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TESIS DOCTORAL

HEALTHCARE UTILIZATION AMONG URBANIZED SYRIAN REFUGEES IN JORDAN: EXPLORING ACCESS, NEEDS, BARRIERS AND ADAPTATION STRATEGIES

POBLACIÓN REFUGIADA DE ORIGEN SIRIO ASENTADA EN JORDANIA Y SISTEMA SANITARIO: EXPLORANDO EL ACCESO, LAS NECESIDADES, LAS BARRERAS Y LAS ESTRATEGIAS DE ADAPTACIÓN

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I would like to dedicate this thesis to Syrian refugees in Jordan who made this highly needed study possible by sharing their memories, needs, challenges and ways of adaption to their competing needs. This work is also dedicated to my parents, who have been a great source of support, guidance, and inspiration since childhood.

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ABBREVIATIONS

CDs: Communicable Diseases

CFSVA: Comprehensive Food Security Vulnerability Assessment

CIP: Civil Insurance Programme

COA: Country of Asylum

COO: Country of Origin

COPD: Chronic Obstructive Pulmonary Disease

DHS: Demographic and Health Survey

EPI: Expanded Programme on Immunization

EU: European Union

GDP: Gross Domestic Product

HAUS: Health Access and Utilization Survey

HCAB: Healthcare Access Barriers model

HH: Household

IDP: Internally Displaced Person

IMC: International Medical Corps

INGO: International Non-Governmental Organization

IOM: International Organization of Migration

IRC: International Rescue Committee

IRIS: Institut de Relations Internationales et Strategiques

ISIS: Islamic State in Iraq and Sham

JoD: Jordanian Dinar

JOHUD: Jordanian Hashemite Fund for Human Development

JRP: Jordan Response Plan

MoH: Ministry of Health

MoI: Ministry of Interior

MOPIC: Ministry of Planning and international Cooperation

NCC: Nuzha Community Center

NCDs: Non-Communicable Diseases

NGO: Non-Governmental Organization

OCHA: Office for the Coordination of Humanitarian Affairs

ODK: Open Data Kit

PhD: Doctor of Philosophy

RMS: Royal Medical Services

SCC: Sahab Community Center

SPSS: Statistical Package for the Social Science

SRAD: Syrian Refugees Affairs Directorate

SRCD: Syrian Refugee Camp Department

SGBV: Sexual and Gender-Based Violence

UN: United Nation

UNHCR: United Nation High Commissioner for Refugees

UNICEF: United Nation Children's Fund

UNRWA: United Nation Relief and Work Agency

USD: United State Dollar

VAF: Vulnerability Assessment Framework

WFP: World Food Programme

WRA: Women at Reproductive Age

YSSD: Youth Society for Self-Development

ZCC: Zarqa Community Center

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ABSTRACT

Since the Syria crisis started, about one quarter of its population have fled to the neighbouring countries, mainly Turkey, Lebanon, and Jordan. Jordan has hosted more than 12% of the refugees from Syria and numbers are increasing. This increase in migration and refugee either due to long-lasting conflicts or ongoing economic crises has made the refugee movement a concern at global level and prompted hosting countries, as well as humanitarian organisations to respond to this alarming crisis. The study explores the access to and utilization of healthcare services among urbanized Syrian refugees in Jordan. Using the mixed method design, this phenomenon was studied among two refugees' communities urbanized in central governorates. The study settings were selected conveniently, the participant sample for the quantitative part were randomly chosen while sampling was purposive for the qualitative part. A cross-sectional survey among 383 refugees aged 18 – 75 years old was conducted between November 2019 and January 2020. Participants answers were entered directly using on tablet using KOBO tool. Concurrently, in-depth semi-structured interviews were conducted among a subset of twenty participants. Data were analyzed with descriptive and thematic analysis, while quantitative data were analyzed with descriptive statistical analysis, qualitative data were transcribed and analysed using Braun and Clarke thematic analysis approach.

Both dataset analyses identified a set of fragmented needs in relation to health needs and help seeking, such as emergency care, psychological-mental support needs, rehabilitation, disability, elderly care, childcare, women's care, and chronic disease care. The analysis of seeking behaviour found that primary awareness, beliefs, access policy, financial capacities and practice are the main drivers for health-seeking behaviours. The standard barriers quantified through quantitative assessment were cost, awareness, quality of services and discrimination. The qualitative assessment detected the same access barriers in addition to access policy, service

availability, waiting time and distance. The standard adaptation strategies quantified by quantitative assessment were a theme in qualitative findings. These include seeking free services, delaying seeking care, reducing, or stopping the use of medication, using alternative medicine, borrowing money or use saving, and moving onward. However, the qualitative assessment also detected adaptation strategies included self-medication, collection donation, illegal labour, and prioritising between health and other livelihood needs. Four themes found under the impact of adaptation strategies include psychological and mental health consequences, compromise of other livelihood needs, deterioration of health status and legal consequences.

The perceived needs, seeking behaviours, and experienced barriers with healthcare interacts with each other. Another contextual set-up, inform Syrian refugees' healthcare utilization behaviours, drive adaptation strategies and result in a negative impact on refugee health status, but also may extend to another means of livelihood. The study's findings may be relevant to the global responses to the refugee crisis. The hosting countries can use it to develop a balanced response regarding health interventions and policies to avoid negative consequences on refugees and host communities. Additionally, the third countries that received the secondary movement of refugees may use these findings to enhance support to host countries for better accommodation for refugees' needs and avoid unnecessary subsequent movements that pose additional global health and other risks.

PROLOGUE

When I joined my current work with refugees as a health officer, I thought it was not abnormal to go through a refugee experience since I am a second-generation refugee. Later, I recognized that being a second-generation refugee is different from being a refugee. The experience and occasions I witnessed throughout 12 years of work on refugees' health at different stages of the refugee crisis have changed my mindset. I see better now how things mix and interrelate from pre refuge stage to the moving stage and until settlement, where a long story of challenges, difficulties and chaos impact every single moment of refugee's life, even when they sleep.

Since I was involved as part of my roles and responsibilities in monitoring and evaluation of refugee's health status, access behaviors and needs using my organization standard tools, a growing conviction developed that the refugee's access to healthcare is a dynamic status, its change over time and could be impacted by changing living circumstances, individual traits, local context, and longevity of refuge. That growing conviction derived me to develop this research to better understand things behind simple numbers and percentages. The mixed method was selected to draw a clearer picture of healthcare access and utilization, adaptations and impact on refugees and host communities.

SUMMARY OF THESIS

Chapter 1: Introduction

1.1-Context

The global migration and refuge movement are increasing trend either due to new global conflicts, long-lasting conflicts or ongoing economic crises, this trend has made the refugee movement a concern at global level and prompted hosting countries as well as humanitarian organisations to respond to this alarming crisis.

The Syria crisis started in March 2011 when a general protest started against regimen all over the country and later 2012 the conflict converted to a civil war. Over next four years the regime lost control over borders, violence against civilians escalated, internal displacement and external flee of millions happened. Currently, Syria alone contributes to more than 27% of the global refugee load (UNHCR, 2021c).

Syria crisis considered one on the major tragedy in 21st century (Guterres, 2012) due to its nature and associated violence encountered and high scale mobility that impacted most of continent globally. Since the eruption of Syria crisis, around one quarter of its population (6.6 million) have fled to the neighbouring countries, mainly Turkey, Lebanon, and Jordan. Subsequently, 130 countries hosted refugees from Syria and European countries currently hosting more than one million refugees from Syria. Jordan as one on neighbouring country, has hosted more than 12% of the refugees from Syria with more than 660,000 refugees registered with United Nation High Commissioner for Refugees (UNHCR) while government estimate that more than 1.3 million refugees living in the country (UNHCR, 2019a). The global migration and refuge movement are increasing trend either due to new global conflicts, long-lasting conflicts or ongoing economic crises, this trend has made the refugee movement a

concern at global level and prompted hosting countries as well as humanitarian organisations to respond to this alarming crisis.

Jordan is a country who is not signatory on 1951 refugees' convention and 1967 protocol. Additionally, Jordan has no specific refugee law or regulations, but during the crisis the government of Jordan adapted several regulations and policies to organize refugees' presence on its territories. Since then, Syrians and other refugees enjoy their residency status and non-refoulment right, as well as some other social and economic rights.

The Syrian refugees in Jordan living in a mixed condition where most of them are settled in urban settings. On the other side, the refugees' camps were established in two governorates by the government of Jordan in support of UN agencies and donor community. The two official camps (Zatari and Azraq) currently host about 18% of total Syrian refugee's case load (UNHCR, 2019a). The refugees in urban settings were allowed to access basic protection services including civil registration and legal justice, labor market, basic education, and health services as average Jordanian if they hold a valid UNHCR registration.

Health is one of the basic needs for any human being and it's a well-established right for all as per global human rights tools. Since the eruption of the Syrian crisis in 2011 Jordan has committed to provide basic health services for Syrian refugees as per global tools and standards, where everyone should have affordable access to the healthcare services they need wherever and whenever. The government of Jordan in order to ensure public health stability during the crisis has adapted several healthcare access policies for Syrian refugees to ensure their access to the basic public health services.

1.2 Problem statement

Studying refugees' health care needs, access behaviours and barriers were an area of interests for many researchers since last century, as the refugees normally facing an increasing

difficulties to access and utilize health services in any new context (Nowak et al., 2022). The current literature has focused on the population needs, utilization behaviors and access barriers (Cope, 2011; Kohlenberger et al., 2019; Le, 2004).

Jordan, as one of the impacted countries with multiple refugees' crisis has the same trend of interests for global refugees' health research, while the factors beyond needs and barriers including adaptation strategies and impact were minimally explored. Additionally, the health systems structure and policy environment have a specific consideration that require in depth investigation and analysis to estimate its impact on refugees' health status and healthcare system, of which considered the core purpose for this thesis.

1.3 Research questions and aim

This multifaceted investigation seeks to explore health service utilization among Syrian refugees who live in urban settings in Jordan, this study focuses on access barriers and adaptation strategies adopted by refugees to meet their long-term health needs. Additionally, this study aims to understand the impact of adaptation strategies thus, predict the threats posed to refugees themselves and public health stability in the country of asylum.

Questions to be answered through this research study include:

- How do Syrian refugees living in urban areas in Jordan access and utilize health services, and what types of barriers might they encounter?
- What are refugees' main adaptation strategies or behaviors to overcome barriers and meet their health needs?
- What is the impact of adopted strategies on refugees and hosting countries' public health stability?

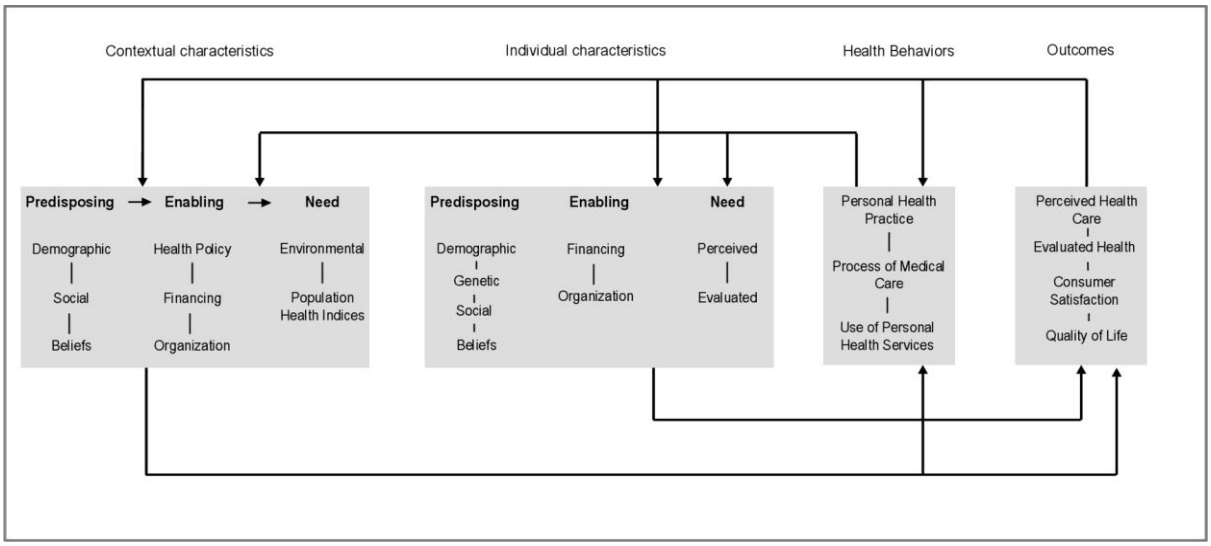
1.4 Significance of the study

Exploring and understanding refugees' healthcare needs within a unique context in Jordan, understand its influence on health behaviors and its interactions with other integration challenges is critical. The current study may provide a piece of evidence for healthcare providers that allow better understanding of refugee's healthcare needs, identify problems might be encountered by the refugee's when accessing healthcare services. Service providers and policy makers will gain better understanding to proactively plan and mobilize resources for an effective response. Additionally, this study will predict the consequences of adopted health policies and possible impact on the stability of the public healthcare system and social support system in country of asylum of which can be preventable.

1.5 Conceptual framework

Gelberg-Andersen Behavioral model for vulnerable populations utilized to understand the dynamic of using healthcare services and determine seeking behaviors. Gelberg-Andersen Behavioral model was developed by Ronald M. Andersen in 1968 and expanded later on several occasions. The model predicts three factors that guide utilization of service; the predisposing factors (age, sex, beliefs, etc.), enabling factors (family support, health insurance) and health needs. The last phase of the developed model (5^{th} phase) highlighted the contextual and individual determinants to best understand utilization of services (Gelberg et al., 2000). Finally, over this phase the model integrates the vulnerability dimensions and been part of the latest developed model as presented in the figure below:

Figure I. Andersen's behavioural model of health services use – phase five



Chapter 2: Background and Literature Review

UNHCR estimates that, over the past decade, 1.1 million refugees around the world became citizens in their country of asylum (UNHCR, 2019b). Jordan as a country with a long history of refugees accommodation and after 10 years on the Syria crisis still stand at the position of repatriation of all refugees including Syrians (Ali, 2021). Despite that, the Syrian refugees in Jordan are part of the system, and they are integrated within the public services systems including education and health; and are part of the economic outlook (Alshoubaki, 2017).

The long presence of Syrian refugees in Jordan has a clear impact not only on Jordan as a hosting country but also on the refugees' access and utilization for public resources (Copperation, 2020). Health sector was one of the impacted sector and presence of refugees poses a new demand to the sector. Overstretching and overutilization of health services reported by local MoH (Copperation, 2020). Healthcare staff ratio declined significantly as well as the hospital bed ratio (Murshidi et al., 2013). Emerging and reemerging of some communicable diseases to the refugee's crisis such as measles, tuberculosis and cutaneous leishmaniosis reported as well (Nimer, 2018).

Currently, most of the studies evaluate the health situation of refugees, immigrants and vulnerable groups prove that the refugees have less access to the health services, suffer from more barriers to get needed services and have poor health indicators compared to local population (Chuah et al., 2018; Department of Statistics/Jordan & ICF, 2019). In fact, the current healthcare access policies adapted for Syrian refugees are at the same level of access to average Jordanian who don't have civil insurance; of which suggest that refugees have more or less the same utilization behaviors thus have almost the same gains by accessing the same package of health services. Nevertheless, this cannot be a fact if we look at refugees' community potentials, demographic characteristics, policy environment, specific needs or vulnerabilities, which predict their ability to meet their several needs including health and others. Additionally, many other risk factors detected among Syrians which make a comparison on gains from the health care system are not fair, such as high percent of chronic illnesses, impairments, teenage marriage, and non-skilled birth attendants.

Health research on refugees' population extensively investigated the needs of vulnerable groups, barriers, and challenges and to a lesser extent the impact of healthcare access disparities that may vary from one refugee context to another.

The healthcare needs for refugees were defined by humanitarian actors thematically including child health, reproductive health, communicable disease, non-communicable disease including mental health and secondary healthcare (UNHCR, 2019d). this set of services were supported by many research findings in actual refugees context at emergency stage, post emergency stage and at protracted refugees situation (Dator et al., 2018; Pavli & Maltezou, 2017). On the other hand, the healthcare needs of vulnerable groups including refugees have been studied in a context of humanitarian crisis as the nature of healthcare needs differ from one context to another. For example, the natural crisis normally brought more health needs to the side of

environmental hazards including sanitation, while conflict base displacement increased the violence related needs such as psychological trauma and injuries.

The reported access barriers varied according to the context and stage of crisis. Among refugee, there have been many healthcare access barriers described in the literatures. For instance, Antoni, and his team, identified many barriers to get healthcare and classified them into cognitive barrier, structural barrier, socio-political barrier and financial barrier (Antonipillai et al., 2017). Many other studies and surveys, look at different access barriers with considerations for context, where the legal status, believes, cultural appropriateness, discrimination, cost, long waiting, transportation, knowledge about services and language were the most (Doocy et al., 2016; Kohlenberger et al., 2019; Le, 2004).

Finally, when the immigrant population finds themselves in a protracted crisis with limited access to the needed healthcare and faced several barriers, they might adopt new strategies to meet their basic health needs and minimize the impact of care barriers. Minimal studies had explored this area from health perspective. However, delayed seeking care, self-diagnosis and treatment, reduce providers visits and treatment intake were reported by some researchers as health related adaptation strategies (Choi, 2013; Siam & Gómez, 2021). While some other indicate to non-health adaptation strategies to minimize livelihood needs such as early marriage (Elnakib et al., 2021).

Chapter 3: Study Methods and design

This study utilized the mixed methods as deemed to be the suitable method for this study. It is expected to overcome the weaknesses inherent in the single standalone methods away from the dichotomy of qualitative and quantitative, but one combined approach where qualitative and quantitative are reinforcing, ensuring reliable results and outcomes. (Creswell & Clark, 2017). Additionally, for long time, the researchers found that utilizing a single method approach could

limit their ability to fully address research questions, thus the Mixed Method could be the solution and seen as a useful approach in social, behavioral and human science (Johnson et al., 2007). Finally, combining quantitative and qualitative research methods meant to enhance the comprehensiveness of answers provided, compared to the use of single method. The comprehensiveness of mixed methods stems from the fact that each method complements each other in order to enable the understanding of phenomenon from different angels and perspectives as well as addressing a wide range of questions related to different stages of that phenomenon (O'Cathain, Murphy and Nicholl, 2007).

This research study used the convergent parallel Mixed Method design, the quantitative and qualitative data had been produced separately and concurrently from the target group. A separate quantitative tool adopted to capture information related to utilization, access barriers and adaptation strategies and the qualitative data collected through semi-structured interviews. The quantitative data analyzed statistically while thematic analysis conducted for the qualitative data set.

3.1 Research tools and techniques

Based on the proposed research methodology, two tools were utilized during the research:

- The survey: a quantitative tool in a form of close-ended questions.
- The interviews: A complementary qualitative tool, in the form of semi structured questions.

3.1.1 The survey questionnaire

A 54 items survey tool adopted using a well-established global survey tool (Health Access and Utilization Survey [HAUS]) developed by United Nation High Commissioner for Refugees (UNHCR) (UNHCR, 2015b).

The final tool constitutes a set of closed question classified into seven sections including family composition, knowledge of available health services, access to immunization, access to women healthcare, access to chronic disease services, monthly access assessment and Head of Household (HH) questions.

3.1.2 The semi structured interview

This research tool selected as the best method to produce information with focus on research problem and research question. Maintaining privacy through using this method aims to bring more in-depth details on family health concerns, needs, barriers and adaptation mechanisms. (Polit-O'Hara et al., 1999).

A semi structured interview guide has been developed through mapping of research questions and reviewing the related literature (Lee, 2016). The structure included a set of open-ended questions including opening questions, access and utilization of healthcare, access barriers, adaptation strategies, and impact.

3.1.3 Instrument's validation

Both instruments including the survey questionnaire and the semi-structured interview tested for content validity using a committee of experts prior to the piloting. Both instruments translated to Arabic and back-translation carried out, the original version and back-translated one compared to ensure the equivalence.

3.1.4 Digitalization of quantitative instrument

The quantitative tool that consists of 54 survey questions has been programmed on the Open Data Kit (ODK) system using open-source KOBO application tool kit, the utilization of ODK enabled the implementation of all data quality check functions and save the time and resources to gain better quality data, enhance complete data and minimize efforts on data transfer and

cleaning. All questions programmed as per interview logical flow. Validation roles, restricting roles, conditionality, grouping of questions, multiple selection, skipping, and repeating roles were all used throughout the programming.

3.2 Piloting Phase

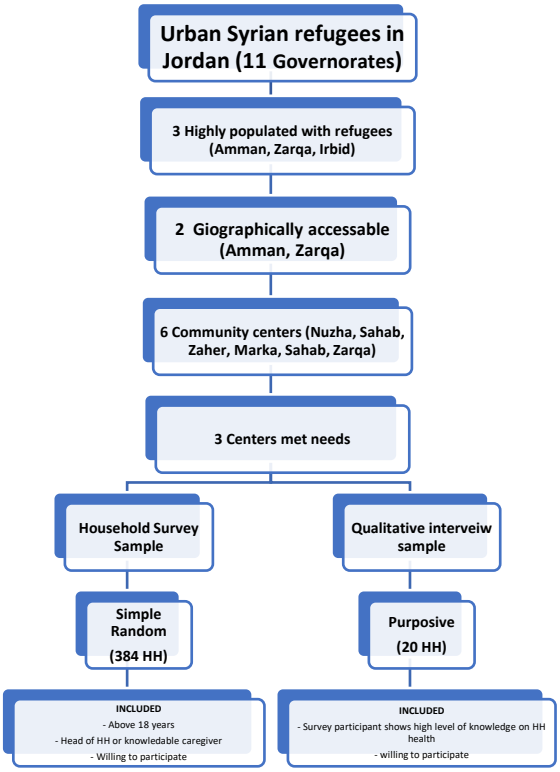
All required approvals from UNHCR to do data collection in a group of community service centers obtained. Selection of community service center against healthcare center was decided in order to ensure diversity of target groups rather than having homogeneous sample from healthcare seekers group which will result in selection bias. Study instruments administered in one site among 11 participants recruited randomly for quantitative tools and 3 head of HH underwent the semi-structured interview. The instruments were tested for clarity. All difficulties or ambiguity were recorded, timing of administration and adequacy of range of responses come from qualitative tools reviewed.

The instrument validation including reliability testing conducted during piloting phase where comprehensibility and relevance were observed toward respondent understanding, identify the impact of the setting, and observe reactive response or response modification.

3.3 Participant's recruitment

Participants were targeted at core refugee center in urban areas in central governorates. The three study settings were selected conveniently, the participant sample for the quantitative part were randomly chosen while sampling was purposive for the qualitative part.

Figure II. Sample recruitment chart



3.3.1 Inclusion/exclusion criteria

All refugees of Syrian nationality registered outside officially recognized refugee camps in Jordan and living in Jordan were considered eligible. Interviewed persons were above the age of 18 and either the head of the HH or knowledgeable caregiver living in the same HH. All unregistered refugees who have moved outside Jordan or into official refugee camps inside Jordan excluded. All below 18 or non-consenting HH were excluded as well.

3.3.2 Sample size and theoretical saturation

Sample size calculation for cross sectional studies/surveys used to calculate sample size, type one error was at 5% with P value < 0.05.

$$n = \frac{z^2 \times \hat{p}(1-\hat{p})}{\varepsilon^2}$$

$$n = \frac{1.96^2 \times 0.5(1-0.5)}{0.05^2} = 384.16$$

The targeted number almost reached for the survey where 383 HH interviewed who were representing 2,199 HH members.

The literature suggested that 12 participants is adequate sample size for an interview (Onwuegbuzie & Collins, 2007) while (Lee, 2016) in his qualitative research among refugees reached saturation at 24 interviews. 20 interviews were conducted among target group for this research. However, the saturation point reached at 18 interviews, but an additional 2 interviews made to ensure sufficient geographical variation in a mixed study sties.

3.3.3 Sample selection

The quantitative component participant selected using simple random technique at the study site waiting area. The qualitative component participant selected purposively from quantitative set participants with maximum variation, from those who participated in quantitative interview those who show eagerness to continue with the investigation, have good expressions and show very good level of knowledge on their family health situation

3.4 Data collection process

The data collection for the quantitative part was conducted among 387 participants using a tablet with KOBO tool installed as a programmed tool for 54 sets of questions. Consent obtained at the beginning of each survey. 383 participants gave their consent while 4 didn't give their consent and dropped out.

The data collected between 29th of November 2019 and 16th January 2020 over 22 working days from the three targeted sites.

The qualitative component; one semi structured interview was carried among 20 participants who were selected from the quantitative participants' pool. Consent obtained for both interviews and recording.

The interviews extended from 12 to 40 minutes, all participants were Arabic speakers, the interview guide followed throughout the interviews with open ended question, probe and follow up questions.

3.5 Ethical considerations

The Institute of Migration Research (University of Granada) proposal review committee reviewed the study protocols and approved it to be implemented.

A support letter obtained from the University of Granada, Institute of Migration Research. UNHCR approved the data collection to be done in the community centers run by their local national partners.

The survey poses no direct risk to participants. The data collection took place in service delivery sites with no home visit involved. No specimen collection involved. No sensitive information collected. The participant interviewed in the waiting area or special dedicated space with privacy considerations.

3.6 Trustworthiness of Methods

I aim to increase the trustworthiness of my study by keeping ethical standards observed during data collection and analysis, a survey questionnaire modified in consultation with the community of practice and an interview guide developed in consultation with three experts.

All tools are either adjusted or developed in line with the conceptual framework. A survey sample was employed randomly, and semi-structured interview subjects were selected purposively with maximum variation ensured. The data collection sites were selected to be community centers rather than a healthcare provider to ensure the heterogeneity of the subject, thus ensuring various health seekers and mixed access behaviors are well captured.

3.7 Analysis Techniques

In reference to the research methodology adopted (convergent Mixed Method), a completely isolated data analysis has been carried out for qualitative and quantitative data sets.

3.7.1 Descriptive and relational analysis

Upon completion of quantitative data collection process for data set, the data was extracted from the KOBO database in Excel Microsoft form. Data check, cleaning, and correction were done and revealed minor missing data. For instance, one case who were not detected as a head of and nine wrong entries detected were the year of birth entered instead of age.

All descriptive statistics were produced, and chi-square was done to find some relations between some variables. The Statistical Package for the Social Sciences (SPSS) version 25.0 software was utilized for descriptive analysis and relation analysis.

3.7.2 Thematic analysis technique

This study used the most prominent guide commonly used, which was developed by Braun and Clarke (Braun & Clarke, 2006) and is currently widely used by qualitative researchers (Clarke & Braun, 2017). The analysis method passed through six standard phases including familiarization, initial coding, or surface meaning, reviewing themes, themes defining and naming, and reporting findings.

Finally, the findings from the qualitative and quantitative data set compared per thematic area using side by side comparison in the discussion to find out equivalences, contradictions or correlations that interpret the refugee's health access behaviors, barriers, and their way of adaptations to meet their health needs and its impact.

Chapter 4: Results

In this chapter, the basic demographic characteristics of study subjects are presented. Followed by the constructed themes explored using the data analyzed; the thematic areas including access and utilization, access barriers, adaptation strategies and impact.

Our demographic finding suggests that the Syrian refugees in Jordan have large families with an average household size at 5.7 individuals with almost equal gender distribution between male and female. The female-headed household constituted almost one quarter (24.5%) of surveyed household. The age distribution shows a young community structure with more than 70% individuals found to be below the age of 30.

Additionally, a significant proportion (57%) found to be with no education and minimal percent (2.3%) found at the level of diploma or university level. Most of the refugees (77.6%) came from four governorates (Damascus, Aleppo, Dara'a and Homs), significant portion of them were living in rural areas in Syria (36.2%) and currently settled in urban center in Jordan (96.1%).

The analysis found an excellent level of awareness among refugees about their eligibilities for subsidized access (100%) and satisfactory level of awareness on places they have access to (79.4%). 86.1% of refugees aware that their children have free access to immunization service while 61.1% received vaccines in Jordan where most of them (97%) received it at public health centers.

Among women at reproductive age, 43.5% found to be pregnant during previous 2 years, the antenatal care uptake rate found at average with low level of full antenatal care at 21%, level of awareness on family planning service availability was below average with low uptake rate with only 19.8% tried to obtain it.

The chronic conditions prevalence was found high among surveyed group at 28.6%, the most prevalent diseases were hypertension, asthma, and diabetes.

The healthcare found to be highly demanded where more than 88% of surveyed household needed healthcare at the previous month. The private providers (hospitals, clinics and pharmacies) were the most accessed by more than 50% followed by public healthcare provider with only 20.4% accessed either a governmental clinic or hospital. Almost 85% of refugees paid for received services and most of them paid less than 100 JoDs (approximately 130 euros).

On the other hand, the participants in the qualitative part identified their health needs under wide set of services including chronic diseases, emergency healthcare, hospitalization or in patient care, psychological - mental health, rehabilitation- disability, childcare, vaccination, elderly care and women health needs. Additionally, the analysis of needs corresponds with analysis of seeking behaviors and suggested a group of sub themes including access policy, financial capacities, practices, awareness, and beliefs.

The analysis of access barriers identifies several barriers among care recipients with wide variations depending on availability and affordability of services for each group of recipients including child vaccination, women health and family planning needs, chronic disease needs and monthly household health needs. However, the most reported access barrier was cost and was significant among those with chronic conditions (23%). On the other hand, the interviewed household identified several thematic barriers including cost, access policies, service availability, discrimination, awareness, distance, quality of service and waiting time.

The data suggest that 53% of survey participants noticed an increase in healthcare cost; most of them identify inability to visit doctor, inability to afford required medication and reduced ability to meet other livelihood needs as a major impact to the healthcare cost increase. Additionally, borrowing money or using savings was detected as a main adaptation strategy

(77.6%) and to a lower extent sought NGO free services, reduce or stop medication, and use of alternative medicine were utilized as well by almost half of participants. On the other hand, the qualitative analysis identifies a group of 11 sub themes under adaptation strategies that were utilize by one or more families including self-medication, use alternative medicine, delay seeking care, stop or reduce medication and seek free services. Another set of non-health related strategies included, reduce consumption of basic livelihood, borrow money, or use saving, collect donation, illegal labor, use other livelihood assistance or plan for onward movement.

Finally, the impact of the adopted strategies was a specific question tackled through qualitative method only. The interviewed HHs have detected many risks and presents its direct impact on their individual health status, as well as the indirect impact that resulted from a consequence connected to their health needs or previous health events. Four themes have been detected throughout most of the interviews that included psychological-mental health consequences, deterioration of health status, legal consequences and finally the negative influence on other livelihood needs.

Chapter 5: Discussion and Conclusion

5.1 Demographic characteristics

The demographic findings of study subjects match with the overall characteristics of Syrian population. Average family size found high at 5.7 and was comparable to the previous UNHCR health surveys and 2017 DHS findings (Department of Statistics/Jordan & ICF, 2019; UNHCR, 2019c), the high average family size is correspondent to high fertility rate as well (Department of Statistics/Jordan & ICF, 2019). Additionally, the low level of formal education found to be dominant where it is confirmed by a lower school attendance level in DHS findings (Department of Statistics/Jordan & ICF, 2019). Gender and age distribution found to be equalized and matched with global statistical reports (Nations, 2019). The proportion of female

headed HHs reported high at 24.5 % but considered normal among women flee from conflict zones and pose an additional protection risk and require special protection services for this vulnerable groups.

