HASHEMITE KINGDOM OF JORDAN
SYRIAN CRISIS
HEALTH NEEDS ASSESSMENT

March 2014 – Report to the Ministry of Health

Ministry of Health
KINGDOM OF JORDAN

PREMIERE URGENCE AIDE MEDICALE INTERNATIONALE

EXECUTIVE SUMMARY

With over 1 out of 10 people actually living in Jordan being a Syrian refugee, the Syrian crisis has a great impact on the country in demographic, social and economic terms.

Over 80% refugees reside in host communities which require more complex interventions to reach out refugee, respond to their needs and mitigate the impact on the host communities.

While demographic data are far from being accurate due to mobility and the refusal of some refugees to register, it is however clear that densely populated areas surrounding important economic centres are attracting significant numbers of refugees, with among other pull factors the cheaper housing costs.

Significant numbers of humanitarian actors are concentrating their efforts on camp settings and on the Northern governorates. Financial means have also been channelled to the main refugee camp of Zaatari, more recently to Azraq camp and to the northern governorates.

However and in view of the fact that governorates located at the centre of the country such as Zarqa Governorate host significant refugee population and vulnerable host communities, there is a lack of services to address basic needs of these populations.

As per a May 2012 Government of Jordan cabinet decree, Syrian refugees with valid registration – both up-to-date UNHCR registration certificate and Ministry of Interior Service card delivered by a police station in the same district of residence - receive free primary, secondary and tertiary health care services at MoH facilities. Refugees who do not have the appropriate registration documents – valid UNHCR and MoI documents - are served by UNHCR Jordan Health Aid Society (JHAS) clinics and Mobile Medical Units (MMUs) as well as NGO and private clinics.

However, and on the basis of information collected through household visits conducted to screen the needs of beneficiaries in the context of shelter kit distribution as well as on a previous assessment conducted in the third quarter of 2013, PU-AMI came to the realization that access to health care is of concern for many families, in spite of the services offered by MoH and the Humanitarian response to the Syrian crisis, and that (basic) healthcare needs are not met. Additionally, access to information still appeared to be insufficient for many e.g. in regard to existing services, registration procedures etc.

Therefore, and with the MoH approval - a health assessment was conducted in March 2014 to evaluate the unmet needs of Syrian refugees and vulnerable host communities in the Zarqa governorate as well as to tailor PU-AMI health intervention in Jordan.

Through a combination of methods including focus group discussions and individual interviews with Syrian refugees and host communities, health facility assessments, interviews with key stakeholders and thorough desk research, the needs, demand and response aspects were assessed to obtain a comprehensive picture of the unmet health needs.

The assessment confirmed that significant barriers exist that prevent Syrian refugees from access quality affordable health care services. The most significant factors influencing access to health care include financial pressure and priority given to house rental costs, administrative regulations (police/MoI registration, UNHCR

registration) – as well as lack of information, perception of healthcare quality including staff attitude, drugs availability, waiting time – and overall lack of services due to the saturation of existing facilities.

On the response side, most health services accessed by Syrian refugees are provided by the MoH followed by the national NGO JHAS supported by UNHCR. The MoH reported an increased utilization of its health services of 9%[1] - as for June 2013. The burden of Syrian refugees on the public health services was confirmed during the assessments of the 11 health facilities visited. In view of the fact the MoH only caters for MoI and UNHCR registered refugees, an important share of the Syrian refugees in Jordan falls out of the Government policy of free access to health care. The existing private clinics in Zarqa are not sufficient to cover the needs. Additionally, accessibility to these services is often limited due to the lack of financial means to pay for transportation.

The health needs of the Syrian refugees are relatively similar to the morbidity patterns in Jordan with a high burden of chronic diseases. However Syrian refugees are also presenting specific needs related to communicable diseases - TB, measles, Hep A, polio – as well as significant mental health and psychological issues resulting from the war experience and displacement.

In view of these findings, a comprehensive and continuous intervention is recommended combining the provision of health care through MoH primary care level facilities to the offering of psychosocial and mental health services at the community level. This two-component approach is required to improve both access to health and the general health status of Syrian refugees and vulnerable host communities and increase their resilience. Great opportunities of collaboration with key stakeholders as well as areas of support to MoH existing health facilities where identified which will allow PU-AMI to offer a comprehensive and sustainable response to Syrian refugee and host communities in Zarqa governorate and hopefully pave the way for a wider intervention in Jordan.

[1] MoH (January 2014). Joint Rapid Health Facility Capacity and Utilization Assessment (JRHFCUA)

ABBREVIATIONS

ANC: Antenatal care

ARI: Acute respiratory tract infections

CBC: Complete blood count

CBO: Community-based organization

CHC: Comprehensive health centre

CHB: Community health based

CHW/V: Community health worker/volunteer

GoJ: Government of Jordan

HC: Health centre

IUD: Intra uterine device

JFDA: Jordan Food and Drugs Administration

JHAS: Jordanian Health Aid Society

MHPSS: Mental health and psychosocial support

MMU: Medical Mobile Unit

MoH: Ministry of Health

MoPIC: Ministry of Planning and International Cooperation

MoSD: Ministry of Social Development

NCD: Non communicable diseases

PHC: Primary health centre

PNC: Postnatal care

RH: Reproductive health

RMS: (Jordanian) Royal Medical Services

URTI: Upper respiratory tract infection

WB: World Bank

CONTENT

PART I: INTRODUCTION & METHODOLOGY

1. INTRODUCTION

1.1. CONTEXT

The Hashemite Kingdom of Jordan is among the most stable countries of the Middle East. It enjoys good diplomatic relations with its regional neighbours and is one of the only two countries in the region to have a peace treaty with Israel. It is a constitutional monarchy headed by the King Abdullah II since 1999. The country is predominantly Muslim with 92% of people identified as Sunnis. Jordan has a population of 6.56 million; a delicate balance exists between the different demographic groups with over 60 per cent of the population of Palestinian origin. Jordan has received large flows of refugees from Palestine, Iraq and more recently Syria. The current situations in these countries make it unlikely that these refugees will return in the near future.

Impact of the crisis

Jordan is the country hosting the third largest number of Syrian refugees**, with 587,308[2] refugees** as of March 24th, 2014, after Lebanon (980,732 refugees) and Turkey (642,482 refugees); the other countries hosting refugees are Iraq (226,934 refugees) and Egypt (135,378 refugees). At a regional level, the exodus of Syrian refugees has continued to massively flee their country with over half a million refugees arriving since the last quarter of 2013. More than half of registered refugees are children and 86% of refugees are living with local communities (as per WHO estimates). If current trends persist, it can be expected that 3 million Syrians will have fled their country by summer 2014.

Although the number of Syrian refugees is still increasing, the numbers of arrivals have slightly reduced and averaged to 3,400 arrivals per week since February 18th3.

With over 580.000 refugees officially registered with the UNHCR and an undetermined number of unregistered refugees[4], the Hashemite Kingdom of Jordan hosts more than 10% of its total population which was recently estimated at 6,558,795 inhabitants[5].

In Jordan, the first response to the needs of the refugees was carried out by the host communities alongside Jordan civil society and charity organizations. International humanitarian actors have then arrived although an important number of these focus on camp settings while the greatest majority of refugees are in host communities.

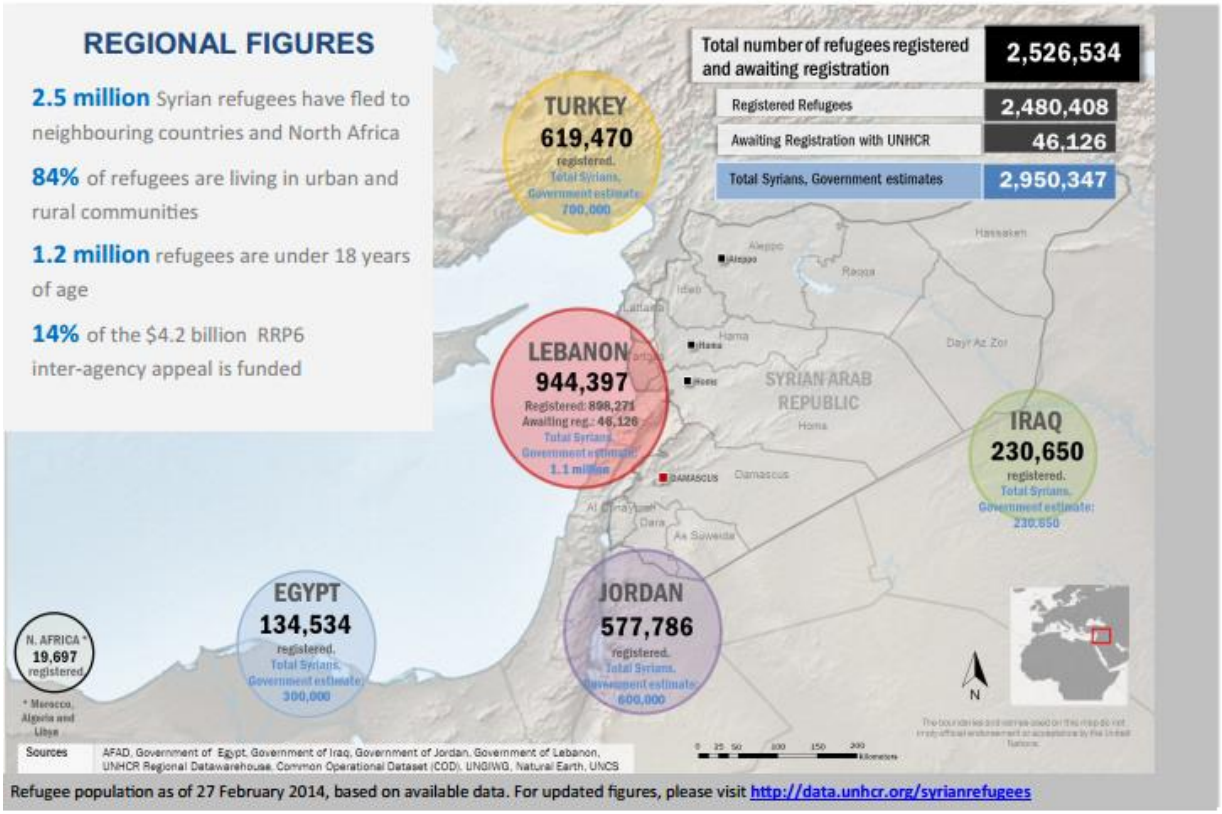
The influx of large numbers of refugees has also led to an increase in housing prices; this trend is spreading towards Zarqa Governorate and Amman as the Syrian people move towards the South of the country in

[2] http://data.unhcr.org/syrianrefugees/regional.php latest accessed on March the 24th.

[4] As per the Government estimates, 800,000 Syrian refugees are on the Jordanian soil without being registered, which brings the total number of refugees to 1,400,000 people (source: discussion with Dr Bassam, former Director of Primary Health care, MoH).

[5] As per the Jordanian Deparment of Statistics (March 2014), and where the CIA World Factbook estimates at 7,930,491 inhabitants for January 2014 (including refugees?) https://www.cia.gov/library/publications/the-world-factbook/geos/jo.html

search for more accessible and affordable living space. The GOJ has calculated that it incurred additional costs in the order of US$250 million in 2012 and the first quarter of 2013 to accommodate the increased demand for services. In health care, the MOH has already spent US$53 million to cover the health care needs of the Syrian refugees. The latest GOJ Response Plan (see below) estimates the cost of accommodating the Syrian refugees in 2013 at US$850 million[6].



1.2. PU-AMI IN JORDAN

Following PU-AMI's regional strategy, it was decided to set up an operational base in Amman that also serves as the Middle East region office under the management of a Regional Representative. On the basis of a multi-sector assessment conducted in Amman and Zarqa end 2012-begining 2013, a regional project proposal was granted in July 2013 by ECHO for Syria, Lebanon and Jordan. The planned activities include shelter, rehabilitation, health and education interventions, with different activities in each country. In Jordan, the ECHO project consists of (i) shelter rehabilitation and upgrading houses through the distribution of Sealing-off kits, (ii) Emergency cash assistance and (iii) a screening and referral system for the governorates of Amman, Zarqa, Balqa and Jerash.

In the fourth quarter of 2013, PU-AMI led a second multi-sector assessment in Amman in order to refine the understanding of urban refugee distribution and needs. The assessment revealed gaps in health care

[6] WB, Human development department 0 MENA region (July 2013). Project appraisal document on a proposed loan in the amount of us$ 150 million to the Hashemite Kingdom of Jordan for an emergency project to assist Jordan partially mitigate impact of Syrian conflict.

access for Syrian refugees as well as for the most vulnerable Jordanian families in various neighbourhood of Amman suburb.

1.3. ASSESSMENT RATIONALE AND OBJECTIVES

PU-AMI's outreach activities in Zarqa revealed important gaps in health care and psychosocial support that do not seem to be addressed by the current humanitarian response. It was therefore decided to conduct an assessment to further assess health needs of Syrian refugees and most vulnerable host communities as well as the existing response in order to inform the definition of PU-AMI health and psychosocial integrated approach in Jordan.

Through its intervention in Lebanon, Jordan, Iraqi Kurdistan as well as Syria, PU-AMI has developed a regional approach to the Syrian crisis and acquired profound knowledge of and experience with addressing needs of refugees in various fields, including health.

This assessment received the approval of the Ministry of Health in February 2014.

2. METHODOLOGY

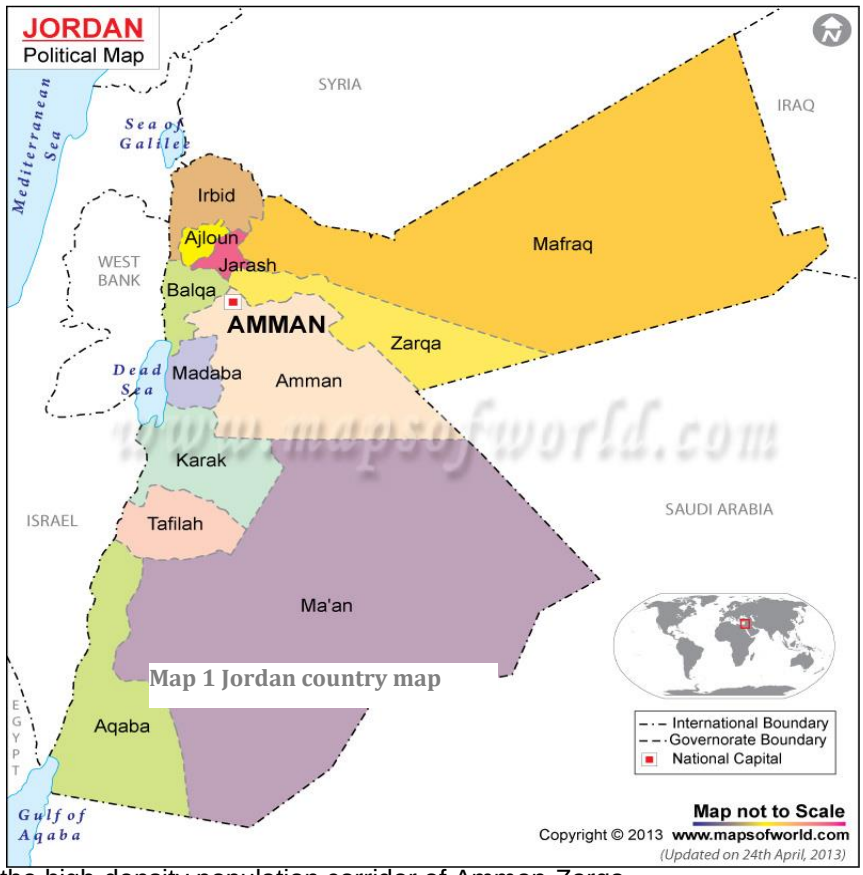
2.1. COMPOSITION OF THE ASSESSMENT TEAM

To allow for a comprehensive overview of the health needs, the assessment was conducted by a multidisciplinary team with the following profiles:

- The assessment coordinator, responsible for the overall assessment design, implementation and reporting
- A Jordanian nurse (female) with a wide working experience in the Jordanian health system, both public and private, as well as a good knowledge of the Zarqa communities
- A Jordanian field officer (male) with a good knowledge of the visited communities and a background in marketing and assessment methods
- A Syrian medical doctor (female), trained in surgery and with a solid experience in mental health assessment since the beginning of the crisis.

