugee policy and refugees’ access to health care

3.1.1. An overview of Jordan’s refugee policy

Jordan is facing an extremely complicated refugee scenario, having the second-largest ratio of refugees per capita and the tenth-largest refugee population in absolute terms at the global level(14). Since the eruption of conflict in Syria, 671,579 Syrian refugees have taken shelter in Jordan. Of these, approximately 84% live in host communities, mainly in Aman, the capital and in the northern governorates bordering with Syria. The three camps host the remaining 16% of Syrian refugees(15). By the end of 2015, it was estimated that Syrian refugees comprise 15% of the Jordan total population(16).

Despite hosting a massive refugees’ community in the Middle East, the Jordanian government policy on refugees is indistinct. Jordan has not signed any international conventions or protocols that govern the refugee's issues, including the 1951 UN Convention on the Status of Refugees and its extended protocol of 1967(31).

Jordan has had a relatively welcoming attitude towards refugees at the initial stage of crisis and has followed international norms on the refugees' treatment. Its bilateral agreement with the UNHCR describes the scope of Jordan's non-Palestinian refugee policy. The agreement contains the principles of international protection for the displaced population, including the definitions of refugee and asylum seeker outlined in the 1951 UN Convention. However, the said agreement does not cover some of the fundamental legal rights for refugees, such as the right to accommodation, work, education, freedom of movement, and utilisation of public services(32).

Refugees living in countries that are the signatory of the 1951 UN convention are entitled to all fundamental rights for livelihood. As Jordan has not signed the UN convention on refugees, it has no formal duty under the international mandates to guarantee all aspects of the refugees' rights in its territory. The MOU signed with UNHCR in 1998 also does not place legal obligations on Jordan’s authorities and leaves space for the GoJ to change and adapt their refugees’ policies at any time (32).

From mid-2014, the government has modified its refugee's policies recurrently. The closure of borders for new arrivals, in 2016; limiting refugees’ movement in Urban areas through suspending the bailout process, in 2015; repeal of the free care policy in Nov 2014, and the repeal of subsidized care policy in Feb 2018(Table:2) are examples of the recurrent policy modification by the GoJ(31)(33)(34).

Table 2: Chronology health Policy changes 2011-2019 (34: p17)

Period	Curative services	Preventive services
2011-Nov 2014	Registered Syrian refugees can access free of charge health care services in Public health facilities	Free of charge
2015-Jan 2018	Syrian refugees Registered with UNHCR can access Public health services with a subsidized rate as uninsured Jordanian	Vaccination and all essential MCH services entirely free of charge in public facilities
2018- April 2019	Registered Syrian refugees are eligible to Access public health facilities and will be charged with a price rate applicable for foreigners	Vaccination and some MCH services (excluding hospital services) are still provided free of charge
April 2019- current	Rolled back to uninsured Jordanian scheme for payment of services in Public facilities	

Source: adapted from “Jordan Migration and health challenges,” WHO Jordan 2018 (34: p.17)

3.1.2. Factors that drove recurring policy changes in Jordan on the delivery of health care services for the Syrian refugees

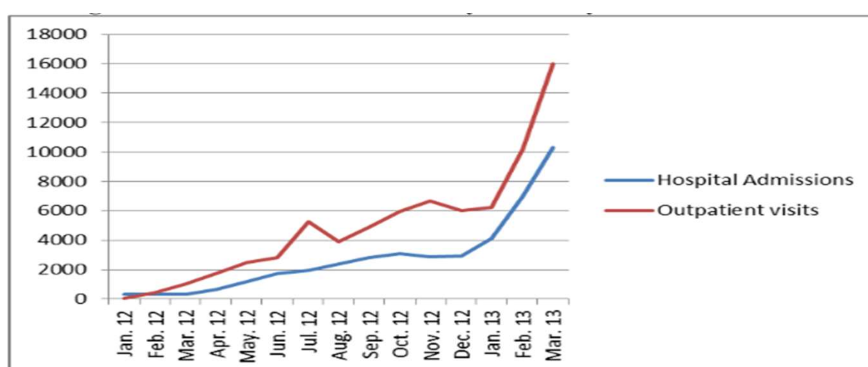
3.1.2.1. Financial and Health system capacity strains

At the initial phase of refugee crises, between 2011 and 2014, the Jordan government's policy favoured the integration of Syrian refugees into the Jordanian health care system so that they can use public health facilities free of charges. The unexpected rise in the influx of Syrian refugees over a short period and their increased health demand have placed tremendous financial and service capacity strains on Jordan's healthcare system(35).MOH reported increased admission rates in Public hospitals. The monthly admission rate, for example, raised from 300 in Jan 2012 to 10,330 in March 2013 (Fig:3), challenging the service capacity of those hospitals in term of the health workforce, medical supply, and quality of care(36).

Furthermore, the financial burden to respond adequately to the health care demands of the Syrian refugee was significant; Only between 2011 and 2012, drugs procurement expenditures increased by 15 per cent, amounting an extra 14 million USD for MoH. Fearing the re-emergence of vaccine-preventable disease in Jordan; providing vaccinations to Syrians was the priority public health task for the Jordanian MOH, which was extremely costly. Overall, only MoH expended about an extra 53 million USD to cover Syrians health demands over 15 months from January 2012 to March of 2013 (37).

Besides, the overcrowded public health facilities caused delayed access of the Jordanian to health care services. Government legal obligation in the provision of timely care for its citizen made MOH opt to refer Jordanian patients to the costly private facilities. Only between 2011 and 2012, around 10,069 cases have been referred to private facilities, indicating an 11% increase in the number of referrals compared to previous years with an extra cost of 124 million USD; showing a 50% increase in referral expenditures comparing to previous years(37).

Figure 3: Trend of Syrian refugees Outpatient consultation and Hospital admission in public facilities between Jan 2012 to March 2013 (37: p.35).



3.1.2.2. Internal Socio-political pressure on Jordan's Government

There has been increased social tension between Syrian refugees and Jordanians due to competitions for limited jobs, accommodations, and public services(38). Most Jordanians believe that Syrian refugees have affected their chances for job opportunities and worsened

their working conditions by accepting lower wages, making it hard for Jordanians to compete and gain the job(39).

The influx of refugees also augmented public spending, which led the state to rise by 42% on taxpayers. This situation also led to the socio-economic dilemma of "free- ridership," in which Jordanian have to pay the cost but Syrian to enjoy the services without paying the services, resulting in insufficient services provision for Jordanians(13).

Due to the decline in the living condition of lower and middle-class Jordanians, Jordan's citizens perceived the GoJ humanitarian programs unfair, saying that GoJ tries to improve the livelihood of refugees at the cost of its citizens; this, in turn, put the legitimacy of the government at stake(40).

Negative public attitudes towards Syrians refugees affected adversely the Jordanian government's willingness to respond adequately to the refugee crisis. Several protests were organised in Amman, and North Jordan against the worsened living conditions, blaming Syrian refugees for the given circumstances and failure of GoJ to solve the problem of Jordanians(13).

The grown tension among Jordanian made GoJ listen to vocal public frustration by reducing its sympathy and generosity toward Syrian refugees. Furthermore, the GoJ has likely assumed that the tension created in the Jordanian society due to the presence of Syrian refugees may threaten domestic stability if not managed carefully(40).

3.1.2.3. The shortfall in the commitment of international funding agencies

The Syrian refugee crisis put a substantial burden on Jordan's socio-economic situation. The support provided by the international community has not been adequate to cover the needs of Syrians, placing massive pressure on Jordan health system(41). Similarly, the International aid agencies were recurrently facing the problem of shortage of fund, including the UNHCR, which is the leading agency for refugees' affairs. In July 2019, UNHCR reported that only 26% of the defined budget for the year 2019 was covered by the international community and donor agencies(42).

3.1.3. Policy changes impacts on Syrian refugees' access to health care

3.1.3.1. Rendered access to medical care

The Jordan's government first attempt on regularising access to health services of Syrian refugees goes back to December 2012 where "service card," was granted by the government to all Syrians upon their enrolment with the Jordanian police. Although holding a service card granted free access to health services, however, the limitation of the procedure was that Syrian refugees could only get care in health centres that were falling under the security card registration area. In case of relocation, free care services in the new residential area were not accessible; this modification of policy was found challenging for many Syrians who had no fixed place to live and have to relocate quite frequently(43).

The 2014 Jordan's government policy changes, implied registered Syrians to participate with a co-payment share of 20% when utilising outpatients and inpatients services in public facilities, that was equal to the co-payment rate applied for uninsured Jordanians as a subsidised rate (44). The government of Jordan described the main motive behind the change of the free care policy the extreme financial burden and deficit in the financial resources (31).

The subsidised rate was apparently not affordable for many Syrians who already suffered from limited livelihood choices; opting to prioritise other fundamental needs of the household than health. Besides, direct service cost (user-fee) was not the only health-related expenses, but refugees often have to pay for transportation and also to buy certain medicines from private pharmacies(23).

Data from Jordanian health facilities indicate that after the endorsement of the subsidised care policy, the service utilisation of public facilities by Syrians decreased(Fig:4) by 60% over two years period(44). The effect of policy change on access to NCD care services was more bothersome as NCDs care requires regular follow-up visits, and additional cost related to lab tests, and costly medicines. A health access survey conducted in 2015 by UNHCR revealed that 58.3% of refugees with NCDs, reported difficulty in accessing required NCD services, including access to medicine, among them,57.4% reported the reason as not being able to afford the user-fee(45).