A huge shift reported in nature of living between Syria and Jordan, where most of those who were living in rural areas shifted to urban sites in Jordan. The change in living condition poses new challenges for refugee's families and may require special attention for mainstreaming strategies when it comes to social, political, economic and civil services such as healthcare and education services (Norman, 2021) from one side and the capacity of urban systems to absorb shock and meet the increasing demands from another side (Tuncay et al., 2022).

5.2 Health access and utilization behaviors

Refugees showed excellent level of awareness on available services and "privileges" they have as a refugee when 100% confirm that the possession of required documents allow subsidized access to public health services and 86.1% knew that the free vaccination coverage is provided. This excellent level of awareness on access policy and health services availability is connected with long stay of refugees (Schober & Zocher, 2022). The qualitative findings showed that the services that provided free, such as vaccination and preventive antenatal care, had a little concern among refugees families compared to other services that need to be paid out of their pockets. This optimal access behaviors when the services provided free found supported by other study findings in Iran and Turkey (Kiani et al., 2021; Tuncay et al., 2022).

The antenatal care assessment and family planning meant to assess women healthcare access needs and behaviors. The high fertility rate reported reflected on the high proportion of pregnant women among those at reproductive age (Department of Statistics/Jordan & ICF, 2019; Sieverding et al., 2019). Additionally, the high fertility rate contributed by the sub optimal level of knowledge on family planning availability and the very low uptake among those who tried

to obtain contraceptive. However, the freeness of services and good level of access rule was not applied over family planning services, of which suggest an additional barrier may be found beyond only cost of services in this sense, and suggest that more need to done beyond provision of free service (Inci et al., 2020).

Additionally, the chronic disease was one of the prominent healthcare needs among Syrian refugees due to high prevalence (Naja et al., 2019). Both quantitative and qualitative findings addressed the chronic conditions as one of the most pressing access needs that require continuous support and wide range of healthcare services.

On the other hand, the qualitative assessment for healthcare needs revealed much more needs beyond standard quantitative assessment findings that focused on three aspects (women health, child health and chronic condition). For instance, the emergency healthcare and hospitalization addressed as a pressing need of which match with other research findings that detected emergency medical care and acute occasions that require hospitalization as one of a main healthcare needs that impacted a significant portion of refugees community (Assi et al., 2019; Ay et al., 2016).

Among refugee's children, the findings from quantitative and qualitative correspond to the global literature where most of the children health needs directed toward vaccination services and communicable diseases treatment, and to a lesser extent the chronic conditions that connected with early childhood disabilities such as physical and visual impairment (Ay et al., 2016; Harkensee et al., 2021; Hjern & Kling, 2019).

Mental health and psychosocial needs were among significant needs that detected. The reported disorders was low at less than 1% of which considered very low compared to other surveys (UNHCR, 2019c, 2021b). While the quantitative analysis raises a significant concern among refugees' families toward psychological issues (17 out of 20 families). The high level of

psychological and mental disorders is thematic among refugees, and specifically among those who arrive from a conflict-induced context (Hunter, 2016); this high vulnerability has magnified the needs for mental health and psychosocial healthcare services. However, the gap between those who reported mental health issues and those who express several types of psychological challenges may suggest that the stigma around mental disorders is still a barrier and hinder better seeking behaviors (Al-Soleiti et al., 2021).

Despite the fact that the elderly refugees are more disadvantage, they still more vulnerable and has more barriers that impact their seeking behaviors (Kristiansen et al., 2016; Strong et al., 2015), the elderly refugees health needs has been addressed under management of chronic health condition and special personal care needs aspects that require special attention at a longer term humanitarian programming.

Disability prevalence found to be high (22.9%) among Syrian refugees in Jordan due to the conflict nature of crisis (Humanity et al., 2018) this finding is consistent with our findings, as 20% of interviewed families found having at least one disable person living among HHs. However, refugees' families sees disability as a pressing needs due to longevity of need and excessive health and other livelihood demands (Polack et al., 2021).

The monthly access assessment support high demand on healthcare among refugees when 88.5% of surveyed HH needed healthcare, this high demands on healthcare reflects high utilization rate found among refugees compared to non-refugees communities (Kiss, Pim, Hemmelgarn & Quan, 2013) and high uptake rate as well, which is supported by other studies and surveys (Doocy et al., 2016; UNHCR, 2019c, 2021b).

The utilization behaviors showed high utilization for private providers. On the other hand, the qualitative findings explain some of these directions when some interviewees mentioned their knowledge about subsidized access policy to the public healthcare was a driver to seek services

there (Tomkow et al., 2020). Additionally, the drug access policy derived some refugees to get their medication from private pharmacies directly using self-medication approach as policy allows. Both, non-awareness about public healthcare access policy and drug access policy contributed to high utilization rate for private providers thus increase the expenditure on health and made the cost as one of the major barriers that impacted refugees' accessibility to the services.

Financial capacity and cost of care was another factor driving health seeking behaviors. With compromised financial capacities, some refugees sought free healthcare or subsidized healthcare (Douangmala et al., 2012); some other utilized self-medication, delayed care or used traditional medicine to reduce cost of healthcare of which is consistent with results of other research (Ojeleke et al., 2020). Furthermore, facing barriers through the previous experience was another driver for the seeking behaviors (Tomkow et al., 2020).

Finally, beliefs played an important role in defining one's health-seeking behaviors. For instance, recognize benefit of seeking healthcare or seriousness of not seeking care for a condition was additional driver for seeking behaviors, (Andersen, 2008; Champion & Skinner, 2008).

5.3 Healthcare access barriers

The findings show wide set of access barriers experienced by Syrian refugees, were similar to those reported by many other research and systematic reviews among refugees globally (Antonipillai et al., 2017; Parajuli & Horey, 2019). The findings show a significant variation in prevalence of barriers among different targeted group. For example, access barrier was minimal among children for vaccination access, pregnant women for antenatal care and family planning. While were significant among chronically ill patients and those who require monthly access.

The group of barriers reported among children and women were all minimal and it was clear that the free access policy adopted for vaccination and preventive antenatal care and family planning had a positive impact on access and utilization among refugees women and children (Kohlenberger et al., 2019). On the other hand, the more significant barriers faced by those who require monthly access mainly was due to the cost of service, patient preferences when they don't like service provider and knowledge on where to go. The increased demand on healthcare due to frequent access increases the expenditures thus it made the cost a primary barrier among this group (Strong et al., 2015). However, the long stay of refugees in Jordan may suggest that the good level of awareness on available health services and access policy, but the frequent fluctuation in access policy may considered as access barriers that hinder access to services when needed.

The qualitative findings clearly supported the access barriers reported by quantitative finding, but also brought up a new set of access barriers such as administrative barriers related to documentation, service availability, discrimination in provisions, waiting time or proximity of providers that is supported by other research (Parajuli & Horey, 2019). On the other hand, there were some access barriers detected by other research were not an issue for Syrian refugees in Jordan due to sociocultural proximity to country of asylum such as linguistic barriers and cultural barriers (Asgary & Segar, 2011; Kohlenberger et al., 2019).

Finally, the qualitative analysis revealed some finding that was not aimed to be detected when some refugees described some facilitators to their access to healthcare. Those facilitators were seen as an antagonist to access barriers such as affordability of cost, good quality of services received, good and equal treatment. These findings may suggest the proportionality of barriers encountered by some refugees due to presence of facilitator.

5.4 Adaptation strategies

The adaptation strategies identified in quantitative assessment found to be connected to the increase of healthcare cost reported by more than half of surveyed refugees, the impact of raising of healthcare cost must be considered when explaining the context of adaptation strategies. Lack of financial resources has had a direct impact on the need to visit a doctor or obtain medication or medical procedures, thus it has an extended impact to the non-medical needs such as shelter, food, or education.

The detection of adaptation strategies that extend beyond meeting the health needs to another means of livelihood was one of main research question that sought for answers, so the cluster of adaptation strategies reported in the quantitative assessment was minimally supported by the literature. However, spent saving or borrow money was the most utilized strategy followed by sought for free services, reduce or stop medication and use of alternative medicine. Those findings were supported by only one assessment carried out by International Rescue Committee (IRC) in 2018 (IRC, 2019).

Our qualitative analysis revealed deeper direct and indirect adaptation strategies, as well as supported all findings detected in quantitative analysis. The new thematic adaptation strategies detected in qualitative analysis supported the group of another six standard adaptation strategies.

The adaptation strategies found were classified as direct adaptation strategies if they directly affect the health domain. While those classified as indirect, if their impact is connected to other dimensions of refugees' lives. The direct adaptation strategies detected were seeking free healthcare, delaying care seeking, stop medication use, using alternative medicine and self-medication. The indirect adaptation strategies included borrow money or use saving, collect

donation, illegal labor, onward movement or prioritize between health and other livelihood needs.

The adaptation strategies detected were all find to be negative and/or have negative impact on health and other means of livelihood. Nabulsi and his team supported some of our findings in their qualitative assessment conducted among Syrian refugees in Lebanon; they found informal employment, child labor, accruing debt and poor living condition were adapted by refugees to meet their all family's needs including health (Nabulsi et al., 2020).

When the refugees have low health promotion scale and poor health outcome compared to local national who have established welfare systems (Alzoubi et al., 2021), then it is more important to understand how refugees behave when they face shortages in their means of livelihood including health. The causal analysis for the root causes revealed that no clear reasoning or connection between health and other livelihood shortages. Additionally, causal relationship seems very difficult to detect and the shortages faced in basic needs brought many adaptation strategies that is interrelated when the families decide to deprioritize something over other, or shift resources from one need to another, or utilize negative indirect strategies such as child labor to meet needs. However, the common reason found to be trans across all livelihoods needs including health was the financial hardship. The financial hardship correlation was studied by Torlinska and his team in their longitudinal study among refugees and they confirmed that the financial hardship is correlated with poor physical and mental wellbeing (Torlinska et al., 2020).

In conclusion, three scenarios found to be conductive to negative decision making when refugees population face a challenge to meet their health needs. The first; when the head of HHs have a health condition limit their ability to gain income to cover their health and other livelihoods needs like those who suffer from disability or limiting condition. The second scenario is among those who suffer from health conditions that require additional financial

resources to stabilize their health condition such as those who have a family member or members suffer from chronic or long-lasting conditions. And the third is those group who have other pressing basic needs that is prioritized over health needs such as shelter, food, and education requirements, so that health-related needs are minimized and/or neglected.

5.5 Impact of adaptation strategies

The impact of adaptation strategies was the last research question that specifically looked at impact of adaptation behaviors followed by refugees to meet their health needs, of which tackled through qualitative methods where most of it found negative and have direct or indirect impact on individuals and family's health status.

The general deterioration of refugee's health status who found themselves with limited options to get needed care, among those who moved to a risky seeking behavior like using traditional medicine, reduces the care seeking frequencies by reducing visit to the care provider, reduce utilization of medicine in order to reduce healthcare cost or prioritize other needs over health were major predisposing factors. Syrian refugees in Jordan as per access policies have less access privileges compared to the local national as most of Jordanians have certain type of health insurance (Department of Statistics/Jordan & ICF, 2019), this discrepancies in access magnify the impact on health status. Schneider and others found that asylum seekers are less accessing the service provider and have significant likelihood to report bad health status compared to nationals (Schneider et al., 2015).

However, when the refugees deprioritize medical needs, they believe this could reduce cost of care; this is not always the case. For instance, Wal confirmed that the early detection for chronic disease is un doubtfully more cost effective for both refugees and hosting healthcare system (Wal, 2015), this has been confirmed as well by Daynes who found that not addressing noncommunicable disease (NCDs) needs in European refugees is more likely to magnify

human and economic needs (Daynes, 2016).Other peer review study confirmed from an economic perspective that an improvement of immigrant access to healthcare might reduce cost through improvement of primary prevention (Nandi et al., 2009). In conclusion, addressing the healthcare needs for refugees will improve health outcome and will reduce cost of social and health demand, protect public health gains locally and globally and contribute to long-term development outcomes (Gushulak et al., 2009).

On the other hand, the psychological and mental consequences appeared as a significant theme, most of studies who looked at psychological aspects among refugees found them suffer from a higher level of psychological distress and disorders, either because of refuge journey (Van Loenen et al., 2018) or because of poor living conditions and poverty they live due to displacement and being a victim of violence in country of asylum (Daynes, 2016).

Furthermore, putting other livelihood needs in a critical situation, weather to make some saving to meet health needs or the other way around, will have a major impact on the unmet needs to other livelihood components. This finding were supported by others (Nabulsi et al., 2020) and may indicate to the variation in adaptation strategies adopted and the way families prioritize the needs among each other (Torlinska et al., 2020). However, when refugees found it very difficult to meet health needs, it may self-limit their access to health to avoid incurring more expenses and increase the pressure on financial requirement (Bozorgmehr & Razum, 2015), this shortages make them reprioritize between health and other livelihood needs; therefore the unlimited consequences may extend to other means of livelihoods on one hand, and the un predictable impact may extend to affect all other livelihoods.

Finally, the legal consequences that the refugees faced due to unsettled debts. The debt originated from medical needs such as unsettled hospital bills or other housing needs such as

rent, or sometimes originated from work (in situations of illegality) injuries that is not covered by any insurance schemes.

The legal consequences faced such as being subject to a detention due to unsettled debt, limit family's ability to secure necessary resources due to the detention of income generators members. Additionally, falling in debt and being subject to legal disciplinary action including detention may become a predisposing to bush some refugees to accept working in very poor labor condition and illegal works, women may subject to increased violence and conditions might reach a trafficking and face increasing poorer work conditions (Murray, 2018). Furthermore, those who trapped in a huge debt, a subsequent migration might be the only left option to escape this situation and leave the country of asylum to country of origin or largely to a third country. The debt driven migration increase the risks and normally lead to a family separation pose an additional protection risks on vulnerable members such as women and children (Heidbrink, 2019).

5.6 Limitations

This research revealed some weaknesses and limitations due to several contextual conditions. Ethical considerations arose during data collection phase that was mainly related to subjects' vulnerability and my identity as humanitarian worker of which in a way or another has impacted the consent process due to increased vulnerability of participants and their expectations.

Additionally, there was a focus on using simple random technique over quantitative sample, but the qualitative subjects have been selected using purposive sample driven from quantitative sample participants. Furthermore, the sample has been selected from three community centers of which mostly receives urban refugees and were located in two governorates only, this homogeneity may limit the maximum variation we targeted for this study. Finally, the interrelated nature of refugees' vulnerabilities including health vulnerability made it difficult to

understand how the accumulation of vulnerabilities can be interpreted among some other facilitator to access health of which was not captured by this study.

5.7 Implication and recommendations

This thesis has an implication for healthcare professionals, providers, institutions, humanitarian organizations, hosting countries and health policy makers. Given the current experience with multiple long term refugees crisis, the refugee crises are normally protracted, rather than short term; the average refugee remains a refugee for years (Loescher & Milner, 2006) and integration within local community is a priority. Therefore, the understanding of refugee's health needs, utilization behaviors, barriers and identification of its impact on refugees themselves, hosting communities and countries is essential to have better health outcome, and minimize disparities that raised due to different contextual conditions (Lima Junior et al., 2022).

Healthcare practitioners will have better understanding for better addressing refugees' healthcare needs and focuses on specific health vulnerabilities among refugees. On the other hand, the identification of refugees' health specific needs will help the healthcare institution at local level to be better prepared in term of infrastructure, logistics and staffing. Additionally, the international and humanitarian organization who are involved on short- and long-term interventions for refugees during crisis will be able to construct evidence driven interventions that focuses on area of weakness in refugees' behaviors, minimize or eliminate barriers, advocate for better access to essential health services and mobilize resources as need be.

The hosting countries can better identify health response outlook rather than relying on contingency plans, thus the identified needs and contextual variation will help them to mobilize resources wisely, advocate for donor support, develop health access polices and minimize impact on public healthcare system and public health indicators stability.

Finally, health seeking behaviors and changing the refuge context is a dynamic environment especially with protracted refugee's crisis, studying of health seeking behavior, refugees' health needs, barriers identification and measuring the impact of those behaviors on public healthcare system is recommended to be a continuous practice for all involved in response including humanitarian organization and local government.

5.8 Conclusion

The proposed thesis focused on healthcare access and utilization among Syrian refugees living in urban setting, it explored their needs, utilization behaviors, access barriers, adaptation strategies and impact.

The healthcare needs identified including emergency healthcare, hospitalization, mental care, rehabilitation, vaccination, elderly care, childcare, chronic disease care and women care were within the standards group of services that any human being needs. The variation detected by refugees' community was a little bit different from local community due the predisposing factors that made some healthcare needs at more pressing stage.

The healthcare seeking behavior was impacted by several factors as detected earlier by Gelberg-Andersen model. Access policies, financial capacities, individual practices knowledge and beliefs were major drivers detected for seeking behaviors with no detection for its impact whether as a facilitator or barrier to healthcare seeking.

On the other hand, the set of identified barriers included again the access policy, services availability, discrimination, waiting time, quality of healthcare, distance, awareness and majorly the cost. The identified barriers had a varied level of impact on refugees depends on refugees contextual and individual factors. The identified barriers normally obliged refugees to adopt several adaptation strategies to meet their health needs, some of those adaption strategies was non-harmful, but other were health harmful or had extended impact on health as well as

other livelihoods aspects. Adaptation strategies included a group of balanced strategies such as seek free healthcare or collect donation; some others were harmful to the health, safety and stability such as self-medication, delay seeking care, stop use of medicine, and use alternative medicine. While another group had extended impact on other livelihoods such as borrow money, illegal labor, onward movement or re prioritize between health and other livelihood needs.

Furthermore, the strategies adopted by refugees poses a new risk on refugees themselves while some have an extended impact on hosting community as well. The impact of adaptation strategies included deterioration of refugee's general health status, poor health outcome that limit refugees' ability to meet their health needs and other livelihood needs and overburden the local healthcare system with increased preventable demands. On the other hand, compromise other livelihood needs or facing a legal consequence such as detention as part of refugee's effort to meet health needs or the other way around it may produce another set of risks.

Refugees' health access and utilization behaviors could be explored by defining their individual characteristics, pre refuge health outlook, current needs, identifying seeking behaviors, access barriers and adaptation strategies, and measuring that impact on refugees themselves and hosting countries. However, understanding the interrelation between all health identifiers and other livelihoods still need more in-depth research and modelling.

Finally, leaving the refugees for long time facing a shortages and barriers to access basic healthcare services, as well as other livelihoods needs will have interrelated, negative and complex consequences. The disparities in health care and social services available for refugees will bring many new and unpredictable adaptation strategies and subsequent impact that require continues monitoring using several monitoring strategies such as sensitized health information system or refugees' specific surveys.

RESUMEN DE LA TESIS

Capítulo 1. Introducción

1.1. Contexto

El movimiento global de migración y refugio es una tendencia creciente, ya sea debido a nuevos conflictos globales, conflictos de larga duración o crisis económicas en curso, esta tendencia ha convertido al movimiento de refugiados en una preocupación a nivel mundial y ha llevado a los países de acogida, así como a las organizaciones humanitarias, a tener que responder a esta situación de crisis alarmante.

La crisis de Siria se inició en marzo de 2011 cuando se organizó una protesta general contra el régimen político en todo el país. Este conflicto derivó en 2012 en una guerra civil. Durante los siguientes cuatro años, el régimen perdió el control de las fronteras, se intensificó la violencia contra los civiles, se produjeron desplazamientos internos y la huida del país de millones de personas. Actualmente, el 27% de las personas refugiadas en el mundo son de origen sirio (ACNUR, 2021c). Así, la llamada “crisis de Siria” se considera una de las principales tragedias del siglo XXI (Guterres, 2012) debido a su naturaleza, la violencia asociada y la movilidad a gran escala que afectó a la mayor parte del continente a nivel mundial. Desde el estallido de la crisis de Siria, alrededor de una cuarta parte de su población (6,6 millones) ha huido a los países vecinos, principalmente Turquía, Líbano y Jordania. Posteriormente, 130 países han acogida a personas refugiadas de origen sirio, de entre estos los países europeos acogen actualmente a más de un millón de personas. Jordania, como país vecino, ha acogido a más del 12% de los refugiados de Siria con más de 660.000 personas registradas en el Alto Comisionado de las Naciones Unidas para los Refugiados (ACNUR), mientras que el gobierno jordano estima que son más de 1,3 millones las personas refugiadas que viven en el país (ACNUR, 2019a).

Jordania es un país que no firmó la convención de refugiados de 1951 ni el protocolo derivado en 1967. Además, Jordania no tiene leyes o reglamentos específicos sobre refugio, pero durante la crisis, el gobierno de Jordania adaptó varios reglamentos y políticas para organizar la presencia de población refugiada en sus territorios. Desde entonces, la población de nacionalidad siria refugiada (entre otras) disfruta de su estatus de residentes y tienen derechos a la "no devolución" (así como otros derechos sociales y económicos).

Los refugiados sirios en Jordania viven en diversas condiciones, pero la mayoría de ellos están asentados en entornos urbanos. El gobierno jordano estableció dos campamentos para personas refugiadas con apoyo de las agencias de las ONU y la comunidad de donantes. Dichos campamentos oficiales (Zatari y Azraq) actualmente albergan alrededor del 18% del total de personas refugiadas sirias que residen en Jordania (ACNUR, 2019a). A los refugiados ubicados en entornos urbanos con un registro válido del ACNUR, se les permitió acceder a los servicios básicos de protección -incluido el registro civil y la justicia legal, el mercado laboral, la educación básica y los servicios de salud- en las mismas condiciones que a los ciudadanos jordanos.

La salud es una de las necesidades básicas de cualquier ser humano y es un derecho establecido para toda la población según las herramientas globales de Derechos Humanos. Desde el estallido de la crisis siria en 2011, el gobierno de Jordania se comprometió a brindar servicios básicos de salud a las personas refugiadas sirias que, de acuerdo a los estándares globales deben ser garantes del acceso a los servicios de atención médica que se necesitan donde y cuando sean necesarios. Así, con el fin de garantizar la estabilidad de la salud pública del país durante la crisis, Jordania adoptó varias políticas de acceso a la atención médica para los refugiados sirios.

1.2 Planteamiento del problema

Estudiar las necesidades de atención médica de las personas refugiadas, los comportamientos que esta población tiene en el acceso a dicha atención y las barreras que se encuentran, ha sido un asunto de interés para la investigación desde el siglo pasado, ya que normalmente las personas en situación de refugio enfrentan mayores dificultades para acceder y utilizar los servicios de salud en cualquier contexto nuevo (Nowak et al., 2022). La literatura actual se ha centrado en las necesidades de la población, los comportamientos de uso del sistema sanitario y las barreras de acceso al mismo (Cope, 2011; Kohlenberger et al., 2019; Le, 2004). Jordania, como uno de los países afectados por múltiples crisis de refugiados, se interesa por cuestiones relacionadas con la investigación global sobre la salud de las personas refugiadas, mientras que factores como las estrategias de adaptación o el impacto de estas en la toma de decisiones, se han explorado mínimamente.

Además se debe tener en cuenta que la propia estructura del sistema sanitario, así como las políticas que lo regulan tienen una consideración específica que requiere una investigación y un análisis en profundidad para estimar su impacto en el estado de salud de los refugiados y su relación con el sistema de atención médica, cuestión que se considera central en esta tesis.

1.3 Preguntas de investigación y objetivo

Esta investigación de carácter multifacético, busca explorar los usos de los servicios de salud entre la población refugiada siria que vive en entornos urbanos en Jordania. Así, este estudio se centrará en conocer las barreras de acceso y las estrategias de adaptación que dicha población despliega para satisfacer sus necesidades sanitarias a largo plazo.

Además, comprender el impacto de las estrategias de adaptación nos permitirá predecir las posibles amenazas que representan para los refugiados, así como para la estabilidad de la salud pública en el país de asilo.

Las preguntas que se responderán a través de este trabajo de investigación incluyen:

- ¿Cómo acceden y utilizan los servicios de salud los refugiados sirios que viven en áreas urbanas de Jordania, y qué tipo de barreras pueden encontrar?
- ¿Cuáles son las principales estrategias o comportamientos de adaptación que adoptan las personas refugiadas para superar las barreras y satisfacer sus necesidades de salud?
- ¿Qué impacto tienen las estrategias adoptadas sobre los refugiados y sobre la estabilidad de los sistemas de salud pública de los países de acogida?

1.4. Importancia del estudio

Explorar y comprender las necesidades de atención médica de la población refugiada dentro de un contexto único como es Jordania; comprender las cuestiones que influyen en los comportamientos relativos a la salud y sus interacciones con otros desafíos de integración social, es fundamental. El estudio actual puede proporcionar evidencias para los proveedores de atención médica que permitan una mejor comprensión de las necesidades de la población refugiada en este sentido, al identificar claramente los problemas que pueden encontrar los refugiados al acceder a los servicios de atención médica.

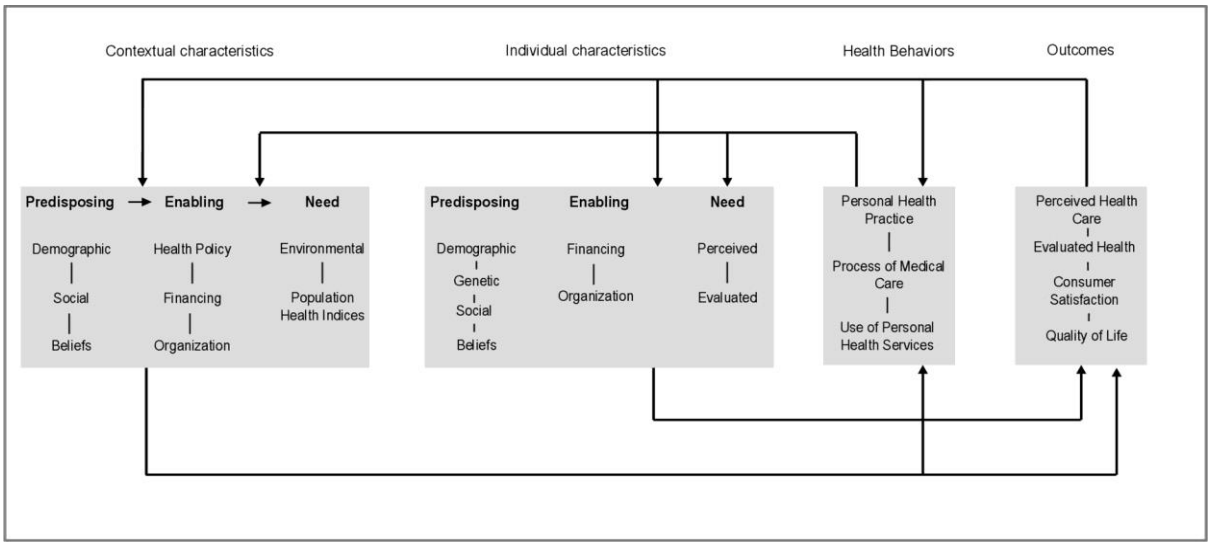
Los proveedores de servicios, así como los gestores políticos y legisladores, obtendrán una mejor comprensión para planificar y movilizar recursos de manera proactiva para una respuesta efectiva. Además, este estudio predecirá las consecuencias de las políticas de salud adoptadas y el posible impacto – y factores preventivos- en la estabilidad del sistema de salud pública y el sistema de apoyo social en el país de asilo.

1.5 Marco conceptual

Se ha partido del modelo conductual Gelberg-Andersen para poblaciones vulnerables utilizado para comprender la dinámica de utilización de los servicios sanitarios y determinar los comportamientos de búsqueda.

El modelo Gelberg-Andersen Behavioral fue desarrollado por Ronald M. Andersen en 1968 y ampliado posteriormente en varias ocasiones. El modelo predice tres factores que guían la utilización de los servicios: los factores predisponentes (edad, sexo, creencias, etc.), los factores facilitadores (apoyo familiar, seguro médico) y las necesidades sanitarias. La última fase del modelo desarrollado (5ª fase) puso de relieve los determinantes contextuales e individuales para comprender mejor la utilización de los servicios (Gelberg et al., 2000). Por último, en esta fase el modelo integra las dimensiones de vulnerabilidad y forma parte del último modelo desarrollado, tal y como se presenta en la siguiente figura

Figura I. Modelo de comportamiento de uso de servicios de salud de Andersen: fase cinco.



Capítulo 2: Antecedentes y revisión bibliográfica

ACNUR estima que durante la última década, 1,1 millones de refugiados en todo el mundo se convirtieron en ciudadanos en su país de asilo (ACNUR, 2019b). Jordania, como país con una larga historia de alojamiento de refugiados, y a pesar de verse directamente afectado en la última década por la crisis de Siria, todavía plantea la opción de la repatriación de todos los refugiados, incluidos los sirios (Ali, 2021). A pesar de eso, las personas refugiadas sirias en Jordania son parte integrante de la sociedad y tienen acceso a los sistemas de servicios públicos que incluyen

educación y salud; al mismo tiempo que forman parte del panorama económico del país (Alshoubaki, 2017).

La dilatada presencia de refugiados sirios en el territorio jordano tiene un claro impacto no solo en Jordania como país de acogida, sino también en el acceso y la utilización de recursos públicos por parte de las personas refugiadas (Copperation, 2020). El sector de la salud fue uno de los ámbitos afectados directamente, y la llegada y presencia de refugiados ha planteado nuevas demandas en este sentido. Algunos estudios apuntan a que el Ministerio de Salud está denunciando una sobreexplotación y sobreutilización de los servicios sanitarios (Copperation, 2020). La ratio del personal sanitario disminuyó significativamente, al igual que de camas de hospital (Murshidi et al., 2013). También se reportaron emergencias y reemergencias de algunas enfermedades de transmisión vinculadas con la crisis de refugiados como el sarampión, la tuberculosis y la leishmaniasis cutánea (Nimer, 2018).

Actualmente, la mayoría de los estudios que evalúan la situación sanitaria de las personas refugiadas, inmigrantes y otros grupos vulnerables, demuestran que los refugiados tienen menos acceso a los servicios sanitarios, se enfrentan a más barreras para obtener los servicios necesarios y tienen indicadores de salud deficientes en comparación con la población local (Chuah et al., 2018; Departamento de Estadística/Jordania & ICF, 2019). De hecho, las actuales políticas de acceso a la atención sanitaria adaptadas para los refugiados sirios, sitúan en teoría a esta población con el mismo nivel de acceso que el ciudadano jordano medio que no tiene seguro civil. De esto podría deducirse que los refugiados tienen más o menos los mismos comportamientos de uso, por lo que tienen casi las mismas ganancias al acceder al mismo paquete de servicios sanitarios. Sin embargo, este planteamiento no es realista si nos fijamos en el potencial de la comunidad de refugiados, las características demográficas, el entorno político, las necesidades específicas o las vulnerabilidades que predicen su capacidad para satisfacer sus diversas necesidades, incluida la salud y otras. Además, hay diversos factores de

riesgo detectados entre la población siria que hacen que la comparación sobre los beneficios del sistema sanitario no sea justa (como el alto porcentaje de enfermedades crónicas, las discapacidades, el matrimonio adolescente o las parteras no cualificadas).