2.2. EXPLORED AREA

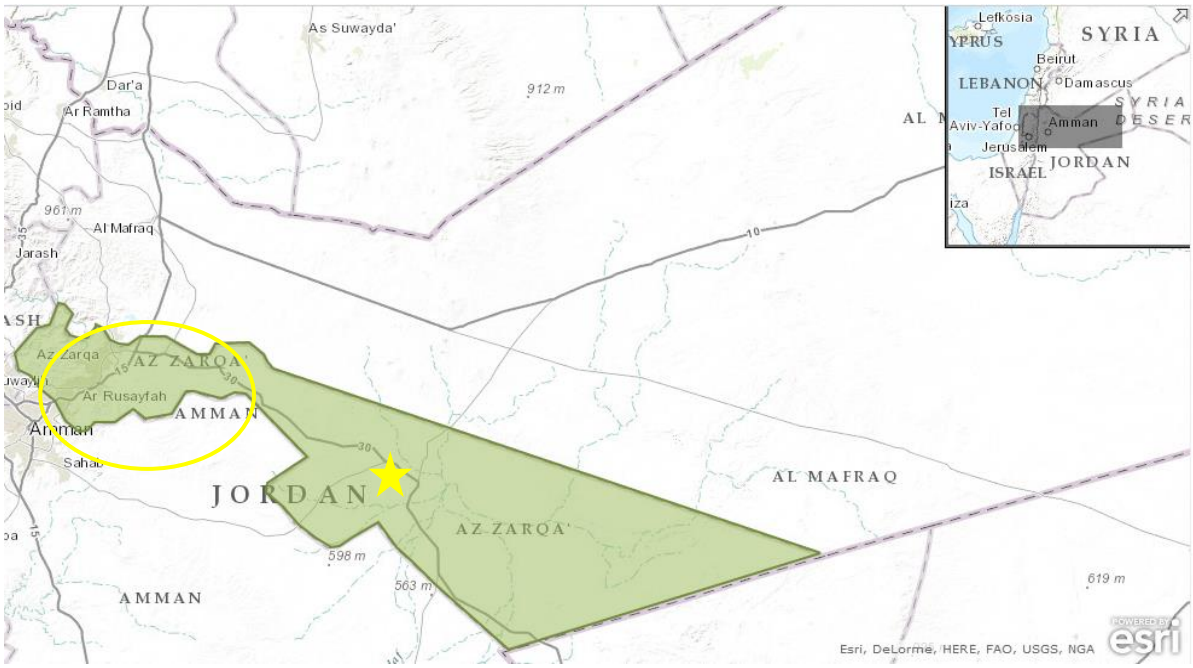
While it was initially planned to assess the needs in three of the four governorates where PU-AMI operates - Balqa, Jerash and Zarqa - the Jordanian authorities decided to focus the assessment on the Zarqa governorate as needs were said to be direr and information on health needs and coverage was lacking in the Governorate. Additionally, this assessment was coordinated with the health working group and other assessments that were being implemented/analysed at the time of this assessment.



Map 1 Jordan country map

The population of Zarqa Governorate is mostly concentrated in the cities of Zarqa and Ruseifah that are located on the high-density population corridor of Amman-Zarqa.

In addition, Zarqa Governorate recently saw the implementation of an additional UNHCR camp for Syrian refugees that is located in Azraq.



Map 2 Zarqa governorate with densely population area of Zarqa and Ruseifah towns and Azraq camp

2.3. METHODOLOGY

In line with the assessment terms of reference validated by the Ministry of Health, several methods were used to establish a comprehensive picture informing on the three perspectives that are key for planning a relevant intervention, i.e. the healthcare response, the needs and the demand. The assessment activities included focus group discussions, rapid appraisal of primary health centres – public, private and NGO – stakeholder interview. Additionally, a desk research was performed using an extensive review of existing literature. The methods used are further described in the following sub-sections:

Focus group discussions with Syrian refugees and host communities

13 group discussions were conducted with Syrian refugees (10) and host communities (3) in Ruseifah and Zarqa towns and included over **110 male and female participants**, as described below:

#	Location	Group	Gender	Number of participants
1	Russaifah	Syrian	Female	12
2	Russaifah	Syrian	Male	6
3	Russaifah	Syrian	Female	12
4	Russaifah	Jordanian	Women	12
5	Russaifah	Jordanian	Male	6
6	Russaifah	Jordanian	Female	8
7a & b	Russaifah	Syrian	Male	6
8	Zarqaa	Syrian	Female	10
9	Zarqaa	Syrian	Male	12
10	Zarqaa	Syrian	Female	9
11	Zarqaa	Syrian	Male	7
12	Zarqaa	Syrian	Female	10
13	Zarqaa	Syrian	Male	6

Table 1 Focus group discussion types and location

A discussion grid was elaborated consisting of two main parts: the first one on health issues and health seeking behaviours, the second one on psychosocial challenges.

The discussions were orchestrated by a discussion facilitator. One person was in charge of taking notes while the other person was translating the discussions to the assessment coordinator.

All group discussions took place in quiet venues provided by CBOs and lasted for an hour. Participants' consent to take part in the discussion was always asked orally prior to kick off the meeting.

Home visits: household and individual interviews

In addition to the group discussions, around 20 families were visited in order to collect rich information on psychosocial, mental health challenges as well as specific experiences with accessing health care.

The first group of home visits included 14 families who were interviewed on their living conditions and their experiences of fleeing Syria. Visiting these families at home provided a more conducive setup to discuss issues related to personal and psychological experiences of the crisis. The interview was guided by a household questionnaire which was followed by individual interviews conducted with members of the family

including adults and children. Of the 14 families visited, 12 adults (10 women, 2 men, age group 18-43) and 3 children were interviewed.

To complete the group discussion findings on health care access, 5 more home visits were conducted to families in Zarqa periphery (Sohkneh) and Ruseifah (Hitten camp), in areas bordering Palestinian camps. These discussions allowed to discuss the experience of specific groups to health care such as Palestinian from Gaza as well Syrian refugees living in semi-urban areas.

Rapid appraisal of health centres

Based on an appraisal questionnaire that was previously validated by the MoH, the assessment team visited 11 governmental health centres and 4 non-state clinics, including:

- 10 public primary health centres in and around Zarqa and Ruseifah cities (full list in Annex)
- 1 comprehensive health centre in Ruseifah city
- 1 private clinic ran by two Syrian doctors licensed to operate in Jordan
- 3 NGO clinics (JHAS, JWU, NHF)

The questionnaire was built to collect information on resource and assets, processes.

Stakeholder interview

Over 30 interviews with 26 CBOs, national and international organizations; governmental, bilateral and UN agencies were conducted to discuss their views on existing needs as well as healthcare services.

Desk research

A sound desk research was performed to analyse the context and specifically looked at the following aspects:

- Health system organization and health service utilization
- Existing interventions for Syrians and host communities in regard to general health and mental health
- General situation of Syrian refugees.

PART II: MAIN FINDINGS: ANALYSIS OF HEALTH NEEDS, DEMAND & SERVICES

3. HEALTH NEEDS AND DETERMINANTS

The below section presents the health needs of Syrian refugees and host communities as well as factors influencing health seeking behaviours and health status of these populations in the urban areas of Zarqa Governorate.

3.1. DEMOGRAPHICS

The Governorate of Az Zarqa (Zarqa) is composed of the districts of Zarqa, Ruseifah, Hashemieh and Azraq and is one of the most populated governorates of Jordan with more than 1,400,00 inhabitants. Zarqa Governorate has been identified as an area that needs focused development attention due to high level of poverty as well as pollution[7]. The Governorate's population is mostly concentrated in the high-density cities of Zarqa and Ruseifah hosting 792,665[8] and around 600,000[9] people respectively. The immense area lying eastward Zarqa town mostly consists of a desert and has fewer cities of smaller size. The new UNHCR camp of Azraq was established in this desert area of Zarqa.

3.1.1. Syrian refugees: High mobility and lack of data on geographic distribution

Of the 580.000 refugees officially registered with the UNHCR (March 2014), 18.3% are under 5, more than 50% under 18 and 51% are women. As per WHO estimates, 84% of the refugees reside in the host communities with the majority staying in urban settings.

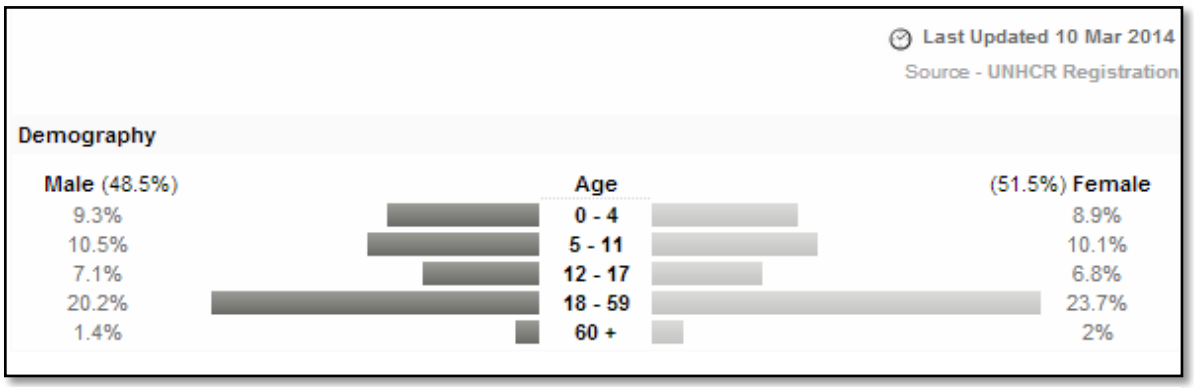


Figure 1 Age pyramid of Syrian refugees in Jordan

[7] http://www.jo.undp.org/content/dam/jordan/docs/Poverty/MDG%20Zarqa%20ProDoc_JO.pdf

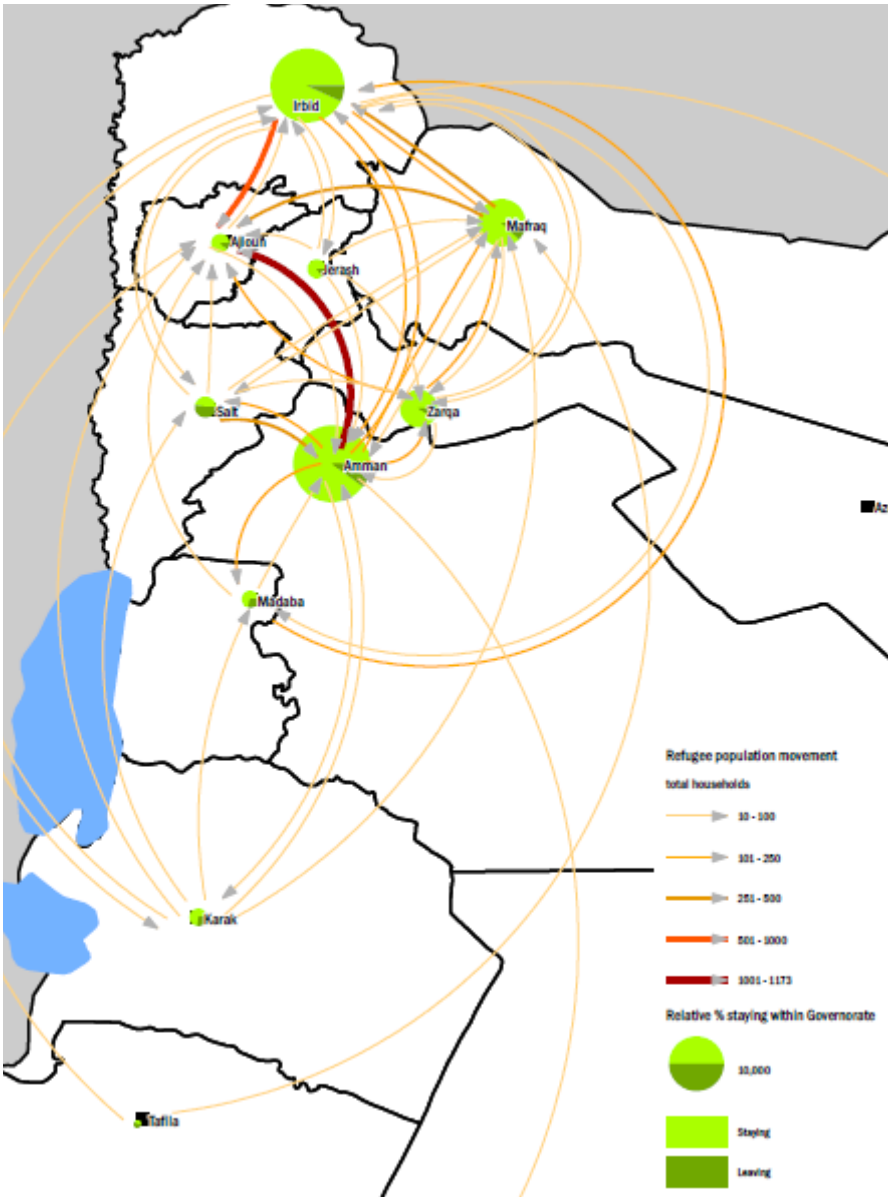
[8] Ibid. However, and according to its Mayor, Zarqa town is one of Jordan's most populated cities, with a population estimated at one million.

[9] This information was provided by Zarqa Governorate of Health, although no recent data could be found on the exact population number in Ruseifah.