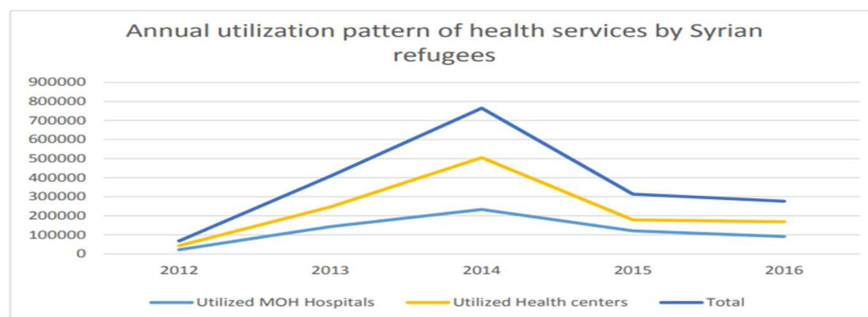
Although the next year household survey on access, reported a slight improvement in access comparing to the year 2015, yet, among those not able to access NCD care (37%), inability to pay user-fees remained the main reason preventing their(75%) access to NCD care services (43).

As demonstrated by Amnesty International, the slight improvement in access to NCD care in the year 2016 could have been due to the active engagement of charity organisations, as soon after the endorsement of co-payment policy by GoJ, several international organisations, such as MSF, International rescue committee (IRC), International Medical Corp (IMC) and UNHCR attempted to fill the gaps, and maintain free care services, including NCD care for the vulnerable Syrian refugees in the urban setting(23).

A review by W.Dator et al. (16) of access studies, concluded financial factor as a leading barrier with a prevalence of 66% (95% CI: 0.449–0.823%), hampering Syrian refugees access to health care including NCD care services in Jordan. The financial burden included mainly the service cost, the costs of medications and transport (16).

In the GoJ another attempt, the repeal of subsidised care in February 2018, required Syrian refugees to pay the 80% of what foreigners pay in Jordan for health services. This GoJ policy change brought about broad criticism of the international aid agencies in a logic that while 80% of the Syrian refugees live below the poverty line, how can they afford the service cost at 80% of foreigners rate(24)(25). In April 2019, the GoJ decided to roll back to the subsidised care policy of 2014 (46).

Figure 4: Trend in the Utilization of Health care services by Syrian refugees in Jordan 2012-2016(44: p12)



3.1.3.2. Procedural barriers affecting Access

3.1.3.2.1. "Urban verification exercise" (UVE)

Accessing public services in the urban area in Jordan, require Syrian refugees to register with UNHCR and to hold a Ministry of Interior (MoI) new biometric services card. In Feb 2015, the GoJ launched an Urban Verification Exercise (UVE) aiming to re-register Syrian refugees residing in urban areas.

The UVE process implies bureaucratic procedures; it requires Syrians to present proof of residence place, including lease agreement for rental and copies of the landlord ID, which has been difficult for many refugees to present. Furthermore, refugees above age 12 years should get health certificates from MOH, incurring some cost that was unaffordable to many Syrians(47).

On the other end, lack of civil or legal papers, which is the case for a significant number of refugees, brought about cascading sequences when passing through the UVE process. For instance, lack of marriage certificate of parents deprives a newborn to obtain a birth certificate, and children without birth certificate were ineligible to get the new MoI card. Likewise, missing one legal documentation may also make refugees ineligible to obtain the new MoI card. For example, refugees lacking Syrian passports or ID card may find it hard to receive the new MoI card(48). The assessment survey conducted by REACH in 2014 concludes that access to health services by some vulnerable groups such as women and children was low due to lack of required documentation(38).

By the end of 2017, three years after the initiation of the UVE about, 403,332 refugees have completed their enrolment and obtained the new MoI card. It was predicted that around 110,331 Syrians still did not finish or were unable to satisfy the criteria for updating their legal registration under UVE(48).

Considering the number of Syrian refugees who obtain new MoI card between August 2016 (363,000 individuals) and December 2017 (403,332 individuals), the MoI only issued 40,000 new MoI cards over 17 months period indicating the slowness of the UVE process.

Joint qualitative research, by Norwegian Refugee Council (NRC) and International Human Right Clinic (IHRC), documented that common problems encountered by non-camp Syrian refugees during the UVE period included: long waiting time and refusal of providing health service in health centres. Besides, problems related to UVE were reported to be, long waiting time at the police stations, and that the Police were also asking additional documents, other than the one officially required(47).

Due to the bureaucratic nature of UVE procedures; delay in acquiring the new MoI card rendered timely access of many Syrian refugees to essential medical services. Besides the cost barrier (affordability), the issue of a new MoI card was an additional obstacle imposed on Syrians. Limited or interrupted access to public facilities by UVE, pushed refugees to opt for unhealthy coping mechanisms such as buying medicine without consulting a physician or seeking care at the costly private sector (47).

Furthermore, the lack of a new MoI card restricted the right of refugees to work. Moreover, refugees without new MoI cards were subject to police detention, involuntary relocation to camps, and even deportation to Syria(47).

The qualitative study of the NRC / IHRC shows that among interviewees who sought care in public health centres and were requested to demonstrate their new MoI card, 85 % of them were denied access to services. Moreover, many Syrian families who did not have the new MoI card reported that they went to pharmacies to buy medicine or to visit private hospitals instead, with a cost that was hard to manage(47).

3.1.3.2.2. Suspending the "bailout" process and restriction on movements

From July 2014, the government of Jordan started to reinforce the bailout process for the camp refugees; this exercise led to an increased restriction on "freedom of movement" for refugees' families who were willing to leave the camps to urban areas. This policy placed extra procedural barriers, making refugees to skip the formal bailout mechanism(33)(23).

Under the new attempt, the GoJ instructed UNHCR to issue Asylum Seeker Certificate (ASC) to only those who leave camps with proper "bailout" documents. ASC is an essential document that enables refugees to access UNHCR food and cash assistance as well as it is a prerequisite for obtaining a new MoI service card(33).

In August 2015, UNHCR announced that thousands of Syrian refugees left Zaatari camp to urban areas, without going through the bailout process (23). The bailout process was suspended entirely in January 2015, stopping the Syrians leaving the camp in any conditions.

3.2. Jordan Health delivery system and Refugees access to health care

3.2.1. Jordan health care system: an overview

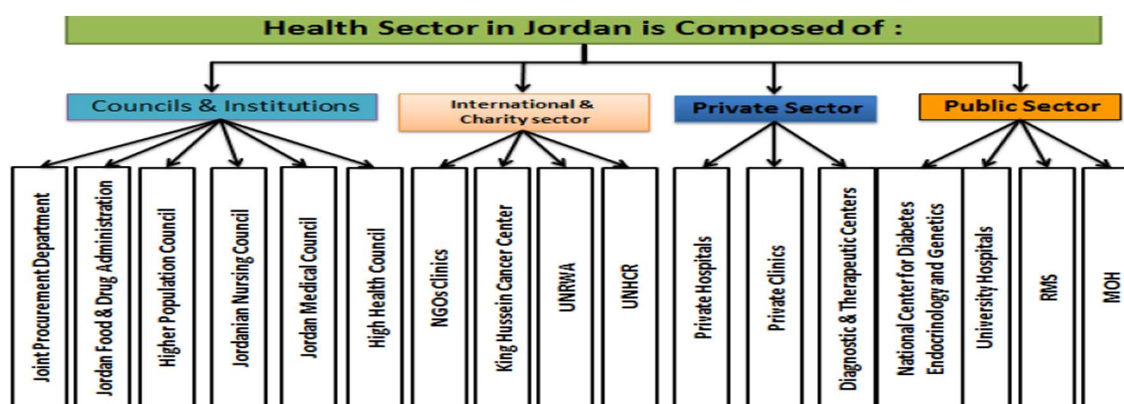
3.2.1.1. Health system organisation and governance

Jordan has the uppermost health situation in the Middle East, as numerous health development plans and initiatives aligned with Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) have been established and implemented. The health care system of Jordan has had outstanding progress over the past decades. Health indicator such as Neonatal, Infant, and Under-five mortality rates[i] have declined significantly from 17.4, 24.5 and 29.4 per 1000 live births in 2002 to 12.2, 17.3, and 20.2 live births in 2012, respectively(49). Maternal Mortality Ratio (MMR) dropped from 41 /100,000 live births in 1996 to 19.1/100,000 live births in 2008(50).

Health service Providers in Jordan include public, private, and charity organisations that rely on donor funds. Moreover, several institutions and councils complement the public health sectors, involved in the development of health policies and strategies (Fig:5). The public service providers include the Ministry of Health (MOH), the Royal Medical Services (RMS) and two university hospitals, namely: the "Jordan University Hospital," and the "King Abdullah University hospital"(51). Other vertical Medical centres such as "Centre for Diabetes, Endocrinology, and Genetics" and the National Centre For Woman's Health are also part of the Public medical service providers(50).

The private health providers comprised of private hospitals and numerous numbers of diagnostic and treatment centres. The International aid agencies and charity organisation include the United Nations Relief and Work Agency for Palestine (UNRWA), the UNHCR, Hussein Cancer Centre and other local charity association clinics. Development of national health policies and regulatory affairs in health sector is managed through High Health Council (HHC)in collaboration with other institutions such as, "the Higher Population Council", "the Jordanian Medical Council", " the Jordanian Nursing Council", "the National Council for Family Affairs" and "the Jordan Food and Drug Administration" (JFDA)(50).

Figure 5: Jordan's Health care system's structure and organisation (50: p.9)



[i] National Average Mortality Rate (WHO)

Concerning Health system financing, there is no specific tax earmarked to finance the health services. General tax revenue provides financial support to the public health sector, run by MOH and RMS through annual budgeting exercise; however, sin tax on cigarette and tobacco has partly earmarked from 2004, for treating Cancer patients in Hussain Cancer centre(51).