La investigación sanitaria sobre la población de refugiados ha estudiado ampliamente las necesidades de los grupos vulnerables, las barreras y los retos y, en menor medida, el impacto de las disparidades en el acceso a la atención sanitaria, que pueden variar de un contexto de refugio a otro.

Las necesidades sanitarias de los refugiados fueron definidas por los actores humanitarios temáticamente. Así se puso el acento en la salud infantil, la salud reproductiva, las enfermedades transmisibles, las enfermedades no transmisibles, incluida la salud mental y la atención sanitaria secundaria (ACNUR, 2019d). Este diagnóstico fue apoyado por diversos resultados de investigación en el contexto real de los refugiados en la etapa de emergencia, en la etapa posterior a ese primer momento de emergencia y en la situación prolongada de los refugiados (Dator et al., 2018; Pavli & Maltezou, 2017). Por otro lado, las necesidades sanitarias de los grupos vulnerables, incluidos los refugiados, se han estudiado en un contexto de crisis humanitaria, ya que la naturaleza de las necesidades sanitarias difiere de un contexto a otro. Por ejemplo, las crisis naturales suelen acarrear más necesidades sanitarias por el lado de los peligros medioambientales, incluido el saneamiento; mientras que los desplazamientos basados en conflictos armados aumentan las necesidades relacionadas con las violencias, como los traumas psicológicos o las lesiones.

En cuanto a las barreras o limitaciones para el acceso, estas han variado dependiendo del contexto y la fase de crisis. Entre los refugiados, se han descrito diversas barreras de acceso a la atención sanitaria en la literatura científica. Por ejemplo, Antonipillai y su equipo, identificaron múltiples barreras para obtener asistencia sanitaria y las clasificaron en barreras

cognitivas, barreras estructurales, barreras sociopolíticas y barreras financieras (Antonipillai et al., 2017). Muchos otros estudios y encuestas analizan diferentes barreras de acceso teniendo en cuenta el contexto, entre las que destacan el estatus legal, las creencias, la adecuación cultural, la discriminación, el coste, las largas esperas, el transporte, el conocimiento de los servicios o el idioma (Doocy et al., 2016; Kohlenberger et al., 2019; Le, 2004).

Por último, cuando la población inmigrante se encuentra en una crisis prolongada con un acceso limitado a la asistencia sanitaria necesaria y se enfrenta a diversas barreras, puede adoptar nuevas estrategias para satisfacer sus necesidades básicas (en cuando a salud) y minimizar el impacto de las barreras asistenciales. Son muy escasos los estudios que han explorado este ámbito desde la perspectiva sanitaria. Sin embargo, algunos investigadores han identificado como estrategias de adaptación relacionadas con la salud, el retraso en la búsqueda de atención sanitaria, el autodiagnóstico, la reducción de las visitas a los centros médicos o consultas y el tratamiento de manera autónoma (Choi, 2013; Siam y Gómez, 2021). Mientras que otros estudios, apuntan a que esta población despliega estrategias no relacionadas con la salud para minimizar las necesidades de subsistencia, como puede ser el matrimonio precoz (Elnakib et al., 2021).

Capítulo 3: Métodos de estudio y diseño de la investigación

Este estudio ha utilizado métodos de investigación mixtos por considerarlos adecuados para el trabajo. Se espera que supere las debilidades inherentes a los métodos independientes y se aleje de la dicotomía entre lo cualitativo y lo cuantitativo, para adoptar un enfoque combinado en el que lo cualitativo y lo cuantitativo se refuercen y garanticen resultados fiables (Creswell & Clark, 2017).

Durante mucho tiempo, los investigadores encontraron que la utilización de un enfoque de método único podría limitar su capacidad para abordar plenamente las preguntas de

investigación, por lo que el Método Mixto podría ser la solución y ser visto como un enfoque útil en las ciencias sociales, conductuales y humanas (Johnson et al., 2007).

Consideramos que la combinación de métodos de investigación cuantitativos y cualitativos mejora la exhaustividad de las respuestas, en comparación con el uso de un único método. La exhaustividad de los métodos mixtos se deriva del hecho de que cada método se complementa entre sí para permitir la comprensión del fenómeno desde diferentes ángulos y perspectivas, así como abordar una amplia gama de cuestiones relacionadas con las diferentes etapas del fenómeno a investigar (O'Cathain, Murphy y Nicholl, 2007).

En este trabajo de investigación se utilizó el diseño de método mixto paralelo convergente; los datos cuantitativos y cualitativos se produjeron por separado y simultáneamente con el grupo destinatario. Se adoptó una herramienta cuantitativa independiente para producir información relacionada con los usos, las barreras de acceso y las estrategias de adaptación. Por su parte, los datos cualitativos se produjeron mediante entrevistas semiestructuradas. Los datos cuantitativos se analizaron estadísticamente, mientras que el análisis temático se realizó para el conjunto de datos cualitativos producidos desde las entrevistas.

3.1 Herramientas y técnicas de investigación

De acuerdo con la metodología de investigación propuesta, se utilizaron dos herramientas durante la investigación:

- Encuestas: Herramienta cuantitativa en forma de preguntas cerradas.
- Entrevistas: Herramienta cualitativa complementaria, en forma de preguntas semiestructuradas.

3.1.1 La encuesta

Se adoptó una herramienta de encuesta de 54 ítems utilizando un instrumento de encuesta global bien establecido (Health Access and Utilization Survey [HAUS]) desarrollado por el Alto Comisionado de las Naciones Unidas para los Refugiados (ACNUR) (ACNUR, 2015b).

El producto final consiste en un conjunto de preguntas cerradas clasificadas en siete secciones que incluyen la composición familiar, el conocimiento de los servicios sanitarios disponibles, el acceso a la inmunización, el acceso a la atención sanitaria de la mujer, el acceso a los servicios de enfermedades crónicas, la evaluación mensual del acceso y preguntas sobre el cabeza de familia (HH).

3.1.2 La entrevista semiestructurada

Esta herramienta de investigación se seleccionó como el mejor método para producir información centrada en el problema y la pregunta de investigación. El mantenimiento de la privacidad mediante el uso de este método, permite aportar detalles más profundos sobre las preocupaciones de salud de la familia, las necesidades, las barreras y los mecanismos de adaptación (Polit-O'Hara et al., 1999).

Se ha desarrollado un protocolo de entrevista semiestructurada a través del mapeo de las preguntas de investigación y la revisión de la literatura relacionada (Lee, 2016). La estructura incluía un conjunto de preguntas abiertas con preguntas de apertura, acceso y utilización de la asistencia sanitaria, barreras de acceso, estrategias de adaptación e impacto percibido.

3.1.3 Instrumentos de validación

Antes de la aplicación de los instrumentos de investigación, un comité de expertos comprobó la validez del contenido de ambas herramientas, incluidas las preguntas de la encuesta y de la entrevista semiestructurada.

Ambos instrumentos (elaborados en inglés) se tradujeron al árabe y se retro-tradujeron; la versión original y la retro-traducida se compararon para garantizar la equivalencia.

3.1.4 Digitalización del instrumento cuantitativo

El instrumento cuantitativo, la encuesta, que consta de 54 preguntas, se ha programado en el sistema Open Data Kit (ODK) utilizando el kit de herramientas de aplicación KOBO de código abierto. La utilización de ODK permitió implementar todas las funciones de comprobación de la calidad de los datos y ahorrar tiempo y recursos para obtener datos de mejor calidad, mejorar los datos completos y minimizar los esfuerzos de transferencia y limpieza de datos. Todas las preguntas se programaron según el flujo lógico de la encuesta. Durante la programación se utilizaron funciones de validación, restricción, condicionalidad, agrupación de preguntas, selección múltiple, omisión y repetición.

3.2 Fase piloto

Se obtuvieron todas las autorizaciones necesarias del ACNUR para realizar la recopilación de datos en un grupo de centros de servicios comunitarios. La selección del centro de servicios comunitarios frente al centro de atención sanitaria se decidió con el fin de garantizar la diversidad de los grupos objetivo en lugar de tener una muestra homogénea del grupo de solicitantes de atención sanitaria, lo que daría lugar a un sesgo de selección.

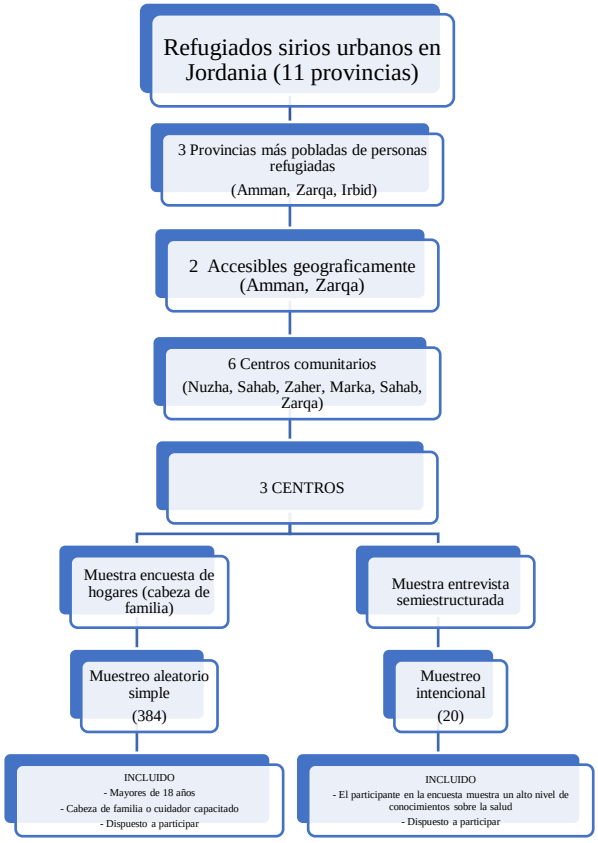
Los instrumentos del estudio se administraron en un centro a 11 participantes seleccionados aleatoriamente para las herramientas cuantitativas y 3 “cabeza de familia” accedieron a participar en la entrevista semiestructurada. En esta primera fase, se comprobó la claridad de los instrumentos. Se registraron todas las dificultades o ambigüedades detectadas, se valoró el momento de la administración y la adecuación de la gama de respuestas procedentes de las herramientas cualitativas revisadas.

La validación de los instrumentos, incluidas las pruebas de fiabilidad, se llevó a cabo durante la fase de pilotaje, en la que se observaron la comprensibilidad y la relevancia para las personas encuestadas, la identificación del impacto del entorno y las respuestas reactivas o las pautas de modificación de las mismas.

3.3 Selección de participantes

Se seleccionó a las personas participantes en los centros de refugiados de las zonas urbanas de las gobernaciones centrales. Los tres escenarios del estudio se seleccionaron convenientemente, la muestra de participantes para la parte cuantitativa se eligió al azar, mientras que el muestreo fue intencional para la parte cualitativa.

Figura II. Modelo de cuadro de selección de informantes



3.3.1 Criterios de inclusión/exclusión

Se consideraron elegibles todas las personas refugiadas de nacionalidad siria registradas fuera de los campos de refugiados oficialmente reconocidos en Jordania y que vivían en dicho país. Las personas entrevistadas debían tener más de 18 años y ser el cabeza de familia o un cuidador informado que viviera en la misma familia. Se excluyeron todos los refugiados no registrados que se hubieran trasladado fuera de Jordania o a campos de refugiados oficiales dentro de Jordania. También se excluyó a los menores de 18 años o a los miembros de la familia que no dieran su consentimiento.

3.3.2 Tamaño de la muestra y saturación teórica

Para calcular el tamaño de la muestra relacionado con las encuestas se utilizó un error tipo del 5% con un valor P < 0,05.

$$n = \frac{z^2 \times \hat{p}(1-\hat{p})}{\varepsilon^2}$$

$$n = \frac{1.96^2 \times 0.5(1-0.5)}{0.05^2} = 384.16$$

Casi se alcanzó el número previsto para la encuesta, en la que se entrevistó a 383 cabezas de familia, que representaban a 2.199 miembros totales.

Sobre el tamaño de la muestra para la entrevista, la bibliografía sugiere que 12 participantes es un tamaño de muestra adecuado (Onwuegbuzie & Collins, 2007), mientras que (Lee, 2016) en su investigación cualitativa entre refugiados alcanzó la saturación con 24 entrevistas. Para esta investigación se realizaron 20 entrevistas entre el grupo objetivo. Sin embargo, el punto de saturación se alcanzó con 18 entrevistas, pero se realizaron 2 entrevistas adicionales para garantizar variación geográfica suficiente en un estudio mixto.

3.3.3 Selección de la muestra

Para la realización de encuestas (vinculada a la producción de datos más cuantitativa), los participantes se seleccionaron a través de técnicas aleatorias simples en la sala de espera de los centros en los que se llevó a cabo el estudio. En el caso de las entrevistas, la selección de las personas participantes se realizó de manera intencional entre los participantes de la anterior muestra (es decir, de entre quienes hubieran realizado la encuesta), garantizando que existiera diversidad y teniendo en cuenta que estas tuvieran buena expresión, tuvieran un conocimiento significativo de la situación de salud familiar y, por supuesto, mostraran disposición a continuar con la investigación.

3.4 Proceso de producción de datos

La producción de datos para la parte cuantitativa se realizó entre 387 participantes utilizando una tablet con la herramienta KOBO instalada como herramienta programada para realizar 54 conjuntos de preguntas. Se obtuvo el consentimiento de las personas participantes al principio de cada encuesta. 383 participantes dieron su consentimiento mientras que 4 no dieron su consentimiento y abandonaron la investigación.

Los datos se recopilaron entre el 29 de noviembre de 2019 y el 16 de enero de 2020 durante 22 días laborables en los tres lugares seleccionados.

Por otro lado, se realizaron entrevistas semiestructuradas a 20 participantes seleccionados de entre las personas que realizaron la encuesta. Se obtuvo el consentimiento tanto para las entrevistas como para la grabación de las mismas.

Las entrevistas duraron entre 12 y 40 minutos, todos los participantes eran hablantes de árabe, se siguió la guía de entrevista durante las entrevistas con preguntas abiertas, preguntas de sondeo y preguntas de seguimiento.

3.5 Consideraciones éticas

La comisión de evaluación de planes de investigación del Instituto de Migraciones (Universidad de Granada) -al que se adscribe el programa de doctorado en el que se enmarca esta tesis-, revisó los protocolos del estudio y aprobó su realización.

Se obtuvo una carta de apoyo del propio Instituto de Migraciones de la Universidad de Granada y ACNUR aprobó que la recogida de datos se realizara en los centros comunitarios gestionados por sus socios nacionales locales.

La encuesta no ha supuesto ningún riesgo directo para los participantes. Es importante destacar que los datos de produjeron en los lugares de prestación de servicios (centros comunitarios), sin visitas domiciliarias. No se recogieron muestras, ni información sensible. Además las personas participantes fueron entrevistadas en la sala de espera o en un espacio especial del mismo centro (por consideraciones de privacidad).

3.6 Fiabilidad de los métodos

Con el objetivo de aumentar la fiabilidad del estudio, en la investigación se ha cuidado que en todo momento se preservaran las normas éticas durante la producción y análisis de datos. La encuesta se modificó tras la consulta con la comunidad y el protocolo de entrevista fue revisad por tres personas expertas. Todas las herramientas se ajustaron o desarrollaron en consonancia con el marco conceptual. Como ya se ha mencionado, la muestra de la encuesta se realizó de forma aleatoria, y las personas que realizaron las entrevistas semiestructuradas se seleccionaron de forma intencionada garantizando la máxima variación de perfiles. Finalmente, el hecho de que los lugares en los que se llevó a cabo gran parte de la investigación fueran los centros comunitarios, y no en un centro sanitario, garantiza que los perfiles sean heterogéneos y los discursos sobre las necesidades sanitarias y los comportamientos, diversos.

3.7. Técnicas de análisis

En referencia a la metodología de investigación adoptada (Método Mixto convergente), se ha llevado a cabo un análisis de datos completamente aislado para los conjuntos de datos cualitativos y cuantitativos.

3.7.1 Análisis descriptivo y relacional

Una vez finalizado el proceso de producción de datos cuantitativos, los datos se extrajeron de la base de datos KOBO en formato Excel de Microsoft. Se verificaron, depuraron y corrigieron los datos y se detectaron pequeñas omisiones. Por ejemplo, un caso que no se detectó como cabeza de familia y nueve entradas erróneas detectadas relativas al año de nacimiento introducido en lugar de la edad.

Se elaboraron todos los datos estadísticos descriptivos y se hizo chi-cuadrado para hallar relaciones entre algunas variables. Se utilizó el programa Statistical Package for the Social Sciences (SPSS) versión 25.0 para el análisis descriptivo y el análisis de relaciones.

3.7.2 Técnica de análisis temático

En este estudio se ha seguido una guía de uso común para el análisis temático, que fue desarrollada por Braun y Clarke (Braun & Clarke, 2006) y que actualmente es ampliamente utilizada por la investigación cualitativa (Clarke & Braun, 2017). El método de análisis pasó por seis fases estándar que incluyen la familiarización, la codificación inicial o generación de categorías, la búsqueda y revisión de los temas, la definición y denominación de los temas y la producción del informe de los hallazgos.

Por último, los resultados del conjunto de datos cualitativos y cuantitativos se compararon por áreas temáticas utilizando la comparación en paralelo en la discusión para encontrar equivalencias, contradicciones o correlaciones que nos permitieran interpretar los

comportamientos de acceso a la salud de las personas refugiados, las barreras encontradas y sus formas de adaptarse para satisfacer sus necesidades de salud, así como el impacto de estas.

Capítulo 4: Resultados

En este capítulo se presentan las características demográficas básicas de los sujetos de estudio. A continuación, se exploran los temas construidos a partir de los datos analizados; las áreas temáticas incluyen el acceso y la utilización, las barreras de acceso, las estrategias de adaptación y el impacto.

Nuestros hallazgos demográficos sugieren que los refugiados sirios en Jordania tienen familias numerosas con un tamaño medio de 5,7 personas y una distribución de género casi igual entre hombres y mujeres. El hogar encabezado por una mujer, constituye casi una cuarta parte (24,5%) de los hogares encuestados. La distribución por edades muestra una estructura comunitaria joven, con más de un 70% de personas menores de 30 años. Además, una proporción significativa (57%) no tiene estudios y un porcentaje mínimo (2,3%) son titulados y/o universitarios. La mayoría de los refugiados (77,6%) proceden de cuatro provincias (Damasco, Alepo, Dara'a y Homs), una parte significativa de ellos vivía en zonas rurales de Siria (36,2%) y actualmente están asentados en centros urbanos de Jordania (96,1%).

El análisis reveló un excelente nivel de conocimiento entre los refugiados sobre sus posibilidades de acceso subvencionado (100%), y un nivel satisfactorio de conocimiento sobre los lugares a los que tienen acceso (79,4%). El 86,1% de los refugiados sabía que sus hijos tenían acceso gratuito al servicio de vacunación, así el 61,1% recibió vacunas en Jordania, la mayoría de ellos (97%) en centros sanitarios públicos.

El 43,5% de las mujeres en edad reproductiva habían estado embarazadas en los dos años anteriores. En este sentido, la tasa de utilización de los servicios de atención prenatal se situaba en la media, con un bajo nivel de atención prenatal completa (21%). El nivel de concienciación

sobre la disponibilidad de servicios de planificación familiar era inferior a la media, con una baja tasa de utilización (sólo el 19,8% intentaron obtenerlos).

La prevalencia de las enfermedades crónicas entre el grupo encuestado era elevada (28,6%); siendo las enfermedades más prevalentes la hipertensión, el asma y la diabetes.

En más del 88% de los hogares de las personas encuestadas, necesitaron asistencia sanitaria el mes anterior. Más del 50% acudió a servicios privados (hospitales, clínicas y farmacias), seguidos de los servicios públicos de atención primaria; y sólo el 20,4% acudió a clínicas u hospitales públicos. Casi el 85% de las personas refugiadas pagó por los servicios recibidos, y la mayoría pagó menos de 100 dinares jordanos (130 euros aproximadamente).

Por otro lado, los participantes en la parte cualitativa identificaron sus necesidades sanitarias entre un amplio conjunto de cuestiones, entre las que se incluyen las enfermedades crónicas, la atención sanitaria de urgencia, la hospitalización o la atención al paciente, la salud psicológica y mental, la rehabilitación y la discapacidad, la atención infantil, la vacunación, la atención a las personas mayores y las necesidades sanitarias de las mujeres. Además, el análisis de las necesidades se corresponde con el análisis de los comportamientos de búsqueda y sugiere un grupo de subtemas que incluyen la política de acceso, las capacidades financieras, las prácticas, la concienciación y las creencias.

El análisis de las barreras de acceso muestra la existencia de limitaciones diversas con amplias variaciones en función de la disponibilidad y asequibilidad de los servicios para cada grupo de población. Así se ha valorado la vacunación infantil, las necesidades de salud de la mujer y de planificación familiar, las necesidades relacionadas con enfermedades crónicas y las necesidades mensuales de salud del hogar. Sin embargo, la barrera de acceso más señalada fue el coste de determinados servicios, y fue especialmente significativa entre las personas que padecían enfermedades crónicas (23%). Por otra parte, entre las personas entrevistadas, se

identificaron varias barreras temáticas comunes en distintos hogares, como el coste, las políticas de acceso, la disponibilidad de servicios, la discriminación, la concienciación, la distancia, la calidad del servicio y el tiempo de espera.

Los datos sugieren que el 53% de los participantes en la encuesta notaron un aumento de los costes sanitarios. La mayoría de ellos identificaron la imposibilidad de visitar al médico o de poder permitirse la medicación necesaria y señalaron la reducción de la capacidad para satisfacer otras necesidades de subsistencia como el principal impacto del aumento de los costes sanitarios. Además, se detectó que pedir dinero prestado o utilizar los ahorros era la principal estrategia de adaptación (77,6%) y, en menor medida, casi la mitad de los participantes recurrieron a los servicios gratuitos de las ONG, redujeron o suspendieron la medicación o utilizaron medicinas alternativas.

Por otra parte, en el análisis cualitativo se han identificado 11 subtemas ligados a las diversas estrategias de adaptación que fueron utilizadas por una o más familias, incluyendo la automedicación, el uso de medicina alternativa, el retraso en la búsqueda de atención, la interrupción o reducción de la medicación y la búsqueda de servicios gratuitos. Otro grupo de estrategias no relacionadas directamente con la salud, incluían reducir el consumo de medios de subsistencia básicos, pedir dinero prestado, recurrir al ahorro, recaudar donativos, realizar trabajos ilegales, recurrir a otros medios de subsistencia o incluso planificar el traslado de residencia.

Por último, el impacto de las estrategias adoptadas fue una cuestión específica abordada únicamente a través de la entrevista. Entre las personas entrevistadas, se indica que las familias han detectado muchos riesgos y perciben su impacto directo en su estado de salud individual. Además se detecta un impacto indirecto derivado de una consecuencia relacionada con sus necesidades sanitarias o acontecimientos sanitarios anteriores. En la mayoría de las entrevistas

se detectaron cuatro temas destacables y recurrentes: las consecuencias psicológicas y mentales, el deterioro del estado de salud, las consecuencias jurídicas y, por último, la influencia negativa en otras necesidades de subsistencia.

Capítulo 5: Debate y conclusiones

5.1 Características demográficas

Los perfiles demográficos de las personas participantes en este estudio coinciden con las características generales de la población siria. El tamaño medio de la familia es alto, (5,7 miembros), y puede compararse con las encuestas de salud anteriores que ha llevado a cabo ACNUR y con los resultados de las Encuestas de Salud (EDS) de 2017 (Departamento de Estadística/Jordania y el ICF, 2019; ACNUR, 2019c). El tamaño medio de la familia también se corresponde con la alta tasa de fertilidad (Departamento de Estadística/Jordania y el ICF, 2019). Además, el bajo nivel de educación reglada resulta ser dominante, lo que se confirma por un menor nivel de asistencia escolar en los resultados de las encuestas demográficas y de salud (Departamento de Estadística de Jordania y el ICF, 2019). Se encontró que la distribución por género y edad estaba igualada y coincidía con los informes estadísticos globales (Nations, 2019). La proporción de hogares encabezados por mujeres fue alta, del 24,5 %, pero se considera normal entre las mujeres que huyen de zonas de conflicto. Esto supone que debe plantearse una protección adicional y requieren servicios de protección especiales para estos grupos vulnerables.

Se ha registrado un enorme cambio en la forma de vida entre Siria y Jordania, donde la mayoría de los que vivían en zonas rurales en su país de origen se han trasladado a zonas urbanas de Jordania. El cambio en las condiciones de vida plantea nuevos retos para las familias de refugiados y puede requerir una atención especial para adaptar estrategias de integración en lo que respecta, por un lado, a los servicios sociales, políticos, económicos y civiles, como los

servicios sanitarios y educativos (Norman, 2021); y por otro, supone un reto para la capacidad de los sistemas urbanos que deben absorber el impacto y satisfacer las crecientes demandas (Tuncay et al., 2022).

5.2 Comportamientos de acceso y uso de la sanidad.

Los refugiados mostraron un excelente nivel de conocimiento sobre los servicios disponibles y los "privilegios" que tienen como personas refugiadas cuando el 100% confirmó que la posesión de los documentos requeridos permite el acceso subvencionado a los servicios sanitarios públicos, y el 86,1% sabía que se proporciona cobertura de vacunación gratuita. Este excelente nivel de conocimiento sobre la política de acceso y la disponibilidad de servicios sanitarios, está relacionado con la larga estancia de esta población en el territorio de acogida (Schober & Zocher, 2022). Los resultados cualitativos mostraron que los servicios gratuitos, como la vacunación y la atención prenatal preventiva, preocupaban poco a las familias refugiadas en comparación con otros servicios que debían pagar de su bolsillo. Este comportamiento de acceso óptimo cuando los servicios son gratuitos, está respaldado por los resultados de otros estudios realizados en Irán y Turquía (Kiani et al., 2021; Tuncay et al., 2022).

Cuanto se preguntó sobre los servicios de atención prenatal y planificación familiar, se pretendía evaluar las necesidades y los comportamientos de las mujeres en materia de acceso a la atención sanitaria en este sentido. La alta tasa de fecundidad notificada reflejaba la elevada proporción de mujeres embarazadas en edad reproductiva (Departamento de Estadística/Jordania y CIF, 2019; Sieverding et al., 2019). Además, la alta tasa de fecundidad puede relacionarse con el escaso conocimiento de la disponibilidad de planificación familiar, así como la baja aceptación entre los que trataron de obtener anticonceptivos. En este caso, la regla de la gratuidad de los servicios y el buen nivel de acceso no se aplicó a los servicios de

planificación familiar, lo que sugiere que puede encontrarse una barrera adicional más allá del coste de los servicios en este sentido, lo que sugiere que se debe ir más allá de este criterio económico para entender estos comportamientos (Inci et al., 2020).

Las enfermedades crónicas fueron una de las necesidades sanitarias destacadas entre los refugiados sirios debido a su alta prevalencia (Naja et al., 2019). Tanto los hallazgos cuantitativos como cualitativos abordaron las afecciones crónicas como una de las necesidades de acceso a la atención sanitaria más apremiantes que requieren apoyo continuo y una amplia gama de servicios sanitarios.

Por otra parte, la evaluación cualitativa de las necesidades sanitarias reveló muchas más necesidades que los resultados de la evaluación cuantitativa estándar centrada en tres aspectos (salud de la mujer, salud infantil y enfermedades crónicas). Por ejemplo, la atención sanitaria de urgencia y la hospitalización, se abordaron como una necesidad apremiante que coincide con los resultados de otras investigaciones que detectaron la atención médica de urgencia y crisis que requieren hospitalización como una de las principales necesidades sanitarias que afectaron a una parte significativa de la comunidad de refugiados (Assi et al., 2019; Ay et al., 2016).

Entre la población infantil refugiada, los resultados cuantitativos y cualitativos se corresponden con los hallazgos de la literatura científica mundial, donde se expresa que la mayoría de las necesidades de salud en la infancia se dirigen hacia los servicios de vacunación y el tratamiento de enfermedades transmisibles, y en menor medida se dan condiciones crónicas que se relacionan con discapacidades en la primera infancia, como la discapacidad física y visual (Ay et al., 2016; Harkensee et al., 2021; Hjern & Kling, 2019).

La salud mental y las necesidades psicosociales se encontraban entre las necesidades significativas detectadas. Los trastornos notificados fueron bajos, menos del 1%, lo que se considera muy bajo en comparación con otras encuestas (ACNUR, 2019c, 2021b). Mientras

que el análisis cuantitativo plantea una preocupación significativa entre las familias de los refugiados hacia los problemas psicológicos (17 de 20 familias). El alto nivel de trastornos psicológicos y mentales es central entre los refugiados, y específicamente entre aquellos que llegan de un contexto inmerso en el conflicto bélico (Hunter, 2016). Esta importante vulnerabilidad ha aumentado las necesidades de servicios de salud mental y atención sanitaria psicosocial. Sin embargo, la brecha entre los que informaron de problemas de salud mental y los que expresan varios tipos de desafíos psicológicos puede sugerir que el estigma en torno a los trastornos mentales siga siendo una barrera y dificulte mejores comportamientos de búsqueda de apoyo sanitario (Al-Soleiti et al., 2021).

Aun reconociendo que la población refugiada de edad avanzada se encuentra una situación más desfavorecida, son más vulnerables y tienen más barreras que afectan a sus comportamientos de búsqueda (Kristiansen et al., 2016; Strong et al., 2015), en este estdio las necesidades de salud de los refugiados de edad avanzada se han abordado en el marco de la gestión de las condiciones de salud crónicas y los aspectos especiales de las necesidades de atención personal, lo que requiere una atención especial en una programación humanitaria a largo plazo.

Anteriores estudios han destacado la alta prevalencia de la discapacidad (22,9%) entre los refugiados sirios en Jordania, debido a la naturaleza conflictiva de la crisis (Humanity et al., 2018). Este hallazgo es consistente con esta investigación, ya que el 20% de las personas entrevistadas indicaron tener al menos una persona discapacitada en su unidad familiar. Las familias de refugiados consideran que la discapacidad supone una necesidad acuciante debido a lo duradero de la situación y a las excesivas exigencias sanitarias y de otros medios de subsistencia que conlleva (Polack et al., 2021).

La evaluación mensual del acceso, muestra una elevada demanda de asistencia sanitaria entre la población refugiada, ya que el 88,5 % de las personas entrevistadas indicaron que en sus

hogares necesitaron asistencia sanitaria en dicho periodo. Esta elevada demanda de asistencia sanitaria refleja un mayor uso de los servicios sanitarios entre los refugiados en comparación con las comunidades de no refugiados (Kiss, Pim, Hemmelgarn y Quan, 2013), así como la elevada tasa de aceptación, que se ve respaldada por otros estudios y encuestas (Doocy et al., 2016; ACNUR, 2019c, 2021b).