Due to the significant mobility of Syrian refugees, official data on refugee population distribution in Jordan is not accurate. While the bulk of refugees are registered in the northern Governorates of Mafraq and Irbid, the centre Governorates of Amman and Zarqa also host significant numbers. This notwithstanding, accurate figures on refugee geographical distribution are lacking due to the fact that many refugees do not always inform UNHCR nor change their MoI service card (please kindly see below the section on registration process). For instance, the official number of Syrian refugees registered in Zarqa Governorate is 51,757 (March 14, 2014) which seems rather underestimated. The Health Governorate estimated that it may be 4 to 5 fold higher and that the Mayor of Zarqa city stated that over 100,000 refugees live in his town[10].

An assessment of over 60,000 Syrian households conducted by IRD/UNHCR[11] confirmed significant mobility among Syrian refugees for the purpose to search for job opportunities, particularly in agriculture, but also in the construction and service sectors. Family links and charity networks also motivate refugee movement within the country (see map).

Zarqa is one of the four governorates with the highest proportions of refugees who came through Zaatari camp (other three are Mafraq, Irbid and Jarash) where an average of 65% refugees came through Zaatari. The refugees who came through Zaatari have specific vulnerabilities related to the bailout and re-registration processes, which initially exclude them from the established humanitarian



Map 2 Movement of Syrian refugee households assessed (January - October 2013) compared to their original place of registration, by governorate

[10] http://jordantimes.com/zarqa-municipality-struggles-with-refugee-burden

[11] By comparing the original governorate of registration (via UNHCR's global refugee registration database, proGres) with the current place of residence at the time of the home visit. IRD, UNHCR (2013). Syrian refugees living outside camps in Jordan. Home visit data findings.

assistance systems.

3.1.2. Syrian refugee registration

Upon legal entrance in Jordan through the official borders, Syrian refugees register with the UNHCR at Raba Al Sharab camp. Refugees who managed to cross outside the official borders and who are caught up by the police are sent to Zaatari camp to regularize their status. UNHCR registered refugees are then required to register with the Jordanian authorities who will issue the Ministry of Interior service card that acts as official identification documents listing basic information about cardholders and their families as well as the place of residence.

In order to access public services, refugees must present their MoI service card that has to be registered at the same District of the health centre they want to access. Therefore refugees who moved to another district are required to regularize their MoI service card – i.e. have the residence place changed, which represents a cumbersome and expensive process for the second registration[12]. Therefore, many families who have moved out of the initial registration place do not have the right residency place on their service card. As mentioned earlier, this constitutes a factor of vulnerability as refugees with invalid MoI service card are not allowed to access public health services for free.

In parallel to the MoI registration that is compulsory, Syrian refugees who left the camp have to register with UNHCR to be entitled to access a number of services such as food coupons, free public medical services and school and, according to set criteria, cash assistance. The UNHCR registration is valid for six months after initial registration[13]. However access to public health care is only possible during the UNHCR registration document validity period (access to food coupons remain).

One of the major issues faced by Syrian refugees relates to the renewal of expired UNHCR document, which currently takes around 6 months in Zarqa. This constitutes an important barrier in accessing public health care. The UNHCR is working on reducing this delay. In order to ensure that refugees in need for medical care can access health services (e.g. chronic patients, pregnant women, emergency cases), the UNHCR public health and registration units have decided to develop a fast track registration process by giving them a priority to be registered to gain free access to governmental health facilities as alternative solution since those services are not provided by UNHCR and its implementing partners[14].

3.2. EPIDEMIOLOGICAL PROFILE AND NEEDS

3.2.1. Jordan epidemiological profile

Jordan's population and epidemiological profiles are a result of both the demographic and epidemiological transitions that characterize most middle-income countries. Drastic declines in death rates and continued high birth rates along with the shifting composition of illness away from infectious diseases to non-communicable diseases shape Jordan's population and epidemiological circumstances.

[12] Minimum of 80JoD excluding transport costs.
[13] UNHCR is currently discussing with the GoJ the possibility to extend the Syrian refugee registration to a year.
[14] UNHCR SOP: Fast track registration for medical reasons (available on UNHCR portal)

Jordan is among the countries with the lowest infant[15] mortality rate in the region. Universal child immunization was achieved in 1988, no case of polio was reported since the second half of the 90s and no cases of measles had been reported since 2009, until the recent arrival of Syrians. Considerable progress was made in reducing the major health risks to infants and children as well as in lowering the maternal mortality rates.

Communicable diseases made up 15% of registered causes of death in 2008. Although mortality from diarrhoeal and respiratory diseases is very low, these diseases are the leading causes of morbidity among Jordanian children[16].

With regard to non-communicable diseases, cardiovascular conditions were the leading reported cause of death in 2010. In addition, neoplasms, diabetes, respiratory diseases and external injuries were major causes of morbidity. Increasing rates of non-communicable diseases are due to the increasing population of elderly, increasing food consumption, smoking and lack of exercise[17]. In link with NCDs, and while malnutrition is not a major concern in Jordan with a relatively diverse national diet, rates of overweight and obese children and women of childbearing age are increasing due to changing lifestyles and diets.

3.2.2. Epidemiological trends of Syrian refugees

Similarly to Jordan, the Syrian refugee health profile is that of a country in transition with a high burden of NCDs. Additionally, both common and conflict-related conditions including injuries, psychological illnesses and communicable diseases are often found in other refugee settings worldwide – e.g., respiratory illnesses, diarrhoea, skin and eye conditions – plus other costlier and longer term chronic diseases such as diabetes, hypertension and cardiovascular illnesses as well as expensive referral care that is more commonly diagnosed and treated in middle income countries.

As for communicable diseases, the major cause of morbidity in and outside camps remains acute respiratory tract infections (ARIs), followed by skin infections (scabies) and diarrhoea. Additionally and as previously mentioned, measles outbreak in Jordan in 2013 and a polio outbreak in Syria also raised concern over public health as a result of the Syrian refugee flows. There are also increased rate of some communicable diseases such as TB and leishmaniasis among Syrian populations compared to Jordanians, which could increase the national prevalence[18].

In addition to respiratory diseases, data on morbidity of Syrian refugees in Jordan confirms the importance of cardiovascular disease and diabetes[19]. Factors related to cardiovascular/circulatory system were the leading causes of death in Jordan and NCDs accounted for 17% of clinic visits in Jordan of Syrians in 2013. In

[15] Between 2008-2012, under-5 mortality rates averaged 21 per 1,000 births, with the vast majority of deaths occurring during the first year of life (SNAP: Jordan baseline information – 23 January 2014 citing DoS 2013/03).
[16] Ibid, citing MoPIC/UNDP 2013/11, WHO 2011/08.
[17] Ibid, citing MoPIC/UNDP 2013/11, WHO 2011/08 and FAO 2011.
[18] No case of cholera has been reported so far.
[19] As indicated in the Health RRP6 monthly update for January, the main causes of morbidity were cardiovascular diseases (38% of visits), diabetes (24%), and lung diseases (14%).

addition, 23 % of Syrian refugees have chronic diseases or serious medical conditions that require medical follow up[20].

In spite of the epidemiological similarities between the two countries, comparative morbidity data show a different disease profile with increased levels of morbidity for Syrians refugees than Jordanians which may affect the disease burden in the future, for instance in regard to cancer and TB[21].

There were increasing numbers of surgeries for Syrians, particularly for trauma and weapon-related wounds, increased from 105 to 622 between January and March 2013.

While the reported mortality rates remain low across the regional, mortality data disaggregated for Syrian refugees is not available outside the camps which constitutes an important information gap and may hide important needs for instance in regard to chronic patients and pregnant women[22].

The reported cases in the latest available bulletin[23] (week 7) include a cluster of measles cases localized in Ma'an governorate, diarrhoea cases that exceeded the upper threshold in two locations (Der Alla and Jarash) and a case of Tetanus was reported in Mafraq.

3.3. PSYCHOSOCIAL AND MENTAL HEALTH NEEDS

Jordan's National Centre for Mental Health estimates that 20% of the population requires psychiatric care, although the vast majority do not seek treatment due to stigmatisation. Schizophrenia was the most common diagnosis among mental health facilities[24].

An IMC/WHO/MoH/EMPHNET[25] assessment conducted in the second half of 2013 in both host community and camp settings revealed that 39% of family members experienced feeling distressed, disturbed or upset to the point of having serious difficulties with being active[26], which was higher in camp settings (47%) than in

[20] UNHCR (March 2013). Inter-Agency Regional Response for Syrian refugees. Health and nutrition bulletin for Iraq, Jordan and Lebanon January – March 2013.
[21] According to Jordan's national cancer statistics, Syrian refugees presenting with cancer at health facilities rose from 134 in 2011 to 169 in the first quarter of 2013, representing a 14 % increase in Jordan's total cancer disease burden. Similarly, morbidity data from the MOH show a rise in selected communicable diseases. For example, TB case notification increased from 5/100,000 in 2009 among Jordanians to 13/100,000 among Syrian refugees in 2013. While no measles cases have been reported in Jordan since 2009, MOH data show that 18 Jordanians and 23 Syrians have been diagnosed with the disease in 2013. Polio, which had been eliminated since 1999 in Jordan, was also detected in two cases in 2013.
[22] In Za'atri camp, the age-specific under-5 mortality rate for November was estimated at 0.3 per 1000 per month and crude mortality rate (CMR) at 0.2 per 1000 per month.
[23] Jordan Weekly Epidemiological Bulletin, Hashemite Kingdom of Jordan, Ministry of Health, Directorate of Communicable Diseases. Week 7: 15 February – 21 February 2014
[24] UNHCR (23 January 2014) Syria Needs Analysis Project (SNAP). Jordan Baseline information citing WHO 2011/01, The National 2008/11/16
[25] IMC, WHO, MoH, EMPHNET (July 2013). Assessment of Mental Health and Psychosocial Needs of Displaced Syrians in Jordan. http://data.unhcr.org/syrianrefugees/working_group.php?Page=Country&LocationId=107&Id=40
[26] The identified significant problems included Feelings of distress, sadness, fear, anger, nervousness, disinterest, hopelessness; Difficulties with daily functioning and self-care; Worry and concern over situation and relatives in Syria and Social isolation.

the community (29%). 15 to 38% of the respondents reported relatively sever symptoms of distress as being present 'all of the time' in the last 2 weeks.

Crisis such as wars resulting in population movement affect the psychological state of most people. Experiences of displacement due to armed conflict put significant psychological and social stress on individuals, families and communities. The ways in which refugees experience and respond to loss, pain, disruption and violence vary significantly and may in various ways affect their mental health and psychosocial wellbeing or increase their vulnerability to develop mental health problems.

Many refugees are able to cope with these difficult experiences, and even build resilience, provided a supportive family and community environment is available. However, normal and traditional community structures such as extended family systems and informal community networks, which often regulate community well-being, may not exist anymore in settings of mass displacement, which may lead to social and psychological problems or exacerbate existing problems - some will newly develop mental disorders while others with pre-existing mental disorders may experience exacerbation of their symptoms. The usual systems for providing mental health care may be negatively affected, leaving people with mental disorders without adequate treatment[27].

The degrees to which people are affected differ in severity, with a great majority of people experiencing normal distress and around 20% affected by mild or moderate mental disorders. According to the WHO projections of mental disorders in adult populations affected by emergencies, the following distribution of psychological issues and severity can be expected[28]:

	Before the emergency 12-month prevalence [a]	After the emergency 12-month prevalence [b]
Severe disorder e.g. psychosis, severe depression, severely disabling form of anxiety disorder	2% to 3%	3% to 4% [c]
Mild or moderate mental disorder e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate post-traumatic stress disorder	10%	15% to 20%[d]
Normal distress / other psychological reactions no disorder	No estimate	Large percentage

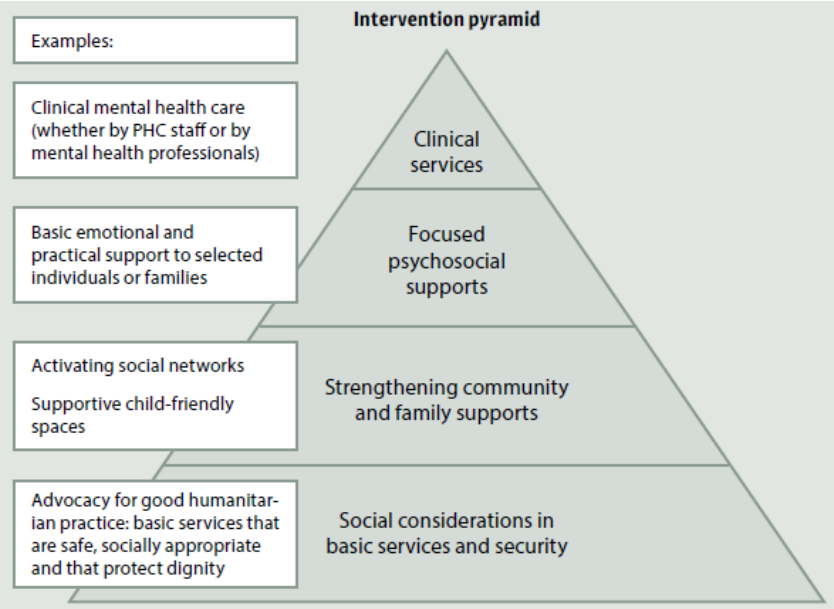
a. The assumed baseline rates are median rates across countries as observed in World Mental Health Surveys.
b. The values are median rates across countries. Observed rates vary with assessment method (e.g. choice of assessment instrument) and setting (e.g. time since the emergency, socio-cultural factors in coping and community social support, previous and current exposure to adversity).
c. This is a best guess based on the assumption that traumatic events and loss may contribute to a relapse in previously stable mental disorders, and may cause severely disabling forms of mood and anxiety disorders.
d. It is established that traumatic events and loss increase the risk of depression and anxiety disorders, including posttraumatic stress disorder

Table 2 WHO projections on mental health disorders in adult populations affected by emergencies

The Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings represented the MHPSS approach as a pyramid of multi-layered services to represent the 4 levels of interventions such to be considered in the context of mass displacement (see also figure and table 3):

- Layer 1: Provision of basic services and security ensuring basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security.

[27] UNHCR (2013). Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations.
[28] WHO & UNHCR. (2012). Assessing mental health and psychosocial needs and resources: Toolkit for major humanitarian settings. Geneva: World Health Organization. http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/



- Layer 2: Strengthen community and family supports: In view of significant disruptions of family and community networks, this layer aims at enabling refugee communities to (re) establish these support systems through activities to foster social cohesion amongst refugee populations.
- Layer 3: Focused psychosocial supports for people requiring more focused individual (e.g. people with difficulty coping with their existing support network) family or group interventions by trained and supervised general health workers or community workers.