Although in 2013, the total health expenditure per capita was 29 JOD lower compared to 2012 (231.8 JOD), however, the total amount for health expenditure has increased from 1.66 billion JOD in 2012 to 1.88 billion JOD in 2013. The Total Health Expenditure (THE) as a Percentage of GDP was 7.89 for the year 2013, slightly higher than the 7.58% reported for 2012(Tab:3) (50).

The total out-of-pocket expenditure for health, in 2013, was 28.8%, showing an increase of 3% compared to 2012. In the same year, spending on hospital services comprised 75% of the total expenditure of the public sector, amounting 807 million JOD. The expenditure for the delivery of primary care services amounted 168 million JOD, showing a 15% increase compared to the previous year(50).

Table 3: Jordan's national health account indicators 2008-2013 (50: p.31)

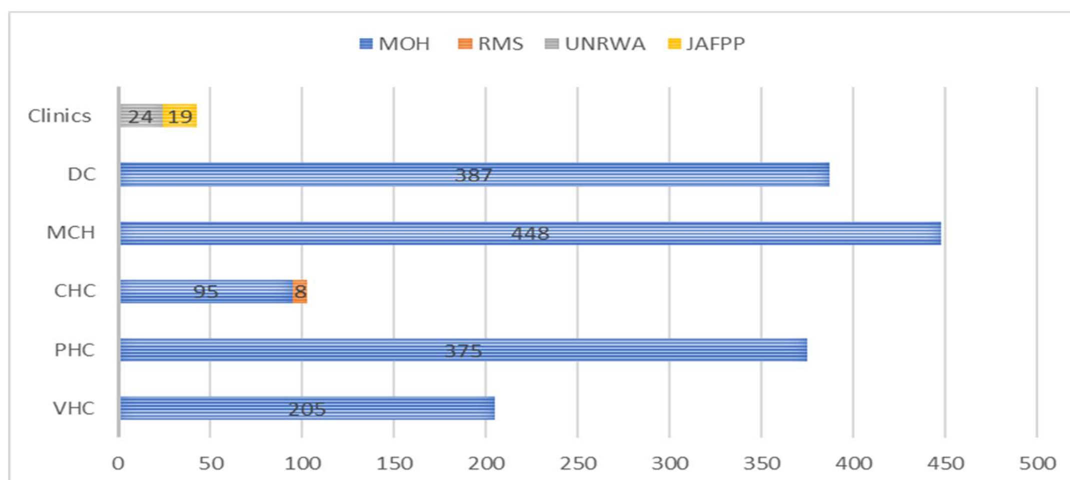
	2008	2009	2010	2011	2012	2013
Total Healthcare Expenditure (JD)	1,381,460,034	1,610,352,435	1,537,135,395	1,580,677,286	1,665,014,650	1,880,953,104
Per Capita Healthcare Expenditure (JD)	236	269.3	251.5	252.9	260.6	231.8
Per Capita GDP	2753.5	2828.1	3069.2	3275.8	3438.6	2939.6
Healthcare Expenditure as a Percent of the GDP	8.58%	9.52%	8.19%	7.72%	7.58%	7.89%
Percent of Governmental Budget Allocated to Healthcare	%10.16	%10.52	%9.76	%9.14	%10.50	11%
Health Expenditure by sector						
Public Sector	60.78%	69.17%	67.94%	66.85%	66.17%	65.75 %
Private Sector	38.24%	29.80%	30.27%	31.34%	31.88%	31.57%
UNRWA	0.69%	0.59%	0.75%	0.67%	0.75%	0.74%
NGO's	0.29%	0.43%	1.04%	1.14%	1.20%	1.93%
Public Healthcare Expenditure as a Percent of the GDP	5.21%	6.59%	5.57%	5.16%	5.02%	5.18%
Private Healthcare Expenditure %GDP	3.37%	2.93%	2.62%	2.56%	2.56%	2.70%
Total Expenditure on Pharmaceuticals	496,453,222	449,395,115	423,658,862	427,835,670	445,408,952	500,330,700
Per Capita Pharmaceuticals Expenditure	84.86	75.15	69.30	68.46	69.73	61.66
Pharmaceuticals Expenditure as a percent of the GDP	3.08%	2.66%	2.26%	2.09%	2.03%	2.10%
Pharmaceuticals Expenditure as a percent of the Total Healthcare Expenditure	35.94%	27.91%	27.56%	27.07%	26.75%	26.60%

3.2.1.2. Health system structure

3.2.1.2.1. Primary Care services

In 2013, a network of 95 Comprehensive Health Centre (CHC), 375 Primary Health Centres (PHC) and 205 Village Health Centres (VHC) were providing primary care services under the umbrella of MOH across Jordan. Moreover, MOH was running 448 Mother and Child Health Centres (MCH) and 387 Dental Clinics (DC). Besides, The Royal Medical Services (RMC) were providing primary care through 8 CHCs (Fig:6). UNRWA was covering the primary care needs of Palestinian refugees through its 24 clinics, and "The Jordanian Association for Family Planning and Protection" (JAFPP) were delivering services through its 19 clinics (50).

Figure 6: Number and Type of health facilities providing Primary care services in Jordan, 2013*



*Source: Adapted from National health strategy 2016-2020, MOH Jordan

The primary care package includes curative and preventive services. Distance and population need are the two main attributes determining the geographical distribution of health care centres across Jordan. The average travel time to reach the nearest centre is about 30 minutes(51).

3.2.1.2.2. Secondary and Tertiary Care services

Equipped with modern technology and qualified Medical workforce, Jordan possesses one of the most contemporary health-care infrastructures in the Middle East, (51). Both Public and private sector are engaged in the provision of secondary and tertiary care services. As of 2013, 106 Hospitals were providing specialised in-patients care with a total capacity of 12690(Tab:4) beds(50).

Table 4: Hospital's beds capacity distributions in Jordan 2013**

	Public Sector						Private Sector	Total beds
	MOH	RMS	JUH	KAH	Bashir H	PE &PR Hospitals	Private Hospitals	
N of Beds	4618	2439	534	501	500	100	3998	12690
%	36.4	19.2	4.2	3.9	3.9	0.8	31.5	100

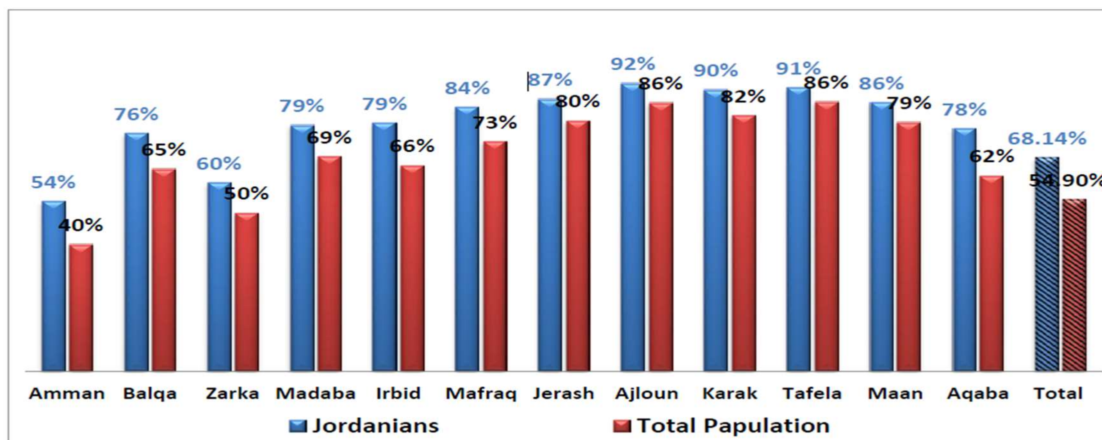
**Source: Adapted from National health strategy 2016-2020, MOH Jordan

3.2.1.2.3. Health Insurance Coverage

The 2015 national census survey, estimated the total population of Jordan at around 9.5 million, out of which, 6.6 million were Jordanian citizens. The health insurance coverage for the entire population was estimated to be approximately 55%, and for the Jordanian citizen 68%. MOH and the RMS, including Military Health insurance (MHI), covered the health insurance for 42% and 38% of the insured Jordanians, respectively(50).

The Census findings also demonstrated a wide geographical disparity (Fig:7) in term of insurance coverage at governorates level; Amman the capital, and Zarqa were recognised to be the governorates with the lowest insurance coverage among the Jordanian citizens (50).

Figure 7: Insurance Coverage in Jordan, geographical distribution, 2015 (50: p.33)



All uninsured, which comprise 32% of Jordanian citizens are offered health care services in a subsidised rate. (50).

3.2.2. The burden of non-communicable disease in Jordan

Over the past three decades, Jordan health system has made significant progress in the control of the communicable disease. Jordan achieved universal vaccine coverage in 1988, Polio eradication objective achieved in 1995. Furthermore, Infant, and child mortality rates, as well as maternal mortality ratio, declined significantly since 1994 (51).

As any Low and Middle Income Country (LMIC), Jordan encounters a high burden of non-communicable diseases due to the demographical and epidemiological transitions; characterized by its aging population and modification in the population lifestyle, mainly related to smoking habits (Jordan's smoking prevalence among male, age 15 and above is 49%), sedentary lifestyle, and consumption of unhealthy food(52)(50). CVDs, Cancer, DM, and COPD are the leading causes of disability and death in Jordan, with CVD (38%) and Cancers (14%), both being accountable for half of the total deaths in Jordan (50).