El análisis de los comportamientos de utilización, mostraron una clara preferencia por el uso de proveedores privados. Por otra parte, los hallazgos cualitativos aportan explicaciones en esta dirección, ya que algunas personas entrevistadas mencionaron que su conocimiento sobre la política de acceso subvencionado a la sanidad pública era un motor para buscar servicios allí (Tomkow et al., 2020). Además, la política de acceso a los medicamentos llevó a algunos refugiados a adquirir sus medicamentos directamente en farmacias privadas utilizando el método de automedicación, ya que la norma lo permite.

Tanto el desconocimiento de la política de acceso a la sanidad pública (en cuanto a saber qué servicios son subvencionados o no), como la política de acceso a los medicamentos, contribuyeron a la demanda importante en el uso de proveedores privados, lo que aumentó el gasto sanitario e hizo que el coste fuera una de las principales barreras que afectaron a la accesibilidad de los refugiados a los servicios.

La capacidad económica y el coste de la atención fueron otros factores que influyeron en los comportamientos de búsqueda de atención sanitaria. Con capacidades financieras comprometidas, algunos refugiados buscaron atención sanitaria gratuita o subvencionada (Douangmala et al., 2012); otros se automedicaron, retrasaron la atención o recurrieron a la medicina tradicional para reducir el coste de la atención sanitaria, lo que coincide con los resultados de otras investigaciones (Ojeleke et al., 2020). Además, enfrentarse a barreras a

través de la experiencia previa fue otro factor impulsor de los comportamientos de búsqueda (Tomkow et al., 2020).

Por último, las creencias desempeñaron un papel importante en la definición de las conductas de búsqueda de atención sanitaria. Por ejemplo, reconocer el beneficio de buscar asistencia sanitaria o la gravedad de no buscar atención para una afección, fue otro factor impulsor de las conductas de búsqueda (Andersen, 2008; Champion y Skinner, 2008).

5.3 Barreras de acceso a la atención sanitaria

Los hallazgos muestran un amplio conjunto de barreras de acceso experimentadas por los refugiados sirios que fueron similares a las reportadas por muchas otras investigaciones y revisiones sistemáticas entre la población refugiada a nivel mundial (Antonipillai et al., 2017; Parajuli & Horey, 2019).

Así los datos analizados muestran una variación significativa en la prevalencia de las barreras entre los diferentes grupos objetivo. Por ejemplo, las barreras de acceso fueron mínimas entre la población infantil para el acceso a la vacunación o entre las mujeres embarazadas para la atención prenatal y la planificación familiar, mientras que fueron significativas entre los pacientes con enfermedades crónicas y los que requieren acceso mensual.

El grupo de barreras señaladas entre la población infantil y las mujeres fueron todas mínimas y quedó claro que la política de acceso gratuito adoptada para la vacunación, la atención prenatal preventiva y la planificación familiar, han tenido un impacto positivo en el acceso y la utilización de los servicios sanitarios entre estas poblaciones de personas refugiadas (Kohlenberger et al., 2019). Por otro lado, las barreras más significativas a las que se enfrentan quienes requieren acceso mensual, se debieron principalmente al coste de los servicios, las preferencias de los pacientes cuando no les gusta el proveedor del servicio y el conocimiento sobre dónde acudir.

El aumento de la demanda de asistencia sanitaria debido al acceso frecuente incrementa los gastos, por lo que el coste se convirtió en la principal barrera para este grupo (Strong et al., 2015). Sin embargo, la larga estancia de los refugiados en Jordania puede sugerir que existe un buen nivel de conocimiento sobre los servicios sanitarios disponibles y la política de acceso, pero la frecuente fluctuación de la política de acceso puede considerarse una barrera que dificulta el acceso a los servicios cuando se necesitan.

Los hallazgos cualitativos apoyaron claramente las barreras de acceso indicadas por los hallazgos cuantitativos, pero también trajeron a colación un nuevo conjunto de limitaciones de acceso: como las barreras administrativas relacionadas con la documentación, la disponibilidad de servicios, la discriminación en las disposiciones, el tiempo de espera o la proximidad de los proveedores –cuestiones avaladas por otras investigaciones (Parajuli & Horey, 2019)-. En este sentido nos parece importante destacar que algunas de las barreras de acceso detectadas por otras investigaciones, no han supuesto problemas para los refugiados sirios en Jordania debido a la proximidad sociocultural con el país de asilo, como son las barreras lingüísticas y las barreras culturales (Asgary & Segar, 2011; Kohlenberger et al., 2019).

Por último, el análisis cualitativo reveló algunas cuestiones que no se pretendía detectar cuando algunas personas refugiadas describieron algunos facilitadores de su acceso a la asistencia sanitaria. Estos facilitadores se consideraron antagonistas de las barreras de acceso, como la asequibilidad de los costes, la buena calidad de los servicios recibidos y el trato correcto e igualitario. Estos hallazgos pueden sugerir la compensación de las barreras encontradas por algunos refugiados debido a la presencia de dichos facilitadores.

5.4. Estrategias de adaptación

Las estrategias de adaptación identificadas en la evaluación cuantitativa resultaron estar relacionadas con el aumento del coste de la atención sanitaria denunciado por más de la mitad

de la población encuestada. Por ello el impacto del aumento del coste de la atención sanitaria debe tenerse en cuenta a la hora de explicar el contexto de las estrategias de adaptación que se despliegan.

La falta de recursos económicos ha tenido un impacto directo en la necesidad de visitar a un médico, obtener medicación o acceder a otros procedimientos médicos, por lo que tiene un impacto indirecto en las necesidades no médicas como el alojamiento, la alimentación o la educación formal. La detección de estrategias de adaptación que se extienden más allá de la satisfacción de las necesidades sanitarias a otro medio de subsistencia era una de las principales preguntas de investigación que buscaban respuesta, por lo que el grupo de estrategias de adaptación notificado en la evaluación cuantitativa estaba mínimamente respaldado por la bibliografía. Sin embargo, ahorrar o pedir dinero prestado fue la estrategia más utilizada, seguida de la búsqueda de servicios gratuitos, la reducción o interrupción de la medicación y el uso de medicina alternativa. Estos hallazgos solo fueron respaldados por una evaluación realizada por el Comité Internacional de Rescate (IRC) en 2018 (IRC, 2019).

Nuestro análisis cualitativo reveló estrategias de adaptación directas e indirectas más profundas, además de respaldar todas las conclusiones detectadas en el análisis cuantitativo. Las nuevas estrategias de adaptación detectadas en el análisis cualitativo apoyaron al grupo de otras seis estrategias de adaptación estándar.

Las estrategias de adaptación encontradas se clasificaron como estrategias de adaptación directa, si afectan directamente al ámbito de la salud, e indirectas si su impacto está relacionado con otras dimensiones de la vida de las personas refugiadas.

Las estrategias de adaptación directas detectadas fueron: buscar asistencia sanitaria gratuita, retrasar la búsqueda de asistencia, dejar de tomar medicamentos, utilizar medicina alternativa y automedicarse. Por otro lado, las estrategias de adaptación indirectas incluían: pedir dinero

prestado, utilizar los ahorros, recaudar donaciones, realizar trabajos ilegales, desplazarse o priorizar entre la salud y otras necesidades de subsistencia.

Todas las estrategias de adaptación detectadas resultaron ser negativas y/o tener un impacto negativo en la salud y otros medios de subsistencia. Nabulsi y su equipo corroboraron algunas de nuestras conclusiones en una evaluación cualitativa realizada entre la población de refugiados sirios en el Líbano. En este trabajo descubrieron que los refugiados se adaptaban al empleo informal, al trabajo infantil, a la acumulación de deudas y a las malas condiciones de vida, para satisfacer todas las necesidades familiares, incluida la salud (Nabulsi et al., 2020).

Así, cuando la escala de promoción de la salud de los refugiados es baja y sus resultados sanitarios son deficientes en comparación con los de la población nacional-local que tienen sistemas de bienestar establecidos (Alzoubi et al., 2021), entonces es más importante comprender cómo se comportan los refugiados cuando se enfrentan a la escasez de sus medios de subsistencia, incluida la salud. El análisis causal de las causas fundamentales de estos comportamientos reveló que no existe un razonamiento o conexión clara entre la escasez de medios de subsistencia y la de salud. Además, la relación causal parece muy difícil de detectar y la escasez de necesidades básicas dio lugar a muchas estrategias de adaptación que se interrelacionan cuando las familias deciden dar menos prioridad a una cosa que a otra, cambiar los recursos de una necesidad a otra, o utilizar estrategias indirectas negativas como el trabajo infantil para satisfacer las necesidades. Sin embargo, la razón común que se encontró en todas las necesidades de subsistencia, incluida la salud, fueron las dificultades económicas. Torlinska y su equipo estudiaron la correlación de las dificultades económicas en un estudio longitudinal entre refugiados y confirmaron que las dificultades económicas están correlacionadas con el bienestar físico y mental deficiente (Torlinska et al., 2020).

En conclusión, hay tres escenarios que conducen a una toma de decisiones negativa cuando la población refugiada se enfrenta a un reto para cubrir sus necesidades sanitarias. El primero, cuando el cabeza de familia tiene un problema de salud que limita su capacidad de obtener ingresos para cubrir sus necesidades sanitarias y otros medios de subsistencia, como en el caso de las personas discapacitadas o con problemas de salud en general. El segundo escenario se da entre aquellos que sufren condiciones de salud que requieren recursos financieros adicionales para estabilizar su estado de salud, como los que tienen un miembro o miembros de la familia que sufren de enfermedades crónicas o de larga duración. Y el tercero es el grupo que tiene otras necesidades básicas urgentes que se priorizan sobre las necesidades sanitarias, como la vivienda, la alimentación y la educación, de modo que las necesidades relacionadas con la salud se minimizan o se descuidan.

5.5 Impacto de las estrategias de adaptación

El impacto de las estrategias de adaptación fue la última pregunta de la investigación que se centró específicamente en el conocer los efectos de los comportamientos de adaptación seguidos por los refugiados para satisfacer sus necesidades sanitarias. Este asunto se abordó mediante las entrevistas, en las que se apuntaba a la valoración negativa de estas estrategias que han tenido un impacto directo o indirecto en el estado de salud de las personas y las familias.

Los principales factores predisponentes en el deterioro general del estado de salud de las personas refugiadas, tienen que ver directamente con el despliegue de estrategias –que se consideran de riesgo- como el uso de la medicina tradicional, la reducción de las frecuencias de búsqueda de atención, la reducción del uso de medicamentos con el fin de aminorar el costo de la atención médica o priorizar otras necesidades sobre la salud.

Los refugiados sirios en Jordania, según las políticas de acceso, tienen menos privilegios de acceso en comparación con la población nacional, ya que la mayoría de los ciudadanos jordanos

tienen algún tipo de seguro médico (Departamento de Estadística/Jordania & ICF, 2019). Estas discrepancias en el acceso magnifican el impacto en el estado de salud. Schneider y su equipo descubrieron que los solicitantes de asilo acceden menos a prestaciones sanitarias y tienen una probabilidad mayor de informar de un mal estado de salud en comparación con la población nacionales (Schneider et al., 2015).

Cuando las personas refugiadas restan prioridad a las necesidades médicas, creen que esto podría reducir el coste de la atención, pero no siempre es así. Por ejemplo, Wal confirmó que la detección precoz de enfermedades crónicas es sin duda más rentable tanto para los refugiados como para el sistema sanitario de acogida (Wal, 2015), lo que también ha sido confirmado por Daynes, que descubrió que no abordar las necesidades de enfermedades no transmisibles (ENT) entre los refugiados europeos –población delimitada en su estudio- conlleva que aumenten las necesidades humanas y económicas (Daynes, 2016). Otro estudio de revisión por pares confirmó, desde una perspectiva económica, que una mejora del acceso de las personas inmigrantes a la asistencia sanitaria podría reducir los costes mediante la mejora de la prevención primaria (Nandi et al., 2009). En conclusión, abordar las necesidades sanitarias de los refugiados mejorará los resultados sanitarios y reducirá el coste de la demanda social y sanitaria, protegerá los beneficios de la salud pública a escala local y mundial y contribuirá a los resultados de desarrollo a largo plazo (Gushulak et al., 2009).

Por otro lado, las consecuencias psicológicas y mentales aparecieron como un tema significativo, la mayoría de los estudios que analizaron los aspectos psicológicos entre los refugiados encontraron que sufren de un mayor nivel de angustia psicológica y trastornos, ya sea a causa del viaje de refugio (Van Loenen et al., 2018), a las malas condiciones de vida y la pobreza que viven debido al desplazamiento y/o a ser víctima de la violencia en el país de asilo (Daynes, 2016).

Además, poner otras necesidades de subsistencia en una situación crítica, ya sea para ahorrar algo para cubrir las necesidades de salud o al revés, tendrá un impacto importante en las necesidades no cubiertas. Este hallazgo fue apoyado por otras investigaciones (Nabulsi et al., 2020) y puede indicar la variación en las estrategias de adaptación adoptadas y la forma en que las familias priorizan las necesidades entre sí (Torlinska et al., 2020). Sin embargo, cuando a los refugiados les resulta muy difícil satisfacer las necesidades sanitarias, pueden autolimitar su acceso a la salud para evitar incurrir en más gastos y aumentar la presión sobre las necesidades financieras (Bozorgmehr y Razum, 2015), esta escasez hace que vuelvan a priorizar entre la salud y otras necesidades de subsistencia; por lo tanto, las consecuencias ilimitadas pueden extenderse a otros medios de subsistencia. Por último, las consecuencias legales a las que se enfrentan los refugiados debido a las deudas pendientes es un tema que no debemos pasar por alto. Las deudas tienen su origen en necesidades médicas, como facturas hospitalarias pendientes de pago u otras necesidades de vivienda, como el alquiler, o a veces en lesiones laborales –que se producen en situaciones de ilegalidad- que no están cubiertas por ningún régimen de seguros.

Las consecuencias legales a las que se enfrentan, como la detención por deudas pendientes, limitan la capacidad de la familia para obtener los recursos necesarios debido a la detención de los miembros generadores de ingresos. Además, endeudarse y ser objeto de medidas disciplinarias legales, incluida la detención, puede predisponer a algunos refugiados a aceptar trabajar en condiciones laborales muy precarias y en trabajos ilegales; las mujeres pueden ser objeto de una mayor violencia y las condiciones pueden llegar a la trata y enfrentarse a condiciones laborales cada vez peores (Murray, 2018). Además, para aquellos que están atrapados en una enorme deuda, la migración posterior puede ser la única opción que les quede para escapar de esta situación y abandonar el país de asilo para dirigirse al país de origen o, habitualmente, a un tercer país. La migración impulsada por la deuda aumenta los riesgos y

normalmente conduce a la separación familiar, lo que supone un riesgo de protección adicional para los miembros vulnerables, como las mujeres y los niños (Heidbrink, 2019).

5.6. Limitaciones

Esta investigación reveló algunas debilidades y limitaciones debidas a varias condiciones contextuales. Durante la fase de producción de datos surgieron consideraciones éticas relacionadas principalmente con la vulnerabilidad de los sujetos y mi identidad como trabajador humanitario, que de un modo u otro influyeron en el proceso de consentimiento debido a la mayor vulnerabilidad de los participantes y sus expectativas.

Además, se hizo hincapié en el uso de la técnica aleatoria simple en la muestra cuantitativa, pero las personas a las que se entrevistó se seleccionaron mediante una muestra intencionada a partir de los participantes de la muestra cuantitativa.

Por otra parte, la muestra se eligió a partir de la población usuaria en tres centros comunitarios que acogen principalmente a refugiados urbanos y que se encuentran en dos gobernaciones únicamente, por lo que esta acotación (en cuanto a contexto) puede limitar la variación máxima que nos propusimos para este estudio.

Por último, la naturaleza interrelacionada de las vulnerabilidades de los refugiados, incluida la sanitaria, dificultó la comprensión de cómo la acumulación de vulnerabilidades puede interpretarse entre otros factores que facilitan el acceso a la sanidad y que no se han tenido en cuenta en este estudio.

5.7. Implicaciones y recomendaciones

Esta tesis tiene implicaciones para los profesionales sanitarios, los proveedores, las instituciones, las organizaciones humanitarias, los países de acogida y los responsables de las políticas sanitarias. Dada la experiencia actual con múltiples crisis de refugiados de larga

duración, las crisis de refugiados son normalmente prolongadas, más que de corta duración; el refugiado medio permanece como tal durante años (Loescher & Milner, 2006) y la integración en la comunidad local es una prioridad. Por lo tanto, la comprensión de las necesidades de salud de los refugiados, los comportamientos de utilización, las barreras y la identificación de su impacto en la propia población, las comunidades de acogida y los países, es esencial para tener mejores resultados de salud y reducir al mínimo las disparidades que surgen debido a las diferentes condiciones contextuales (Lima Junior et al., 2022).

Se espera que los profesionales sanitarios comprenderán mejor las necesidades sanitarias de los refugiados y puedan centrarse más en aspectos vulnerables. Por otra parte, la identificación de las necesidades sanitarias específicas de esta población ayudará a las instituciones sanitarias locales a estar mejor preparadas en términos de infraestructura, logística y personal. Además, las organizaciones internacionales y humanitarias que participan en las intervenciones a corto- y largo- plazo para los refugiados durante la crisis podrán elaborar intervenciones basadas en pruebas que se centren en los puntos débiles del comportamiento de los refugiados, minimizando o eliminando barreras, abogando por un mejor acceso a los servicios sanitarios esenciales y movilizando los recursos necesarios.

Los países de acogida pueden identificar mejor las perspectivas de respuesta sanitaria en lugar de depender de planes de contingencia, por lo que las necesidades identificadas y la variación contextual les ayudarán a movilizar recursos de forma inteligente, abogando por el apoyo de los donantes, desarrollando políticas de acceso sanitario y minimizando el impacto en el sistema sanitario público y la estabilidad de los indicadores de salud pública.

Por último, se recomienda que todos los implicados en la respuesta, incluidas las organizaciones humanitarias y los gobiernos locales, sigan estudiando los comportamientos de búsqueda de

atención sanitaria, las necesidades sanitarias de los refugiados, la identificación de obstáculos y la medición del impacto de estos comportamientos en el sistema sanitario público.

5.8. Conclusiones

La tesis propuesta se ha centrado en indagar sobre el acceso a la atención sanitaria y su utilización entre los refugiados sirios que viven en un entorno urbano, explorando sus necesidades, comportamientos de utilización, barreras de acceso, estrategias de adaptación e impacto de las mismas.

Las necesidades sanitarias identificadas, entre las que se incluyen la atención sanitaria de urgencia, la hospitalización, la atención mental, la rehabilitación, la vacunación, la atención a las personas mayores, la atención a la infancia, la atención a las enfermedades crónicas y la atención a las mujeres, se encontraban dentro del grupo de servicios estándar que necesita cualquier ser humano. La variación detectada en la comunidad de refugiados fue un poco diferente a la de la comunidad local debido a los factores predisponentes que hicieron que algunas necesidades sanitarias fueran más urgentes.

La conducta de búsqueda de asistencia sanitaria se vio afectada por varios factores, tal como había detectado anteriormente el modelo de Gelberg-Andersen. Las políticas de acceso, la capacidad económica, los conocimientos sobre las prácticas individuales y las creencias, fueron los principales factores que influyeron en los comportamientos de búsqueda, sin que se detectara su impacto como facilitador o barrera para la búsqueda de asistencia sanitaria

Por otro lado, entre las barreras identificadas se encuentran la política de acceso, la disponibilidad de servicios, la discriminación, el tiempo de espera, la calidad de la asistencia sanitaria, la distancia, la concienciación y, sobre todo, el coste económico. Dichas barreras tuvieron un nivel de impacto variado en los refugiados, dependiendo de sus factores contextuales e individuales.

Las barreras identificadas normalmente obligaban a los refugiados a adoptar varias estrategias de adaptación para satisfacer sus necesidades sanitarias. Algunas de estas estrategias de adaptación no eran perjudiciales, pero otras sí lo eran o tenían un impacto extendido en la salud, así como en otros aspectos de la vida de las personas.

Las estrategias de adaptación incluían un grupo de estrategias equilibradas, como la búsqueda de asistencia sanitaria gratuita o la recogida de donaciones; otras han sido identificadas como perjudiciales para la salud, la seguridad y la estabilidad, como la automedicación, el retraso en la búsqueda de asistencia sanitaria, la interrupción del uso de medicamentos y el uso de medicamentos alternativos; mientras que otro grupo tenía un mayor impacto en otros medios de subsistencia, como el préstamo de dinero, el trabajo ilegal, el traslado o la reasignación de prioridades entre la salud y otras necesidades de subsistencia.

Por otra parte, las estrategias adoptadas por los refugiados suponen un nuevo riesgo para ellos mismos, mientras que algunas tienen también un impacto extendido en la comunidad de acogida. El impacto de las estrategias de adaptación incluye el deterioro del estado de salud general de los refugiados, los malos resultados sanitarios que limitan la capacidad de los refugiados para satisfacer sus necesidades de salud y otras necesidades de subsistencia y sobrecargan el sistema sanitario local con el aumento de demandas evitables.

En este sentido, comprometer otras necesidades de subsistencia o enfrentarse a consecuencias legales como la detención como parte del esfuerzo del refugiado por satisfacer sus necesidades sanitarias, o al revés, puede producir otra serie de riesgos.

El acceso de los refugiados a la sanidad y los comportamientos de utilización podrían explorarse definiendo sus características individuales, las perspectivas sanitarias previas al refugio, las necesidades actuales, identificando los comportamientos de búsqueda, las barreras de acceso y las estrategias de adaptación, y midiendo ese impacto en los propios refugiados y en los países

de acogida. Sin embargo, la comprensión de la interrelación entre todos los identificadores sanitarios y otros medios de subsistencia sigue necesitando una investigación y modelización más profundas.

Por último, dejar que los refugiados se enfrenten durante mucho tiempo a la escasez y las barreras de acceso en los servicios sanitarios básicos, así como a otras necesidades de subsistencia, tendrá consecuencias interrelacionadas, negativas y complejas. Las disparidades en la atención sanitaria y los servicios sociales disponibles para la población refugiada, traerán consigo nuevas e impredecibles estrategias de adaptación y el consiguiente impacto que requerirá un seguimiento continuo utilizando varias estrategias de seguimiento, como un sistema de información sanitaria sensible o encuestas específicas para los refugiados.

CHAPTER 1 . INTRODUCTION

The global mobility of populations has been increasing trends over the last two decades due to numerous of natural and human-made disasters (Boomer, 2021). The people's mobility is driven by push factors, including the economic crisis, conflicts, famine, and natural disasters, or pull factors, including economic opportunities, good education, safety and better livelihood conditions (*Population and migration*, n.d). However, between 2010 and 2021, the number of forcibly displaced doubled due to the increased number of natural disasters and global conflicts (UNHCR, 2021a).

As per United Nations (UN) records, by the end of 2021, as a result of persecution, conflict, violence and human rights violations, there were more than 94 Million forcibly displaced worldwide; those were classified as 21.2 million refugees, 20.8 million were under UNHCR mandate and 5.6 under United Nation Work and Relief Agency for Palestinian (UNRWA) (UNHCR, 2021a). Additionally, there were 51.3 million classified as Internally Displaced Persons (IDPs) and 4.6 million asylum seekers.

However, several terms are similar for the audience, but each has its operational definition and binding base concerning a global understanding made earlier. Before the establishment of UNHCR in 1951 and later, several international tools were to provide a legal framework to

protect human rights generally and specifically for vulnerable groups, including migrants, refugees, asylum seekers and displaced persons. Those international tools ranged from law such as International humanitarian law and Human rights law, Constitutions such as the 1946 "Constitution of the International Refugee Organization", Declarations, such as the 1985 "Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live", Conventions such as 1951 "Convention relating to the status of refugees" and 1949 "Geneva Convention relative to the Protection of Civilian Persons in Time of wars", Protocols such as 1967 "Protocol relating to the status of refugees" and guiding principles such as 1998 "Guiding principles on internal displacement". (Deng, 1999)

1.1. Conceptual and operational definitions

As per the above international tools following are the main definitions related to human movement and displacement:

- *Asylum Seeker:*

"Is a person who has fled from his or her own country due to fear of persecution and has applied for (legal and physical) protection in another country but has not yet assessed their claim for protection. Operationally, it is an individual who is seeking international protection. In countries with individualized procedures, his claim has not yet been decided on by the country where he or she has submitted it. In a nutshell, not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker (UNHCR, 2006). In European Union (EU) context, it defined as a third-country national or stateless person who has made an application for protection under the Geneva Refugee Convention and Protocol in respect of which a final decision has not yet been taken" (Spijkerboer & Arbaoui, 2010).

- *Internally Displaced Persons (IDPs):*

Internally Displaced Person is someone living inside the borders of their own country but cannot safely live in their home or region. IDPs are defined as a Persons or groups of persons who have been forced or (IDPs) obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border" (Deng, 1999)

- *Migrant:*

"Is someone who voluntarily chooses to leave his or her own country and make a new life in another country. Migrant is an umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes some well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students" (IOM, 2021).

- *Refugee*

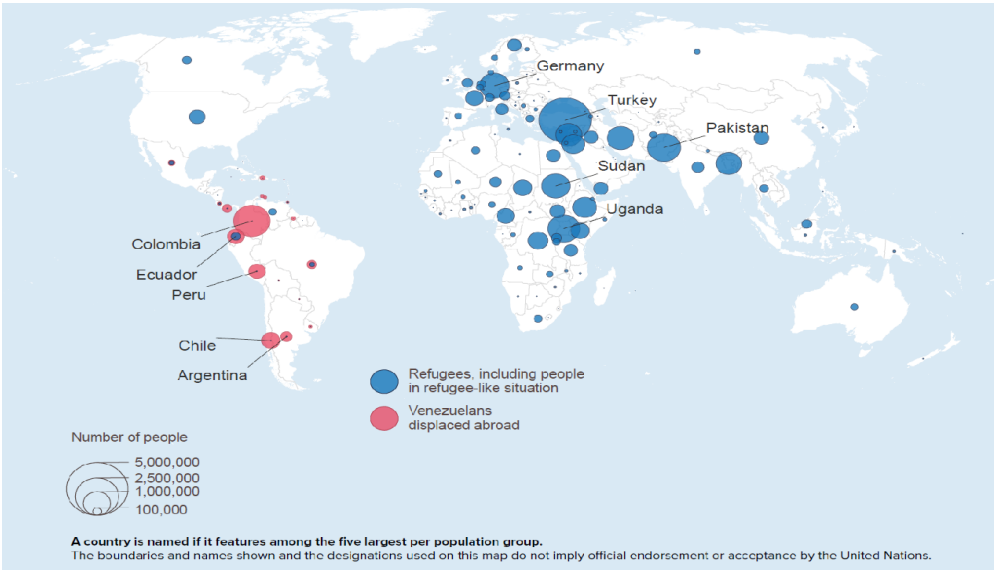
The primary and universal definition of a refugee that applies to States is contained in Article 1(A)(2) of the 1951 Convention, as amended by its 1967 Protocol, defining a refugee as someone who:

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being

outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it (UNHCR, 2015a)

As per the UNHCR record, there are 13 global emergencies recorded currently in 3 continents; 7 are in Africa, 4 in Asia and 2 in central and south Americas. The top 5 sources of refugees were Syria, Venezuela, Afghanistan, South Sudan, and Myanmar, while the top 5 recipients of refugees were Turkey, Colombia, Pakistan, Uganda, and Germany. Proportionally, Africa hosts 6.3 million (26.4%), the Americas hosts 4.3 million (17.9%), and Asia hosts 4.2 million (17.4%), see Figure 1-1.

Figure 1-1 Refugees in a refugees-like situation and Venezuelans displaced abroad, end of 2019



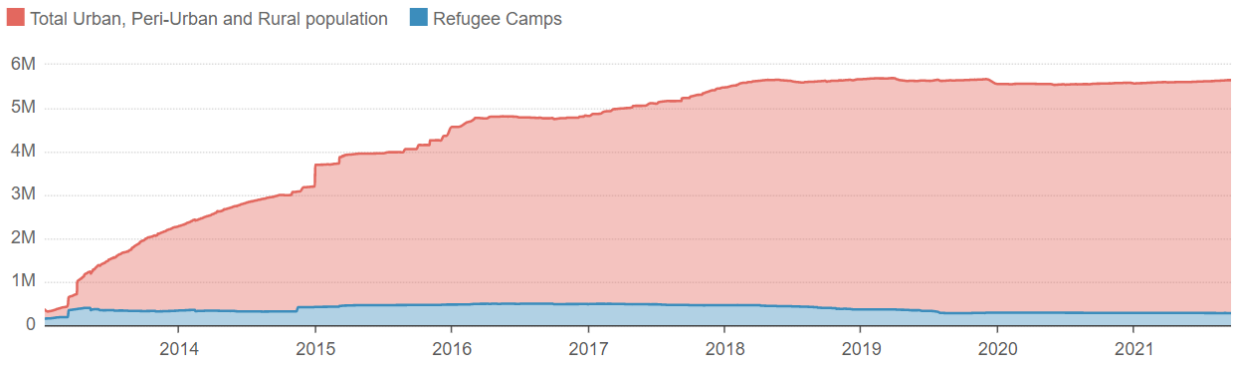
Source: UNHCR, 2019b

1.2. Socio political history of the Syria crisis

The Syria crisis started in March 2011 when a general protest started against regimen all over the country. The authorities used extreme force to control the demonstrations. Later in 2011, an opposition militia was created, and over 2012 the conflict converted to a civil war (Wikipedia, 2021). From 2012 to 2016, the regime lost control over borders, fighting between military

groups and army continued, violence against civilians escalated, internal displacement and external flee of millions happened. As per UNHCR, there was a sharp incremental increase in the number of Syrian refugees up until the end of 2017 where more than 5.48 million Syrian refugees were registered on their database, while beyond, there was a static increase reached currently 5.64 million registered in Turkey, Iraq, Jordan, Lebanon, Egypt and other north Africa countries (UNHCR, 2021c). However, the Syria refugee crisis has the same trend as most of the Middle East region crises, where most of the refugees settled in urban sites (see Figure 1-2)

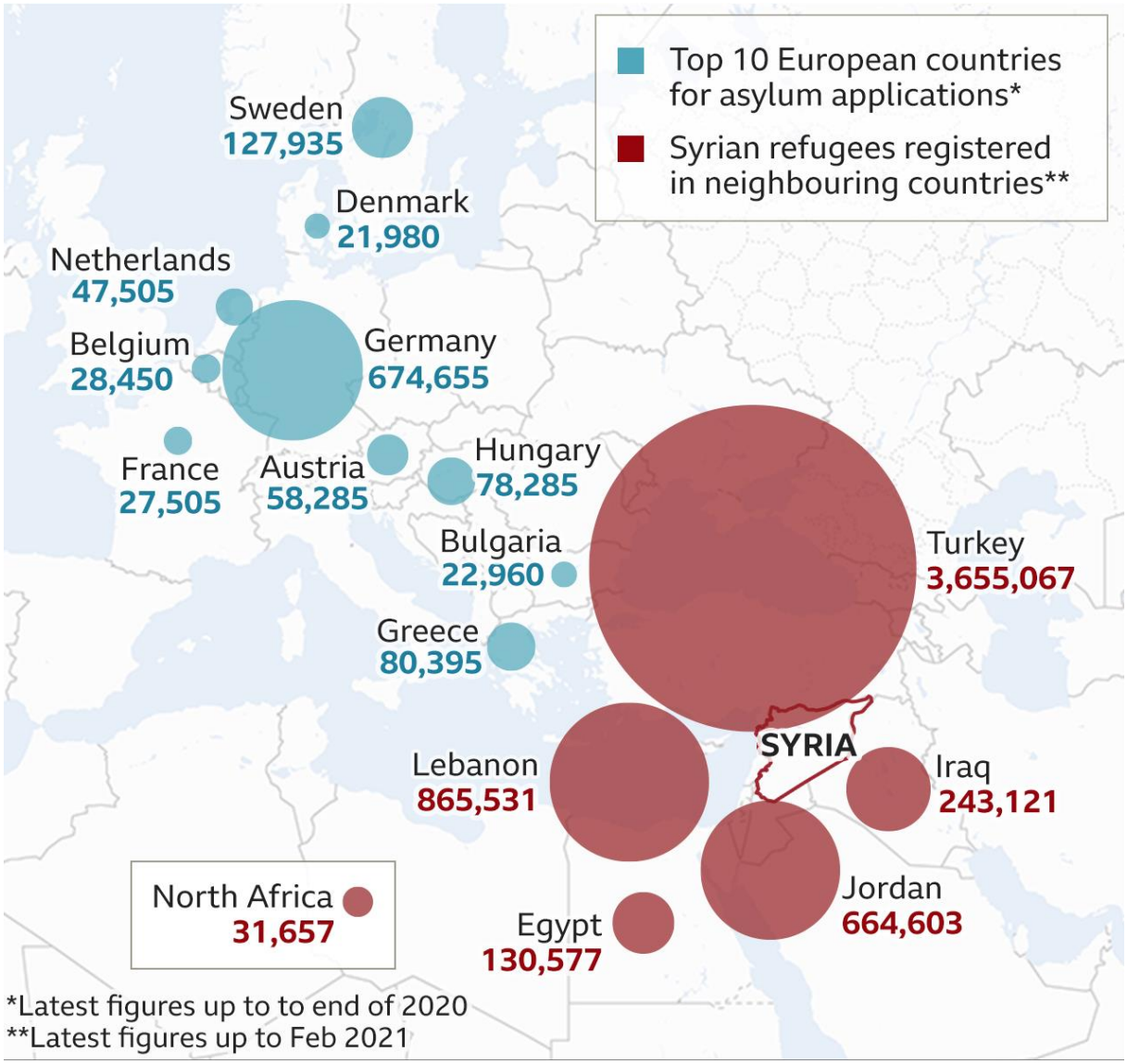
Figure 1-2 Trend of Registered Syrian Refugees



Source: UNHCR, 2021c

Currently, Syria alone contributes to more than 27% of the global refugee load, with more than 6.6 million refugees registered mainly in the Middle East, North Africa, and Europe. There has been a steady increase in the number of refugees who have fled Syria since the eruption, with a clear peak between 2014 and 2016. However, since 2018 there has been an intangible increase in the number of refugees who fled. Additionally, u critical neighboring countries' geographical proximity played an essential role in defining the refuge ways. For instance, north of Syria conflict made Turkey and Lebanon the first destination for refugees from that side, where more than 4.5 million fled to that side, while south conflict made Jordan the first option for southern inhabitants (see Figure 1-3).