Figure 3 The IASC pyramid[29]

- Layer 4. Clinical service: A relatively small percentage of the population has severe symptoms, and/ or an intolerable level of suffering, and great difficulties in basic daily functioning (e.g. psychosis, drug abuse, severe depression, disabling anxiety symptoms, and people who are at risk to harm themselves or others). This group includes people with pre-existing mental health disorders and emergency-induced problems. Examples of interventions include delivery of basic primary mental health care by trained doctors and nurses, as well as supervision and monitoring of primary care staff by a visiting/supervising psychiatrist.

[29] UNHCR (2013). Operational Guidance: Mental Health & Psychosocial Support Programming for Refugee Operations

4. HEALTHCARE PROVISION

4.1. THE JORDANIAN HEALTH SYSTEM

With the Government's strategy to ensure access to health services within 10 km proximity to all citizens including those residing in remote areas, the country established a wide network of primary health level facilities supported by a range of secondary and tertiary care facilities.

Jordan has one of the most advanced health systems in the region. The Government of Jordan spends approximately 8% of the GDP on health, which is considered high for a low middle income country. Health services are provided by both the public and private sectors in Jordan. Public health services are primarily provided and funded by the Ministry of Health (MoH) and the Royal Medical Services (RMS). Non-state health services include for-profit companies, university hospitals, UNRWA clinics (please also see Box 1 below) and non-profit charities. Health coverage is also widely available to most of the population (88% of the population have some form of health insurance).

In 2011, the WHO reported that the primary challenges to Jordan's health system were the lack of efficient referral systems, weak coordination among health service providers, weak information management services and duplication of services.

4.1.1. Organization of the national health system

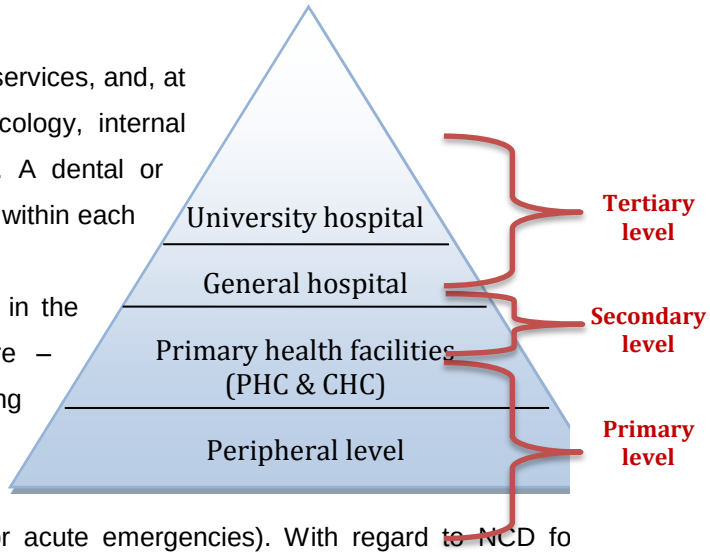
There are a number of agencies involved in healthcare provision in Jordan. The Ministry of Health (MoH) is the largest provider of health services in Jordan, and the second largest financing after out-of-pocket payment. Other major components of the public health care system are the Royal Medical Service (RMS), the university hospitals, and the Jordan Food and Drug Administration that, with the Ministry of Health, made up 57% of total health care spending in 2008[30].

The Ministry of Health (MOH) provides primary, secondary and tertiary health care services through three levels of care, namely the peripheral/village level, the primary health care level and the hospital level (please also refer to Annexes for an overview of the Jordanian key health indicators):

1. **Peripheral** (also, sometimes, called "village") health centres, on the other hand, are usually manned by an assistant nurse (6-month training) who receive support from an itinerant Ministry general physician, who is typically responsible for more than one peripheral centre, with scheduled hours during which medical consultations take place.
2. **Primary Health Care level:** this level encompasses the activities of two distinct types of centres: primary and comprehensive health centres.
    - Primary health care centres offer outpatient services by general practitioners and, in some cases, family practitioners. They may also have a dental and/or a mother and child centre.

[30] USAID (Aug. 2011). Health Public Expenditures Perspectives. JORDAN FISCAL REFORM PROJECT II

- Comprehensive health centres: a full range of services, and, at a minimum, they offer obstetrics and gynaecology, internal medicine, paediatrics and outpatient surgery. A dental or mother and child centre is generally co-located within each comprehensive centre.



The primary healthcare level in Jordan is the entry point in the public healthcare system and provides preventive care – including immunization for mother and child, family planning – as well as curative care for common diseases. As such, the primary healthcare level acts as a gate keeper preventing from irrational hospital service use (except for acute emergencies). With regard to NCD fo instance, chronic patients are required to get a referral letter at primary level prior to consult a specialist (internist) to obtain a three-month drugs prescription. Medicine for chronic patients will then be distributed at the primary health centre where the patient is registered.

3. Secondary and Tertiary Health Care Services (Hospitals)

There are five types of secondary and tertiary health care providers that include general and university hospitals, as shown in the table below.

Sector/Year	2012		
	No. of Hospital	No. of Beds	%
Ministry of Health	31	4,610	38
Royal Medical Services	12	2,383	20
Jordan University Hospital	1	547	5
King Abdullah Hospital	1	536	4
Private	61	4,041	33
Total	**106**	**12,117**	**100**

Table 3 Hospitals According to Health Sectors in Jordan (2012) 31 32

There were 1.89 hospitals beds available per 1,000 people in 2012[33]. The hospital level within the Government sector consists of 31 hospitals for a total of 4,610 beds as of 2012. Another key provider of health care is the Royal Medical Services, which offers some 2,383 beds across 12 hospitals. A key component of RMS is the King Hussein Medical Centre, which is a compound of five hospitals, in addition to a reference centre for laboratory studies. The King Hussein Medical Centre provides around 600 beds. With the 547 and 526 beds provided by the Jordan University Hospital and the King Abdullah University Hospital, the public sector supplies 77% of the total beds in the Kingdom. The remaining 3,918 beds are provided by the 61 private hospitals across the Kingdom.

[31] http://www.moh.gov.jo/EN/Pages/HealthStatisticsandIndicators.aspx
[32] Jordinvest (September 2012). The Jordanian Health Sectors.
[33] 12,117beds/6,388,000 inhabitants

4.1.2. Mental health in Jordan

Governmental mental health strategy and services

Jordan has been identified by the WHO as a country in need of intense support for strengthening the mental health system. In 2008, the WHO engaged on a reform of the mental health system in partnership with the MoH, which lead to the creation of the Mental Health department in 2010.

The first national mental health policy and action plan was developed and a shift was operated from purely hospital care to community based services[34][35], through the integration of mental health into primary health care, and following a thorough assessment of the GoJ's mental health system and capacity[36].

Up to date, the program consists of training of trainers who will in turn train medical doctors and nurses in primary health centres in the "meet and treat" approach for patients presenting mental health issues. The program also plans the establishment of outpatient community mental health centres in Amman, Irbid and Zarqa - with only the centre in Amman that kicked off and no clear information as to when the centres in Irbid and Zarqa will open. In addition, acute inpatient model units within general hospitals in the Ministry of Health and at university facilities are in the process of being established, as an alternative to psychiatric hospitals. This program in Zarqa has not been roll out yet to Zarqa governorate.

The lack of sustainability and unpredictable continuity of WHO funds were identified by WHO as challenges, as well as the lack of children and adolescent mental health services (only 12% of schools offer counselling services)[37].

Non-state MHPSS actors

Since the Syrian refugee influx in Jordan, a number of mental health and psychosocial stakeholders are offering services at various levels of the MHPSS pyramid both in camp and urban settings and mostly in the Northern governorates and in Amman:

- The major NGOs in this field mostly provide clinical mental health services related to levels 3 and 4 of the pyramid and include IMC and JHAS in Zarqa.
- Bright Future together with MDM offer more comprehensive MHPSS services and as such has been identified as a potential partner for technical assistance and capacity building of PU-AMI teams/intervention

[34] National Mental Health Plan, The Hashemite Kingdom of Jordan, January 2011 and National Mental Health Policy, The Hashemite Kingdom of Jordan, January 2011

[35] The mental health approach of WHO (mhGAP) uses the bio-psychosocial model of health that encompasses a multidisciplinary approach among different healthcare team members to address biological, psychological and social influences upon one's functioning.

[36] Please refer for the overview of existing services to: Hijiawi B, Elzein Elmousaad H, Marini A, Funk M, Skeen S, Al Ward N, Saeed K. Ayoub Z. WHO Profile on mental health in development (WHO proMIND): Hashemite Kingdom of Jordan. Geneva, World Health Organization, 2013.
http://apps.who.int/iris/bitstream/10665/92504/1/9789241505666_eng.pdf

[37] http://www.emro.who.int/jor/jordan-news/mental-health-in-jordan.html (access Thursday 13th of March 2014)

- Several organizations offer levels 2 and 3 services targeting specific groups of population, e.g. Handicap international for wounded/people with disabilities, CVT for victims of tortures, Save the Children, NICCOD for youth etc.
- CBOs are also active in providing PSS activities mostly related to level 1 and 2 and include for Zarqa and Ruseifah Al Sabirin, Working women society, among others.

Interesting partners have been identified for direct partnerships and/or linkages as further developed in Section Recommendations and include Bright Future for capacity building and assistance to intervention design, AARD-legal aid, HI and linkages/referrals CVT, IMC WHO/German-supported government mental health clinics/services (please also refer to Section *Stakeholder mapping* for an overview of key actors).

4.1.3. Health financing

Health spending makes up about 18% of the GoJ's total spending and has increased constantly over the last decade. The GoJ funds 68% of all health expenses; the remaining 3% was funded by international donors and the private sector, though this is likely to have increased since 2011 due to the Syrian refugee influx. In 2011, per capita health expenses were estimated at JD 278 (USD 392) including both private and public health, which amounts to 8.4% of GDP.

About 88% of the population is covered by health insurance. The MoH's National Health Insurance covers 42% of the population, including civil servants and their dependents, vulnerable groups (those certified as poor by the Ministry of Social Development (MoSD), children under 6, elderly people, the disabled, etc.) and also acts as the provider of last resort by providing services at subsidised rates. RMS covers 27% of the population, including those in the military services while private insurers, UNRWA and university hospitals cover the remainder of the insured population[38].

Access is free for some preventive services such as ANC and PNC for pregnant women, family planning as well as vaccination. Besides, medicines and laboratory/radiology are offered at subsidized costs:

Item	Price (JoD)	Remarks	Item	Price (JoD)	Remarks
White card	Free	Free of charge	Dentist	1.10	
Child health (vaccination)	Free	Birth certificate is required	Medical procedures	100% of the cost	Already highly subsidized
ANC/PNC	Free	Free of charge	Prescriptions	100% of the cost	Already highly subsidized
Consultation (GP)	0.40		Emergency consultation	1.65	
Consultation (specialist)	1.65				

Table 4 Government primary health service price list for non-insured

Primary public health care services are available to all Iraqis as per the non-insured Jordanian rates in government primary and comprehensive health centres only. UNHCR will support secondary and tertiary hospital services for Iraqis if they are referred through JHAS or Caritas and the referral meets UNHCR's referral criteria[39].

[38] SNAP: Jordan baseline information – 23 January 2014 citing DoS 2013/03.
[39] Health service guide – UNHCR-supported2013.

In May 2012, the GoJ decided to offer free access to governmental health services for registered Syrian refugees – i.e. with valid UNHCR certificate and MoI service card registered in the district of residence.

4.1.4. Health policy for Syrian refugees and impact of the Syrian crisis on the Jordanian health system

The UNHCR Public Health Unit's mission is to ensure that all refugees receive health care services at Government Health Centres and hospitals as well as through UNHCR supported clinics. As per May 2012, all UNHCR registered Syrian refugees – with valid registration and their Ministry of Interior service card registered in the town of the health facility[40] - can access primary, secondary and some tertiary health care services free of charge at Public Health Centres and Governmental Hospitals (referral from public health centres is necessary except for emergencies). Other refugees can access public health care but must pay for the service provided at the foreigner's tariff of 4JoD.

Unregistered refugees can also access UNHCR-funded comprehensive health care services including mental health services to unregistered refugees through its partners Jordan Health Aid Society (JHAS) and International Medical Corps (IMC). Primary health care is directly provided by the NGOs while secondary care is offered through referrals to partner clinics.

Tertiary health care can be provided through the Exceptional Care Committee (ECC) with prior approvals for emergency cases[41].

In view of the important numbers of Syrian refugees in need for chronic treatment and high cost treatment which is not provided by UNHCR supported services, a fast track registration process was setup by UNHCR for those cases in need for medical care by giving them a priority to be registered or to renew their registration. This allows chronic patients or pregnant women for instance to gain free access to governmental health facilities, as those services are not provided by UNHCR and its implementing partners[42].

4.1.5. Human resources

In 2012, there were sufficient trained medical personnel in Jordan, with around 27.1 physicians, 46.6 nurses, 16.3 pharmacists and 10 dentists per 10,000 people[43], in spite of the staff retention challenges due to the brain drain phenomenon[44]. In order to attract rare specialities in the public sector, the MoH contracted private specialized doctors working part time at higher wages than the Governmental salary scale.

Since the Syrian crisis, the MoH estimated that these ratios decreased by 15% and shortages in staff are experienced in areas hosting the majority of refugees – e.g. in the northern governorates, there are shortages in specialists such as gynaecologists, paediatricians, psychiatrists and dermatologists.

[40] Ibid.
[41] Guide to UNHCR Supported Health Care Services in Jordan (2013).
[42] UNHCR SOP: Fast track registration for medical reasons (available on UNHCR portal)
[43] http://www.moh.gov.jo/EN/Pages/HealthStatisticsandIndicators.aspx
[44] The comparatively low salary scale for qualified physicians compared to the Golf countries, Europe and the U.S. incites qualified and experienced physicians to relocate outside the Kingdom. The higher wages offered in the private health sector in Jordan also attracts the best staff outside the public health system.

In spite of the increased needs, the MoH has frozen public health staff recruitment for budget control purpose for more than 2 years.

MoH Health workers capacity	As of mid-2012	Projected by end 2013
Physician / 10,000 population	27.1	23.05
Dentist / 10,000 population	10.0	8.5
Nurse (all categories) / 10,000 population	46.	39.6
Pharmacist / 10,000 population	16.3	13.9

Table 5 Impact of the Syrian refugee crisis on Jordan/s health sector: health workers[45]

4.1.6. Supply systems of medical equipment and drugs

Jordan has a pharmaceutical industry which supplies 25% of its domestic consumption, with the vast majority produced for export. Medicines make up more than one-quarter of Jordan's health expenditures, a rate which has been growing in recent years due to increases in drug costs and consumption. The Jordan Food and Drug Administration (JFDA) is responsible for quality control, licensing and price controls[46].

End of 2013, QUAMED conducted an assessment to evaluate the quality of the national pharmaceutical industry. The main local suppliers were validated as providing acceptable quality drugs.

While the drug and medical equipment procurement system of other NGOs could not be explored in details, most medicine and medical supplies can be procured locally. JHAS for instance mostly buys – tax exempted - drugs on the national market. In addition, JHAS also has experience in clearing drug shipment through customs as well as lifting taxes for imported drugs (e.g. donated drugs) and should therefore be considered in case importation is required.