The Jordan National Strategy for Non-communicable diseases was endorsed in 2011 by Jordan's council of ministers. Diseases targeted in the strategy are DM, Hypertension, Obesity, and lipid abnormalities(50). The strategy main scope is on NCDs prevention, with strong emphasis on the early detection of NCDs risk factors and promotion of a healthy lifestyle among the Jordanian population.

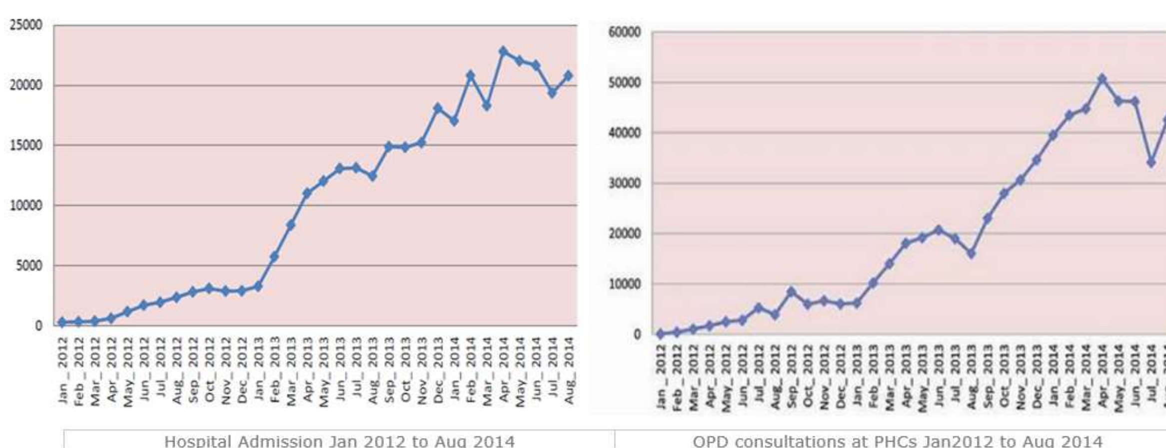
3.2.3. Impact of the refugee crisis on Jordan's health care system

The massive influx of Syrian refugees in 2012 and 2013 has increased the population growth rates significantly in Jordan, putting tremendous pressure on the structure of health delivery system; a system which was already suffering from financial deficits(37). The number

of foreign nationals living in Jordan until mid-2014 was estimated to be around 2.5 million individuals that include the 1.4 million Syrian refugees (50).

Increased health demands of Syrian refugees, exceeded the capacity of the health delivery system (Fig:8 & Tab:5), especially in the northern governorates that held the large caseload of refugees. The workload at primary care centres increased five-folds, bed occupancy rate exceeded 100% in public hospitals in Irbid and Mafraq, putting a high level of stress on the health workforce. High consumption of medicine and materials resulted in rupture of stocks and shortage of medical supply. In general, absence of adequate fund, shortage of health workers, and lack of health facilities in sufficient number to cover the health demands of Syrian refugees were the three main challenges faced by the Jordanian health care system (50).

Figure 8: Service utilisation of public health facilities by Syrian refugees under Free care policy (50: p.49)



Overcrowded health facilities also had its negative implications on the capacity of Jordanian to access health services timely and utilise it effectively. The impact has been more disastrous for the uninsured Jordanian who have to now compete for limited resources.

Table 5: Health Indicators affected by Refugees crisis in Jordan 2014 (50: p.51)

Indicator	Before Syrian Refugees (population number = 6.4 million	After Syrian Refugees (population number = 8 million)
Doctor/ 10.000 population	28.6	23.4
Dentist/ 10.000 population	10.4	8.5
Nurse/ 10.000 population	44.8	36.6
Pharmacist/ 10.000 population	17.8	14.5
Bed/ 10.000 population	18	15.1
Bed/10.000 population in Mafraq	8	6
Proportion of population covered by health services	98%	90%

Furthermore, the re-emergence of infectious diseases after the refugee crisis (Tab:6), challenged Jordan's health system to achieve and maintain health-related MDGs. The Jordanian MOH encountered fiscal deficit due to the extra expenditure spent on health care services for Syrian refugees. Only in 2013, MOH spent an extra 53 Million JOD for the health care of Syrian refugees(50).

Table 6: annual incidence rate of communicable diseases in Jordan (Syrian refugees versus Jordanian) in 2013 (36: P.71)

Disease	Incidence rate among Jordanians	Incidence rate among Syrian refugees
Pulmonary TB	5 per 100.000	13 per 100.000
Measles	2.8 per million	51.2 per million
Leishmaniasis	3.1 per million	158.1 per million

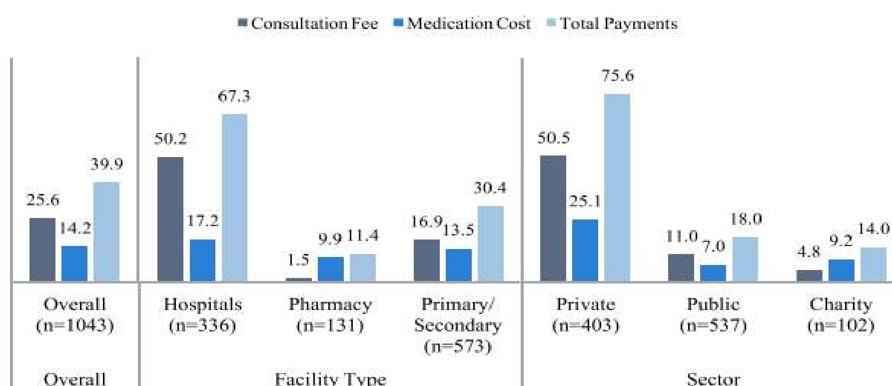
3.2.4. Health system's barriers affecting access of Syrians to NCD care:

In general, most of the studies conclude that Syrian refugees living in the urban area have experienced a satisfactory level of access to preventive and primary care services. However, two main challenges outlined by all studies are the high direct cost of services and the type of services available.

Doocy et al. (53) reported that for NCD patients who avoided to seek care, inability to afford the cost (64.5%) was the main barrier and not the availability of the NCD service(53). Other structure barriers affecting refugee decision making on seeking care included; lack of knowledge on where to get the care (5.9%), perception of not getting the right medicine (5.3%), delayed appointments (5.3%), lack of transport or long distance (4.1%) and poor behaviour of health workers in the facilities (3%)(53).

Furthermore, among those seeking care, 51.8% of households reported a considerable out-of-pocket payment(Fig:9). The average total out-of-pocket payment per visit among all who sought care (either paid or not paid) was found to be 39.9 USD (25.6 USD for consultation and 14.2 USD for drugs). The average total out of pocket payment (39.9) equated 6% of the monthly household spending and 12.4 % of the monthly household income(53).

Figure 9: Household out-of-pocket Payment (USD) for recent health care visit of adults (n=1043 households) (53: p.9)



Manuela Rehr et al. (22) makes the same conclusion in her research: saying that the perceived high cost of NCD service was the main factor preventing Syrian refugees from seeking care and not the absence of NCD services in the area (22).

Among 260 NCD patients, 61.5% (95% CI:54.7–67.9) reported not seeking care due to the high direct cost of service. Lack of knowledge, where to seek care affected 12.7% of patients.

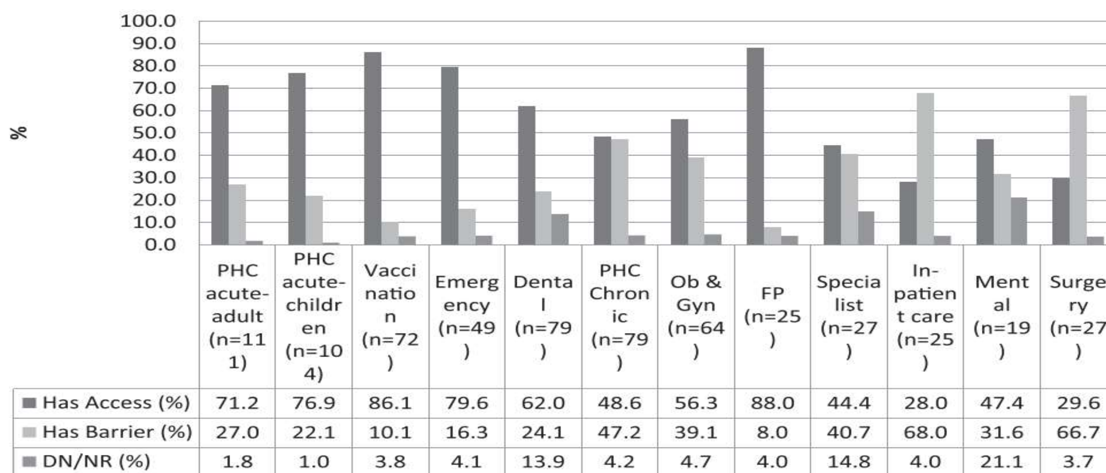
Long waiting time, perceived poor quality care, and absence of health workers made 9.6% of patients not to seek care. 5.4% of patients did not seek care due to either inability to affords the transportation cost or lack of legal documentation (Table:9). The study also revealed an association between decision making to seek care and household income level; those in the lowest quantile were twice unlikely to seek care(22).

Among 831 patients who received NCD care in Irbid governorate, 38.2% paid out-of-pocket payment at the point of care, with the average payment rate of 64.2 USD, this amount equated to 19% of household last month wages. Those who received free of charge care, almost half of them sought and received care in INGOs supported facilities(22).