Figure 1-3 Regional and global distribution of Syrian refugees, February 2021

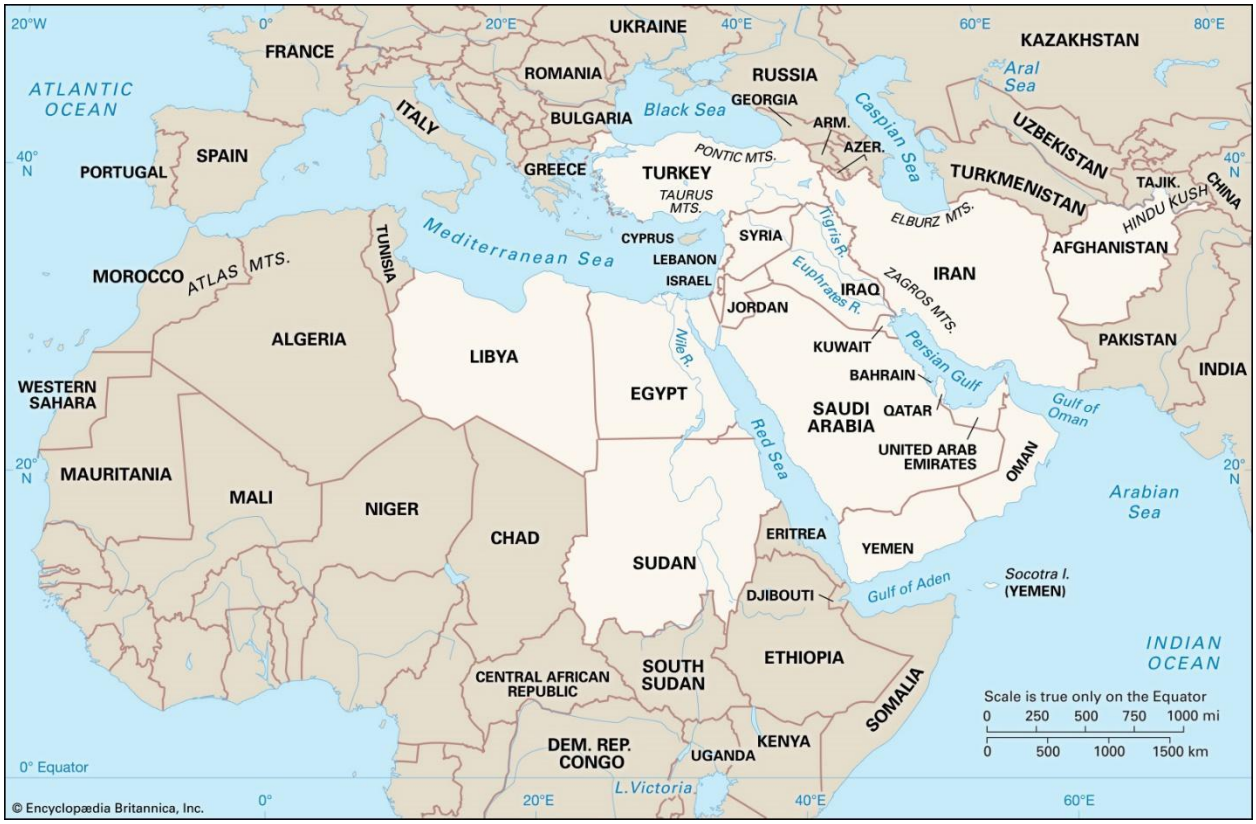


Source: Eurostat, 2021

The Middle East, the lands around the southern and eastern shores of the Mediterranean Sea, encompassing at least the Arabian Peninsula and, by some definitions, Iran, North Africa, and sometimes beyond. The central part of this general area was formerly called the Near East; a name was given to it by some of the first modern western geographers and historians, who tended to divide what they called the Orient into three regions. Near East applies to the region nearest Europe, extending from the Mediterranean Sea to the Persian Gulf; Middle

East (see Figure 1-4), from the Persian Gulf to Southeast Asia; and the Far East, those regions facing the Pacific Ocean (Encyclopaedia, 2021).

Figure 1-4 Middle East Map



Source: Encyclopaedia, 2021

Middle East countries still host the vast majority of Syrian refugees globally. Turkey, as the neighboring north country, hosts almost two third of the Syrian regional load with more than 3.7 million refugees, followed by Lebanon with 15% and Jordan with almost 12%, Iraq and Egypt hosting 6,8 while other north African countries hosting less than 1% (see **Table *1.1***) (UNHCR, 2021c).

Table 1.1 Registered Syrian refugees in the Middle East

Location name	Source	Data date	Population
Turkey	*Government of Turkey*	16 Sep 2021	65.7% 3,710,497
Lebanon	*UNHCR*	31 May 2021	15.1% 851,717
Jordan	*UNHCR*	31 Aug 2021	11.9% 670,637
Iraq	*UNHCR*	31 Aug 2021	4.4% 248,721
Egypt	*UNHCR*	30 Jun 2021	2.4% 133,568
Other (North Africa)	*UNHCR*	31 Jan 2020	0.6% 31,657

Source: UNHCR, 2021c

The other important result of the Syria crisis was the internally displaced situation, as per UNHCR statistics currently there are around 6.2 million IDPs inside Syria (UNHCR, 2021c) of which is considered the biggest IDP situation globally.

Syria crisis today mark its 10th anniversary; the UN considered the crisis the greatest tragedy of the 21st century and the worst refugee crisis since the second World War (Guterres, 2012). However, the number of refugees from the Syrian Arab Republic (Syria) across the Middle East region continued and the need remains for a large-scale response to address the needs of refugees already present in the hosting communities.

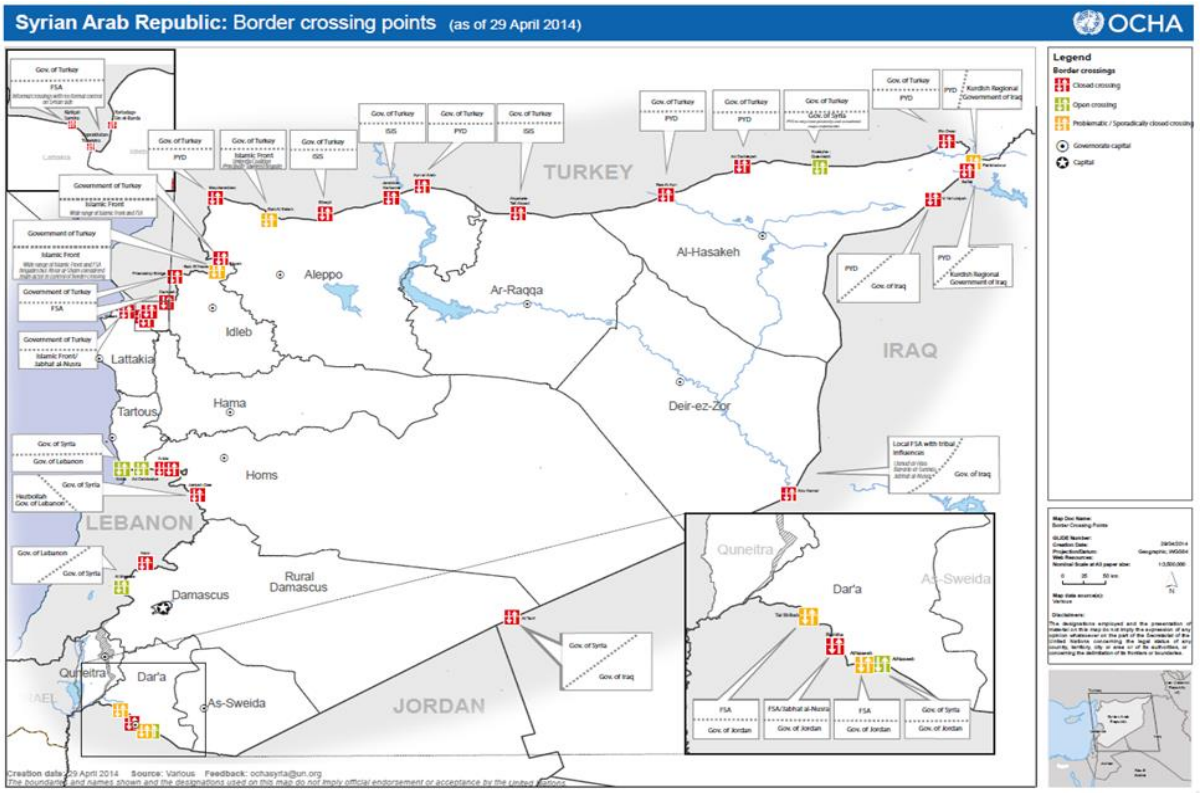
Since the eruption of the Syria crisis in 2011, Jordan, as a neighboring country, was one of the most affected countries where more than 666,000 Syrians fled to, where 1 in 15 people was a refugee. Syrian refugees started their new life in Jordan, the vast majority of them (81,5 %) settled in major urban settings across the country while United Nation and hosting government settled the other 18.5% into two main camps (UNHCR, 2019a).

The fleeing of refugees started to happen right after the escalation of the conflict, the Syrians living in the south of Syria, where the spark of the conflict started, fled to Jordan through unofficial crossing points. From 2012 to 2014, the government of Jordan adopted an open border policy in which Syrians mainly used three crossing points to cross into Jordan from the west part of the southern borders, and all were under the control of the Jordanian authorities

(OCHA, 2014). However, throughout 2014 there was a regular decrease in the number of refugees accessing Jordan due to new directions of the government of Jordan to control the number of refugees accessing borders (Achilli, 2015). During the early influx time and from mid-2011 to mid-2012, the refugees were received in a small reception center in Ramtha city (northern bordered city) with a capacity of couple of hundred capacity, and two other small sheltering areas in the same city with capacity around 2,000 individuals (UNHCR, 2012), later with the escalation of the influx and lack of the capacity in sheltering sites (King Abdullah park and Cyper City shelters) the government of Jordan with support of UN agencies established another standardized reception center next to the western border and officially open the first refugees camp in Jordan (Zatari camp) on July 2012. Early 2014 the Zatari camp reached its full capacity at 120,000 refugees; accordingly, the government of Jordan decided to open the other contingency place that was under construction in Azraq Area (Azraq Camp) in April 2014 (UN, 2014). Azraq Camp was planned to host 130,000, but only reached around 40,000 by mid of 2016 when the government of Jordan decided to seal the borders completely after a terrorist attack targeted their soldiers and resulted in 4 deaths in July 2016. The sealing of the border resulted in a new border refugee situation where around 77,500 individuals stranded in eastern southern borders in no man lands, and denied access to the Jordan (IRIS, 2017) (see Figure 1-5) .

However, Jordan has no specific refugee law or regulations, but during the crisis the government of Jordan adopted several regulations and policies to organize refugees' presence on its territories. For instance, in 2012 a cabinet decision made to establish a special directorate under Ministry of Interior (MoI) called Syrian Refugee Camp Department (SRCD) which later replaced with Syrian Refugees Affairs Directorate (SRAD), where it's become country wide official coordination body for monitoring and implementation of refugees' programs and policies (UN, 2013).

Figure 1-5 Syria borders crossing points



Source: OCHA, 2014

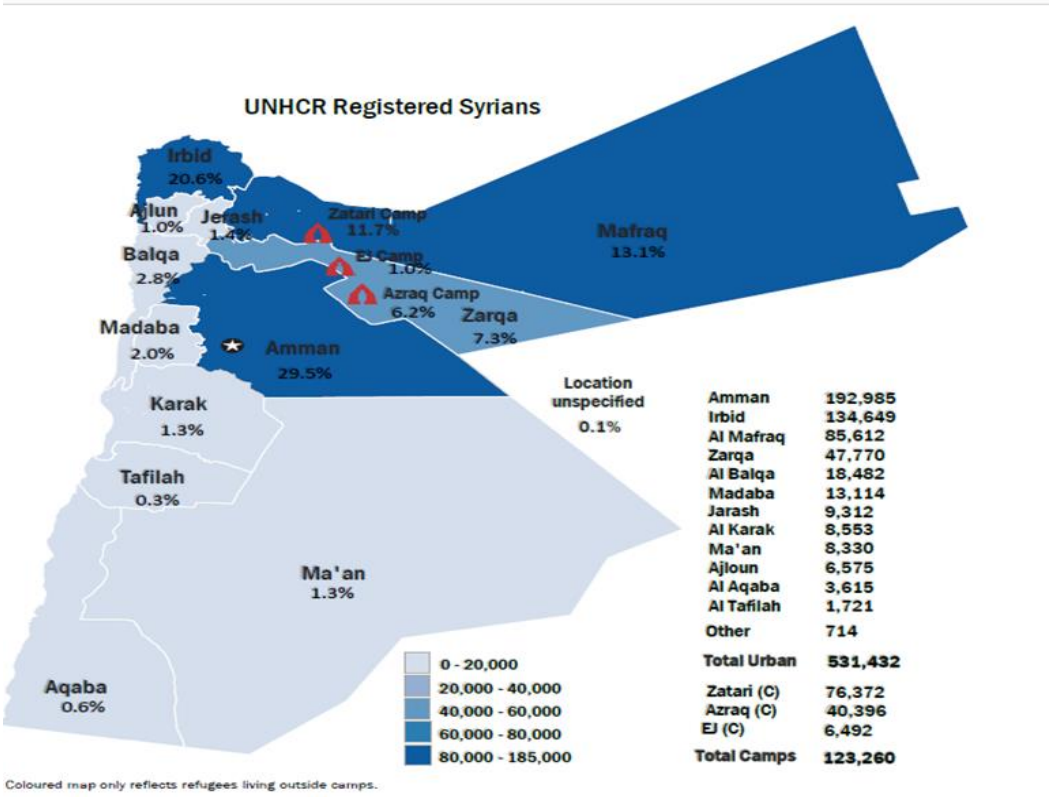
1.3. Syrian refugees' life in Jordan

Syrian refugees in Jordan are split between camps and urban sites (UNHCR, 2012). The refugees camps were established by the government of Jordan with a political intentions in order to keep the crisis profile prominent for international community (Ali, 2021). Refugees inside camps establish their life in newly made settings where UN agencies and the government of Jordan structured the whole livelihood systems to meet refugees' needs; including shelter, food, water, healthcare, and others. In comparison, the urban refugees established their new life into the urban systems including shelter, health, education, labor market and civil registration.

The government of Jordan, in the first phase of the crisis and due to the low interest of refugees to live in the official camps, decided to restrict movement of refugees living in the camps and

to allow a limited number of refugees to leave. Therefore, the government of Jordan authorized MoI to control the bail out system in camps. Additionally, there was a registration system used in urban setting where the refugees have to go through as per residency regulation that was implemented on refugees; each refugee HH has to register all members in near public security center and get registration card (Ministry of Interior card; MoI card) in order to be allowed living in urban setting (UNHCR, 2015b). However, all regulations presented by government of Jordan that time were derived by security concerns when there was a lack of control on the other side of the border with increased security incidents and surfacing of Islamic State in Iraq and Sham (ISIS) (Ali, 2021).

Figure 1-6 Syrian refugees' distribution in Jordan



Source: UNHCR, 2019a

On the other side, the refugees in urban settings were allowed to access basic protection services including civil registration and legal justice, labor market, basic education and health services as average Jordanian if they hold a valid MoI card (UNHCR, 2015b).

Prior to the Syria crisis Jordan had challenges related to social security, poverty, unemployment, violence against women, child labor and early marriage; those challenges exacerbated by Syria crisis (Copperation, 2020). Jordan Response Plan (JRP) indicated to the main protection challenges faced by Syrian refugees, it includes strengthening self-reliance; basic needs including shelter, food and water/sanitation; child labor; Sexual and Gender-Based Violence (SGBV); mental health and psychosocial issues; marginalized groups such as disabilities and elderly and lack of security of tenure (Copperation, 2020).

Since the early time of crisis the Syrian refugees children enjoy free access to essential education with around 136,000 children enrolled in 2020, this achievement has improved the outcome on families and resulted in decrease of education vulnerability among refugees from 71% to 54% (Brown et al., 2021). Furthermore, given the crosscutting vulnerabilities found among refugee communities and hosting, the Jordan response plan addressed the need to improve the economic empowerment that focus on enabling protection and improve self-reliance (Copperation, 2020). Livelihood and food security were the main two areas of concern, in 2016 Jordan Compact reduced restrictions on Syrian participation in Jordan's formal labor market (Ali, 2021), thus between 2016 and 2019 177,000 work permits were issued for Syrian refugees. Additionally, the food security situation estimated to be deteriorated among host community with increase in poverty from 14.4 to 15.7 between 2010 and 2018 (Bank, 2020) while among Syrians the Comprehensive Food Security Vulnerability Assessment (CFSVA) showed an increase in food insecurity levels for Syrians living outside camps from 10 percent to 14 percent between 2016 and 2018 (Jordan, 2019) and currently most of them rely on international aid programs.

Additionally, the social protection programs that aim to support most vulnerable refugees includes several interventions that have been provided for Syrians in systematic and coordinated approach, it included the monthly cash assistance programs which reached more than 23,000 HH and winterization assistance that reached 80,000 HH in 2019 (Copperation, 2020)

Finally, health was one of the sectors under critical situation due to the nature of the crisis and health profile of Syrian refugees, the government of Jordan, adopted different access policies for Syrians over the crisis while the UN agencies adapted complementary approaches to cover the basic health needs of vulnerable Syrians (UNHCR, 2015b). However, the refugees enjoy a satisfactory level of access for health services with acceptable health outcome while many challenges encountered at different level for many specific needs (UNHCR, 2017).

1.4. Jordan health sector overview

The Jordan Ministry of Health (MoH) was established during the occupation of east Jordan river territories in 1921 while the first public health law issued in 1926 followed by the first public health law in 1966. Currently, MoH considered the overall umbrella for all health affairs as per Public Health Law No. 47 of 2008 (MoH, 2020). The MoH is heavily involved in the provision of preventive health services, curative care and provide health insurance for Jordanians. By end of 2019, 676 healthcare centers were run by the ministry of health covering 12 governorates and 22 health directorate, it has also 31 hospitals run in 10 governorates with total bed capacity of 4,969 beds (Health, 2020). However, Jordan is considered one of the most modern healthcare systems in the Middle East region.

Jordan's health system is a combination of three major sectors: public, private, and humanitarian. The public sector consists of three major public programs that deliver various levels of healthcare: the Ministry of Health (MoH), Royal Medical Services (RMS) and

Universities institutions. The RMS is the military medical service section; it covers the military servants, retirees, and their families, it covers six governorates and serves as a referral entity for public health needs at advanced medical care. The Universities hospitals are another group of public services providers, it is connected to the educational institutions and covers two governorates and serves as a backup for MoH hospitals at advanced level of care.

The Private sector in Jordan is considered a major pillar for the health system at primary and secondary healthcare level with about 66 hospitals own 36.3% of total country hospitals capacity.

The humanitarian sector has established in correspondence to several refuge waves since 1948 including UN agencies supported programs such as United Nation Relief and Work Agency for Palestinian refugees (UNRWA) of which serve in 11 refugees camps in urban sites, United Nation Children's Fund (UNICEF) that support children health programs and UNHCR that support health needs of non-Palestinian refugees in 2 camps (Zatari and Azraq refugees camps) and other major urban centers across Jordan. Finally, many major International Non-Governmental Organization (INGOs) also provide relief programs in Jordan for all refugees such as Save the Children, Medair, International Medical Corps (IMC) and International Rescue Committee (IRC).

The total expenditure on healthcare in Jordan by the end of 2019 amounted to 3.1 billion USD and the per capita expenditures to 330.14 USD, while the total expenditure on health was 7.79% of the GDP (Economy, 2019).

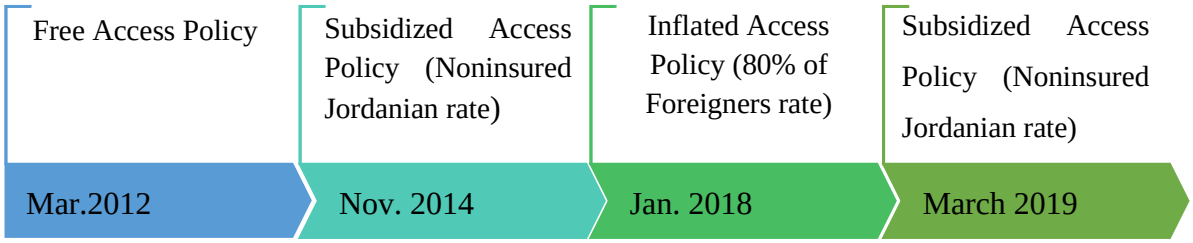
1.5. Healthcare access policy overview for refugees in Jordan

Jordan has a long history in hosting refugees for more than 70 years. Since the eruption of the Syrian crisis in 2011, Jordan has committed to provide basic health services for Syrian refugees,

as health is considered one of the basic human rights where everyone should have affordable access to the healthcare services they need wherever and whenever. The Government of Jordan act to ensure public health stability during the crisis and adapted several access policies for Syrian refugees to ensure their access to the basic public health services, as illustrated in (Figure 1-7). On March 2012, the government of Jordan based on Ministry of Interior (MoI) and Ministry of Health (MoH) recommendations decided to allow urban registered Syrian refugees to access MoH health centers and hospitals free of charge for all packages of available services, this decision continue effective until November 2014 when Cabinet's issued new decision stated that Syrian refugees have to pay the non-insured Jordanian rate, when UNHCR has considered this rate highly subsidized but not affordable for vulnerable refugees. The noninsured rate is a payment rate adopted by the health insurance department for Jordanian who are not included in the Civil Insurance Programme (CIP).

Later in January 2018, the government of Jordan issued a new decision regarding access to health services for refugees; this decision cancelled the non-insured rate and allowed the Syrian refugees to access all types of health services provided by MoH at 80% of the foreigner rate. Finally, after 14 months of implementation of this limited access policy, the government of Jordan decided again a reversal of the old subsidized access policy where the uninsured Jordanian rate reactivated in April 2019, since then the government of Jordan maintained this access policy and the refugees enjoy the inclusion conditions and were increasingly utilizing public healthcare services at all levels of care. However, throughout these fluctuations the government of Jordan maintained an important exception to this for all expanded programmes on immunization (EPI) and vaccinations, of which were provided free of charge to children and pregnant women.

Figure 1-7 Development of Healthcare access policies illustration (investigator-developed infographic)



Finally, all refugees and foreigners residing in Jordan have the same level of access to the full set of healthcare services run by the private sector including over the counter medications. The private sector currently constitutes around one third of the health care system outlook, including the clinics, pharmacies, nursing homes, rehabilitation center, medical laboratories, diagnostic centers, and hospitals.

1.6. Conceptual framework

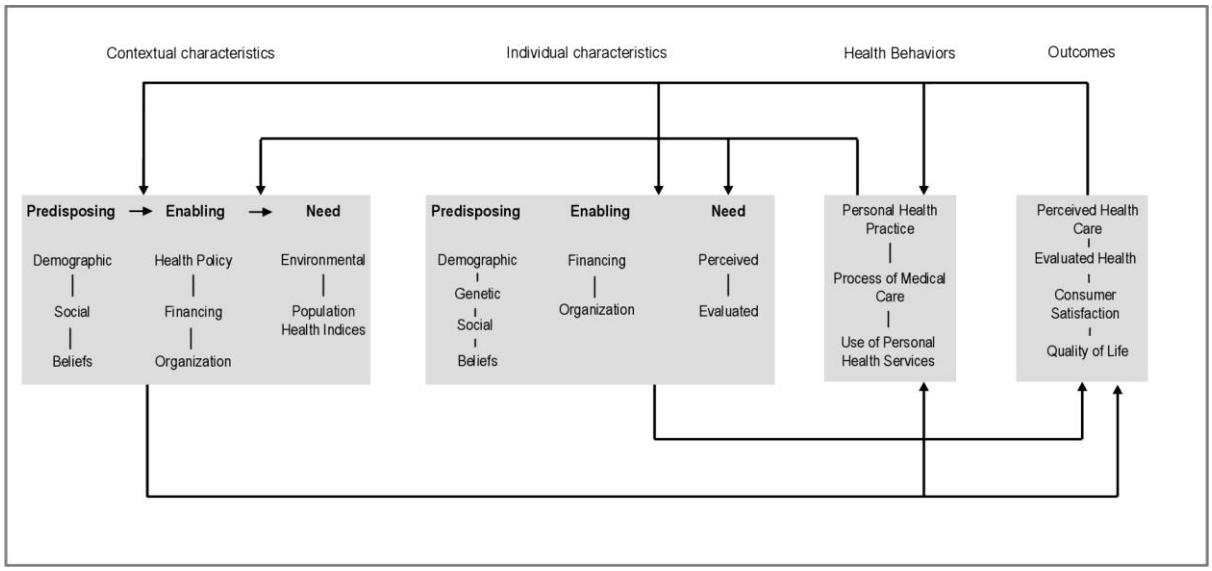
The conceptual or theoretical framework serves as a paved road for the research (Ravitch and Riggan, 2016), it clarifies how many factors come together and inform the research question and methodology. Additionally, the conceptual framework eases the understanding of relationship between concepts and variables for better explanation of phenomena over the real world (Jabareen, 2009).

To understand the dynamic of using health services and determine seeking behaviors, this research will use the Gelberg-Andersen Behavioral model for vulnerable populations. This model was developed by Ronald M. Andersen in 1968 and expanded later on several occasions. models predict three factors that guide utilization of service; the predisposing factors (age, sex, beliefs, etc.), enabling factors (family support, health insurance) and health needs (Gelberg et

al., 2000). All these factors shape the individual health practices and how each vulnerable individual use the health services.

The last phase of the developed model (5th phase) highlighted the contextual and individual determinants to best understand utilization of services. The supply side of healthcare added as well through health behaviors that included provider behavior and quality of care (Andersen, 2008). Finally, over this phase the model integrates the vulnerability dimensions and been part of the latest developed model as presented in the figure below (Figure 1-8).

Figure 1-8 Andersen's behavioral model of health services use – phase five



Source: Andersen, 2008

This model constructs the health seeking behaviors and outcome on a set of variables, some of those are modifiable such as health policies and financing while others are fixed like age, gender, and health indices.

The latest version of the model (2008) defines a set of characteristics, behaviors and outcomes that are interrelated and have mutual impact which define the health seeking behaviors. In the early model, Andersen and Newman (1973) define individual characteristics for health seeking and identify a set of predisposing factors, enabling and needs to be the main driver for health seeking behaviors. The predisposing factors includes the demographic characteristics that

identify individual tendency to use healthcare at any time, such as beliefs, age, and sex. The enabling factors defined as individual capacities that facilitate access to the needed services including financial capacities and community support. Finally, the need factor is defined as the illness level of the individual which can be self-perceived or defined by the healthcare system.

Andersen and his colleagues within the health access framework identify contexts where the vulnerable groups find themselves as one of the major sources of inequity and greatly impact the individual's ability to meet their needs. The context variables are again classified like individual variables into predisposing factors, enabling factors and needs. The predisposing factors again appear as sociodemographic variables, social support systems or health beliefs while the enabling factors include availability of affordable healthcare, adapted healthcare policies and sufficient funding for vulnerable groups specific needs. The needs within the context will be defined based on the population health profile and nature of the lived crisis.

The health behaviors pillar is a main component defined by Andersen model. The personal health practices, process of medical care and use of personal health services will draw a full picture on community’s health seeking behaviors, satisfaction with available services and define the healthcare needs for vulnerable groups and those with specific health needs.

At the end of the access model the outcome identified as interrelated factors that might have a reversal impact on individual characteristics and behaviors. The outcome of experience in healthcare will impact the individual behaviors toward provisions regardless of whether those perceptions come from individual perceptions or through system evaluation. However, individual satisfaction will play a crucial role in individuals' behaviors to continue seeking healthcare services or looking for alternatives as personal traits or systems allow.

Finally, the vulnerability found among refugees affects the healthcare behaviors that the Gelberg-Andersen Model found useful. However, this model is already utilized by many

researchers in public health, social science and health policy to conceptualize use of services by vulnerable groups (Gelberg et al., 2000).