The supply of medicine to public health facilities is coordinated by the health Governorate. Based on monthly drug requests sent by health facilities through the governorate level to the central medical store, medicine orders are dispatched to the health facilities. In case of shortage, the health facility sends an emergency request that is usually addressed within 2 days.

Systematic shortages are experienced in the last quarter of the year when general stocks (and budgets) are depleted. No information could be found as to whether there is contingency plan developed by the MoH.

In spite of budget and medicine support from World Bank, WHO and other UN agencies, it is not clear whether the MoH will be able to better control annual drug availability or to cover increased utilization due to Syrian refugees influx especially if UNHCR registration is to be extender to a year.

Numerous private pharmacies selling a wide range of drugs are widely available. It seems that most drugs can be sold over the counter.

4.1.7. Epidemiological monitoring

The epidemiological situation is monitored weekly and information is collected from the peripheral level (PHC and CHC) to the Governorate level. Information is collected and registered on specific (paper) registers and

[45] Ministry of Health, Hashemite Kingdom of Jordan (December 2013). Impact of Syrian Refugees on Jordan's Health Sector. Presentation by Dr. Ahmad Abu Slaih – Marrakech conference. Projections based on a population of 600,000 Syrian refugees.

[46] SNAP: Jordan baseline information – 23 January 2014 citing MoPIC/UNDP 2013/11 and WHO 2011/08.

data is sent on a weekly basis to the Governorate level in charge of analysing and compiling data from all PHC and CHC. In case of high epidemic potential disease, the information is immediately shared with the health governorate team that is responsible for the response. Most epidemic potential cases are referred to the hospital that has the appropriate medicine and equipment to handle such cases.

The most common epidemic-potential cases reported at the visited health centres are Hepatitis A and chicken pox that are systematically referred to the hospital for treatment.

The WHO supports the MoH on epidemic surveillance[47], through the implementation of a surveillance system of epidemic-potential diseases in both in camps and urban settings, the latter constituting a challenge in view of the information gap. Cases of measles in Jordan and of poliomyelitis in Syrian triggered the 4 country-wide vaccination campaigns, the most recent being the third round for Polio beginning of March.

4.1.8. Health management team

Health service management is partially decentralized to the Governorate level. The governorate health team is responsible for the coordination of public health care provision through the network of primary, comprehensive health centres and hospitals, which include human resource development (continuous training and supervision) and management, distribution of medicine and medical supply, communication of order requests as well as health information reports to the central level and maintenance of infrastructure and equipment. The Health Governorate is also responsible for regulating private health care provision (licensing) and ensures regular inspection of both governmental and non-state health care providers, including NGOs and CBOs as well as private facilities.

USAID and more recently WHO have been supporting the Jordanian health system by strengthening the management and coordination skills of the Governorate health management teams. Additionally, several partners provide capacity building activities in collaboration with the Governorate of health in clinical and public health/health service management fields.

At Governorate level, needs were expressed as to strengthen the skills of the health management team in regard to health information management. Further assessment of the health governorate training needs should be conducted at the start of any PU-AMI health project to ensure comprehensive support.

[47] E.g. Jordan Weekly Epidemiological Bulletin, Hashemite Kingdom of Jordan, Ministry of Health, Directorate of Communicable Diseases. Week 7: 15 February – 21 February 2014

4.1.9. Health care providers in Zarqa Governorate

There are currently over 40 public health facilities in Zarqa Governorates, including 29 primary and 9 comprehensive health centres and 2 hospitals of 300 and 220 beds. A bigger hospital of 400 to 450 beds is about to be completed and will replace the old hospital of Zarqa. Besides, there are 1 military (Prince Hasham) and 4 private hospitals in the Governorate (including D'lail), as well as numerous private clinics and general practices.

Level	Zarqa Governorate
Hospitals	• Zarqa hospital (300 beds) • Prince Faysal hospital (220 bed) • Other secondary level services (4 sites)
Primary & Comprensive health centres: Most facilities provide Mother & Child and Dental services	• 9 Comprehensive health centres • 29 Primary health centres
Village health centres	• 6 village health centres

Table 6 Governmental health facilities in Zarqa Governorate

Through 24 health care facilities, UNRWA provides over 1.9 million general consultations each year, and over 67,000 dental screenings. It also supports nearly 70,000 patients with non-communicable diseases (NCDs), generally diabetes or hypertension.

The Family health approach To address the changing needs of Palestine refugees, a major reform initiative in 2011 was introduced with the Family Health Team (FHT) approach, based on the World Health Organization-indicated values of primary health care. The FHT offers comprehensive primary health care services based on holistic care of the entire family, emphasizing long-term provider-patient relationships and ensuring person-centeredness, comprehensiveness and continuity. Moreover, the FHT helps address cross-cutting issues that impact health, such as diet and physical activity, education, gender-based violence, child protection, poverty and community development.

The implementation of the FHT also saw the introduction of an appointment system, along with a health informatics platform and electronic medical records (E-Health).

The FHT approach roll-out will be completed by 2015 in all 139 health centres across UNRWA five fields of operations.

The UNRWA health centres offer good quality health care to significant numbers of patients. Strict attention is paid to ensure that resources are used efficiently.

In parallel, a full-computerized patient information system is being rolled out to the health centres.

Participants of the group discussions unanimously commented on the good quality of care provided by UNRWA.

Box 1 Notes on visit of two UNRWA health facilities in Zarqa and Ruseifah camps

Since the Syrian crisis, international and national non-governmental as well as community-based organizations are providing health services to Syrian refugees. While most of these organizations are located in the northern Governorates, Zarqa has seen the establishment of a limited number of organizations. The main health care services available to Syrian refugees are provided by international and National NGOs as well as by (Syrian and Jordanian) private providers as summarized below:

Service provider	Services/Staff	Utilization	Conditions
JHAS Zarqa town	2 FTE GP 2 gynaecologists (2 days/week) 1 Internist (1 day/week) 1 FTE paediatrician 1 FTE dentist 1 FTE psychologist	120 to 160 consultations / day (overall average of JHAS is 80 consultations/day)	All for free in Zarqa Referral to government 2ry hospital is taken in charge
Caritas Zarqa town	No information	No information	No clear information: participants reported that only UNHCR registered patients can access Caritas.
Syrian private practice Zarqa town	1 FTE Rheumatologist 2 FTE Gynaecologists 1 FTE ENT 1 FTE Paediatrician 1 psychologist	100 to 120 / day	1 JoD for consultation and drugs Drugs are donated

	(1day/week)		
Islamic clinics Zarqa and Ruseifah (camp)	PHC + some specialities		User fees 2 to 5JoD
JWU Zarqa opened in January 2014	1 GP 1 gynaecologist 1 nurse/midwife (Syrian)	30 to 35 / day	All for free Agreement with one pharmacy, monthly budget of 1,000JoD (not enough)
IMC Occasional mobile clinic in Zarqa	NA	No precise data but some days, reached 300 consultations / MMU day in Zarqa	All for free
Khaoula CBO in Zarqa town in partnership with Noor Al-Hussein Foundation Will open in April or May 2014	1 FTE GP experienced in gynaecology 1 staff nurse 2 psychologists	Not yet operational (in Amman, over 200 consultations/day)	Services will be free except for laboratory analysis (without tax) 4JoD Patients have to procure the drugs by themselves at the pharmacy
United Nations Relief Works Agency (UNRWA) 2 clinics Zarqa camp 2 clinics Hitten camp (Ruseifah) Sohkneh camp	Comprehensive health services Comprehensive primary health care services secondary and tertiary care on referral	Palestine refugees including Palestinian refugees from Syria	PHC free of charge Referral care: 75% covered, the rest is paid by patients For Palestinian refugee from Syrian, referral care is completely free of charge

Table 7 Non-state health care services in Zarqa Governorate

4.2. IMPACT OF SYRIAN CRISIS ON HEALTH SYSTEM

It is widely recognized that the health sector is one of the key sectors that is facing pressures as a result of the influx of Syrian refugees[48]. Rising oil prices and inflation, alongside the Kingdom's weak economic performance and rising and already stretched Government budget foretell a decline in the level and quality of services provided in the longer term, unless private sector participation – including international agencies - both in terms of healthcare provision and health insurance, rises sufficiently to compensate for the increased healthcare demand.

4.2.1. Impact on the public health system

In spite of the Jordanian health system achievements, continuity and sustainability of health service delivery in Jordan is at risk of being compromised, and past achievements in the sector - such as control of epidemics - are potentially threatened. As described by the UNHCR, the increasing number of people needing medical care is straining existing health services, which constitutes a growing challenge of providing

[48] Jordan Economic Monitor. Poverty Reduction and Economic Management Unit. Middle East and North Africa Region, The World Bank. Fall 2013. The quoted assessment also investigated the impact on the education sector but, for a variety of reasons, it estimated that the fiscal impact was lower in magnitude than in the health sector, at least as of early 2013. These reasons include: (1) the room to absorb in classrooms a large number of students at minimal marginal cost for the state given the low initial student-teacher ratio existing in Jordan; and (2) the fact that some UN agencies and donors are directly financing some of these education costs for the Syrian refugees (e.g., UNICEF/EU finances teachers and books needed in schools were double-shifting is occurring).

access to quality health care for Syrian refugees – particularly for people living outside of camps, with low funding for the refugee crisis[49].

The higher demand for health services that followed the GOJ's policy to provide refugees with access to the country's health care services decided in May 2012 put the health sector under significant financial pressures and resulted in shortages, particularly in drugs and vaccines, as these are being depleted at a faster rate.

Data on utilization of health services by Syrians and the actual burden on the system are very scarce. The main available information provides from an assessment conducted in June 2013 that evaluated that 9% of all consultations in MoH facilities in five northern governorates and Zarqa are provided to Syrian.

The Ministry of Health continues to bear most of the burden with 132,432 primary level services provided to Syrians in public health centres in 2013[50]. MOH data show that the number of outpatient visits to MOH primary health care centres (PHCCs) by Syrian refugees increased from 68 in January 2012 to 15,975 in March 2013. Similarly and during the same period, Syrian refugees attending MOH hospitals increased from 300 to 10,330 to 20,804 patients. This was associated with a sharp increase in the number of surgeries performed at these hospitals going from 105 to 622 surgeries to 660. Altogether, services provided to Syrians increased to 43,491 in February 2014, compared with 10,217 for the same month in 2013.

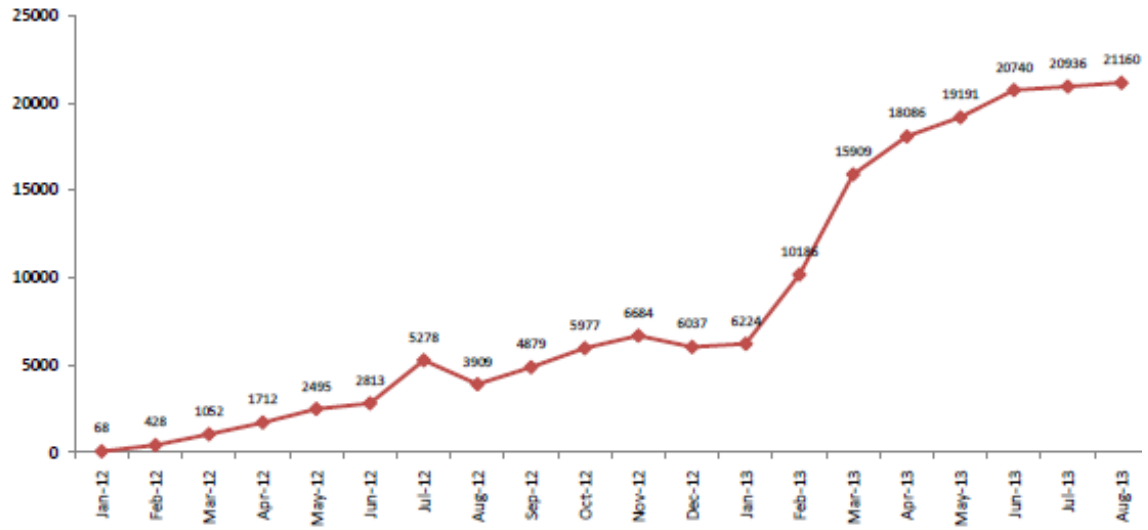


Figure 4 Syrian refugees attended MoH PHC centres Jan 2012 - August 2013

In response to this strain on the public sector, several international agencies are supporting the Ministry of Health through funding of some of the immediate healthcare needs, mainly hospital referrals, drugs and vaccines (World Bank, WHO, UNICEF, UNFPA). However, most support to the health system is provided at the central level, which does not sufficiently translate in actual service capacity increase in the most strained

[49] UNHCR (March 2013). Inter-Agency Regional Response for Syrian refugees. Health and nutrition bulletin Iraq, Jordan and Lebanon January – March 2013.

[50] Ministry of Health, Hashemite Kingdom of Jordan (December 2013). Impact of Syrian Refugees on Jordan's Health Sector. Presentation by Dr. Ahmad Abu Slaih

health centres in urban settings[51]. As an illustration, the Zarqa health governorate shared that the national budget for drugs was likely to dry out in the third or fourth quarter of the year leading to significant shortages.

While there have been some increases in human resources and drug quantities, the busiest health centres visited in Zarqa are not able to meet the increase demand. The existing UNHCR-funded health services for unregistered Syrian refugees in Zarqa seem insufficient to cover the growing needs and demand (from 80 to 100 consultations/day).

As for Zarqa Governorate, the percentage of primary level services provided to Syrian refugees is comprised between 9% and 10% for the two first months of 2014 (both Primary and Comprehensive Health Centres).

	Jan-14	Feb-14
Total consultations CHC & PHC	38,447	33,942
Consultations to Syrians CHC & PHC	3360	3420
Share	8.7%	10.1%

Table 8 Number and share of Primary level consultations provided to Syrian refugees in Zarqa Governorate (source: Zarqa Health governorate)

Zarqa hospital is the third most utilized hospital in the country after Albashir Hospital (Amman) and Princess Basma hospital (Irdbid) as presented in Table 10 below:

	Feb-14
Albashir hospital (Amman)	NA
Princess Basma hospital (Irbid)	NA
Zarqa hospital	1,702

Table 9 Number of hospital services provided to Syrian refugees in the three most used hospitals (source: Ibid)

4.2.2. Non-state health and psychosocial services actors

The current services provided by non-state actors are insufficient to cover the needs of refugees who are not able to access public health facilities. Although little information could be found on actual numbers of services provided –most health care providers as well as psychosocial and mental health actors reported not being able to meet the demand and have to open waiting lists.