Furthermore, 92.2% of patients among the 1243 NCD patients interviewed, knew the importance of adherence and regular medication intake, among them 23.1% reported a longer than two weeks interruption of medicine; 63.4% among patients with interrupted supply indicated the cost of medicine as the main reason for the interruption of treatment(22).

Ay et al. (54) in a Qualitative cross-sectional study that included 196 Syrian refugees (respondents) from the urban area concluded that access to Inpatient (IPD) care had been a critical challenge for many Syrian refugees. 68% among study respondents who needed IPD services reported challenges in accessing hospital admission(Fig:10); among those who needed a specialist visit and surgery services, 40.7% could not get access to a specialist, and 66.7% faced barriers accessing surgical service(54).

Figure 10: perceived accessibility barriers by type of services among refugees (54: p.8)



Long waiting times, delayed appointments, lengthy procedures, and the long-distance to health centres were the usual barriers reported by more than 60% of respondents. Furthermore, 38% of respondents reported the refusal of care provision at the facilities. 40.8% reported discrimination by health workers. 28.2% of respondent did not know where to seek care, and 24.3% of respondents favoured to take medicine without seeing a physician(54).

REACH study of 2016 on examining the tensions between Syrian refugees and the host community concerning access to healthcare, reported that 67% of Syrian refugees were

satisfied with health care services provided. However, this perception was more predominant among registered refugees who possessed the proper documentation, and therefore, access to required care in public structures should not be a challenge. Moreover, REACH report also argues that this high level of satisfaction is mostly attributable to the existence of free care services provided by INGOs supported facilities(38).

The REACH report concludes that funding for health care has not been adequate to meet the enormous demands of Syrian refugees and the vulnerable Jordanians(38).

3.3. Syrian Refugees' characteristics impact on access to health care

3.3.1. The Burden of NCD among non-camp Syrian refugees

Besides the high incidence of communicable disease among Syrian refugees' in Jordan, studies (Tab:7) also suggest a high prevalence of Noncommunicable diseases in this population. Doocy et al. in a cross-sectional study, concluded that more than 50% of Syrian refugees' households might have at least one member of the family suffering from NCDs. The prevalence of four NCDs was found significant among the people surveyed; 9.7% of the sample population reported having hypertension, followed by Diabetes Miletus in 5.3%; Cardiovascular Diseases, and Chronic Obstructive Pulmonary Diseases presented in 3.7% and 3.1% of the study population, respectively (20).

Two years later, the observational study, conducted by Manuela Rehr et al. reported a relatively higher prevalence of NCDs among the Syrian refugees in the northern Irbid governorate. 14% of NCD patients presented with Hypertension, 9% was suffering from DM. Moreover, 44.7% of NCD patients reported Multi-morbidities due to NCDs. Furthermore, among the 8041 adults surveyed, 21.8% reported having at least one member of the family with NCD.(22).

The extended analysis of the 2014 study by Doocy et al., examining the utilisation of health care services by non-camp Syrian refugees; revealed that the most common reason for seeking care among respondents were NCDs (21.1%), and communicable diseases(21.5%), almost at an equal percentage (53).

The study conducted in 2016 by Ay et al. , assessing health care need of Syrian refugees in an urban setting, revealed that 36.7% of respondents reported NCD care services as their primary need(54).

Figure 11: Burden of NCD among Syrian refugees (26: p.10)

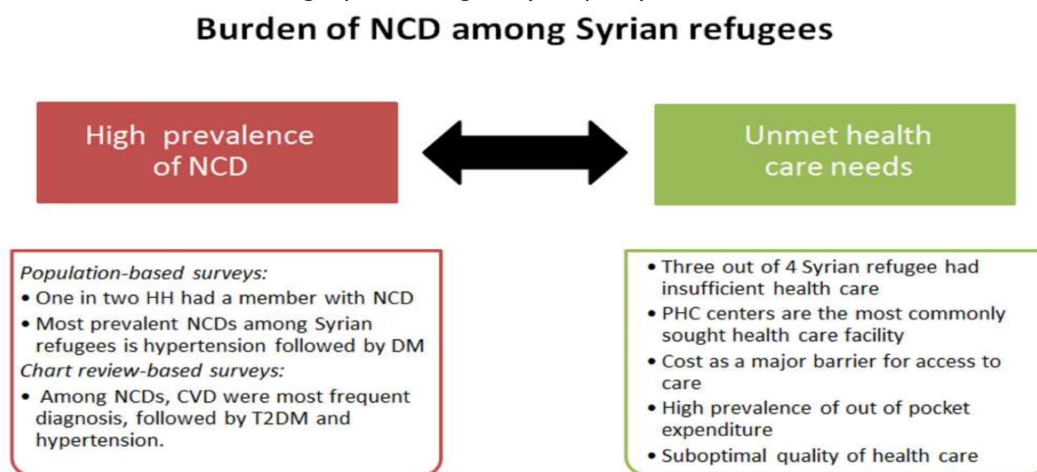


Table 7: Studies assessing NCD burden among Syrians in Jordan

Study type	Doocy et al. 2014 Cross-sectional study	Manuela Rehr et al. 2016 cross-sectional study	Doocy et al. extended the analysis	Ay et al.2016 Cross-sectional study (health need assessment survey)
Date data collection	June 2014	March 2016	June 2014 (extended analysis)	April 2014
N of Households (members) surveyed	1550 household (9580 individuals)	2587 household (17579 individuals)	1550 household (9580 members)	196 (individuals)
Location /setting	Clusters of respondents across 11 Governates (Non-Camp)	Irbid Northern governorate (Non-Camp)	Clusters of respondents across 11 Governates	Four Governorates including Amman, Karak, Maan, Irbid Non-Camp

3.3.2. Social determinants of health for Syrians refugees living in urban areas

The vast majority of Syrian refugees fled to Jordan are from the Sothern Syria region, having a close business tie and family connections with the Jordanian living in the North. At the initial phases of the refugee's crisis, displaced Syrians received a warm welcome in Jordan. However, over time, the rise in the number of refugees placed massive pressure on the host community, especially on the poor Jordanians, restraining their access to public services.

Worsened Jordan's economy further triggered competition for jobs between Syrians and vulnerable Jordanians, which in turn affected the host community sympathy toward their Syrian guests. The study conducted by CARE INTERNATIONAL in the five densely populated governorates in 2016, revealed that 75.3% of the Jordanian respondents demonstrated that the presence of Syrian refugees had impacted their life negatively in term of accessing public services, and finding and maintaining jobs and accommodations (55).

The Amnesty International report of 2016, expressed grave concerns over the dire living condition of Syrian refugees in Jordan connected to the GoJ stringent policies and the shortfall of the international aid agencies to cover refugees' needs adequately (36).

The vast majority of Syrian refugees are dependent on UNHCR cash and food assistance for survival; however, the assistance provided by UNHCR is not sufficient to cover the basic livelihood needs. Furthermore, strict government policy narrowed the space for Syrians to get a job and generate income. As a consequence, both, the failure of the international aid agencies in the provision of adequate support, and the legal obstacle imposed by the Jordanian government affected severely the quality of life for the majority of Syrian refugees living in an urban setting (36).

The UNHCR "Vulnerability Assessment Framework Baseline Survey" conducted in 2015, reported that 86% of Syrians refugees' households live below the Jordanian poverty line; earning less than 68 JOD /capita/month (highly vulnerable group), and 10% among them earn even less than 26 JOD /capita/month (defined as severely vulnerable). The low earning per capita also indicate a larger family size in the vulnerable Syrian refugees' households(56).

The UNHCR assessment survey also revealed that refugee families differed in their qualifications, capacities, and possessions. A small number came to Jordan with some

savings while the vast majority of refugees fled Syria with only what they could carry. Some families relied on remittances coming from their relatives working abroad. UNHCR concluded that living for five years in a dire environment with limited access to sustainable livelihood alternatives, made many refugees enter a cycle of asset exhaustion with depleted savings and a raised debt levels (56).

In the series of policy modification by GoJ comes the Urban Verification Exercise (UVE) that was launched in Mid-2014, aiming to legalise refugee's social status in urban areas. The NRC/IHRC study, assessing the implementation of UVE and its impact on refugees' access to public services showed that refugees' ability to obtain new MoI card was strictly conditional to the presentation of civil and legal documentation to the Authorities. Females and children were the more affected group; children lacking a birth certificate and women lacking marriage certificate were unable to complete the UVE process successfully and to obtain new MoI card, and hence their access to subsidised health care services hindered(47).

Both Amnesty International and the NRC/IHRC study reported that : Inability of Syrian refugees to meet the basic livelihood needs make many Syrian families adopt negative coping mechanism for survival such as, reduced food intake, child labour, forced and teenage marriage(family using bride price for livelihood), prostitution and other kinds of informal underpaid employment that can be dangerous (23)(47).

According to the UNHCR report on refugees livelihood in Jordan, as of Sept 2017, there were about 297,000 Syrian adults of working age in Jordan(57). Aiming to improve the livelihood of Syrian refugees, under the "Jordan Compact initiative", the GoJ committed to grant 200,000 work permits to Syrian refugees over three years period. However, since the start of this initiative in 2016 until December 2017, only 83,507 work permits were issued; meanwhile, the number of refugees holding valid work permit in December 2017 was approximately around 40,000 (48). The number of issued work permit increased to 122,000 in 2018 (15); but still, the opportunity of getting well-paid jobs and professional jobs stayed closed to Syrians, driving many Syrian refugees to either opt to work in the informal sector with no labour protection or remain jobless. (48).