1.7. Problem statement and study objective

Studying the refugees' health care needs, access behaviours and barriers has been an area of interest for many researchers since last century. However, the twenty-first century has brought huge mobility of the world population from east into the west, and within the world of the same language. This has posed a devastating challenge to the healthcare systems world widely. Since high immigration volume and its consequent burden are increasing and expected to continue, at the same time, refugees normally facing an increasing difficulty to access and utilize health services in any new context (Nowak et al., 2022; Pitkin Derose et al., 2009). Currently, numerous studies have shown the role of accurate understanding of exploring their healthcare needs, and most of the researchers have focused on the population needs, utilization behaviors and access barriers (Cope, 2011; Kohlenberger et al., 2019; Le, 2004), while very minimal research digs into the adaptation strategies and impact of utilization behaviors and access barriers (Choi, 2013).

In Jordan, as one of the most impacted country with multiple refugees crisis, many health topics have been investigated among refugees such as healthcare access behaviors and healthcare needs (Doocy et al., 2016; El Arnaout et al., 2019), as well as access barriers (Ay et al., 2016; Dator et al., 2018). However, the trend of global refugees' health research is the same in Jordan, where the factors beyond needs including adaptation strategies and impact were minimally explored. Additionally, the health systems structure and policy environment have a specific consideration that requires in-depth investigation and analysis to estimate its impact on refugees' health status and healthcare system stability, which is considered the core purpose of this thesis.

1.8. Research questions and aim

The ongoing health crises among millions of refugees depend on timely and accommodative steps, which in turn must be guided by rigorous evidence. This multifaceted investigation seeks to explore health service utilization among Syrian refugees who live in urban settings in Jordan, this study focuses on identification of access barriers and subsequent adaptation strategies adopted by refugees to meet their long-term and unmet health needs. Furthermore, since studies minimally explored the adapted health strategies, it could be a good way to understand whether the refugees are using positive or negative adaptation mechanisms to meet their health needs. This study will additionally investigate adaptation strategies and its impact in order to predict the threats posed to refugees themselves and public health stability in the country of asylum.

Questions to be answered through this research study include:

- How do Syrian refugees living in urban areas in Jordan access and utilize health services, and what types of barriers might they encounter?
- What are refugees' main adaptation strategies or behaviors to overcome barriers and meet their health needs?
- What is the impact of adopted strategies on refugees and hosting countries' public health stability?

1.9. Significance of the study

Studying refugees' populations in low- to middle-income countries is an urgent need, particularly for protracted crises when the refugees stay for a long time with a lack of viable solutions. It is critical to explore and understand Syrian refugees' healthcare needs within a unique context in Jordan, its influence on health behaviors and its interactions with other integration challenges. The current study may provide a piece of evidence for healthcare

providers that allow better understanding of needs, problems might be encountered by the refugee's when accessing healthcare services. The international and national humanitarian actors, including UN and other national and international NGOs, can proactively reduce the burden of unmet health needs through better service planning and mobilization of resources. Furthermore, the policy makers can be better equipped to predict the consequences of adopted health policies and possible impact on the stability of the public healthcare system and social support system. Finally, the study sheds light on the impact of refugees' marginalization and could be used to advocate among host governments and donor states to support the essential health needs of refugees and host communities for better outcomes.

CHAPTER 2 . BACKGROUND AND LITERATURE REVIEW

With the increased number of global crisis, longevity and limitation on other durable solutions available for refugees communities such as repatriation or resettlement, there is an increase interest and ongoing debate regarding the local integration of refugees into country of asylum as the most appropriate and viable option (Fiddian-Qasmiyeh et al., 2014).

Local integration "is a complex and gradual process with legal, economic, social, and cultural dimensions. It imposes considerable demands on both the individual and the receiving society. In many cases, acquiring the nationality of the country of asylum is the culmination of this process." (UNHCR, 2002). UNHCR estimates that, over the past decade, 1.1 million refugees around the world became citizens in their country of asylum (UNHCR, 2019b).

Jordan, a country with a long history of refugees accommodation and after 10 years of Syria crisis eruption, still stands at the position of repatriation of all refugees including Syrians while the use of or only having a discussion on local integration is prohibited (Ali, 2021). Despite that, factually the Syrian refugees in Jordan are part of the system, they are integrated within the public services systems including education and health; and are part of the economic outlook (Alshoubaki, 2017).

The long presence of Syrian refugees on Jordanian soil has a clear impact not only on Jordan as a hosting country, but also on the refugees' access and utilization for public resources (Copperation, 2020). Tumen in his Qusai experimental study detected three impacts on local economy including labor market where the labor loss reported among native workers and cost of labor force substituted while the housing rent for good quality houses reported an increase (Tumen, 2016). Other assessment done in Jordan to evaluate the impact of Syrian on the education outcome found no impact on teacher to student ratio and on size of classroom per student due to additional shifts that added to the school in highly populated area, but the report indicate to a notion loss due to over utilization of education facilities (Assaad et al., 2018). The impact on labor market was also studied by several researchers, (Fakih & Ibrahim, 2016) found no impact for Syrian refugees on local labor market and the same found by Fallah and his colleagues (2019) who detect no impact on labor market in areas of highly populated with Syrian has the same outcome for those with low concentration (Fallah et al., 2019).

Several organizations and researchers assessed another prominent sector was the health sector. The presence of refugees poses new demands to the health sector, overstretching and overutilization of health services reported by local MoH. For instance, In some areas with high refugee density the hospitals bed occupancy rate reach more than 90% (Copperation, 2020). Furthermore, healthcare staff ration declined significantly as well hospital bed ration per 10,000 declined from 18 to 16 between 2012 and 2013 (Murshidi et al., 2013). Finally, some reports refer to the emerging and reemerging of some communicable diseases due to refugee’s crisis such as measles, tuberculosis and cutaneous leishmaniasis (Nimer, 2018).

The other domain of the impact is the refugees themselves, where most studies have proved that the refugees, immigrants, and vulnerable groups have less access to health services. Moreover, they suffer from more barriers to getting needed services and have poor health indicators compared to the local population (Chuah et al., 2018; Department of Statistics/Jordan

& ICF, 2019). Currently, several researches and surveys have investigated healthcare utilization, needs and access barriers among Syrian refugees in Jordan (Al-Rousan et al., 2018; Doocy et al., 2016). However, many researchers conducted have not taken into consideration the healthcare access policies and its impact on long term strategies among refugee communities to meet their health needs. The current access policies adapted for Syrian refugees are at the same level of access to average Jordanian who don't have civil insurance; in theory this may suggest that refugees have more or less the same utilization behaviors, thus have almost the same gains by accessing the same package of health services. Nevertheless, this might not be the case if we investigate refugees' community potentials, demographic characteristics, policy environment, specific needs or vulnerabilities which predict their ability to meet their several needs including health and other than health. A survey conducted by UNHCR in 2018 showed that 78% of Syrian found severely or highly vulnerable based on their welfare score, the same survey found that almost half of refugees are highly or severely vulnerable in regards of their health status (UNHCR, 2019c). Other health Survey conducted by UNHCR in 2017 (UNHCR, 2017) and in 2018 (UNHCR, 2019c) showed that the refugees are suffering from increase of healthcare cost while only 27% firstly accessed the subsidized public health services in 2017 and reduced to 14% in 2018 due to increased cost. Additionally, the 2018 DHS found that the average family size for Syrians was 5.2 compared to 4.7 among Jordanians, while the fertility rate among Women at Reproductive Age (WRA) was 4.7 compared to 2.6 among Jordanians (Department of Statistics/Jordan & ICF, 2019).

Many other risk factors detected among Syrians that compare gains from the health care system are not fair. For instance, 6.5 % of Syrians girls marry below age of 18 compared to 0.2 among Jordanians, which increase the likelihood of having perinatal complications such as anemia and miscarriage (Paul, 2018). Another alerting behavior among Syrian refugees was the tendency to have a non-skilled birth attendant where home deliveries experienced among 4.8% of total

deliveries compared to 0.3% among Jordanian (Department of Statistics/Jordan & ICF, 2019). However, these kinds of behaviors might be connected to the social beliefs or health policies, but it cannot be separated from family potentials including financial capacities as its found in UNHCR survey conducted in 2018 where 55% of women indicated to the cost as a main barrier to receive antenatal care (UNHCR, 2019c).

2.1. Healthcare needs among refugees

Healthcare needs are defined as a gap "in a person's health state, which would benefit from appropriate and effective care intervention" (Dictionary, 2011). The healthcare needs rely on many factors, not on the patient's demands only when everyone seeks better health and avoiding being sick, the consumer set up is the first driver for needs where sociodemographic, beliefs and individual history play its role and drive patient's needs. It is also derived by economic capability including services price and patient income, also the healthcare access policy is another driver for needs and finally, the supply side where the availability of services may influence the need and impact patients behaviors (Babalola, 2017). The healthcare needs for refugees as a vulnerable group are context driven and highly rely on the nature of humanitarian crisis and its predisposing factors. For instance, the conflict based mobilities surface some specific needs for the vulnerable groups like violence against women and children, increase psychosocial and mental disorders and increased injuries level that require advanced surgical capacities (Daynes, 2016; El Arnaout et al., 2019). However, with a long history of humanitarian actors' involvement among various types of conflicts and disasters, they could define the set of full standard healthcare needs that meet various groups' needs in various settings. UNHCR has defined the set of healthcare needs and priorities for displaced population through its global strategies; the strategy defines the set of objectives that aim to define healthcare needs under thematic areas including child health, reproductive health,

communicable disease, non-communicable disease including mental health and secondary healthcare (UNHCR, 2019d).

The healthcare needs of vulnerable groups including refugees have been studied in a context of humanitarian crisis as the nature of healthcare needs differ from one context to another. For example, the natural crisis normally brought more health needs to the side of environmental hazards including sanitation while conflict base displacement increased the violence related needs such as psychological trauma and injuries.

Several studies findings supported the standard package of health services that humanitarian stakeholders defined. For instance, at the post emergency phase; a study conducted among non-Syrian refugees in Jordan found refugees' first need goes to primary healthcare followed by obstetric care, emergency specialist care and last was mental healthcare (Ay et al., 2016). Additionally, significant findings related to Syrian refugees' needs and problems in Jordan were detected in a review paper where eight articles analyzed, found that the access to chronic and acute disease treatment in addition to injury treatment were the most significant needs (Dator et al., 2018). Another study conducted in Jordan looked up for healthcare needs and priorities for Syrian refugees find the needs for Non communicable disease (NCDs) a most significant one (Al-Rousan et al., 2018). Doocy and her group, identified treatment for communicable diseases (CDs) and NCDs as a major need followed by dental care and injuries treatment (Doocy et al., 2016).

Other groups of researchers investigated the needs of refugees at the post resettlement stage or in third countries. For example, A study conducted in Europe among refugees and migrants found almost the same groups of needs at the post emergency stage. It identified communicable disease, non-communicable disease and mental health as major needs among target groups (Pavli & Maltezou, 2017). Another study in Spain found the same when CDs and NCDs were the major reason for refugees to seek medical care (Serre-Delcor et al., 2018). Some other

studies identified specific needs among migrants to Europe where long journeys was a reason behind having more infectious disease and psychological stress (Van Loenen et al., 2018).

In conclusion the healthcare needs of refugees and migrants may differ in type and intensity depending on the nature of the crisis, longevity, stage, population character and healthcare system potentials in Country of Origin (COO) and Country of Asylum (COA).

2.2 Common reported barriers among refugees

Barriers defined as "anything used or acting to block someone from going somewhere or from doing something, or to block something from happening" (Cambridge, n.d). Health care barriers have been defined by several model and all develop specific typology for healthcare barriers, for example, the Andresen's behavioral model identified large-scale access barriers such as demographic variables, social structure, and beliefs. Other model like Healthcare Access Barriers (HCAB) model provide taxonomy on modifiable and non-modifiable access barriers that include structural, cognitive and financial barriers (Carrillo et al., 2011).

Among refugee communities, there have been many healthcare access barriers described in the literatures, also there are many barriers that fall behind the availability and affordability of services, and there are barriers that go beyond model definitions. For instance, Antoni, and his team, identified many barriers to get healthcare and classified them into Cognitive barrier, Structural barrier, Socio-political barrier and Financial barrier (Antonipillai et al., 2017). Many other studies and surveys, look at different access barriers with considerations for context. For instance, a cross sectional survey from Austria found that the cost was not a barrier for refugees access but timing, long waiting, knowledge about services and language were the most reported barriers (Kohlenberger et al., 2019). Another master thesis reported language, legal status, understanding of the system, lack of insurance and culture as major barriers (Le, 2004). Furthermore, a survey conducted among Syrian refugees in Jordan found that perception of

disease, knowledge about services, long waiting, transportation beside the cost were reported as main barriers to access needed services (UNHCR, 2019c). Doocy and her colleague reported cost as a min barrier for accessing health (Doocy et al., 2016). While Morris, and others, found transportation and other logistics as main barriers in their qualitative assessment (Morris et al., 2009). Furthermore, Mangrio, and others, identified the same set of identified barriers in their mixed research conducted in Sweden (Mangrio et al., 2018).

Other researcher in Canada found lack of culturally appropriate services and gender appropriateness were negatively impacting the access to the services (Guruge et al., 2018), these finding also supported by Chuah and his colleagues in their east Asia qualitative assessment (Chuah et al., 2018) and same reported in other place in Australia by Correa-Velez and her team (Correa-Velez et al., 2005).

Furthermore, some refugees reported discrimination and lack of trust in the healthcare provider as barrier (Asgary & Segar, 2011). That was also an issue among refugees in Canada where some eligibility applied to migrants and refugees and was recognized as a barrier by many refugees (McKeary & Newbold, 2010).

Finally, not receiving enough health information was reported as a barrier in several studies; a PhD thesis found that 34% of study participants reported lack of information as a barrier when they accessed health services (Cope, 2011). Additionally, Sheikh-Mohammed and others found not knowing where to go a barrier compared to others (Sheikh-Mohammed et al., 2006).

2.3 Strategies adapted to meet health and another livelihood means

Adaptation is defined as “the process in which a living thing changes slightly over time to be able to continue to exist in a particular environment, or a change like this” (Cambridge, n.d). Why adaptation not coping? In this study, I investigate healthcare access behaviors and its

impact on the longer term where it is more appropriate to use adaptation rather than coping. The coping stage usually is the short term, oriented toward survival and reactive when there is no alternative, while the adaptation stage develops on the longer term when a continuous process aims at sustainability and focuses on finding alternatives and using it in an efficient way (Taylor, 2011)

Understanding health utilization behaviors and barriers to get healthcare are essential, but what are beyond that? When the immigrant population finds themselves in a protracted crisis with limited access to the needed health, they might adopt new strategies to meet their basic health needs and minimize the impact of care barriers. There was a little study that investigated adaptation strategies among marginalized populations. A qualitative study conducted in the US among Korean immigrants found that due to access barriers the population adapted new health seeking behaviors to meet their health needs; the behaviors included delay seeking care, reduced use of preventive care, self-diagnosis and treatment and more access to emergency oriented care (Choi, 2013).

Other review papers in Jordan indicated some adaptation strategies encountered by refugees, including using different service providers, consuming drugs irrationally, minimizing visits to the care provider and reducing intake of medication to reduce cost of care (Siam & Gómez, 2021). Finally, failure to meet basic livelihood means including health may also push some refugee families to adapt either a positive or a negative strategy. In one study conducted in Egypt among Syrian refugees detected the failure to meet livelihood a significant reason behind early marriage as a strategy to minimize demand on means of livelihood among refugees families (Elnakib et al., 2021)

In summary, there are standard healthcare needs developed by international organization that outline the healthcare need needed by refugees at any stage of refuge journey. However, the set

of needs and the intensity may differ from one shape of crisis to another, and from one stage to another, where it highly impacted by individual and contextual factors. On the other hand, the healthcare access barriers were well studied in the scope of refugees and vulnerable groups. However, the set of defined barrier varies based on personal and context traits, and it is highly connected to the facilitators to access healthcare. Finally, the way how refugees and/or vulnerable group react to healthcare access barrier differs depending on availability of other capacities or facilitator but most of the time it bushes refugees to a negative side of adaptations, it also interacts with other livelihood needs and made extended impact to other means of life.

CHAPTER 3 . STUDY METHODS AND DESIGN

Answering the research questions and providing enough explanations for the audience on specific phenomena, requires the researcher to use a rigorous procedure in, producing and analyzing data. However, the complexities of social behaviors, including health-related seeking behaviors, require data from many perspectives to understand the phenomena (Clarke & Yaros, 1988).

Given that the proposed research questions aim to study the effect more deeply, particularly the complexities surrounding health-seeking behaviors, and any encountered barriers among vulnerable and marginalized groups, a mixed-methods design is deemed most appropriate.

The mixed methods approach was deemed suitable for this study to overcome the weaknesses inherent in the single standalone methods away from the dichotomy of qualitative and quantitative, but one combined approach where qualitative and quantitative are reinforcing, ensuring reliable results and outcomes. (Creswell & Clark, 2017) Practically, according to Johnson and Onwuegbuzie, this approach provides a practical, comprehensive and results-based approach to study phenomena (Johnson & Onwuegbuzie, 2004).

For decades, researchers found that utilizing a single method approach could limit their ability to address research questions fully. To that end, Mixed Method could be the solution and seen as a helpful approach in social, behavioral and human science (Johnson et al., 2007).

Additionally, combining quantitative and qualitative research methods meant to enhance the comprehensiveness of answers provided compared to the use of single method. The comprehensiveness of mixed methods stems from the fact that each method complements each other in order to enable the understanding of phenomenon from different angels and perspectives, as well as addressing a wide range of questions related to different stages of that phenomena (O'Cathain, Murphy and Nicholl, 2007)

One of the best definitions for Mixed Method was developed by Johnson et al., (2007) when he defined it as:

> "Is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration" (Johnson et al., 2007)

Why Mixed Method? One common classification for the purpose of using the Mixed Method which is still valid was developed in 1989 by Greene and his colleagues (Greene et al., 1989). Greene detected five uses for mixing methods; the uses included Triangulation, Complementarity, Development, Initiation and Expansion.

The proposed Mixed Method design below focuses on strengthening the researcher's ability to triangulate the data produced from both data set analysis, and complete the picture related to the consequences of regarding access to the basic health services needed.

Which type of Mixed method? The constituent methods within a mixed-methods approach as Creswell and Clark (2017) identified, including convergent, explanatory and exploratory mixed methods. One of the most recent classifications for Mixed Methods was developed by Creswell

and Clark (2017). They classify Mixed Methods into six typologies depending on method structure and purpose; those are:

- Convergent parallel design (“parallels Design”) where the quantitative and qualitative work done independently, and the outcome built up the interpretation.
- Explanatory sequential design (“explanative Design”), initially the quantitative processed and followed by the qualitative data to explain the quantitative results
- Exploratory sequential design (“explorative Design”), initially the qualitative data processed and followed by the c quantitative data to test or generalize the qualitative finding.
- Embedded design (“Einbettungs-Design”), is an old qualitative or quantitative design, added to strengthen the general design.
- Transformative design (“politisch-transformatives Design”), is a transformative theoretical framework used for theory testing or development.
- Multiphase design (“Mehrphasen-Design”). Multi phases or series and parallel strands are combined for a period of a program or project.

This research study used the convergent parallel Mixed Method design, the quantitative and qualitative data had been collected separately and concurrently from the target group. A separate quantitative tool developed to capture information related to utilization, access barriers and adaptation strategies and the qualitative data collected through semi-structured interviews.

The quantitative data analyzed statistically while thematic analysis conducted for the qualitative data set. The proposed technique aims to mainteach data set's strength and enable a better understanding of phenomena through combining two data set findings (Schoonenboom & Johnson, 2017; Tariq & Woodman, 2013). Additionally, this will ensure the wide participation of marginalized groups and improve confidence in findings (O'Cathain et al., 2007).

In conclusion, the Mixed Method receiving increasing recognition and interests (Clark, 2010), and is considered one of the best methods to address proposed wide range of research questions in such complex context and especially when studying aspects related to the healthcare services and behaviors (Tariq & Woodman, 2013).

3.1 Qualitative descriptive method

The qualitative descriptive method produces data that describe the 'who, what, and where of events or experiences' from a subjective perspective (Kim et al., 2017).

I chose to employ open qualitative descriptive approach to this exploratory study as this method provides a comprehensive in-depth perspective for those who experience phenomena (Bradshaw et al., 2017). Additionally, when a little is known about the topic of investigation Sandelowski sees descriptive method provide a straightforward description of perceptions and experiences (Sandelowski, 2010). Additionally, researcher stays close to the data and interpretation (Sandelowski, 2000). In this method, the consideration for subjects' experience and contextual variation boosts the understanding of phenomena (Guba & Lincoln, 2005). Additionally, this design has been frequently used with Mixed-method design where the quantitative data can be validated and corroborated by using qualitative in convergent method (Doyle et al., 2016).

Utilizing the purposive sampling can be limiting, but considering the recruitment of participants from wide base geographical locations and ensuring heterogenicity of subject will foster the data collection, improve outcome of data analysis, and help in creating new knowledge (Palinkas et al., 2015). Hence, in the descriptive qualitative method, all data collection methods can be utilized, including focus group discussion or telephone interviews, but the most common is a semi-structured individual interview (Kim et al., 2017). The semi-structured interview method used to enhance openness of study subject to disclose their health concerns and

challenges given the private nature of HH's health status and barriers that may arise due to being present in a group discussion.

Furthermore, the descriptive research method found to be suitable for health and policies research and is relevant to capture details of phenomena that inform healthcare program design (Chafe, 2017; Doyle et al., 2020).

Finally, the descriptive qualitative design typically give a flexibility for the researcher to select theoretical or philosophical framework that foster study at tool development part as well as analysis part (Kim et al., 2017), of which has been utilized to select the theoretical framework (the Gelberg-Andersen Behavioral model for vulnerable populations) that fit the study context and population characteristics.

3.2 Employment of thematic analysis

Thematic analysis is a method for analyzing qualitative data that entails searching across a data set to identify, analyze, and report repeated patterns (Braun & Clarke, 2006).

Braun and Clarke developed guiding steps to conduct thematic analysis, including familiarization with the data, generation of initial codes, search for themes, review themes, define themes, and write up (Braun & Clarke, 2006). Familiarizing with data is the first step where the researcher read and reread the transcript to develop an initial impression. Then the researcher moves to organize the data to get some initial codes guided by research question, which is considered a second stage that enables better understanding of content to make researcher move to themes identification stage. Themes identification stage captures the significant or interesting data. Later when more in-depth understating for the data evolved, the researcher needs to review the themes and reconnect them together. At the fifth stage, the researcher defines the themes, identify the core of the theme and how it interacts together to make a concrete knowledge about a phenomenon, and lastly the write-up step when the

researcher document the findings, organize it in a readable form and support it with examples (Maguire & Delahunt, 2017).

Braun and Clarke support that thematic analysis can be adapted as an analytic method and be a base for other qualitative research methods. The thematic analysis method is seen as a flexible method since it can be utilized in a wide range of epistemological and theoretical framework, it can be applied on a wide range of study designs and sample size (Kiger & Varpio, 2020).

Some experts point out that thematic analysis will be a best option for novice researchers (Braun & Clarke, 2006; Clarke & Braun, 2017; Nowell et al., 2017). Braun and Clarke recommend using thematic not on the preferences of researchers but because of its appropriateness for the research design; thematic analysis works when seeking experiences, thoughts, or behaviors across a data set (Cooper et al., 2012). Additionally, the thematic method was found to be relevant to other qualitative research methods that rely on coding and themes found in the data set such as Grounded theory and ethnography (Kiger & Varpio, 2020).

On the other hand, Thematic analysis has set of strength, Braun and Clarke in 2006 identified set of advantages for Thematic analysis, those advantages including the flexibility of method of which make it easy for the beginner researcher; the result is easy to understand by general educated; useful method for participatory work so more people can be involved in the process; can summarize key features within large data set but also can identify similarities and differences in responses; can find in predicted findings among a particularity of researcher; can allow social interpretation of data and suited to inform policy makers (Braun & Clarke, 2006).

Finally, given the exhaustive nature, complexity, lengthy and resources consuming nature of this thesis project, possible induced bias because of the nature of the context form one side, and the availability of executive theoretical model (Gelberg-Andersen Behavioral model) that guide the research objectives and questions on the other side it will establish a rigor environment to

study seeking behaviors among vulnerable group (Gelberg et al., 2000). Additionally, the researcher background is considered exhaustive within the field of health programming among vulnerable groups which might reduce biases that may raise in case of utilizing other methods like Grounded theory (Kiger & Varpio, 2020). For the above mentioned reasons, it has been seen that the use of Thematic analysis method will entail better conditions for this study due to flexibility in the analysis whether inductively or deductively, enable understanding of experiences and behaviors and limit biases that might come from the researcher background (Kiger & Varpio, 2020)

3.3. Research tools and techniques

Based on the proposed research methodology, two tools were utilized during the research: a quantitative tool, the survey, in a form of close ended questions. And a complementary qualitative tool, in the form of semi structured questions for the interviews.

3.3.1. *The Survey questionnaire*

A 54 items survey tool developed using a well-established global survey tool (Health Access and Utilization Survey [HAUS]) developed by UNHCR to understand health access and utilization behavior among urban refugees (UNHCR, 2015b). UNHCR has been using this tool since 2013 to predict dynamics of service utilization in urban settings, understand seeking behaviors and identify unforeseen barriers when the refugees have uncertain access to the basic health services (UNHCR, 2015b).

The original tool has been modified to capture the information related to the proposed research questions, thus it has been minimized where technical health details related to the estimation of health coverage and disease prevalence are removed. Additionally, a new section developed to capture the information related to the impact of access barriers and adaptation strategies.

The new developed section focuses on the impact of being not able to access needed health services over previous 6 months, the recall time frame for this question made at 6 months period in order to capture a lengthy impact as the aggregated outcome on health is better to be longer compared to the specific analysis of events (Kjellsson et al., 2014). Additionally, a question on adaptation strategies was added with a range of 8 responses including open narrative, the responses developed from both literature (IRC, 2019) and in consultation with field expertise in public health among vulnerable groups.

The final tool constitutes a set of 54 closed-ended questions classified into 7 sections including family composition, knowledge of available health services, access to immunization, access to women healthcare, access to chronic disease services, monthly access assessment and HH questions (see **Appendix I**). The questionnaire consists of dichotomous questions that aim to capture the presence of health needs or access barriers, and a multiple-choice question (checklist type) that restrict the responses to the set of answers that tool developer, namely the UNHCR have defined.

3.3.2. The semi structured interview

Use of semi-structured interview can produce powerful data that help researchers to better understand subject perception and experience (Peters and Halcomb, 2015). A semi structured interview commonly used for qualitative approach. This research tool selected as the best method to produce information with focus on research problem and research question. Maintaining privacy through using this method aims to bring more in-depth details on family health concerns, needs, barriers and adaptation mechanisms (Polit-O'Hara et al., 1999). Compared to other methods of data collection where confidentiality can’t be maintained such as focus group discussion especially in an open context. Additionally, the semi structured

interview with interview guide approach enabled the researcher to compare and contrast the collected information (Fraenkel et al., 2011)

A semi structured interview guide has been developed through mapping of research questions and reviewing the related literature (Lee, 2016). The structure included a set of open-ended questions including opening questions, access and utilization of healthcare, access barriers, adaptation strategies and Impact. (See **Appendix II**).

The following matrix (**Table *3.1***) developed to indicate the relationship between itemized components of the tools and set of research questions.

Table 3.1 Relationship between itemized component of quantitative and qualitative to research questions

Research Question	Quantitative Components	Qualitative Component
For descriptive and relationship analysis	Family composition questions	Opening question about family composition
How are Syrian refugees accessing and utilizing health services in urban settings in Jordan?	● knowledge of available health services questions ● health service needs among children ● health service needs among women ● health service needs among chronic ill ● monthly health access among HH	● Tell me about a health care provider you are accessing in Jordan when you need care ● Describe when you visited them ● Tell me what you know about health services access policy in Jordan ● Tell me about your impression about the clinics or hospitals you have visited or been to with other family members

		• Tell me about your last visit to any healthcare provider. When? Why? • Tell me about your family members' experience with healthcare providers in Jordan
Do Syrian refugees encounter barriers to health services?	• Encountered barriers among children • Encountered barriers among women • Encountered barriers among chronic ill • Encountered barriers during last month among all HH members	• How do you feel about healthcare you received in Jordan? • Are you concerned about your or your family health needs? What are those concerns? • Are you or have you been concerned about the health needs of women in your family like pregnancy? What are the concerns? • Are you or have you been concerned about the health needs of members with chronic conditions in your family? What are the concerns? • Are you or have you been concerned about the health needs of minors in your family? What are the concerns?

What are the main access barriers they are facing?	• Knowledge as a barrier • Believes as a barrier • Access policy as a barrier • Transportation as a barrier • Financial capacity as a barrier • Availability of service as a barrier • Long waiting as a barrier	• Tell me about a time when you needed medical care but could not. What were the challenges? • Do you think you have enough access to the healthcare services? Or receiving all needed care? • Have you been able to meet all healthcare needs for you and your family? If no, Why?
What are the main adaptation strategies or behaviors adopted by refugees to overcome barriers and meet their health needs?	• What was the impact of healthcare cost increase? • What were the adaptation strategies adopted by HH?	• Have you ever used certain strategies to minimize healthcare burden on you and on your family? • What were the strategies you used to overcome access barriers and minimize burden including cost?
What are the impact of adopted strategies on refugees themselves and their health stability?	• Not feasible by using a quantitative approach.	• Have you felt those strategies prone you or your family to additional risks? • In your opinion, what were those risks?

Source: Own elaboration

3.4. Instrument's validation

Both instruments developed including the survey questionnaire and the semi structured interview tested for content validity using a committee of experts prior to the piloting. The committee of experts consisted of three members who have very extensive experience in refugee's situation with mixed experience in the fieldwork and academic background. One member is working with UNICEF with refugees' programs as a public health and nutrition specialist for more than 12 years. The other two members are academic people (one associate professor and the other assistant professor) with more than ten years of experience conducting research among vulnerable groups. The three members reviewed instruments and cleared them for utilization for this specific study.

Both instruments translated to Arabic and back-translation carried out, the original version and back-translated one compared to ensure the equivalence. However, some modifications were introduced to quantitative instruments to ensure the right flow of questions during the interviews.

3.5. Digitalization of quantitative instrument

The recent development in communication tools and evolution of new data management tools influenced many fields. Information management technologies and its tools have infiltrated to all joints of our life (Amorim et al., 2015). For instance, digital education tools become dominant and become increasingly used by many educational institutions while health becomes a wide space for inspiration and digitalization through health information system applications.

Research is a rapidly evolving field using mass information management tools to facilitate data analysis, as well data collection and organization. The increased cost and resources needed using traditional data collection methods and organization increased interest in digitizing these

processes. Open Data Kit (ODK) as an open-source toolkit is one of the most efficient and cost-effective tools developed to manage data in low resources setting (Maduka et al., 2017), and currently it is considered one of the leading data collection tools, organization, and analysis solution. However, ODK found to be the best tool among other tools that offer full data management solutions (Brunette et al., 2013).