Service provider	Utilization
JHAS Zarqa town	120 to 160 consultations / day (overall average of JHAS is 80 consultations/day)
Caritas Zarqa town	No data but FGD participants and several stakeholders reported long waiting time/days
Syrian private practice Zarqa town	100 to 120 / day
JWU Zarqa opened in January 2014	30 to 35 / day (only started in January 2014)
IMC Occasional mobile clinic in Zarqa	No precise data but some days, reached 300 consultations / MMU day in Zarqa

Table 10 Utilization of non-state healthcare providers in Zarqa

[51] Until now, only MSF (Netherlands, France) and MDM work within existing governmental facilities in Irbid and Ramtha.

Participants in the group discussions reported that although NGO services are appreciated for the perceived quality and staff attitude, services are said to be saturated and patients have to wait for several hours, indicating that these services are overwhelmed. In JHAS, patients are given a consultation numbers and the rest is asked to come back the next day. The health services of IMC (mobile clinic) and JWU were not cited in the group discussions which can be explained by the fact that JWU only started in 2014 and IMC mobile clinic activities are implemented on an occasional basis.

The situation in Ruseifah - known for its higher vulnerability and general poverty level - is even direr as there are no health providers beside the governmental facilities and people have to travel to Zarqa which takes 3 different buses/collective taxis to reach the facility, inducing costs that deter many refugees to take the trip.

With regard to psychosocial and mental health services, IMC is the only mental health organization that seems to be able to take more patients while others such as CVT, NICCOD reported to be saturated.

Two additional Syrian providers of health care were mentioned during meetings with key stakeholders.

4.3. STATE OF GOVERNMENT HEALTH SERVICES

This section presents the main findings of the health facility assessment obtained through questionnaire means in the visited Government health facilities.

The assessment focussed on the primary health care level and included aspects of service utilization, resources (human, drug, equipment), quality (hygiene, processes) and health information management, among others (please kindly refer to Annex for the assessment questionnaire used during the visits).

The visited health centres were selected together with the MoH on the basis of utilization and location criteria and included 10 primary health centres and 1 comprehensive health centre. Additionally, both comprehensive health and hospital levels were visited to provide a full understanding of the MoH service offer, although no structured assessment could be performed (outside the authorization scope). A selection of pictures of the visited facilities is also available in Annexes.

4.3.1. Service utilization

Curative and preventive services

Services provided in the visited facilities are in line with the service norms in the national healthcare delivery pyramid (refer to previous section). Curative and preventive services are provided 6 days a week, from 8am to 4pm, with the peak time finishing between 12 and 1pm.

At the visit time, the health facilities seemed to be extensively utilized and doctors reported significant workload and difficulty to cope with the demand. In addition, health teams and the health Governorate say that service utilization by Syrian refugees is continuously increasing. The health centres also receive patients from other nationalities such as Egyptians, Palestinians from Gaza, Bangladeshis and Iraqi refugees.

As previously mentioned, primary health care centres offer outpatient services by general practitioners and, in some cases, family practitioners and may also have a dental and/or a mother and child centre. All visited

centres have dental and mother and child services, as well as supportive services with simple laboratory performing CBC, urine analysis, blood group and stool analysis.

Curative services mainly cater for common diseases in line with the country morbidities. The most common causes of consultations reported by the health centres include URTI, gastroenteritis infections, skin infections and non-communicable diseases with diabetes and hypertension.

Preventive care constitutes an important part of the primary health centre activities and include child and pregnant women vaccination and follow up[52] and family planning (main contraceptive means are IUD, condoms and pills).

The analysis of utilization data revealed a varied picture, with some centres providing significant services for available staff and other centres being less utilized. Overall, the share of services used by Syrians represents 5.9%[53] of total services, reaching up to 14.5% in some centres located in neighbourhoods with high Syrian refugee density.

Health centre	Catchment population	Reported coverage area	Total consultations in 2013	Total consultations Jan-Feb (incl. dental)	% Syrians	Total consultations excluding dental (estimate[54])	Monthly average consultations excl. dental (Jan-Feb)	Average consultation /day/doctor[55]
Prince Abdallah Zarqa	28,000	5km2	38,758	6,330	**14.5%**	5,330	2,665	27
Zarqa Al Jadida Zarqa	150,000	11km2	38,613	7,259	**9.6%**	6,259	3,130	25
IskanTalal Zarqa	60,000	10km2	47,473	9,766	3.3%	8,766	4,383	**44**
Yajoz Zarqa	150,000	12 Km2	41,961	5,530	1.3%	4,530	2,265	23
Prince Mohamad Zarqa	10,000	3Km2	43,316	8,050	6.4%	7,050	3,525	20
Shabib	65,000	2-5 Km2	44,563	10,444	4.8%	9,444	4,722	27
Al-zawahrih Zarqa	80,000	NA	39,711	8,501	4.2%	7,501	3,751	**50**
Al-Hashmih Zarqa	65,000	25km2	29,633	3,852	3.8%	3,852	1,926	15
Rusaifah/Al Shamali Ruseifah	85,000	15km2	40,842	7,525	**7.8%**	6,525	3,263	**44**
Awajan Ruseifah	100,000	2km2	31,903	5,787	3.7%	4,787	2,394	32
Al-Msharfeih CHC Ruseifah	100,000	3 Km2	67,833	13,503	5.6%	12,503	6,252	23
Total			**464,606**	**86,547**	**5.9%**	**76,547**	**38,274**	**27**

[52] The ANC schedule consists of 10 consultations.

[53] This figure is below the average of 8.65% Syrian refugees accessing health facilities in the northern governorates of Irbida, Mafraq, Zarqa, Ajloun and Jerash. However this assessment also included hospital care levels. In Zarqa governorate, the reported share even reaches 14.5% (Joint Rapid Health Facility Capacity and Utilization Assessment (JRHFCUA))

[54] estimated number of dental consultations was withdrawn from the total number of consultations: 1 dental chair*20patients*25days=500 dental consultations/month

[55] Average consultation/day/doctor= monthly average excluding dental/number of GPs & specialists/25 days

Table 11 Utilization and workload of the 11 assessed health centres

The workload for available staff in the most utilized services in combination with medical processes/habits do not allow for satisfactory level of quality care. With an average of 27 patients per doctor for the 11 health centres and around 40 patients per doctor in the busiest centres, the health personnel is striving to keep up with basic medical quality requirements. For instance patients are very rarely physically examined – to a lesser extent for children. This is particularly the case for female patients due to the absence/lack of female medical doctors[56]. Despite the availability of basic laboratory analysis - urine and Complete blood count, the quality of curative service is limited by the quasi absence of attention to patient signs.

Patients who cannot be handled at the health centre are referred to one of the two general hospitals Prince Faysal hospital and Zarqa hospital – e.g. for specialist consultation, chronic disease or for mental health issues – mostly depression, psychosis, schizophrenia - emergency cases and delivery.

Patients have to go to the hospital by their own means except for acute/emergency cases in which case the health staff will call the public ambulance service provided by the Civil Defence (free for emergency – 911 number). The system seems to be working properly.

Outreach and community linkages

The links with the communities of the catchment area are not very developed and mainly consists of health education sessions for instance on reproductive health, nutrition for pregnant women implemented at CBOs. In some health centres, volunteers from medical and public health school also participate in community activities. One health centre reported conducting home visits for elderly patients although these seem to be rare. Advanced immunization activities at schools were reported as well as health education and dental preventive visits. There is no community health approach beside the services provided in the Village Health Centres in remote areas. Beside the occasional activities conducted by students, there is no system of community health volunteers.

4.3.2. Problems and health needs described by health professionals

The main morbidity causes reported by the managers of the 11 visited health centres are in line with the national epidemiological profile[57]:

U5 children	Adults
• Respiratory tract infection • Urinary tract infection • Gastro-enteric infection • Anaemia	• Upper respiratory tract infections • Urinary tract Infections • Vaginitis • Diabetes mellitus • Hypertension • Deep Vein Thrombosis

Table 12 Main morbidity causes reported at the health centres

[56] In Jordan, the task distribution between doctors and nurses is such that nurse scope of responsibilities only consists of basic nursing tasks with very limited diagnostic and treatment aspects. This can partly be explained by the fact that patients prefer to be examined by medical doctors.

[57] In view of the fact that the assessment was mainly focused on the primary health care level, there was no information on mortality data.

Specific issues affecting more Syrian refugees were also reported by the health staff and included diseases attributed to poor hygiene and living conditions such as skin and fungal infections, scabies and worms. In two health centres, cases of children malnutrition were mentioned.

Beside common morbidities, the health personnel in 5 of the visited heath centres shared that Syrian refugees present important psychosocial difficulties related to the situation in Syria – the issues cited by the health staff range from anxiety, mild depression to urine incontinence of children or psychosis. While needs related to psychological issues are said to be increasing, the health centres and personnel lack skills and time to provide the appropriate support. Additionally, the interviewed health personnel mentioned there are only 2 psychiatrists for the whole Governorate – 1 in each hospital - which is insufficient to treat patients with psychological or mental health problem[58]. The health staff was not aware of existing mental health services available for Syrian refugees such as those provided by IMC or JHAS.

Finally, the health personnel in the visited facilities only reported having received instructions on conditions of access for Syrian refugees, and no other training/information to help them to deal with the influx and specific issues of refugees.

4.3.3. Human resources in health

Primary health centres are manned by the Chief medical manager who is responsible for the health service provision. He manages the health centre team that consists of general practitioners, nurses (staff and practical nurses[59]), midwives, dentists, pharmacists and assistants, laboratory staff (technician and assistants), dentists and assistants, data entry officers (in charge of patient registration and files), accountant (cashier) as well as cleaners. Some centres were staffed with a social worker in charge of identifying vulnerable cases and providing support related to family/socio-economic issues (information mainly).

Staffing of the visited health centres was relatively[60] in line with the required team composition, although some health centres were lacking some personnel as shown in the workload analysis (table 12). The Governorate of Health mentioned that additional staff was seconded to busy health centres, although it is not clear how many health professionals were added.

Female doctors were only present in few health facilities, working in the mother and child department and mostly dedicated to preventive mother and child care – e.g. ANC, PNC and IUD insertion/follow-up. The presence of female doctors in the mother and child department was said to be highly appreciated by patients.

[58] Both comprehensive and primary health centres do not have medicine for mental health issues and refer all cases to hospital level.
[59] Registered nurse: baccalaureate degree, 4-year training including 6-month practical training; Practical nurse: 2-year training, diploma degree including practical training.
[60] The health facility staffing norms are supposed to be based on WHO standards. No exact information was provided as to the minimum staffing requirements for a PHC or for a CHC. It is therefore difficult to evaluate if the exact required number of health staff is in place.

As previously mentioned, none of the health personnel has been recently trained in mental health management and the facility managers reported that there is no room or time to adequately address mental health issues.

Public health staff retention and motivation is generally affected by the fact that the public sector is considered as less attractive than the private or NGO sectors due to lower salaries. Another (de)motivation factor that was cited concerns the fact that training is often reserved to medical doctors in hospital settings in major cities.

4.3.4. Drugs and medical supplies

The main findings of the health facility assessment in regard to drug availability and management include the following aspects:

- Most of the essential drugs on the list of essential medicine were present in the HC[61]. Paediatric antibiotic was reported to be frequently lacking around the 20th of each month.
- Expected shortages in the fourth quarter of the year where the budget for medicine gets exhausted and governorate experience regular/systematic drug shortages.
- Patients are told to go to private pharmacy to buy the medicine that are not in stock (mostly antibiotic for children).
- With regard to chronic patients that were prescribed drugs for NCD at referral level (comprehensive/hospital facility), the health centre orders these drugs that are supplied to the patient on a monthly basis.
- Good level of drug storage and quality management, although none of the centres had air conditioners but were equipped with ventilators.
- High turnover of drugs, so drugs are not staying long in the drug store.
- All fridges were functioning at thetime of the visit, with quality/temperature check system in place and no reported electricity shortage.

4.3.5. Infrastructure, hygiene and equipment

The main findings of the health facility assessment in regard to the state of infrastructure, availability of equipment and general hygiene include the following aspects:

- Acceptable level of hygiene and application of sterilization and Infection Prevention and Control procedures (safety boxes for needles, use of protections) including waste management (disposal of medical waste is done by the Governorate of health).

[61] A number of medicine are provided for free by the Government health facilities: multi-vitamin (children and pregnant women), antibiotic, anti-fungal, mild analgesic (children) and contraceptives (pills, condoms,Copper IUD, Implant)

- In some instances, insufficient/not functioning sterilization equipment (sterilization equipment working on steam & vacuum) and lack of some medical equipment such as examination material (otoscope, stethoscope), laboratory equipment (CBC machine) and ultrasounds (only some HC are equipped with an ultrasound that is mostly used for pregnancy follow up as well as IUD insertion/follow up)
- Infrastructure not always adapted in terms of space, accessibility (2nd or 3rd floor of exiguous building) due to location in very dense urban settings. Some buildings are rented, others are owned by the MoH, limitations as to possible adaptation/rehabilitation in high-density urban areas such as in Zarqa city centre. Some of the buildings need general maintenance. Reliable electricity system.
- While there are some computers and printing equipment, health information management system is mostly paper-based. Moreover, health centres are not connected to internet.
- No transportation vehicle for patient referrals/emergencies at the health centres (apart from Civil service ambulance).

5. STAKEHOLDER MAPPING

The start of the crisis has drawn a number of health and psychosocial actors to Jordan while others were already present – some as long-term partners of the Ministry of Health (IRD, USAID), others arrived or started their operations for Iraqi refugees.

A screening of the main stakeholders in the relevant fields – e.g. health service provision, mental health and psychosocial support and protection – was conducted and included international and national NGOs, private providers, CBOs and international agencies (see table below as well as UNHCR health sector mapping).