For females, the absence of culturally suitable job scenarios, and lack of transportation means to the workplace was the main challenges. Even though women lead a considerable number of Syrian family as the only breadwinner, only four per cent of Syrian refugee women have got work permits under Jordan Compact initiative. Beside, Home-based business opportunity for single Syrian female are limited, not formally regulated and often challenged by the landlords and local Jordanian compotators(48).

The CARE INTERNATIONAL cross-sectional study estimates that the average size of a Syrian refugee family is about 4.7, with 70% of the households headed by males. Average monthly income for a Syrian household was predicted to be around 176 JOD, and that expenditure exceeds the income at 25% monthly, pushing refugees families toward debt (88.9%). The study also found increasing insecurity for rented accommodation for refugees, households headed by females were more subjected to accommodation insecurity (55).

3.3.3. Economic obstacles influencing access to NCD care for refugees:

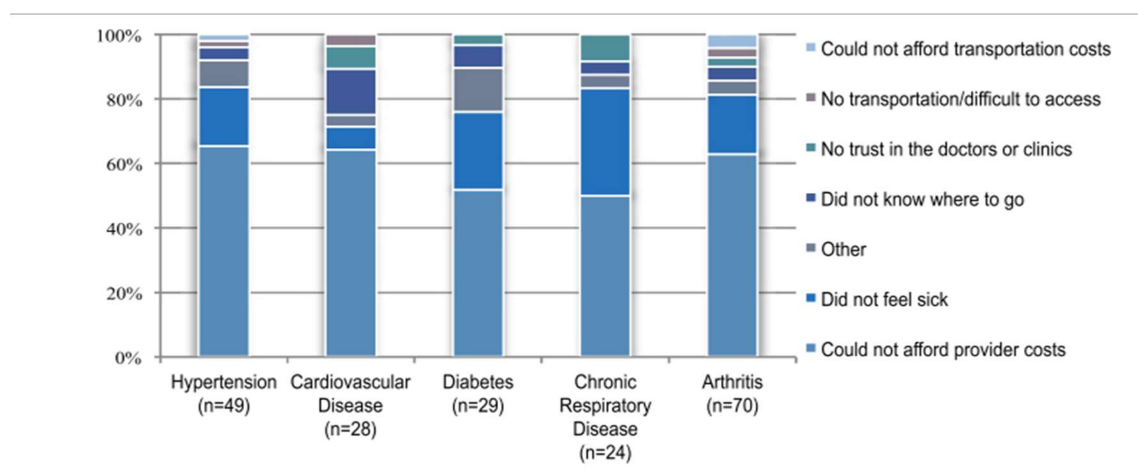
After the repeal of the free care policy for refugees in Nov 2014, a considerable number of refugees were not able to afford even the subsidized cost; as an alternative, they started to seek care in the health centres sponsored by humanitarian aid agencies or even seek care

in refugees camps where they could still get free care. The situation became direr for those who were not able to use the subsidised care due to structural barriers such as inability to register for new MoI card after the GoJ launched the UVE. Access to NCD care is discovered to be more challenging, owing to its high service cost associated with expensive laboratory inquiries and medicines.

A multivariate logistic regression analysis conducted by Doocy et al. (53) on defining the predictors for care-seeking among registered refugees in Jordan, discovered that majority of individuals who represented the lowest socio-economic quartile had to depend on the health services provided by either government or charity-run facilities. The study also revealed that slightly less than two-thirds (64.5%) of all individuals who avoided to seek care (n=169) reported the main reason their inability to pay the cost of services(53).

Doocy et al. also found among NCD patient, unaffordability as the core reason (Fig:12) for not seeking care, patients with Hypertension and CVDs were more affected(20). Important to mention that the Doocy et al. study reflects access to health services before the new policy came into the act so that access could have been more challenging after the repeal of free care policy.

Figure 12: Reasons for not seeking health care services among 200 patients with NCD (20: p.6)



In another observational study on access, Manuela Rehr et al. (22) revealed an association between monthly household income and care-seeking behaviour of NCD patients(Table:8). Patients living in a household of the lowest income quintile were twice less likely to seek care compared to those from households in the highest income quintile(22). However, the study did not show any association between health-seeking behaviour and household debt level and the level of assistance provided by aid agencies (vouchers). This results almost echoes the findings revealed earlier by Doocy et al. (53).

Table 8: Health seeking behaviour association with Household income among 964 NCD patients (24: p.10)

	Did not seek NCD care when needed	Did seek NCD care when needed	Odds Ratios (OR): Sought NCD care when needed		
	% (n)	% (n)	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	p value (Wald test)
Income					
Lowest (first quintile)	25.3% (61)	74.7% (180)	reference	reference	
(2nd quintile)	25.3% (68)	74.7% (201)	1.00 (0.69–1.45)	0.96 (0.65–1.41)	
(3rd quintile)	23.3% (27)	76.7% (89)	1.12 (0.67–1.87)	0.99 (0.58–1.69)	0.076
(4th quintile)	23.9% (43)	76.1% (137)	1.08 (0.72–1.63)	1.00 (0.66–1.53)	
Highest (5th quintile)	12.7% (20)	87.3% (138)	2.34 (1.36–4.02)	2.07 (1.16–3.70)	

Manuela Rehr et al. (22) also highlighted the perceived high cost of services among NCD patients as the key reason for not seeking health care services. Among 1,133, self-reported NCD cases, who needed NCD care in the last six months, 260 patients (23.0%) did not seek care, among them 160 patients (61.5%) reported the high cost of service as the main reason for not seeking NCD care(22).

Table 9: Reason for not seeking Health services among 260 NCD patients, last time when needed (22: p.8)

	n	% (95% CI)
Affordability of NCD services: Direct health care provider costs	160	61.5% (54.7–67.9)
Knowledge of NCD services: Did not know where to go or did not think it was important	33	12.7% (9.1–17.4)
Availability of NCD services: Inadequate service quality, service/staff not available or long waiting list	25	9.6% (6.6–13.9)
Approachability of NCD services: Lack or costs of transport or incomplete legal status	14	5.4% (3.1–9.2)
Acceptability of NCD services: Rude/rejecting staff attitude	2	0.8% (0.2–3.0)
Other reasons	20	7.7% (4.8–12.1)
Don't know	6	2.3% (1.0–5.1)

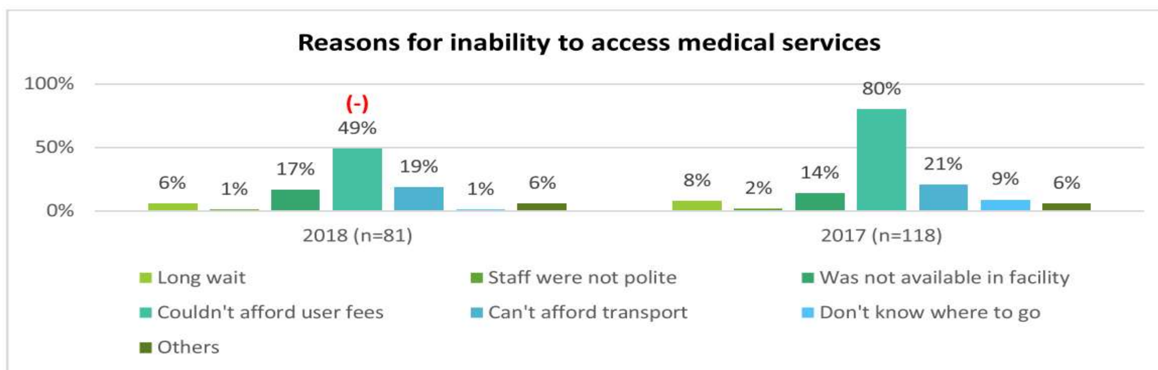
In another observational study, by Ay et al. (54) financial obstacles, such as high health services cost, the cost for medications and transportation, was outlined as the main barriers hindering access to health care services among Syrian refugees. The limitation of this study is related to its sampling method used (convenience and snowballing) and hence subjected to a high level of bias (54). Several other studies, including batches of household surveys conducted by UNHCR, confirm financial barriers as core reason, hampering refugees' access to health care services (43)(45)(58).

Important to note that most of the access studies are conducted before the repeal of subsidised care policy by the GoJ in Feb 2018. Under the new policy, the service payment increased two to five folds: for example, a refugee has to pay for a regular hospital delivery instead of 60 JOD (85 USD) now 240 JOD (338 USD). The service cost for a caesarean section hiked from 240 JOD(338 USD) to 600 JOD (846 USD), while the majority of refugees living below Poverty line with less than 3 USD earning per day(25).

No study was found in the literature, assessing the impact of the GoJ 2018 health Policy modification on the access of Syrian refugees to health care services. However, the only access survey conducted by UNHCR in December 2018, shows conflicting and discordant results, demonstrating that access to NCD care was better in 2018 compared to 2017(58). The survey also appears to have limitation in the methodology and analysis of the data (Fig:12 & Fig:13)

Figure 13: Inability to access medical services for Chronic condition 2017 versus 2018 (58: p.31)

Figure 14: Reasons for not accessing Chronic care 2017 versus 2018 (58: p.31)



Although in April 2019, the GoJ rolled back to subsidised care policy for Syrian refugees; however, the financial barrier was matter of great concern for a significant minority of Syrian refugees, even when the subsidised care program was in place.

3.3.4. Rendered access to health care due to bureaucratic procedures

3.3.4.1. Registered Syrian refugees

The UVE started in mid-2014, implied Syrian refugees to obtain new biometric MoI cards in order to be able to access government-sponsored public services, including health care. This bureaucratic procedure disrupted access to health care services of many Syrians while waiting to obtain the new MoI card.