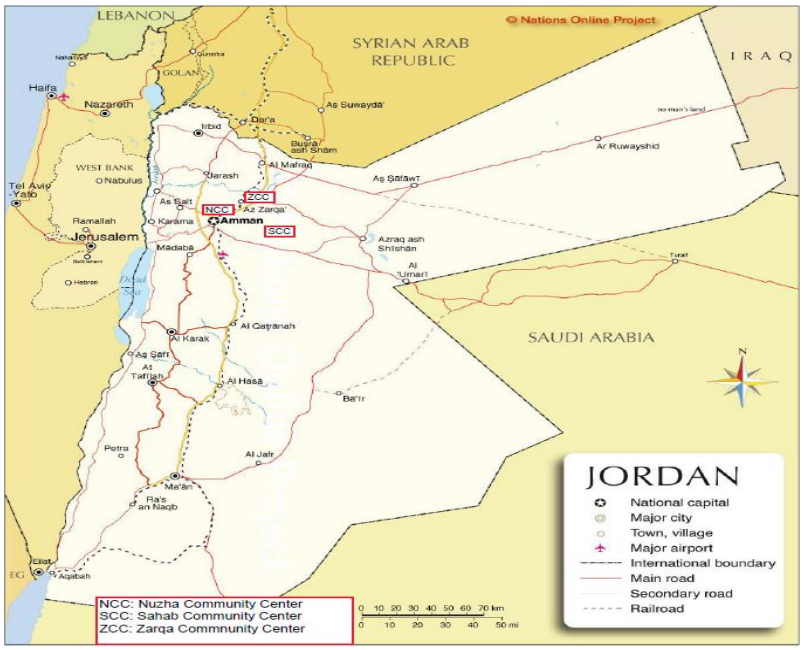
The quantitative tool that consists of 51 survey questions has been programmed on the ODK system using open-source KOBO application tool kit. All questions programmed as per interview logical flow. Validation roles, restricting roles, conditionality, grouping of questions, multiple selection, skipping, and repeating roles were all utilized throughout the programming. For instant question related to pregnant women were appearing if there are women in the HH below age of 50 and at marital status of married, divorced, or widowed. The questions on chronic disease pop up in case of a patient with chronic condition while questions with numeric value answers were restricted to several entries only.

Using ODK through KOBO application tool kit has enabled me to implement all data quality check functions and save time and resources to gain better quality data, complete data and minimize efforts on data transfer and cleaning, and finally it enhanced data protection with a restricted access to the database for me only. For example, out of 383 HH who were agreed to be interviewed, a complete data set was found among all of them with no missing data. Furthermore, very minimal data missing found in details of demographic data with only one entry missing while wrong entry found on age variables were year of birth recorded instead of age in years among 7 participants.

3.6. Piloting Phase

Piloting is essential for planning and modifying the proposed study protocol (Thabane et al. 2010). Through the piloting, I aim to test instrument validity, assess the feasibility of sampling technique and recruitment of subjects, determine logistics and resources needed and identify training needs. Prior to the piloting phase, I obtained the required approvals from UNHCR to do data collection in a group of community service centers in Amman (central capital) where two community center selected including one in north Amman (NCC: Nuzha Community Center) and one in south east Amman (SCC: Sahab Community Center) and another one in north center of Jordan at Zarqa governorate (ZCC: Zarqa Community Center) please see below the research site map (**Figure *3-1***), the selection of community service center against healthcare center were decided in order to ensure diversity of target groups rather than having homogeneous sample from health seeker groups, which will result in selection bias.

Figure 3-1 Map of community centres of study sites



Source: (NOP, 2016)

One study site (community service center) selected in Amman to administer the study instruments, a group of 11 participants recruited randomly for quantitative tools and 3 head of HH selected and attended the semi-structured interview. The instruments were tested for clarity. All difficulties or ambiguities were recorded, timing of administration and adequacy of range of responses come from qualitative tools reviewed.

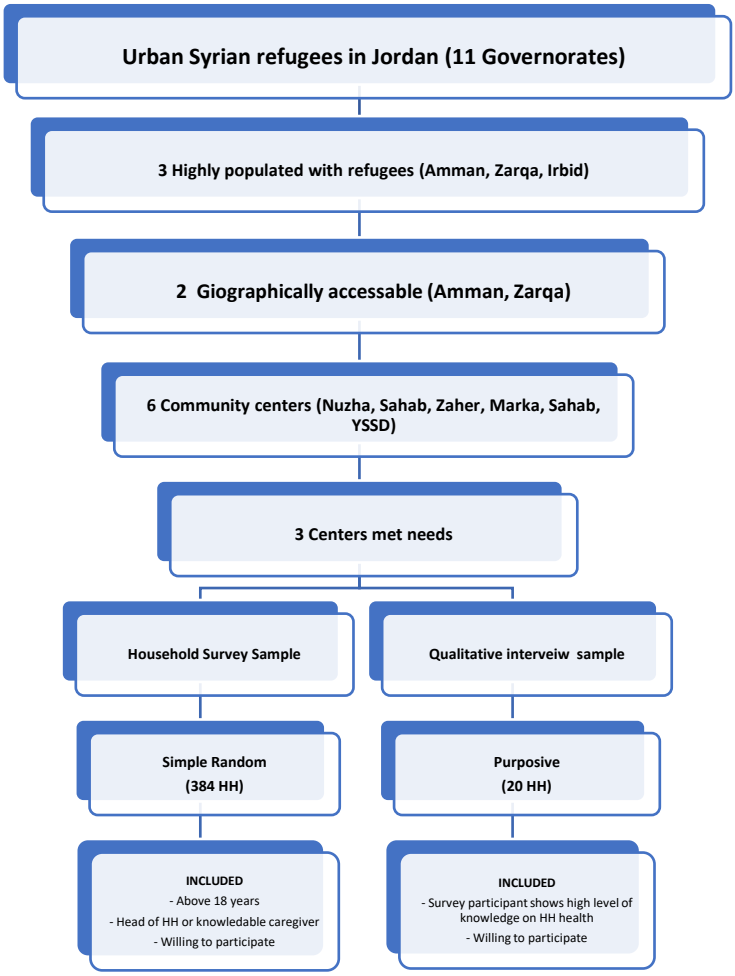
A communication channel was established with UNHCR focal points to coordinate fieldwork, all study sites visited prior to the fieldwork, sites evaluated to ensure smooth workflow during data collection and availability of space to maintain confidentiality during interviews. Finally, communication channels were established with study site managers to coordinate data collection schedules in line with the site's workflow.

The instrument validation including reliability testing conducted during piloting phase where comprehensibility and relevance were observed toward respondent understanding, identify the impact of the setting, observe reactive response or response modification.

3.7 Participant’s recruitment

Participants were targeted at core refugee center in urban areas in central governorates. The two study settings were selected conveniently, the participant sample for the quantitative part were randomly chosen while sampling was purposive for the qualitative part (Figure 3-2).

Figure 3-2 Sample recruitment chart



3.7.1 *Inclusion/exclusion criteria*

All refugees of Syrian nationality registered outside officially recognized refugee camps in Jordan and living in Jordan were considered eligible. Interviewed persons were above the age of 18 and either the head of the HH or knowledgeable caregiver living in the same HH. Households are defined as those who are living in the same place and eating from the same pot (Haviland et al., 1996). All unregistered refugees who have moved outside Jordan or into official refugee camps inside Jordan excluded. All below 18 or non-consenting HH were excluded as well.

3.7.2 *Sample size and theoretical saturation*

Sample size calculation for cross sectional studies/surveys used to calculate sample size, type one error was at 5% with P value < 0.05.

$$n = \frac{z^2 \times \hat{p}(1-\hat{p})}{\varepsilon^2}$$

$$n = \frac{1.96^2 \times 0.5(1-0.5)}{0.05^2} = 384.16$$

The targeted sample almost reached the targeted number for the survey according to the sample size calculation defined by the above formula, 383 HH interviewed who were representing 2,199 HH members. Only 4 participants decided not to participate and dropped from the study.

The literature suggested that 12 participants is adequate sample size for an interview (Onwuegbuzie & Collins, 2007) while (Lee, 2016) in his qualitative research among refugees reached saturation at 24 interviews. The plan was to have 20 interviews for this research However, the saturation point reached at 18 interviews. Anyway, after completing the 18 interviews and during data collection from east Amman (Sahab Community Center), I noticed some variation in the responses due to the nature of that area which considered a mix of sub urban and rural theme compared to other two site which considered fully urban sites, I decided to have another two semi structured interviews in that site to get more insight and improve the rigor of the study.

3.7.3 *Sample selection*

The quantitative component participant selected using simple random technique at the study site. At the waiting area of the community center the first setter on the right side of entry was selected, then jump of every other two applied to select the next participant. During the working

day several turnovers happened among visitors, upon completion of each round of interviews another round of random selection was initiated using the same techniques.

The qualitative component participant selected purposively from quantitative set participants with maximum variation, from those who participated in quantitative interview those who show eagerness to continue with the investigation, have good expressions and show very good level of knowledge on their family health situation selected for qualitative component (semi-structured interview).

3.8. Data collection process

The data collection for the quantitative part was conducted among 387 participants using a tablet with KOBO tool installed as a programmed tool for 54 sets of questions (see **Appendix I**). The Gelberg-Andersen Behavioral model was adapted throughout the tool. Consent obtained at the beginning of each interview. 383 participants gave their consent while 4 didn't give their consent and dropped out.

The data collected between 29th of November 2019 and 16th January 2020 over 22 working days from the three targeted sites. I23 HH interviewed in Zarqa Community Center, 50 in Sahab Community Center, and 211 from Nuzha Community Center.

For the qualitative component one semi-structured interview was carried among 20 participants who were selected from the quantitative participants' pool. 10 interviews conducted in Zarqa Community Center and 10 interviews conducted in both Amman community centers (Nuzha and Sahab). The interviews extended from 12 to 40 minutes, all participants were Arabic speakers, the interview guide followed throughout the interviews with open-ended question, probe and follow up questions. Consent obtained for both interviews and recording. As seen in Appendix 2, the interview started with opening questions, questions about access and utilization

of health services, access barriers and encountered challenges, strategies adapted to meet HH health needs and impact of adapted strategies on health and other aspects of life. All interviews were conducted in a separate space inside each site, which was detected during the piloting and preparation stage. All interviewed members were either the head of HH or main caregiver in the HH, all individuals interviewed were alone during the interview and minimal interruption encountered.

3.9. Ethical considerations

The Institute of Migration Research proposal review committee reviewed the study protocols approved to be implemented. A support letter obtained from the University of Granada, Institute of Migration (see **Appendix III**). The support letter obtained was presented to the UNHCR local representation to get their approval to conduct research activities in UNHCR registration centers in Amman and Mafraq governorate. UNHCR apologized for giving permission to collect data in their registration center and approved it to be done in the community centers run by their local national partners (**Appendix IV**)

However, the survey poses no direct risk to participants. The data collection took place in service delivery sites with no home visit involved. No specimen collection involved. No sensitive information collected. The participant interviewed in the waiting area with privacy considerations, each participant spent around 15 minutes to respond to the survey questions. The interview made in a special closed space made available by local NGO and the interview range was between 12 to 40 minutes. There is no direct benefit for participants, however, it was explained to the participant that the results will be utilized by UNHCR and other agencies working with refugees to improve program delivery. And results may also be used to seek additional support for vulnerable refugees locally and globally.

Informed consent sought from all participants at the beginning of the interview. Only consented members were eligible for participation (**Appendix V**).

3.10. Trustworthiness of methods

I aim to increase the trustworthiness of my study by keeping ethical standards observed during data collection and analysis, a survey questionnaire modified in consultation with the community of practice and an interview guide developed in consultation with three experts. All tools are either adjusted or developed in line with the conceptual framework. A survey sample was employed randomly, and semi-structured interview subjects were selected purposively with maximum variation ensured. The data collection sites were selected to be community centers rather than a healthcare provider to ensure the heterogeneity of the subject, thus ensuring various health seekers and mixed access behaviors are well captured.

Qualitative data analysis including coding subjectivity are managed through the triangulation of qualitative findings versus quantitative findings. Triangulation, or analyzing data using more than one procedure (Curtin & Fossey, 2007) was followed using primary data collected through survey participants. However, the researcher's experience and long involvement with refugees' health programming and policies can be considered a strength and foster qualitative data reliability (Bumbuc, 2016).

3.11. Analysis Techniques

In reference to the research methodology adopted (convergent Mixed Method), a completely separate data analysis has been carried out for qualitative and quantitative data sets.

3.11.1 Descriptive and relational analysis

Upon completion of quantitative data collection process for data set, the data was extracted from the KOBO database in Excel Microsoft form. Data check, and cleaning were done and revealed minor missing data for one case who were not detected as a head of HH. Nine wrong entries detected were the year of birth entered instead of age. The entries were corrected manually to the age and kept within the data set. Among chronic disease open text responses, the data reviewed by clinical specialists to validate the disease classification, twenty-six individuals classify their disease as the chronic disease found not. Mainly those were anemia and desc prolapse. Other six individuals classified their diseases under the category "others" found to be under one of the predefined lists of chronic diseases, their data was modified, and the correct classification was made under the right category.

All descriptive statistics were produced. The Statistical Package for the Social Sciences (SPSS) version 25.0 software was utilized for descriptive analysis and relation analysis.

3.11.2 Thematic analysis technique

There were several guides developed by several researchers on the way to conduction of thematic analysis (Boyatzis, 1998); (Attride-Stirling, 2001). This study used the most prominent guide commonly used, which was developed by Braun and Clarke and is currently widely used by qualitative researchers (Clarke & Braun, 2017) The analysis method passed through six phases as it was described by Braun and Clarke as the following:

Phase 1: Familiarization with the data; a complete transcription of data made in its original language, full careful reading was done several times to contextualize the contents and active searching for patterns or meaning were looked after. During the initial scanning phase, the

analysis started with observation, notes and themes recording as Braun and Clarke (2017) recommended.

Phase 2: Initial code generation, where systematic coding for the entire text to identify semantic and latent themes normally occurring in the next phase. Theme that "captures something important about the data concerning the research question and represents some level of patterned response or meaning within the data set" (Braun and Clarke, 2017, p. 6). A semantic theme is a theme that finds explicit or surface meaning, while a latent is that look for in-depth meaning, assumption or ideologies (Boyatzis, 1998; Braun & Clarke, 2006). Coding is done manually on the original hard copy text using manual writing and colored highlights for segmentation. All codes are recorded separately in soft copy documents regardless of their consistency, frequency, or contradiction as a part of the preparation for the next phase.

Phase 3: Themes identification followed where all code extracted sorted out in a theme, mind map created with a brief description on each theme, some Sub-themes and cross-cutting codes detected while some couple of codes were not classified and kept under the miscellaneous theme.

Phase 4: reviewing themes. During this phase, refining themes was done at two levels; at the first level, I went back to all codes generated and supporting data around them to identify if they appeared in a coherent pattern. Additionally, I validated the extracted themes using Patton's criteria (Patton, 1990), were all themes tested for internal homogeneity and external heterogeneity, and I moved to the second level when I did the validity of individual themes concerning the data set, a complete read for the transcripts done again to ensure that the themes reflect the data set content and evident there. However, no new codes were revealed after this level, but the back and forth during analysis was a continuous activity as a principle that

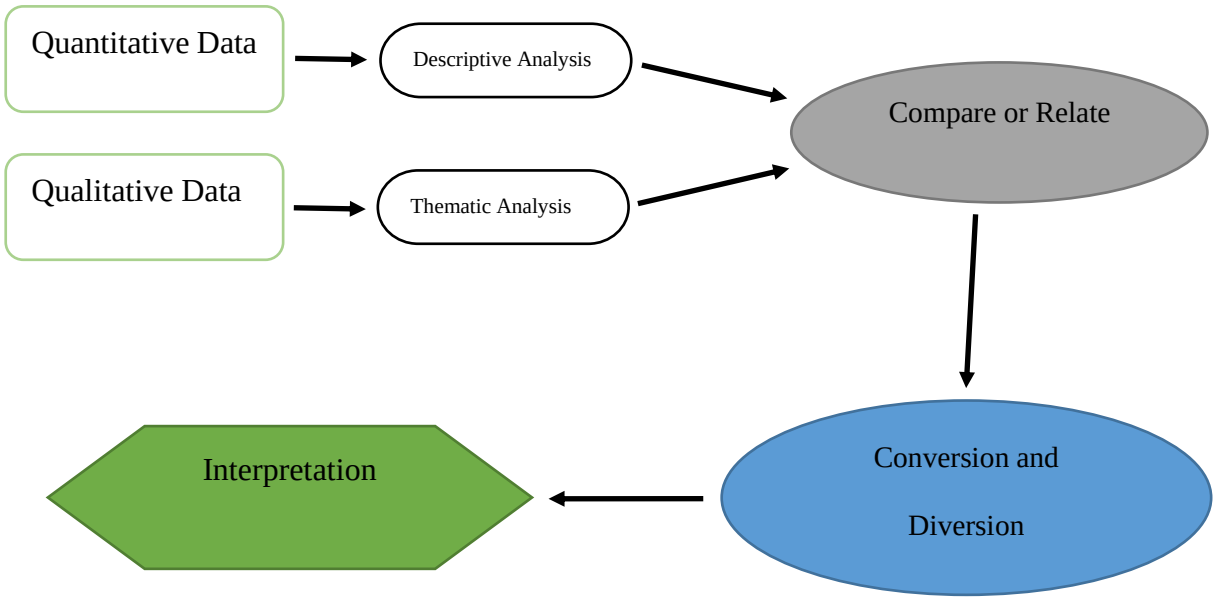
supported validation and flexibility (Ely, 1997). Finally, a well-structured thematic map has been created and validated by the end of this phase.

Phase 5: Themes defined and named. At this stage, the thematic map concluded, all identified themes defined and refined (Clarke & Braun, 2017). The core and root of each theme is coherent and consistent with the data set, an internal organization done, supported by narrative, and made within the context of research problems and questions.

Phase 6: Report findings. Within the report, all mapped themes have supporting information for the analysis finding in a form of analytical narrative. A full argument made in order to support the relation between findings to the research questions.

Finally, the findings from the qualitative and quantitative data set compared per thematic area using side by side comparison in the discussion to find out equivalences, contradictions or correlations that interpret the refugee's health access behaviors, barriers, and their way of adaptations to meet their health needs (see Figure 3-3).

Figure 3-3 Convergent design data processing cycle



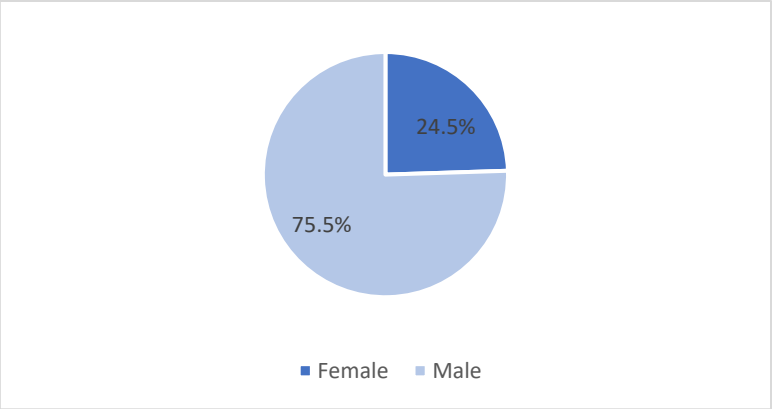
CHAPTER 4 . RESULTS

This chapter presents findings that relate to the research questions. Firstly, the basic demographic characteristics of study subjects are resented. Secondly, the constructed themes are explored using the data analyzed; the thematic areas including access and utilization, access barriers, adaptation strategies and impact. The analysis begins with a descriptive analysis of the quantitative part per thematic areas, and the thematic analysis of qualitative data. Finally, a multiple response analysis for other variables, including barriers and adaptation strategies, was conducted to estimate the weight of multiple answers provided by subjects.

4.1 Demographics characteristics

A total of 383 HH were enrolled in survey parts. (24.5%) among them were females, while (75.5%) males (Figure 4-1).

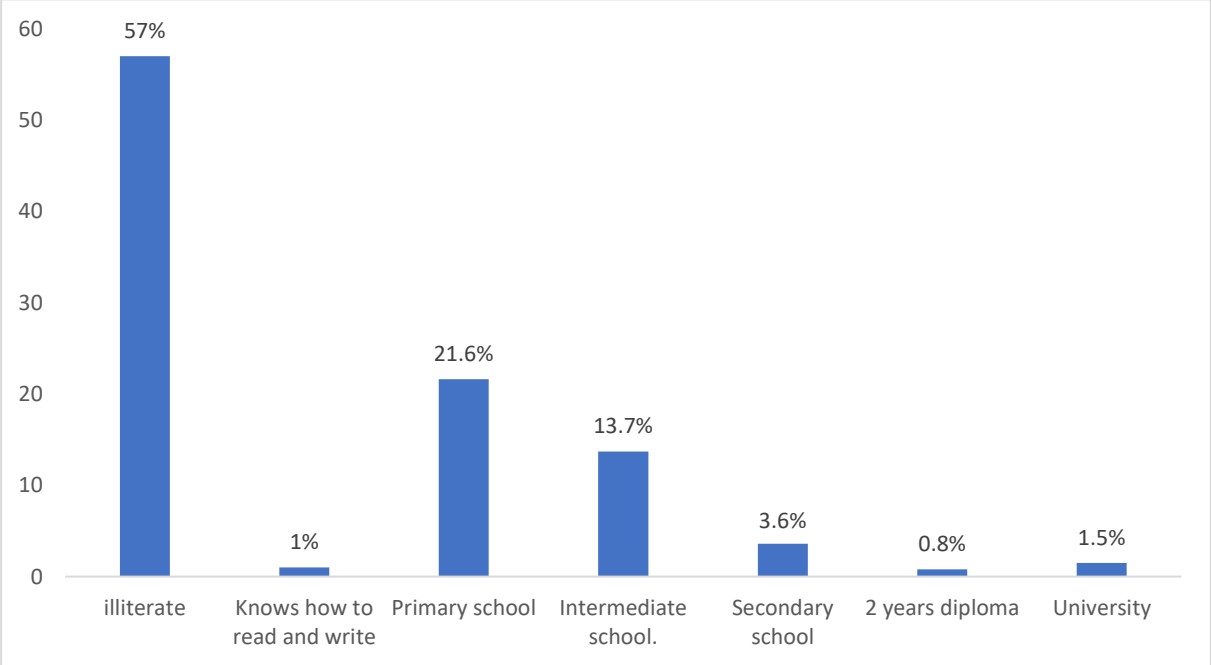
Figure 4-1 Gender of household head - quantitative sample



The languages spoken by the HH included Arabic (100%), English (1.3%) and French (0.3%)

There is variation in the education level of the HH head where the most considerable proportion (57.0%) are illiterate. In comparison (21.6%), completed primary school, followed by (13.7%) who completed intermediate school, completed secondary school (3.6%), had a 2-year diploma (0.8%), university (1.5%), and finally HH head knows only how to read and write (1.0%) (**Figure 4-2**).

Figure 4-2 Level of education of the household head - quantitative sample



Distribution by age for head of HH was 18-24 years (4.17%), 25 to 34 years (17.2%), 35 to 44 (31.0%), 45 to 54 (24.8%), 55 to 64 16.9%), and 65 years or older 5.6%. Most of the HH head were males (75.5%). The distribution by place of birth was mainly in Aleppo (24.5%), Daraa (20.1%), Homs (19%), and Damascus (14%) with minimal proportion from all other governorates that ranged from less than 1% to 5.7% (**Table *4.1***).

Table 4.1 Quantitative sample demographic characteristics

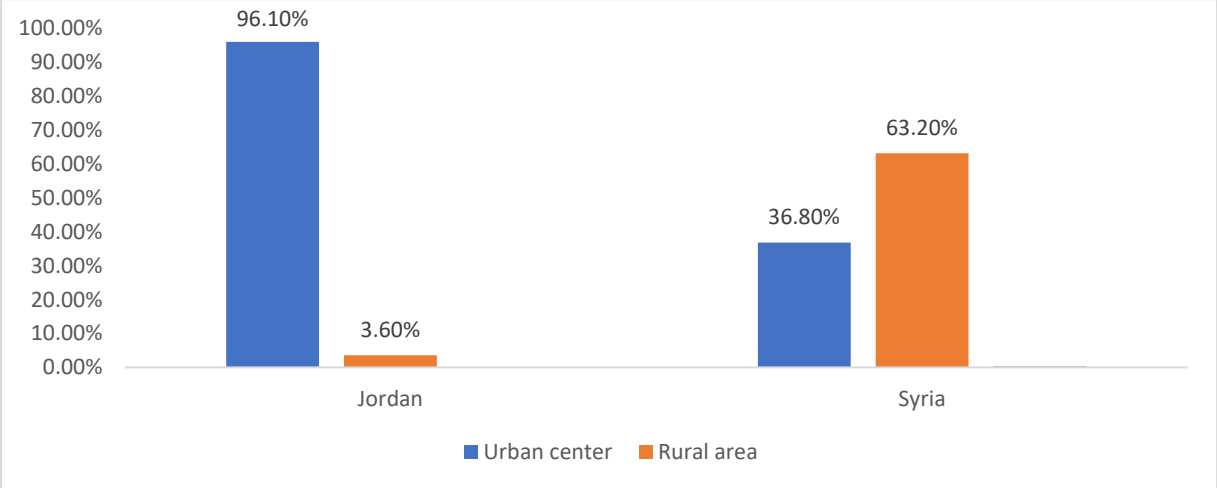
	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Number of HH enrolled	383	-	-
HH members enrolled	2199	-	-
Average family size	383	5.7	-
Gender of HH members (n=2199)			
Female	1089	49.5	49.6(46,3--51,9)
Male	1110	50.5	50.7(49.9-55.9)
Age distribution of HH members			
1-14	973	44.2	44.6(43.7-51.6)
15-29	583	26.5	26.8(24.9-28.1)
30-44	346	15.7	15.9(14.8-17.4)
45-59	197	8.9	9.1(8.9-10.7)
>60	100	4.5	4.5(2.7-6.8)
Gender of HH head (n=383).			
Female	95	24.5	24.4(24.4-24.9)
Male	288	75.5	74.9(74.8-75.4)
Age in years of head of HH (n=383)			
18-24	16	4.17	4.1(3.9-4.5)
25-34	66	17.2	17.3(17.5-17.7)
35-44	119	31.0	31.2(31.4-31.8)
45-54	95	24.8	24.7(25.6-25.9)
55-64	65	16.9	16.2(16.7-16.3)
>65	22	5.6	4.7(4.5 - 5.0)
Language of HH head (n=383)			
Arabic	383	100	99.8(99.7-100)
English	5	1.3	1.3(0.6-2.1)
French	1	0.3	0.2(0.0-1.1)
Education level of HH head (n=383)			
Knows how to read and write	4	1.0	1.1(0.9-2.1)
Primary school	84	21.6	22.1(20.7-23.7)
Intermediate school.	53	13.7	14.0(12.8-15.6)
Secondary school	14	3.6	3.9(3.0-4.9)

2 years diploma	3	0.8	1.3(0.4-2.1)
University	6	1.5	1.3(0.2-2.4)
Illiterate	219	57.0	56.8(56.5-57.1)
Place of birth (n=383)			
Allepo	94	24.5	24.7(23.1-26.0)
Hama	22	5.7	5.2(3.9-6.6)
Ar-Raqqah	12	3.1	2.6(1.5-3.1)
Homs	73	19.0	19.5(17.9-20.5)
Damascus	54	14.0	14.3(13.0-15.5)
Daraa	77	20.1	19.5(18.7-20.3)
Other	50	13	13.2(6.8-20.3)

* Method for weighting: SE = √ [p (1-p) / n)]

Among the HH that lived in Syria before coming to Jordan, (36.8%) were reported to live in urban centers, while (63.2%) lived in rural areas (**Table *4.2***). Most HHs (94.6%) live in urban centers in Jordan (**Figure 4-3**).

Figure 4-3 Lifestyle living - quantitative sample



The distribution by governorate of residency was Amman (67.1%), Zarqa (32.7%), Madaba (0.5%) and Aqaba (0.3%). The majority of the HH (97.6%) arrived in Jordan more than two years ago (**Table *4.2***).

Table 4.2 Qualitative sample geographical characteristics

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Place of living in Syria			
Urban Center	141	36.8	36.4(35.0-37.8)
Rural area	242	63.2	62.5(61.1-64.0)
Governorates live in Jordan			
Zarqa	123	32.7	32.5(31.1-33.9)
Amman	257	67.1	62.5(61.0-63.7)
Other	3	0.8	1.6(0.2-4.1)
Place of living in Jordan			
Urban Center	367	96.1	95.0(93.9-96.2)
Rural area	14	3.6	3.9(3.0-4.7)
Desert- Bedouin / Mobile living	1	0.3	0.2(0.0-1.0)
Time arrives in Jordan			
0 to 2 years	6	1.9	1.3(0.3-3.0)
More than 2 years	374	97.6	97.6(96.1-99.0)
Don't know	2	0.5	1.3(0.0-2.0)

A total of 20 HH adult members, were interviewed under qualitative investigation. Among them, 60% were males. Most of the HHs are in the nuclear structure (90%) only 10% are extended families with an average family size of 5.1 members per HH. The vast majority of interviewees were between 45 and 59 (45%) and between 30 and 44 (40%). There is variation in the education level of the interviewee where the biggest proportion (20 %) illiterate, while (70%) completed primary school, only (10%) completed secondary school and no one at a diploma or university level. Finally, most interviewed families arrived at the peak of the crisis between 2012 and 2014 (80%) and only 10% arrived during 2015 and 2016 (**Table *4.3***).

Table 4.3 Qualitative sample demographic characteristics

	Total (n=20)	**mean, %**
Total number of HHs enrolled	20	-
HH members enrolled	102	-
Gender of head of HH		
Female	2	10%
Male	18	90%
Gender of interviewee		
Female	8	40%
Male	12	60%
Age distribution of interviewee (n=20)		
18-29	2	10%
30-44	8	40%
45-59	9	45%
More than 60	1	5%
Education level of interviewee (n=20)		
Primary school	14	70%
Secondary school	2	10%
University	0	0.0%
Illiterate	4	20%
Family Type (n=20)		
Nuclear	18	90%
Extended	2	10%
Family Size		
Average family size	20	5.1
1-3	2	10%
4-6	10	50%
7-9	8	40%
Year arrives in Jordan		
Before 2011	1	5%
2011	1	5%

2012	3	15%
2013	9	45%
2014 and after	6	30%

4.2. Healthcare access and utilization

4.2.1 Awareness of available health services

Among the HH, (100%) aware that possession of a Ministry of Interior service card (security card) allows subsidized access to government health services at primary healthcare centers and hospitals (**Table *4.4***). Among the UNHCR registered refugees (86.1%) aware that UNHCR registered refugees have free access to immunization programs in Ministry of Health (MoH) healthcare centers (**Table *4.4***). (79.4%) The interviewed HHs were aware of the nearest MoH clinic, UN or NGO supported clinics (**Table *4.4***).