Stakeholder	Activity	Target population	Facilities	Location
National NGOs				
JHAS	Comprehensive PHC PHC with MMU and Outreach team (10pple) Referral Secondary and tertiary HC 24/7 hospital and maternity in camp Medevac team for cross-border medical evacuation	Syrian and Iraqi refugees All services are provided for free in Zarqa (and rest of the country except for the clinic in Amman)	6 CHC clinics Private trauma hospital (D'lail) 2 to 3 MMU 10 outreach workers Zaatari clinic Cyber city PHC	Irbid, Mafraq, Ramtha, Zarqa Zaatari and Cyber city camps
Bright Future for Mental Health	Psychosocial and mental health services: Psychiatric clinic and psychotherapy Teaching recovery techniques Recreational and development program Parental counselling Children and youth counselling Etc.	All Syrians	Psychiatric clinics in Amman and Irbid Psychosocial in Zaatari	Amman, Irbid Zaatari camp
ARDD - LEGAL AID	Legal advice (eviction, rent issues) and protection, registration issues	All Syrian refugees	2 centres	Amman, Zarqa
JWU	PHC	All Syrian refugees	2 facilities (+more in the country?)	Amman, Zarqa
Syrian private practice	PHC and specialist consultations	All (Syrians for 1JoD)	1 clinic in Zarqa town	Zarqa
Noor al Hussein	Primary and secondary health care (Gynaecology, dental care, nutrition, lab.tests, paediatric, physiotherapy, etc..) in IFH clinic Psychosocial services	All	2 clinics (Amman) + new in Zarqa	Amman, Zarqa, Ramtha and Salt
Jordanian Red Crescent	Hospital care	All Syrian refugees, for free		
National Woman's Health care centre (supported by Standard Chartered bank)	Mobile dental and eye clinics, preventive care, scan for breast cancer. pilot in most needy areas, target of 100 women	100 women	Mobile (at CBOs)	Zarqa
International NGOs				
IMC	Mental health Comprehensive PHC through JHAS PHC with MMU Referral Secondary and tertiary HC	All Syrian refugees For free except for clinics in Amman (Vulnerable Iraqis and host community population, including Syrians)		Amman, Zarqa remote areas Mafraq, Salt, Halabat, Ramtha and Zarqa
MDM	Support provision of PHC in MoH facility Community based health (2CHW) Mental health and psychosocial services with Bright Future	All Syrians as well as Jordanians	Ramtha King Abdallah Park + 2 clinics in Zaatari camp	Ramtha Zaatari
MSF France	Reconstructive surgery, orthopaedics, maxillo-facial and plastic Emergency surgical programme in Al Ramtha Hospital OPD treatment - acute needs and chronic conditions such as diabetes and hypertension Paediatrics hospital in Zaatari Mother and child hospital in Irbid	Victims of war related violence (Iraq, Syria, Libya,Yemen, Gaza)	Ramtha MoH hospital Jordanian Red Crescent hospital Hospitals in Zataari, Irbid and Amman	Amman Northern governorates

Caritas	Comprehensive PHC	UNHCR registered Iraqi and non-Iraqis, and vulnerable Jordanians User fees apply	2 clinics	Zarqa Amman
IFRC	Secondary care	Syrian refugees	Jordan Crescent facilities	Amman and others
Medair	Nutrition screening and treatment of acute malnutrition	Syrians	6 JHAS clinics Outreach	Irbid, Ramtha, Mafraq, Zarqa, Amman
Save the Children	Children protection and psychosocial services (level? type?)	Syrian refugees	?	Zarqa Other
Handicap International	Physical rehabilitation services (rehabilitation care, prosthetics and orthotics, assistive devices and mobility aids) Psychosocial support Support to hospitals through training and donation of materials Support to Syrian flats/referrals	Persons affected by the Syrian crisis	Irbid, Ramtha, Mafraq, Zarqa, D'lail hospital and camps Government hospitals and D'lail hospital	Amman, Irbid, Ramtha, Mafraq, Zarqa Governorates
Centre for Victims of Torture	Mental Health Counselling (group, individual, and family) Physical Therapy, Social Referrals of Complex Cases & Case Management	Survivors of Torture (Iraqis, Syrians, and others) and Victims of War Trauma (Iraqis and Syrians). All ages	2 centres + Mobile unites	Amman, Zarqa
Danish Red Cross	Psychosocial services	All Syrian refugees	Amman	Amman
French Red Cross with Jordanian Red crescent	Community-based health volunteers, primary health and chronic conditions	All	Psychosocial centre	East Amman
IRD	Equipment Capacity building Rehabilitation Health education/outreach	All Iraqis and Syrians	MoH facilities	Nationwide
International agencies /cooperation agencies				
UNICEF	Support immunization, capacity building (neonatal and maternal care, IMCI)	All	MoH + camps	Nationwide
UNRWA	Comprehensive PHC Secondary HC on referral	Displaced Palestinian communities	24 clinics Cyber city camp	Nationwide
WHO	Various support to MoH: Mental Health department Surveillance system Immunization Medication support (e.g. life-threatening and chronic diseases) Strengthening of coordination services and crisis management	All	MoH	Nationwide Focus on Northern Governorates for Syrian crisis
UNFPA	Support to NGOs/MoH for provision of reproductive health services	All Syrian refugees and vulnerable Jordanians	Static clinics MMU Urban and rural areas in Northern and southern governorates	Amman (Hashemi Chamali + Nazzal) Zarqa, Irbid, Ramtha and Mafraq
JICA	Support to peripheral level services: training and equipment	Jordanian and registered refugees	Network of Village health centres	Southern Governorate, will soon start in the North
CBOs				
Community development Committee	PSS one on one sessions, Group sessions, children	All	Zarqa	Zarqa
Community development Committee	Community activities	All	Sohkneh	Zarqa
Al Sabirin	PSS sessions, outreach programme Formerly, primary health clinic	All	Ruseifah	Zarqa
Working women society	Community activities	All	Ruseifah	Zarqa
Houswife CBO		All	Zarqaa	Zarqa
Islamic Center CBO	Community activities	All	Zarqaa	Zarqa

Community center/women Al Sokhneh	Community activities	All	Sokhneh	Zarqa
Khawla Bint Al Azwar	Community activities (soon will start a clinic with NHF)	All	Zarqaa	Zarqa
Ramla CBO	Community activities	All	Zarqaa	Zarqa

Table 13 Mapping of key stakeholders

6. DEMAND FOR AND BARRIERS TO HEALTHCARE - COMMUNITY PERCEPTION

This section examines the current health seeking behaviours, health care access challenges and main health needs expressed by Syrian refugees – and to a lesser extent by host communities – living in Zarqa governorate during the focus group discussions as well through household and individual interviews. Psychosocial aspects were also examined during discussions and interviews.

6.1. MAIN HEALTH ISSUES

As a start to the discussions, participants were asked about the main issues that they and people living in the area are usually confronted with. Lack/absence of income, high costs of living – mostly due to expensive rents – poor living conditions (including hygiene, sanitation, poor isolation to cold and humidity, lack of privacy), limited access to affordable and quality health care, difficult access to education and complex bureaucratic processes for UNHCR and MoI registration were cited as the major difficulties. As a result of the difficult living conditions, many Syrian families are forced to of a better and more affordable life: "*We have to move often in search of a suitable place to live*".

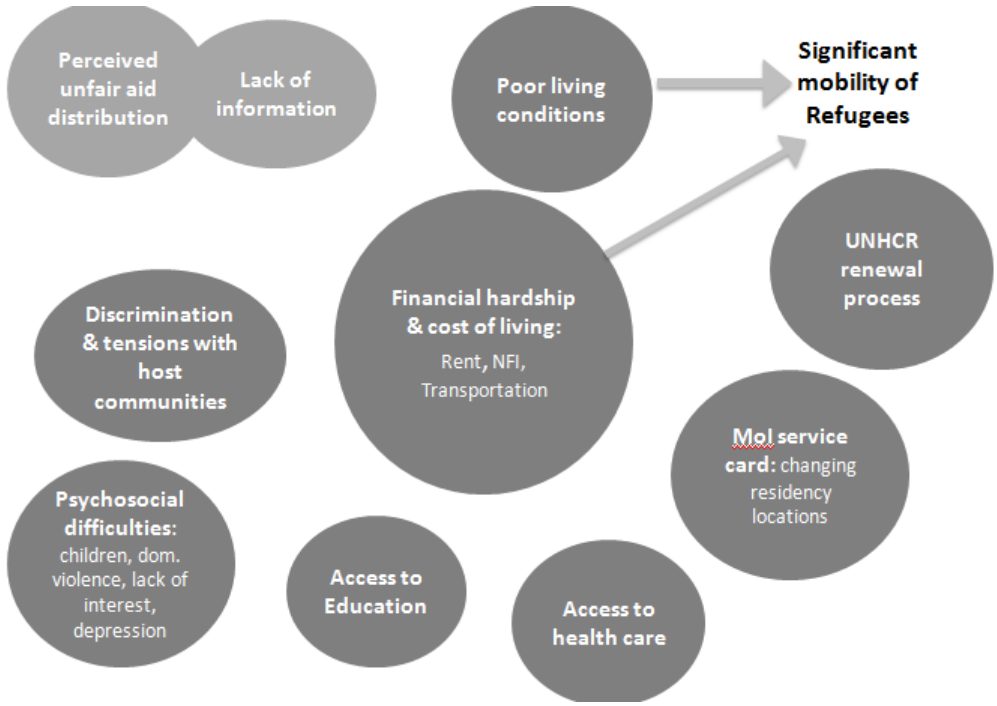


Figure 5 Main challenges faced by Syrian refugees

Most health issues mentioned by participants were attributed to the difficulty to access quality affordable health care, as further developed in the next section. Problems reported by the participants as the main health issues affecting Syrian refugees are in line with the morbidities reported at the visited health centres:

- Common children health issues such as common cold, diarrhoea
- Respiratory problems such as asthma
- Heart problems, hypertension and diabetes

Additionally, and while these issues were not spontaneously related with health[62], all group discussions mentioned that children experience difficulties such as bedwetting (children between 4 and 12), getting afraid of the noise of planes, fireworks and TV, being aggressive with other children. In most group discussions, participants commented on these difficulties and explained these by the absence of open space or parks to bring the children to play like in Syria, the lack of activity rendering children very nervous, angry and negative.

While participants shared more easily the consequences of the war and having to flee the country for their children, they also shared how this situation translates in psychosocial issues with adults. Participants mentioned problems of feeling useless "*The only activity we have is to call the UNHCR*!"; "*the Government deals with us like we are women, they try to have us stay at home" or dis*abled "*How would you feel when you cannot even pay for the transportation of your child?*". It was mentioned that anxiety contributes to worsen the health status of people with chronic diseases. They and their relatives/peers are affected by difficulties such as feeling angry, having poor communication within the family, being aggressive with children or husband/wife "*we have a lot of problems/fights with our husbands*", willingness to isolate "*my father doesn't want to leave his room anymore" or* not wanting to do anything: "*I'm totally depressed. Every day I repeat that I want to bring the kids back to Syria*". Some groups mentioned that they often feel humiliated, for instance with remarks they hear: "*we've lost our dignity, when we hear Jordanians saying that they can have 3 Syrian wives for only 100Jod*" or when they feel hustled by the Intelligence when gathering with friends (male group). More information is provided in the box below on the findings related to psychosocial challenges faced by Syrian refugees.

In all group discussions and household visits, most people demonstrated some degree of distress, mostly anxiety about their families in Syria, decrease of interests for usual activities and interacting with neighbours.

Most of the home visit interviewees reported psychosocial issues to different degrees: anxiety about their families in Syria, little to no communications with neighbours, lack of activity compared to social habits in Syria.

- Significant symptoms were reported that cause significant distress – e.g. loss of interest, anxiety and fear, although these symptoms are not severely affecting their daily functioning. Focused (not specialized) care provided by a trained volunteers - e.g. through support groups and brief counselling sessions - is indicated to support individual showing these symptoms.
- Half of the adults composing the visited families have been exposed to traumatic event, most frequently detention by the regime security forces, having a family member detained, having a family members killed or witnessing neighbours being killed.
- Some individuals presented sever symptoms (one with suicidal attempt) that require specialized mental health care provided by a psychiatrist and/or psychotherapist.

During the household visits, questions were asked in regard to children state. The consequences of the war and of the refugee life in Jordan on children were also discussed during the focus group discussions. Among the visited families and groups that participated in the discussions, numerous psychosocial issues affecting children were reported including isolation and social withdrawal, irritability, hyperactivity, sadness and depression, sleep problems, speech problems, cognitive impairment and enuresis/bed wetting.

Although few participants were from the youth age category, two of the discussion participants were still students when they left Syrian and shared the anxiety and lack of hope they feel as they are not able to continue their studies.

The sources of stress that were reported by refugees include the following:

[62] These issues emerged very rapidly after the discussion kick off, usually as one of the answers to the introductory question on the main challenges faced by Syrian refugees, and even before specific questions were asked about this topic (part 2 of the discussion schedule, available in Annexes).

- Continuous stress and trauma due to ongoing events in Syria
- Housing conditions are not good
- No right to work and no income sources which result in difficulties to secure housing fare and to selling the food coupons
- Tension with Jordanian neighbours, lack of social relationships or recreational activities
- Lack of access to education for children and youth, mainly due to transportation costs (far away schools) and university fees for youth

Consequences and risk of unattended psychosocial needs:

- Increased domestic violence and violence against children
- Isolation, for instance women reported that they do not go out anymore, also due to their husbands not letting them go out, some children refuse to go to school

More vulnerable groups:

- Families of Homs area are the most affected as many were exposed to and witnessed massacres
- Families from Dar'aa area fled because of fear of shelling and arrests. However the presence of extended families in Jordan contributes to alleviate the distress
- Persons exposed to torture are in need of specialized care and follow up
- Youth and children constitute groups that require specific attention as well as tailored activities

Box 2 Psychosocial issues mentioned by discussion participants and home visit interviewees

6.2. HEALTH SEEKING BEHAVIOURS

Health seeking behaviours are influenced by the administrative status of refugees, as unregistered refugees, those with expired UNHCR document/asylum seeker certificate and those with a Ministry of Interior card that does not match their current place of residence are not able to access free public health services.

As depicted in Figure 4, the main health seeking patterns of Syrian refugees include the following paths:

- Syrian refugees with appropriate UNHCR and MoI service cards report to make use of public services for curative care mostly, in spite of numerous complaints and poor perception of services (see section Barriers). The main reason for resorting to MoH centres are related to the affordability of care.
- For refugees without appropriate registration documents or unregistered refugees, several health seeking behaviours emerged from the discussions:
    - Delay and self-medication: participants explained that they prefer to directly visit pharmacies where they can easily and rapidly obtain drugs that are more efficient than what they will be prescribed at the health centre.
    - Consult private doctors/clinics (e.g. Islamic clinic in Zarqa or Ruseifah, Syrian doctors[63], private GPs) whose services are relatively affordable (price ranging from less than 5JoD for consultation; (not always including drugs) to 10 to 15 JoD at a private GP
    - UNHCR-funded JHAS clinic in Zarqa, in spite of the reported long waiting time
    - Private (expensive) healthcare providers in desperate situation/emergencies
- As a result of various obstacles such as financial, registration status (administrative barrier), perception of poor quality services, lack of services among others, Syrian reported taking several

[63] The Syrian clinic is the cheapest and only asks for a symbolic contribution of 1JoD for consultation and drugs.

steps that render the process long and expensive. Numerous experiences were shared of erratic sequences of visits to doctors, public and private health centres, pharmacies and hospitals leading to significant expenses. These complicated and costly processes are mostly related to chronic diseases, delivery and post-operative care that necessitated drugs, laboratory and radiology analysis, in addition to transport costs.

- As for service related to psychological challenges, several participants whom children experienced problems such as (selective) mutism accessed activities organized by Save the Children (international) which were said to have improved the state of their children. No other services were mentioned by the participants, which may also be explained by the stigma associated with resorting to psychological services.