3.3.4.2. Unregistered Syrian refugees

The GoJ estimate of actual Syrians living in Jordan is more than double of what has been reported officially by UNHCR, as registered Syrian refugees, approximately around 1.4 million. Access to health care is strictly conditional to possessing the UNHCR ASC and MoI service card. Ineligibility to access public health facilities pushes this big bulk of unregistered refugees, to either seek care in INGOs facilities; at the private clinics or to opt not to seek care at all.

Amnesty international quoted that the option of seeking care in public facilities (even if affordable) cannot be considered by the cohort of unregistered Syrian refugees, due to the perceived risk of being detained by the police and facing the worst consequences such as imprisonment, resettlement in camp or even deportation back to Syria (23)(59). Although, INGOs sponsored medical facilities, can be a suitable option for the unregistered group of refugees; however, the type, spectrum, and volume of services provided by INGOs are limited and not adequate to meet the broad range of health needs of this marginalised group.

This problem is more apparent when it comes to NCD care access, given that a small number of INGOs provide NCD services due to the lack of financial resources and the distinct high cost of NCD care. Furthermore, seeking NCD care in Private sector bring about catastrophic financial implications in the livelihood of this marginalised group, pushing them further toward poverty.

Chapter 4: Discussion

4.1. Policy changes implication on access

The findings of this research suggest that the recurring policy change of the GoJ takes its root from the notion of "no-duty" or "no-obligation" under the UN mandate. Since Jordan is not the signatory of the UN Convention on Refugees; this stance provided sufficient room for the GoJ to alter and regulate its refugee policy at any time, putting refugees in a delicate situation by limiting their access to fundamental rights and jeopardising their safety and protection.

In order to better understand the policy impact on the Syrian refugees' health access, it is essential to define first the driving factors for such policy changes, identifying the driving factors will help to suggest practical recommendations.

The analysis in this study identified two types of factors that drove the GoJ policy modifications, the enabling and the predisposing factors.

- The Enabling factor is the status of the GoJ as not a signatory to the UN Convention on Refugees; this position of the GoJ may predispose Syrian refugees to any vulnerability, such as restricting their access to fundamental rights and compromising their security and protection.
- Three factors have been identified as predisposing factors that have forced the GoJ to opt for such policy changes that did not serve the interests of refugees;

a) The financial pressure placed by the massive burden of Syrian refugees on Jordan public health sector with insufficient assistance received from the donors.

b) Public sectors unable to meet the increased demands of Syrian refugees, Owing to a lack of adequate workforce and supply

c) Socio-political pressure linked to the perceived unequal distribution of resources by the GoJ (*Jordanians considered the GoJ humanitarian response unfair with the notion of ' free care for refugees, irrespective of their economic status, whereas poor and uninsured Jordanians have to pay for health services at a subsidised price*), placed GoJ's legitimacy at stake, causing increased fear on the occurrence of political instability inside Jordan.

This research argues that while assessing the GoJ policy changes on refugees, it is critical to examine both types of driving factors and identify their weight for pushing on policy modifications. Taking into account the GoJ's receptive attitude to Syria in the initial phase of the refugee crisis through open border policy and the provision of free care services, this study concludes that the role of predisposing factors in policy changes have been more predominant compared to the enabling factor. This study also suggests that with the adequate support of the international community, the three predisposing factors could have been adequately tackled and hence drastic effect of policy changes on refugees could have been prevented.

It is worth mentioning that, when reviewing the results of this study, it was found that the "Aday Andresen model of access " in its original design cannot be effectively applied while examining the health access concept in a refugee setting. The Aday Anderson conceptual framework assumes that the policy adjustment "in regular setting" intend to influence the

health care system in "a positive" way pushing for structural and organisational changes in the system in order to meet the needs of the clients. By doing so, the client's perception improves, and hence, service utilisation increases.

As concluded earlier, the increased health demands of Syrian refugees placed a massive burden on Jordan's health care system, driving GoJ to opt for policy adjustment in a manner that was not favouring the interest of Syrian refugees and adversely affecting their access to health care; this conclusion suggests the opposite of what the conceptual framework of Aday Andersen directs in regular setting.

Henceforth, this study suggests the following adjustments in the original design of the Aday Anderson Model when applied to examine health access in a refugee environment.

- Emphasise on the International community financial and technical support to the hosting states as well as their role as Guarantor for pushing the hosting states to fulfil their obligations in proper treatment of refugees (key push element for shaping healthy refugee policies by hosting states)
- To consider the ethical duty of governments under the concept of "human rights law" and not only of their legal duty under the notion of the signatory state of the UN Convention on Refugees, in order to ensure appropriate health policies that best fit the needs of refugees.
- To Highlight the exquisite role of INGOs in complementing national Health care system in humanitarian response in a refugee context.
- Also, to cover the needs of vulnerable Jordanians in order to ensure social cohesion in society. *(Please see for the detailed description and diagram of the adapted framework, the appendix A)*

This research also found that the three main structure barriers induced by the current GoJ policy, not favouring the interest of refugees are:

- Complexity in the enrolment process of Syrian refugees (registration with UNHCR and MoI) that prevents many Syrians to obtain the legal migrant status which in turn entitle them to access public services in Jordan, including health care.
- Imposed high health services cost after the repeal of free care policy by GoJ.
- Adjournment of the "bailout mechanism", which restricted further the movement of Syrian refugees in urban areas *(affecting refugees who currently reside in camps and those who left the camps to the urban area before Jan 2015).*

The complexity in the enrolment process to obtain legal migrant status made a significant number of Syrian household incapable of accessing the comparatively cheaper NCD care services offered in public facilities. Keeping this obstacle in mind, according to Jordan National census of 2015 the number of Syrians living in Jordan is more than double of what UNHCR reports as registered refugees, and hence, a large number of refugees are deprived of accessing care in public health facilities due to their undefined legal status. This study also discovered a research gap about the health care needs in this marginalised group of Syrian refugees. This research argues that the unmet needs of the marginalised group of unregistered Syrians must be met in the light of human rights law and the UN Convention on Refugees. To achieve this goal, considering the scarce resources of the GoJ, the financial support of the GoJ by the international community is essential.

In summary, the recurrent modification of government policy has critical consequences on Syrian refugees in Jordan; pushing them to opt for unhealthy coping mechanisms in order

to survive. It also shuttered the protection space for refugees. Furthermore, limited freedom of movement affected refugees' access to adequate means for livelihood such as work and income, and lastly, the narrowed space to access health care services even persuaded some Syrian families to either return to their homeland or engage in survival prostitution and child labour.

4.2. Health system's and refugees' characteristics and their impact on access

Syria was known as high burden NCD country before the war. Following the displacement of Syrians, the burden of NCD travelled with them. Studies indicate that more than half of the Syrian refugee's households living in Jordan have at least one or more family member inflected by NCD. Analysis of the findings in this study shows that NCD care remains one of the most unresolved gaps in the humanitarian response plan for the Syrian refugees in Jordan. This research found that the chances of accessing free NCD care at INGOs clinics are minimal and cannot be an optimal alternative for all refugees who need care.

The main structure barrier influencing health access for many Syrian refugees in Jordan is the high service cost (direct cost). This barrier, substantially influenced the care-seeking behaviour of Syrian refugees in Jordan, encouraging them to opt for unhealthy behaviours, such as not seeking care, delaying seeking care or buying medicine from Pharmacies without consulting physicians.

The consequence of such behaviour among NCD patients can be severe, as interruption of NCD treatment increase the risk of complications and that, in turn, pose disastrous financial implications on refugees' household, pushing them toward more poverty.

Although the risk factors for NCD are mostly controllable through promoting a healthy lifestyle, however, refugees are more concerned about their survival than on handling their chronic illnesses. Limited access to decent living conditions, leave refugees more susceptible to multiple risks that adversely affect health, particularly for patients with NCD who need to shift to a healthy lifestyle.

The sharp decline of more than 60% in the utilisation of public health facilities by Syrian refugees after the abolition of the free care policy does not seem to be solely linked to the 20% co-payment cost of service imposed on refugees (Fig:3). This study suggests some additional explanations for such a sharp decline after the repeal of free care policy in 2014.

Among the list of potential other reasons comes the "Urban verification Exercise" that was launched soon after the repeal of the free care policy — the NRC study on UVE of 2015 support this hypothesis.

The involvement of INGO in 2014, may have motivated many Syrian refugees to seek care in INGO facilities instead of government facilities, where care is no longer free. The REACH study carried out in 2014 supports this assumption. However, this research argues that the option of accessing free NCD care at INGOs clinics have been minimal.

The "provider shopping" and overuse of service by Syrian refugees, while care was free, can be another supposition, but no study confirm this, except the assumption made by the World Bank Group and MOH Jordan.

This study also argues that although after April 2019, the GoJ rolled back the subsidised care policy, still the cost of services with the 20% co-payment may not be affordable for a

significant number of Syrian refugees. This argument on the inability of Syrians are well recognised and echoed by the studies conducted before the repeal of subsidised care policy by Doocy et al., Manuela et al., and Aye et al. and the bunches of UNHCR access surveys. The cost incurred is more cumbersome for NCD patients as effective management of NCD requires lifelong treatment with recurrent lab tests and uninterrupted supply of medicine that require more resources comparing to the treatment of acute health conditions. Specific to NCD care, as the cost of the service is expensive, NCD patients approach pharmacies and buy drugs without visiting physicians or interrupt treatment as confirmed by the Manuela et al. study.

The Other argument supporting the incapacity of Syrian refugees to afford the subsidised care, is supported by UNHCR household surveys, indicating that as the crisis already took a protracted pattern many Syrian households already depleted their savings, and as the findings showed their household debt rate is consistently on raise. Furthermore, more than 80% of Syrian refugees still leave under the Poverty line with no access to regular job to secure and maintain income. The poverty drive most of the Syrian family opt for the unhealthy coping mechanism for survival such as, reduced food intake, child labour, and other kinds of informal, underpaid employment that can be dangerous.

Connected to the health system structural barriers; Long waiting times, delayed appointments, lengthy procedures, and the long-distance to health centres and the cost incurred, were found to be additional barriers affecting access and perception of refugees' including their health-seeking behaviour. Refusal of providing care, discrimination, and lack of knowledge and awareness among refugees on where to seek care have been other barriers affecting access. Using home remedies for health problem seems to be also a common practice among refugees.

Based on the analysis of the results, this research recognises that the burden of Syrian refugees and their health demands has challenged Jordan's health care system in a variety of ways. Among them comes the financial strains, the overwhelmed health workforce, and shortage of supplies. The shortfall in the commitment of the international community to support Jordan health system timely and adequately is also a well-known reality.

Almost 30% of the Jordanian lacks health insurance and relying on subsidised care. Offering free care services to Syrian refugees have contested the government legitimacy toward its citizens. Meanwhile, host community access to care has been already affected by the overcrowded public facilities, which caused tension and treated social cohesion, as reported by REACH and the Care International studies.

Taking into consideration the above arguments; this research recognises that it is not feasible for the GoJ to tackle the unmet need of Syrian refugees without the financial support of the international community. Besides, Jordan is High burden NCD country, and one-third of the population does not have health insurance, so the aid provided by the international community should also target and covers the uninsured Jordanian needs. This will help to ensure social cohesion in the community between Syrians refugees and the hosting Jordanians. Furthermore, the evidence suggests that stability will not come soon to Syria and hence, the GoJ has to deal with the burden of Syrian refugees for a longer time. Jordan government needs to lobby the donors and the international community to get more funds from donors to be able to address the unmet needs of its people and its Syrian guests.

Chapter 5: Conclusion and Recommendations

5.1. Conclusion

By critically examining the findings of the existing studies on the Syrian refugees' health access, this study seeks to formulate evidence-informed recommendations to Jordan's MOH and other stakeholders involved. Applying the cross-sectional quantitative method and using standard questionnaires for data collections, almost all of the research conducted so far on refugees' health access in Jordan has been focusing on assessing the access concept from the client (refugees) viewpoint. Besides, there have been few pieces of qualitative research found in the literature (only one) that included the care provider perspective when evaluating health access for Syrian refugees.

The role of health policy as the overarching element in the concept of health access has not been critically examined yet in the refugee context of Jordan; hence, it is crucial to define and understand the key drivers and motivations behind GoJ's repeated policy changes, as resolving such reasons would have helped to prevent policy changes that adversely affect Syrian refugees ' access to health care. It is important to note that only criticising and blaming the GoJ for the unhealthy policy changes is not the solution for improving access; instead, it is critical to identify and understand the motives for the changes and to address them timely and sensibly.

Taking into account the above mentioned arguments, this review has looked into the essential three components of health access as outlined in the Aday Andersen Model of access, namely the health Policy, the features of the health delivery system, and the clients' (refugees) characteristics; with emphasises on the health policy aspect as the overarching element in the concept of access.

Analysis of the findings in this study firmly suggests that in order to improve Syrian refugees' access to health care, it is essential to adjust the present GoJ refugee policy first, by addressing the factors that have promoted policy changes in a direction that have not been favouring refugees' interests. Investment in health delivery system without adjustment of the current GoJ policy on refugees will not ensure health access to Syrians, including those who are unregistered and the most in need.

Since the majority of Syrians live outside camps and there are already competitions for the utilisation of sources and services between refugees and the host community; it is crucial to also cover the needs of the lower-class Jordanian for the sake of social cohesion and fairness.

Last but not least, this study acknowledges that without the technical and financial support of the international community, the GoJ is not able to meet the needs of Syrian refugees and, thus, active participation of the international community in addressing the Syrian refugee needs in Jordan is mandatory.

5.2. Recommendations

This research presents the following recommendations to the government of Jordan and other stakeholders involved in the humanitarian response activities for the Syrian refugees in Jordan.

5.2.1. To the Government of Jordan

- Considering the fact that the future of peace remains unclear and Syrian refugees may not return soon to their motherland,the GoJ should continue to persuade the international community and donor agencies for adequate financial support; In this regard, the GoJ needs to adopt a comprehensive policy on advocacy and communication, taking advantage of the international aid organisations in Jordan, to echo the government's voice in receiving adequate foreign aid.

- Pursuant to the ethical duty of the State, the GoJ should grant access to public services to those Syrians who have not yet been granted legal status as migrants. This objective can be easily achieved; adjusting the current refugee policy by simplifying the enrolment mechanism and preventing bureaucratic procedures is, therefore, a must. As the policy adjustment on refugee enrolment and the planning of services to address refugees' unmet needs may be lengthy; the GoJ may consider the following two alternatives as short term solutions.

    - To Authorise UNHCR to restart its enrolment process for the marginalised group of "unregistered refugees" and provide them with the food and cash assistance.
    - The GoJ should encourage INGOs to shift from short term projects, to invest in a long-term program in coordination and collaboration with the GoJ. NCD care and health promotion on NCD is a field that INGOs can easily cover, however, to encourage INGOs investment in Jordan on NCD care, the government should simplify the process of contracts for the humanitarian assistance projects in Jordan which at this stage is very complex and bureaucratic.

5.2.2. To Jordanian MOH

- MOH to shift the existing NCD care resources from specialised centres and hospitals to primary care level. The NCD service should include an active health promotion component with emphasis on NCDs prevention and self-monitoring (home management). Integrating the NCD care in Primacy care and health promotion activities, including NCD self-management at home, will decrease the caseload of NCD patients on the overcrowded health centres. Self-monitoring of NCDs will encourage patients to take active responsibilities for their health. Technical support on how to fully integrate the NCD care in Primary care facilities can be sought from WHO experts.

5.2.3. To the international community, including donors Agencies

- To encourage the GoJ for policy adjustment that favour the Syrian refugee's interests.
- To encourage the GoJ to facilitate the integration of the marginalised group of unregistered Syrians, meanwhile, to guarantee the protection of refugees if GoJ, launches the enrolment of unregistered Syrians.
- Considering the scarce resources of the GoJ, the commitment of the international community to financially supporting the GoJ to tackle the unmet needs of Syrian

refugees is essential. The support needs to be boosted keeping in the centre, transparency and accountability of GoJ and the international community.

- To support, technically and financially, MOH Jordan in carrying out studies and research in the field of displacement setting, whether related to the needs of Syrian refugees or evaluating the cost-effectiveness of NCD emergency response strategies.

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7. Appendixes

7.1. Appendix A: Adapted version of Aday Andersen model of access in a refugee setting: Facts for the proposed adaptation of the framework

Findings of this research suggest that, when a state is not a signatory of the UN convention on refugees or other related international protocols, under the notion of "no-duty" and "no-obligation" , the refugee policy of the host country may not guarantee refugees to enjoy their fundamental rights, but may instead infringe their freedoms and impede their access to those rights. In such a context, the development of health policy will be driven in a manner that may not favour refugees' interests but more the host state interests that can be harmful to refugees.

In order to guide the government's general policy on refugees favourably, the concept of " no-duty" must be ignored for those states who are not the signatory of UN convention on refugees; instead, the issue should be looked at from the perspective of Human Right Law. The international community should act as guarantor encouraging the states to fulfil their commitment toward the vulnerable group of migrants even if they are not a signatory of the UN convention.Besides, it is important to note that timely technical and financial support of the international community to the host states will help in the formulation of healthy refugee policy.

The latest change of UNHCR stance on refugee's settlement encourages states to let refugees reside in host communities instead of ending up in camps for living. Refugees residing in urban areas will use public health structures for addressing their health needs; this may place unpredicted financial and workforce burden on the host country health system; a system which already has short-falls in addressing the basic health needs of its citizens. Here comes the role international community, to timely support the host country health system, both technically and financially, leaving no room for the state to seek drastic changes in refugee's health policy due to the financial and technical constraints the host states face.

Furthermore, the overcrowded facilities may not be able to provide quality care services, both for the host community and refugees; this may contribute to the conception of negative perception about services delivered and, most importantly, the anticipated health outcomes could also be severely affected.

Increased utilisation of health services by refugees may encumber access of the host community to the existing health care services; causing competition between the two communities. This competition, in turn, becomes a source of social tension and even may lead to socio-political instability within the host country. By this, any program addressing the refugee's needs should also target vulnerable group of the host community.

As the governments may have already developed some long-term health policies and strategies for its native inhabitants, countries may not be prepared to alter these long-term policies temporarily for the sake of state legitimacy; showing that the states are fair to their people while responding to the health demands of refugees. Here arises the role of international humanitarian organisations that may be in the best position to meet the requirements of vulnerable groups within the host community temporarily until the refugee's crisis is over.

INGOs by taking that role may promote state credibility by maintaining a favourable perception within the host community on the fairness of the humanitarian response; meanwhile, it will avoid inappropriate competition for health services between the host community and refugees and hence will diminish social tensions between them.

In addition to the external drivers that may guide healthy state refugees' policy, the Government's health policy on refugees should be informed by the refugee specific descriptors (predisposing and enabling characteristics), and the health system structure and organisation for refugees should be shaped based on this information reflected in the Health policy.

The suggested adaptation in the Aday Andersen framework is based on the evidence and the assumptions derived from this research work in the context of refugees in the kingdom of Jordan.

The Aday Andersen's Adapted Model of Access to health care in a Refugee setting