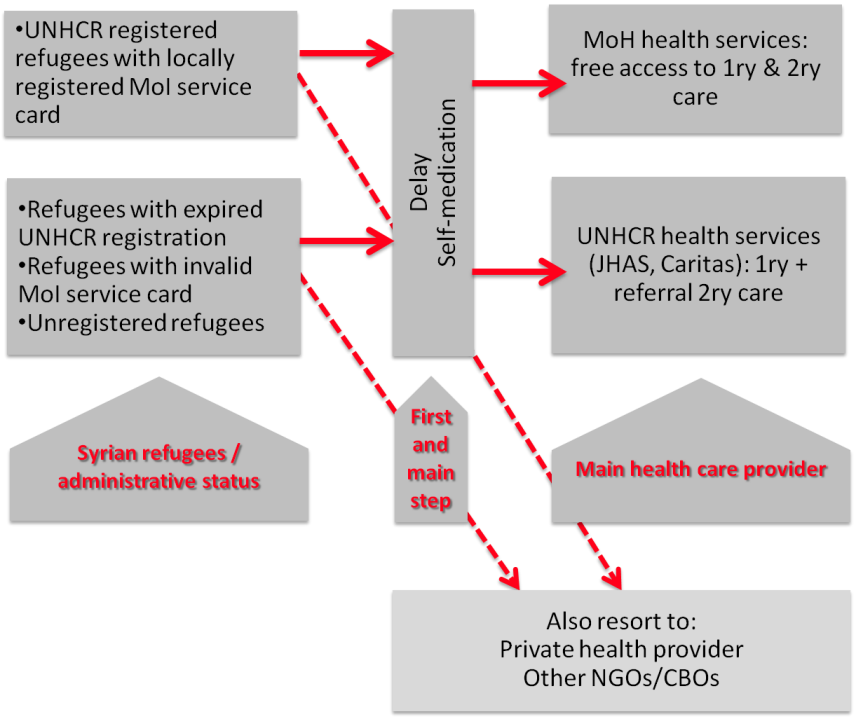


Figure 6 Main health seeking behaviours

6.3. MAIN BARRIERS

As summarized in Figure 5, a number of barriers prevent patients from accessing quality and affordable health care. These barriers are further developed below, in order of significance, and mainly concern the public health services, unless specified:

Cost of living

As a result of the absence/lack of income and the expensive life in Jordan with rising housing costs, priority is given to find a suitable place to live and to avoid unnecessary expenses such as transportation and drug costs. Even though Syrian refugees with valid registration (both UNHCR and MoI) can access free primary, secondary and tertiary health care services at MoH facilities[64], side costs for medicine that is not available at

[64] As per May 2012 Government of Jordan cabinet decree

the health centre and transportation to the health centres still constitute a burden for many refugees. This is even more the case for chronic patients who have to visit both the primary health centre as well as the comprehensive health centre/specialist doctor on a monthly basis in order to get the chronic treatment prescription and drugs.

Administrative status:

As previously explained, Syrian refugees must present both their valid UNHCR certificate as well as a valid Ministry of Interior service card which is registered in the same location as the health centre. Participants of group discussions extensively treated this barrier as being the most significant obstacle. In addition, participants who are entitled to access the government health services free of charge still have to provide with at least 4 copies of the UNHCR registration document for every consultation.

The renewal process of the UNHCR card also takes its toll in terms of steps and delay, with an average waiting time of 6 months between the expiry date and the renewal appointment. While a fast track system is in place to (more) quickly renew the card for chronic patients, pregnant women and emergency cases, the process was still perceived as too slow to ensure timely access to healthcare. It is not clear whether the process was actually slow or if delay in renewing the registration card is also due to the complex process and lack of information on the procedure. However some participants shared stories of relatives having had to resort to expensive private health care as a last resort.

Some of the participants in the group discussions and individual interviews were Palestinians from Syria. Palestinian refugees from Syria face even more difficulties in Jordan as they have a different status from Syrians and cannot access public health services. They are however able to access the UNRWA services once they register.

As for Palestinians from Gaza who live in Jordan for several decades, they reported similar difficulties due to the special status that prevent them from fully integrating the Jordanian society – they have not been granted the Jordanian nationality and do not have access to public services such as health care and education. They also reported feeling stigmatized and regularly humiliated. This notwithstanding, access to health care services provided by UNRWA and quality of care were said to be good.

Box 3 Palestinian refugees from Syria and Gazans

Financial barriers

At the primary health facility level, costs for registered refugees are mainly related to transportation and drugs that are not available at the facility pharmacy (please see section below on perception of drug availability)

For unregistered refugees or without appropriate documents, and in addition to transport costs, little to no costs were reported if they resorted to UNHCR-funded healthcare services. Participants had to pay for drugs and analysis with other NGO health services.

Amounts reported for private for-profit health providers were significant, although it is difficult to evaluate if these costs are exceptional or usual/average.

It is at the referral care level that costs can go up in case the patient does not have access to the MoH or was not refer by JHAS. Some of the stories that were shared during the group discussions – e.g. accidents

of children requiring advanced and onerous care, urgent operation on chronic patients – lead to important costs.

Poor perception of health care quality:

The discussion participants complained extensively about the quality of care provided in the Governmental health centres, and more particularly in regard to the following aspects:

- Limited types of drugs available at the Government facilities: participants said that they constantly have to go to the private pharmacy to buy the majority of the drugs that are on the prescription;
- Limited trust in drugs: participants explained that they feel that the prescribed drugs are not efficient or that the doses are insufficient to be efficient. They compare the drugs to the type of drugs they used to get in Syria, especially for chronic patients. Dissatisfaction may be due to the fact that the drugs have a different name/brand whereas the active substance is the same.
- Limited scope of services: participants complained a lot about the fact that the available services at the health centre level (PHC) is so limited that the staff has to refer most patients to comprehensive health centres and hospitals, which further complicates the process and increase transportation expenses and waiting time.
- Lack of services/capacity: due to the insufficient services, some health centres were said to be overcrowded and doctors are overloaded and do not examine them. This issue was mentioned in all group discussions and participants felt strongly that the lack of attention and physical examination is an indication of low quality of care.
- Contributing to the feeling of poor quality of care, the health personnel was described as being rude and not caring for patients, although there were also some positive comments on some staff. The lack of respect to patients was said to contribute to the feeling of humiliation and discrimination felt by refugees. An overall mistrust results from these previous critics towards the public health services, which does not motivate refugees to timely seek care "*You enter the health centre sick, you get even sicker of the process*".
- While the overall perception of health services provided by NGOs and UNHCR/JHAS is positive, long waiting time and saturation of the services are such that many chose to self medicate instead of wasting time. It was explained in several groups that the first patients who arrived at the clinic are given a number and the rest is sent away – except more acute cases that are immediately attended. Participants reported that they have to get to the clinic early in the morning (6 to 7am) to ensure that they will be seen by a doctor. As for the Caritas clinic, only registered patients seem to be able to access the services and long waiting time are reported.

Lack of information on available services came out as a barrier to health care. Many participants were not clear as to where to access services and under which conditions. The group discussions were conducted during the mass vaccination campaign and although immense efforts were deployed to reach out Syrian refugees, some participants in almost all group discussions were either not aware of the campaign or did not

see the importance to bring their children for vaccination. This confirms that other communication channels than CBOs and the radio must be used in order to reach Syrians and provide information on services.

Low report of mental health/psychosocial service use (and demand for): mental health and psychological disorders, although mentioned as affecting some of the participants' daily life, are not given priority compared to other challenges, except for children. Some parents mentioned that some of their kids were able to access recreational activities mostly through Save the Children which improved their status. Male participants shared that most of their issues including psychological difficulties would be lesser if only they could work. Women explained that having more cultural and social opportunities would help them.

Limited communication and tensions between the host communities and Syrian refugees:

In areas hosting high numbers of Syrians, discussion participants explained that, there, they perceive a strong resentment from the host communities as refugees are accused of receiving all the attention and support while Jordanians are also affected by social issues. Group discussions with Jordanian from Palestinian origin confirmed these perceptions. Jordanian respondents also shared that the host communities perceive Syrians as being responsible for the overall inflation and lack of job opportunities.

From the Syrian refugees' perspectives, participants shared that they often have the feeling of being abused by Jordanians, which results in paying more than the market price (taxi, rent) as well as discriminated and not respected. Some experiences were shared on how Syrian children are discriminated by some teachers. "In the beginning, we got help from Jordanians, but not anymore. They say that we've already received enough help".

Low demand for preventive care: As a result of the overall dissatisfaction of primary health care, participants seem to be mostly concerned about curative care and made little mention of vaccination, ANC, PNC services, which seems to indicate that preventive care does not constitute a priority[65] and explains the reported low demand.

Figure 5 below depicts the barriers that were mentioned by participants as well as the consequences of the lack of access to quality health care:

[65] Consultations for acute illness is the main reason for seeking care accounting for 73% of clinic visits (27% of visits were by children <5years). Of concern is the low routine immunization coverage amongst refugees. Preliminary analysis of in IMC's Assessment of Health Care Access in out-of-camp refugees indicates a gap in the provision of reproductive health services with health facilities being overwhelmed and overcrowded. Refugees reported seeking reproductive healthcare only in case of emergency needs and for delivery itself

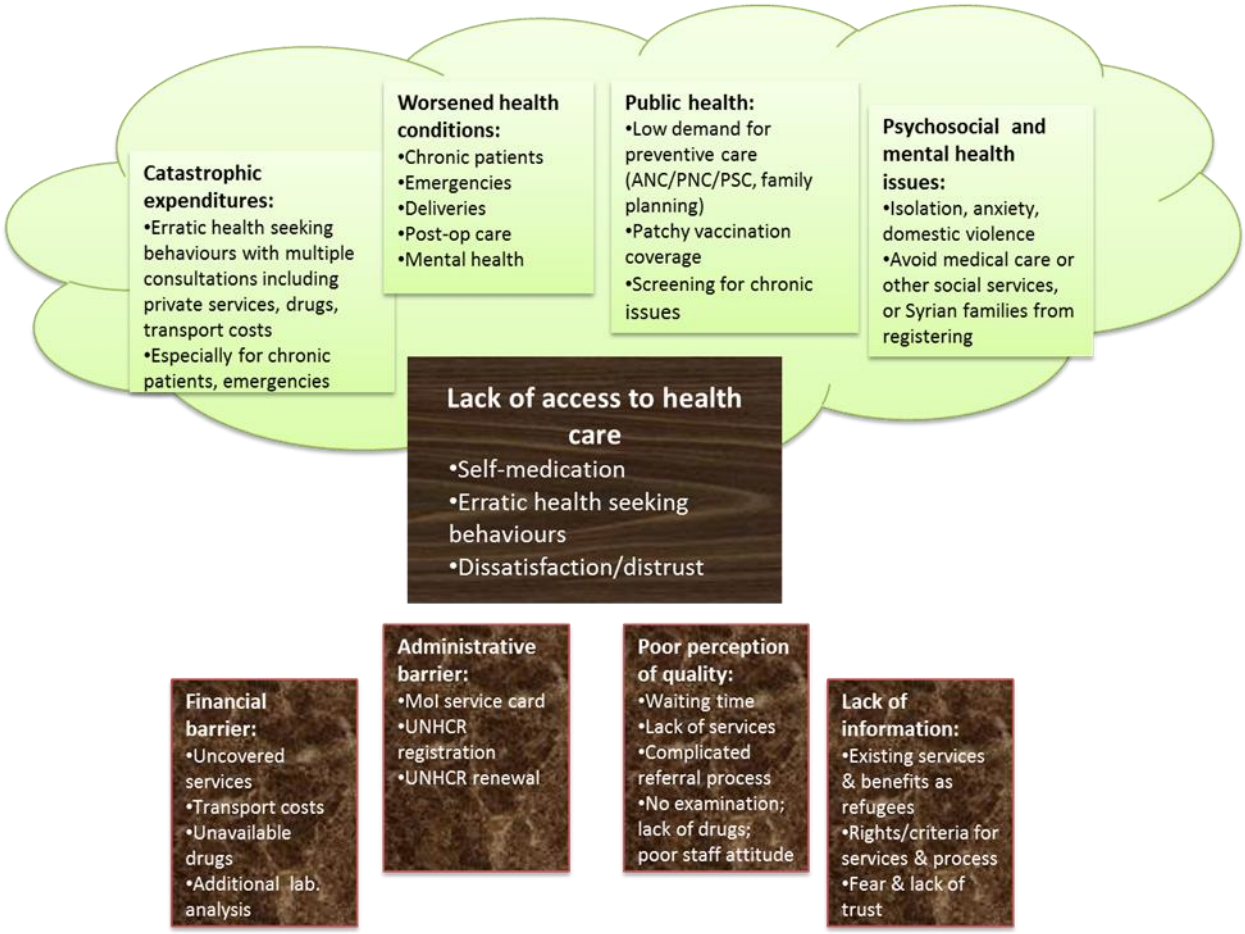


Figure 7 Problem tree: lack of access to health care

6.4. SUPPORTIVE FACTORS

Beside bad experiences with host communities and negative feelings, participants also shared that they receive support from neighbours and CBOs and that staff in health centres can also be very compassionate and helpful. Group discussion participants also explained that there are spontaneous support initiatives. Some participants from the host communities expressed empathy for the fate of Syrians and compared their experience to what happened to them, as most are from Palestinian origin.

The presence of relatives was reported as the most crucial supportive factor that considerably facilitate their everyday life, for instance with information on existing services and on MoI and UNHCR registration process.

Living in an area with fewer refugees facilitates relationships with the host communities and translates into more support from neighbours and better accessibility to public service such as school and health services.

Living in an environment that is similar to home also helps to adapt to the country of relocation - for instance people from the rural region of Da'ara in Syria (near the border with Jordan) who are majorly rural reported to prefer quiet neighbourhood or semi-urban settings to the urban jungle of Ruseifah or Zarqa downtown.

CONCLUSION

In spite of the existing healthcare services made available by the Government and the Humanitarian community, significant health and psychosocial needs of Syrian refugees are still not met within host communities. Major barriers to health care include administrative (lengthy registration system leaving important numbers of Syrian with expired UNHCR card, complex process to have valid MoI service card), financial (general lack of income, high living costs), insufficient (primary) affordable healthcare and psychosocial service offer. Health needs are more acute in deprived areas where important numbers of Syrian families live and where few relief organizations operate, such as in Ruseifah and Zarqa districts.

A comprehensive intervention is required to deal with complexity of Syrian refugee needs. As highlighted throughout the assessment findings, health needs are intertwined with a myriad of other challenges that Syrian refugees are facing in the host communities. It is therefore recommended to consider an intervention addressing the various urgent issues affecting Syrian. For this purpose, any health and psychosocial intervention should be considered in integration with shelter, cash assistance, protection and WASH services. Strong bridges and linkages between services will be crucial.

Through a community-based approach, outreach capacities should be reinforced with 'Community Health Volunteers' that will promote the existing health services and increase awareness as well as identify and refer vulnerable patients to relevant health providers. Through this diminishing of barriers, it would then be essential to strengthen the capacity of existing MoH facilities to absorb the increasing number of refugees and to have adapted facilities for ineligible refugees (MOI card /UNHCR registration out of date) waiting for regularization.

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