Table 4.4 Awareness about available healthcare services

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Aware that possession of Ministry of Interior service card (security card) allows subsidized access to governmental health services	383	100	98.7(97.9-100)
Aware UNHCR registered refugees have free access to the public immunization program	334	86.1	87.2(86.1-88.7)
Aware where the nearest MoH clinic	308	79.4	80.7(79.0-82.0)
Aware where the nearest UN or NGO supported clinic	308	79.4	80.7(79.0-82.0)

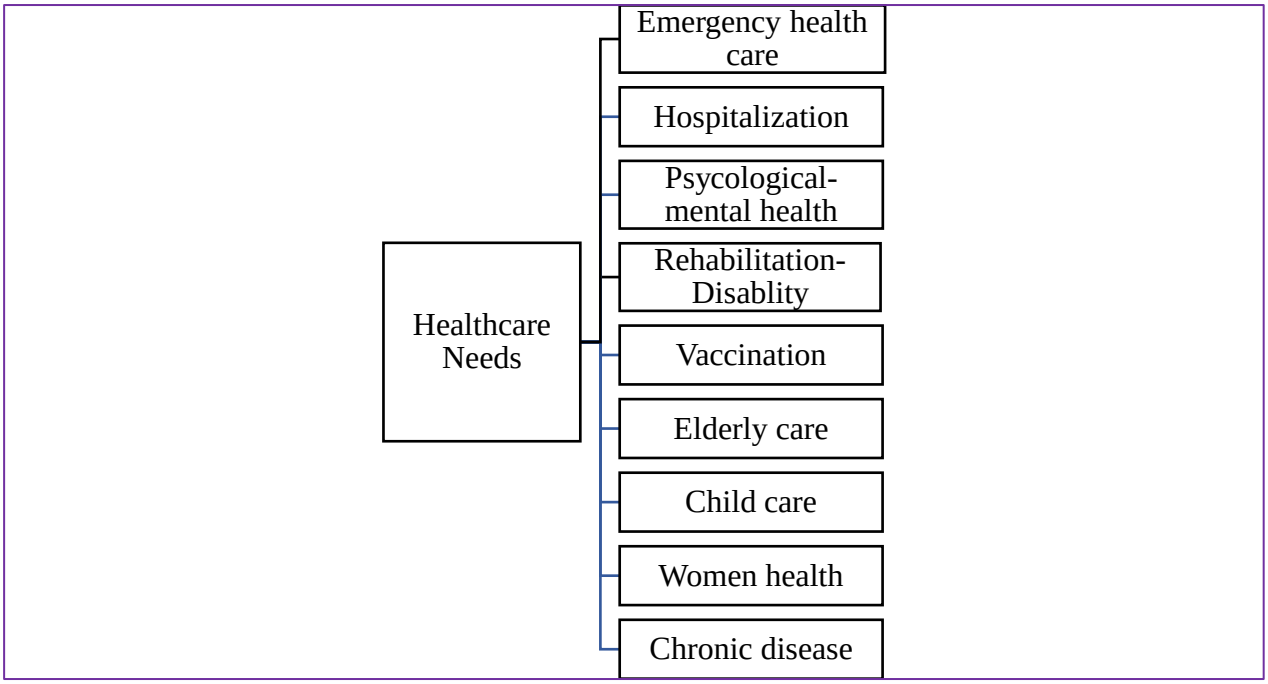
The participants over the semi-structured interview were asked to describe their family's health needs, awareness about health services and policies, and their experience with healthcare services utilized in the country of asylum. It was remarkable to observe several variations in responses. However, more than 60% of interviewed head of HH said that they are aware about

subsidized access policy, but other access barriers more impacted them. Additionally, the fluctuation of access policy was one reason fall behind nonawareness of current policies and were mentioned by a couple of participants.

4.3. Healthcare needs

The survey participants responded to the specific sections that were defined under needs theme including, child vaccination, women health (antenatal care and family planning), chronic diseases and monthly health needs of HHs (**Figure *4-4***). On the other hand, the semistructured interviews participants described a broad set of health needs they faced during the asylum journey, it seems that the individual characteristics of a HH members and contextual chrasterstics related to their unmet needs were the main drivers for refugees families when they indicated to their health needs over interviews. In total, nine feasures were identified by participants, including chronic diseases, emergency healthcare , hospitalization or in patient care, psychological-mental health, rehabilitation- disability, child care, vaccination, elderly care and women's health needs.

Figure 4-4 Healthcare needs thematic map



4.3.1 Health service needs among children

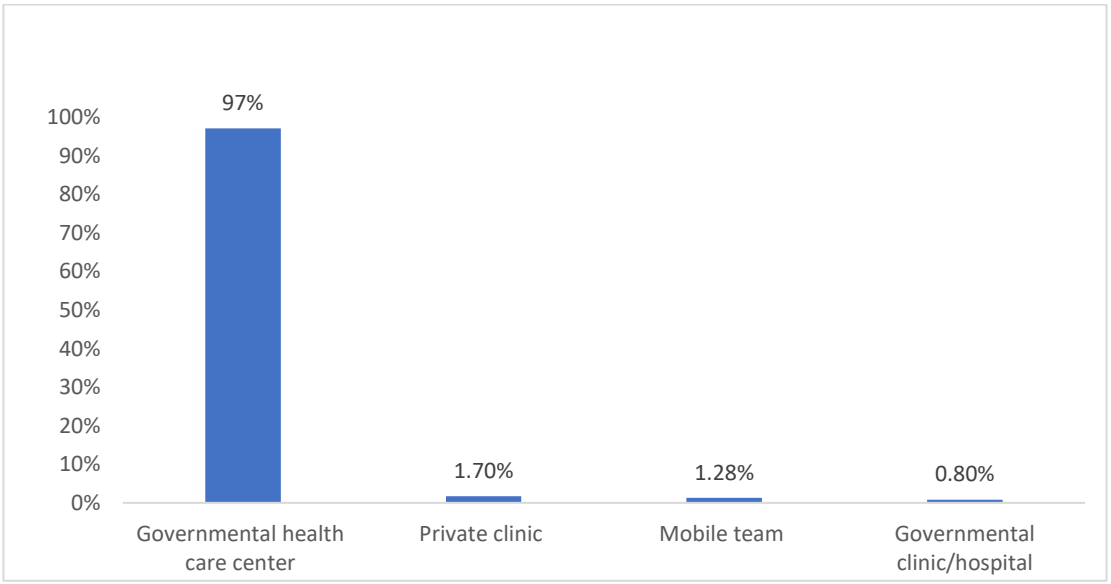
Among the vaccinated children, 61.1% reported receiving the vaccine in Jordan (**Table *4.5***).

Table 4.5 Children vaccination

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Received vaccines in Jordan	234	61.1	59.8(50.7-61.4)
Where children received vaccines (n=234)			
Governmental healthcare Center	225	97.0	97.3(97.1-97.7)
Private clinic	4	1.70	1.3(0.8-2.1)
Mobile team	3	1.28	1.3(1.1-2.0)
Governmental clinic/hospital	2	0.8	1.3(0.5-2.1)

The majority representing 97.0% took the vaccine in the governmental health Centre, 1.7% were vaccinated in private clinics and only 1.2% received vaccines from a mobile team. Finally, 0.8% received vaccines from a governmental clinic/hospital (**Figure *4-5***).

Figure 4-5 Place refugees children receive vaccines n= (234)



On the qualitative side, it was apparent through multiple participants responses that children's most frequently reported needs were acute conditions, malnutrition and its associated complications, and vaccination services.

A mother of two children stated that " my childern mostly needs a medication for flu, cough, pharengitis and chest infection. And my daughter since a while she has sizures" (05-001).

Another mother of 10 months baby said " when my daughter need care I bring medications from pharmacy and I vaccinate her in healthcare center" (19-001).

Another 9 members family left camp illegally, facing a huge dificulties in urban settelment due to their legal status, the head of HH stated " I have Ghofran suffer from anemia and they told me its due to malnutrition" (08-002).

4.3.2 Health service needs among women

Among women at reproductive age, 43.5% were found to be pregnant during the past two years, and the access to antenatal was at 95.8% among those who received any antenatal care during pregnancy. Most women 76.8% did between 3 and 4 visits during their pregnancy, while only about the fifth, 21% had complete antenatal care during their pregnancy with more than four visits, the low antenatal care was found to be very low with only 6.5% had only one or two visits (**Table *4.6***).

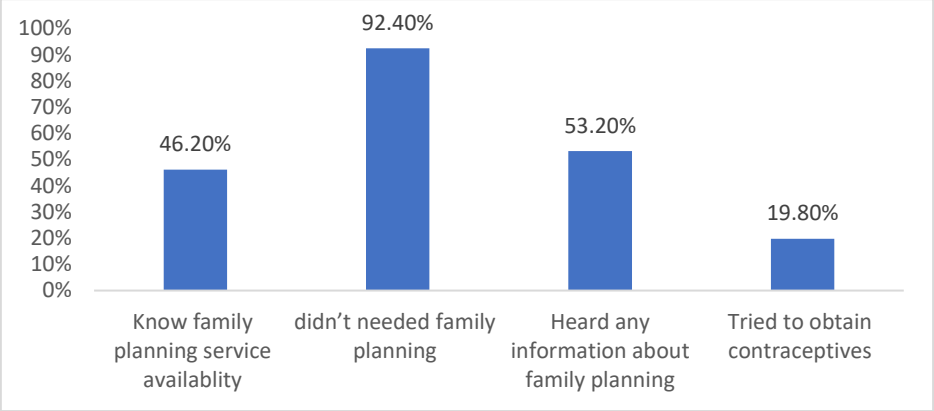
Table 4.6. Antenatal care uptake

	Total) N=331	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Pregnant during the past two years (N=331)	144	43.5	40.5(42.8-44.4)
Receive any antenatal care during the pregnancy	138	95.8	95.9(95.3-96.1)
Number of antenatal care visits			
1 – 2 visits	9	6.5	6.6(6.1-6.9)
3 – 4 visits	106	76.8	76.2(76.1-76.9)

More than 4 visits	29	21.0	21.5(21.1-27.7)

Figure 4-6 shows that the proportion of interviewed refugees who aware that there are available services in Jordan to prevent unwanted or unplanned pregnancy amounted to 46.2%.

Figure 4-6 Awareness and uptake of family planning services available in Jordan



A total of 92.4% of them did not need family planning during the past year (**Table *4.7***). An estimated 53.2% have heard about family planning in the past year, (29.1%) of them heard from community events, (2.8%) from TV/radio or other media, (0.5%) brochures or other writing materials, (11.1%) from health center staff and (11.9%) got the information from other sources (Figure 4-6).

Table 4.7 Family planning awareness and uptake

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Aware that there are services available in Jordan to help prevent an unwanted pregnancy	177	46.2	46.0(45.9-47.4)
Needed family planning services			
No	354	92.4	92.7(91.9-93.2)
Don't know	3	0.8	1.3(0.4-2.7)

Heard information about family planning in the past year	204	53.2	53.3(52.1-54.5)
Source of information (n=204)			
Community event	113	29.1	29.9(28.9-30.9)
TV, radio, or other media sources	11	2.8	2.6(1.2-3.6)
Brochure or other writing materials	2	0.5	1.3(0.4-2.6)
Health Center staff	43	11.1	11.7(10.8-12.1)
Other(specify)	46	11.9	11.7(10.7-12.3)
Members tried to obtain contraceptives within the past year	76	19.8	19.5(18.4-20.6)

Although most of the interviewed participants were women (N=14) and most of them were at reporoductive age (N=9), there was a litle mention of women's health issues. Participants' most frequent mentioned needs were pregnancy, child delivery care, and family planning.

40 year old woman talked about her challenging experience during pregnancy and delivery, she said:

> “since one year, when I was pregnant at 7 months I went to Haooz hospital for a pain crisis, frankly they took some money because I am Syrian; I paid around 16 JoDs. I did some investigation and they found big in may gall bladder, they said nothing can be done as you are pregnant and you have to wait until you give birth. Later, when I gave birth and because my daughter still young and cost; I delayed it and currently use pain killers” (19-001)

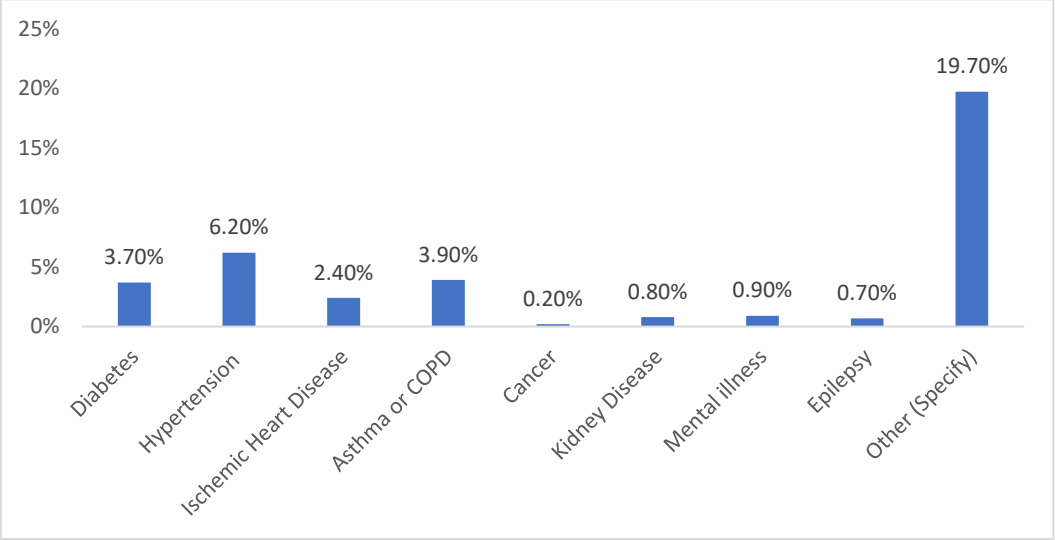
Another 45 years old head of HH said “ my wife needed treatment to get pregnant, she has hypertention” (16-002)

A 26 years old woman stated “ I am currently sick, I have children to care for, I am using isolation method currently and afraid to get pregnant as my little daugter is sick and require about 2 years of care” (05-001).

4.3.3 Health service needs among chronic ill

More than 28% of HH members reported having one or more chronic health condition, among the reported chronic conditions hypertension recorded the highest rate with 6.2% followed by asthma or COPD (3.9%), diabetes (3.7%), ischemic heart disease (2.4%), mental illness (0.9%), kidney disease (0.8%) and finally epilepsy (0.7%) while (19.7%) members reported having other diseases (Figure 4-7).

Figure 4-7 Chronic conditions prevalence among family members



On the other side, nearly most interviewed participants identified chronic disease as one of the primary pressing needs for their family members due to the nature of the disease, which requires continuous follow-up and a wide range of medical services. In addition, the nature of disease care requires continuous financial commitments that are directly related to the disease treatment and indirect support cost such as frequent transportation and investigations.

A woman aged 56, when asked about the reason for her next visit to the health centre, she said:

“I will go for medication for me and him (66 years old husband), I take medication for hypertension and him as well, I take immune modifying agent as I have vessel disease, rheumatoid arthritis and renal impairment. I take medication and he takes as well” (Z18-003)

Another mother stated:

"… life is dificult, I have daughter at age of 9 years has electric waves in her head called Epilepsy, I give her medication in the morning and evening and sometime she relapses so I admit her to the hospitals for 3 days." (Z04-001)

4.3.4 Emergency Healthcare

The emergency healthcare needs stated by some participants as it comes suddenly and without preperations. However, most of the emergency health ocasions encompass catastrophic health expenditures.

A 42 years old refugee man asked about the place of seeking care he said " mostly we go to the hospitals for an emergency cases" (A19). Other 43 years old mother said "I don't go anywhere unless its an emergency situation" (Z18-002).

It was noted through many interviews that the participant gets into emergencies because of natural occurrence of emergency occasions or delayed seeking of healthcare that leads to a deterioration of individual health status, thus occurance of emergency complications. A woman (A08) stated " my husband have hemorrohid, its acute and he developed bleeding some days ago, but cant go to the doctor, he has to wait and be patient"

4.3.5 Hospitalization

Across the data, the participant indicated to the hospitalization or healthcare on an in patient basis as a major health issue they faced. Most participants see hospitalization as a significant health event because of it is catastrophic nature and because its associated with huge health expenditures, where most participants face issues related to the affordablity of healthcare cost. (Z04) said "my old son need surgery for his nose and tonsils, I applied for support several times but no one give a hand".

4.3.6 Elderly healthcare needs

The composition of qualitative sample showed little proportion of elderly among participants. The need of elderly has been a concern for some HHs as the elderly require a special support for daily care and close medical followup, while there are a special requirments for their needs that require a better financial capacities to support them. A care giver stated:

> " I cant work due to my mother situation, my mother health status is very bad, she has sores and need diapers. I went to Caritas clinic but didn't recived me, a doctor told me that your mother should be died long time ago due to bed sores, I stop going there and strat beying medication and treating her" (Z04-004)

Finally, throguh the data its surfaced that the most frequent addressed needs by participants for old ages were needs for chronic condition treatment as its highly prevelant among this group.

4.3.7 Rehabilitation - Disablity care

Among all participants, four interviewees indicated to the disablity, impairment and rehabilitation as a specific needs for one of their HH members. The reported disablities were physical disablity, speech impairment and visual impairment.

A participant stated " my son have a problem, he has to change his eye glases every 6 months, I have to take him to the doctor he used to visit, the doctor take 20 JoDs per visit but because of our situation he take 15 JoD" (19-001)

The existence of such difficulties, coupled with the socio-economic situation of these families, places them in a situation of particular vulnerability, as expressed by this mother:

> "I am concerned about my children, I am sad about them because I am not able to provide them with anything, my old son with thanks to god has no problems and he is

good (meant Akram) but Yaman and Retaj have weaknesses in speech, everyone told me they need speech center or a doctor" (Z25 001)

4.3.8 Psychological – mental health

Finally, under "Needs" theme , another pressing healthcareneed was detected as one of the most prominent health-related issue; almost all participants (17 participants) at several interview stages of interviews mentioned psychological issues and its impact on their health status. The psychological impact was not only or directly related to health isuues but was a consequence to almost all other livelihood conditions, difficulties faced to meet other basic needs and sometimes due to social isolation. Participants described a wide range of psychological and mental health issues, including anxiety, frustration, fear, stress, depression, suicidal thoughts and attempt, violence and drug abuse.

A 60 year old participant have mutiple health problems said " what I can say! How I can say it! I am fed up with my life. Everything is difficult, everthing made psychological dellima because of difficult situation" (11-001).

A 28 years mother, when was asked about her concern on children she said "I have fear on them if they got sick, I cant treat them, I am scared as they might have psychological issue beacuase of weaknesses we live" (22-001).

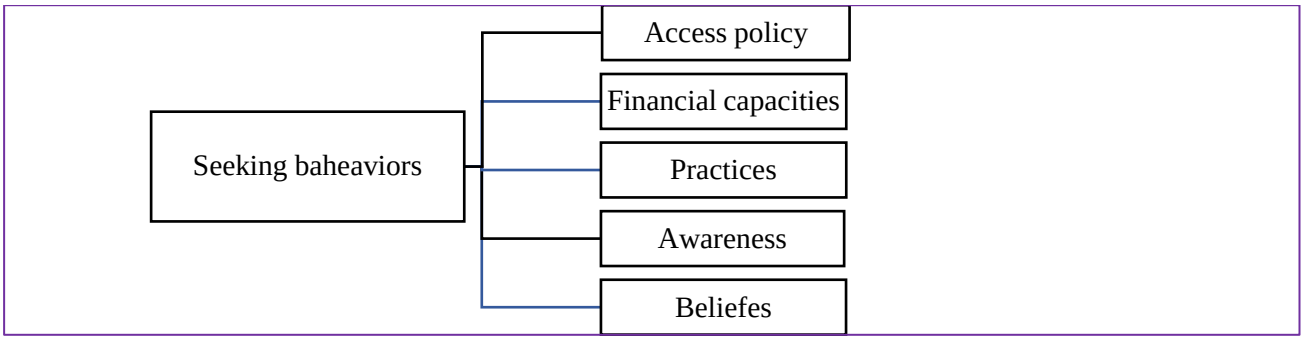
Another 45 years old father when he was asked about challenges he faced to get needed services he stated " I have a son he had stress episode, he took pills and toxic himself" (16-002)

4.4. Healthcare seeking behaviors

Healthcare seeking behaviors were evaluated quantitatively using the designated tool, Health Access and Utilization Survey (HAUS) and the argument was supported qualitatively in the

case of overlapping embedded in the dataset, including the semi-structured interview data. The resultant subthemes under this umbrella theme are illustrated in (Figure 4-8)

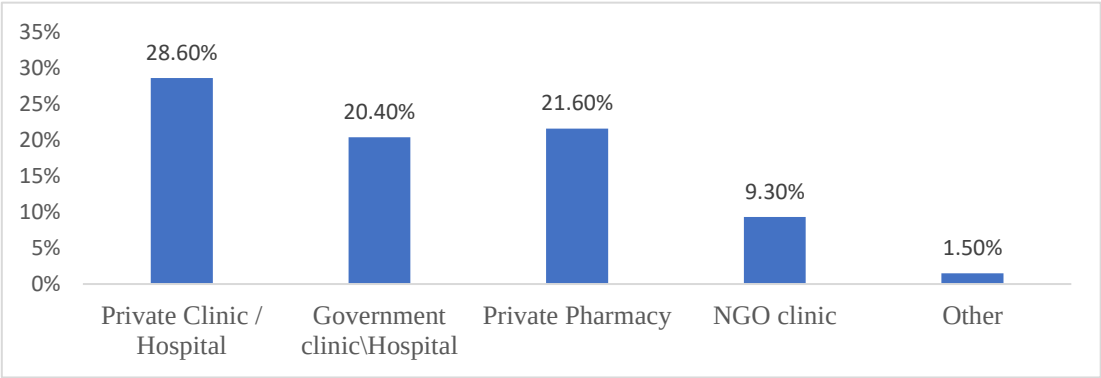
Figure 4-8 Seeking behaviours thematic map



4.4.1 Monthly health access among HH

The HH that needed access to healthcare services was estimated to be 88.5%. The refugees could access healthcare through private clinics/hospitals (28.6%), government clinic/hospital (20.4%), private pharmacy (21.6%) and NGO clinics (9.3%) (Figure 4-9).

Figure 4-9 Place of access to health care



Among the refugees who could obtain healthcare (84.7%) had to pay for the received care. Most refugees (94.8%) paid less 100 JoDs (**Table *4.8***).

Table 4.8 Monthly health access

	Total (n=384)	Unweighted proportion or mean*, %	Weighted proportion or mean*, % (95% CI)
Family members needed access to healthcare services	339	88.5	88.5(87.1-89.9)
First place went to for care(n=316)			
Private provider	111	28.6	28.6(27.0-30.0)
Government provider	79	20.4	20.8(19.4-22.3)
Private Pharmacy	84	21.6	22.1(19.8-23.3)
NGO clinic	36	9.3	9.1(10.2-10.8)
Other	6	1.5	1.3(0.4-3.0)
Paid for the health services	287	84.7	84.5(83.7-85.6)
Amount paid in JoDs			
<100	272	94.8	95.0(94.9-95.1)
100-200	6	2.1	1.3(0.1-2.9)
201-300	3	1.1	1.2(0.2-1.9)
301-400	1	0.3	0.0
>401	1	0.3	0.0

Across the data, the interviewed participant indicated to their access behaviors to the healthcare services in several ways. Multiple domains detected in transcript that played a driver for seeking healthcare (Figure 4-8).

Health policies related to access eligibility and provisions and the need-driven practices among previous experiences were detected as themes across the data set. Additionally, it was prominent that the awareness of refugees and financial capacities found to be additional driver for seeking of healthcare. Finally, in some cases beliefs on how healthcare needs perceived by participant found to be additional domain under health seeking behaviors.

4.4.2 Access policies

Access policies were a major driver among most participants where their access behaviors impacted by one access policy was related to the refugees' eligibility and offered healthcare services by government of Jordan. Some of the refugees used to utilize public package of

healthcare because it is inclusive, easily accessible, and affordable. As a 35 years old woman explain:

> "there is healthcare center in Jabal Al Qosoor, it is a governmental center, we go and present UNHCR registration certificate, we own UNHCR certificate and when we need to go, we take our children, then we submit copy of UNHCR certificate and personal ID and they give us treatment as Jordanian" (Z04-001)

The other face of access policy that drives the healthcare access behaviors and was found to be a theme across most the participants was related to the country's healthcare policies, but not specific to the refugee's access policies. Hence, in Jordan there is no control over pharmaceutical marketing, and the drug market is open, while most of medication can be taken directly over counter without proper prescription. This drug access policy has indirect reflection over participants seeking behaviors and surfaced a prominent theme in almost half of the interviews (45% of interviews); this health-seeking behavior is called self-medication where the individuals can directly access private pharmacies and got their medication over counter without proper prescription.

For instance, when a participant mother asked where she went when she or her family needed healthcare, the first answer was "I go to the pharmacy, frankly; because of any doctor fees is expensive" (31-001).

In this sense, the refugees adapted a new access behavior that reduces the healthcare cost by eliminating doctor fees, testing costs and transportation costs, and limiting it to only medication costs.

4.4.3 Financial capacity

Financial capacity of interviewed HH was another major driver for health seeking behaviors, throughout thematic analysis of seeking behaviors and places where the refugees decide to go

to sought health, it was a fact that the financial capacity of family and its association with the cost of healthcare needs drive family where to seek healthcare. That association appeared in many forms. For instance, some interviewees clearly mentioned their limited financial capacities and how it led to adaptation of certain seeking behaviors to reduce cost of healthcare to be afforded such as seeking NGOs free services, seeking care in governmental subsidized healthcare facilities or self-medication. Some interviewees mentioned delays in seeking care or using alternative or traditional medicines.

An old man, when asked about places he or his family sought care at, gave an obvious example of how families change their seeking behaviors to reduce healthcare cost while meeting their healthcare needs. He said, “I go to Caritas clinic to get my monthly medication” and describe his experience as follow:

I go to Caritas on monthly basis to get my medication, its good, and every three months I see doctor, they test my blood sugar and pressure, it’s good for me but when my children got sick, I take them to Osrat Aljundi (NGO clinic), currently Osrat Aljundi stop dispensing medication, as they don’t have. They direct us to get it from outside. I am obliged now to take them to the public clinic, I pay 0.4 JOD and take medication, it’s all about 2 JoDs (Z04-003)

Other 54 years old woman, when she was asked about healthcare needs and places she go for, she said “we go to bring medication from pharmacy as we don’t have nearby health center, or we go to Aoun or Caritas clinics (NGOs Clinics) where you need to take taxi and pay for transportation” (08-001)

4.4.4 Practices

Practices derived by experience was found to be another behavior driver, some refugees when they encounter access barrier, they tend to change their seeking behaviors to eliminate those barriers, while some others when they have facilitated access to meet their needs, they continue

to use it regardless of its appropriateness or completeness. A wide portion of interviewee has mentioned several reasons for their practices when they were seeking healthcare, the accommodation strategies were followed by many refugees' families where some were using governmental healthcare because its geographical proximity while other avoided it because of geographical distances. Some other used governmental healthcare because of low cost while some other avoid it because of high cost. Some others used other type of services to reduce cost. Some decided not to use governmental healthcare services because they faced poor treatment during their first exposure, mainly due to bad quality, long waiting, and lack of proper documentation. As a38 years old woman explain:

> "The governmental health center is far, I live in Jabal Alhusien and the health center is in east Amman thus I need two and half JoDs transportation, photocopying my papers and paying in the center, the total cost will be around five JoDs. No, I will bring the antibiotics and Revanin (antipyretic) from private pharmacy and no need to wait" (31-001)

Another woman said:

> "I tried to access governmental centers, they told me there are health center help Syrians. I tried to obtain health card for me and my children but unfortunately there was bad treatment, I stopped because the staff humiliate us as Syrian while I didn't do anything, I was shocked because of speech used and stopped going there" (31-002)

4.4.5. Awareness

Awareness of refugees on what is available in terms of health services or how to use or access available services was another factor that impacted the refugee's decision on where to go when they needed any type of healthcare. Many refugees described in a different way how they select or avoid selection of certain care provider based on their awareness or non- awareness. For

instance, a woman when she was asked on places she go when she or her family needed healthcare, she said:

> "Initially, I went to governmental hospitals but face poor response; I mean when I took my daughter, I take her on emergency basis. Some time ago, I took her to Totanji hospital and another time I took her to Albasheer hospital. One time I had no benefit because I didn't know what to do, they sent me from one office to another and from one clinic to another, they told me that the neurologist isn't here so there was no solution, I become more tired and she became more worse, I went back and start search for other providers (25-001)

Some other participants they were not utilizing the public healthcare services, or they did not try it because their nonawareness about their eligibilities for subsidized rate. A mother of seven children used to use NGO supported health services, when she was asked about her awareness on subsidized access to healthcare at public system she said

> "I don't know, never went there" (08-001); while another participant said " I went there previously but I don't know if they will treat me now like Jordanians, four years ago there was subsidized policy but they stopped it now" (16-002).

4.4.6. Beliefs

Finally, beliefs appear to be one of indirect theme that has been impeded in responses of many participants where the way they perceived the seriousness of health conditions and risks associated with unmet health needs drive their behaviors to meet those needs. Few participants delayed their access to healthcare, until situation resolved or worsen, then they decide their way as they have less intense perception about the seriousness of needs and associated risks. Some others perceive those health needs as a serious need and adopted different strategies including

searching for free services, borrowing money, begging, or using food vouchers to meet those health needs. For example, 46 years old woman said:

> "We wait for our health needs until the situation gets worse, then may some good people help to access hospital since I reach point becoming in need for a hospital. For example, my chest disease; when I had difficulty in breathing and temperature above 40, before that I tried to take antibiotics to treat myself, but things weren't improved so when I get worst some good people help me and take me as an emergency case to the hospital on nighttime" (31-002)

Other case when he was asked about health needs and strategies adopted, he said

> "I prioritize health needs over other's needs. For example, I was smoker then I stop in order to meet my family needs, I was paying two JoDs daily for cigarettes which I need them for my family so I stop smoking as its not essential, medication I can't stop it, so I prioritize medication over smoking" (16-002).

4.5. Healthcare access barriers

The quantitative data meant to capture access barriers in main three areas including child immunization, women health, and monthly regular access. The estimated access barriers quantified based the proportion of those who encounter barriers during access and percentage of type of barriers based on pre-set defined barriers as per the following

4.5.1 Child immunization barriers

About 97% of children were able to get their vaccine without any barriers and only 3% of the parents have encountered difficulties while obtaining the vaccines. The most prevalent barriers were inappropriate staff behavior and parent awareness on place of vaccination (**Table *4.9***).

Table 4.9 Child vaccination difficulties

	Total (n=383)	Unweighted proportion or mean*, %	Weighted proportion or mean*, % (95% CI)
Children received vaccines in Jordan	234	61.1	59.8(50.7-61.4)
Encountered difficulties while obtaining the vaccine	7	2.99	
Encountered difficulties while obtaining the vaccine(n=7)			
Long wait	1	0.3	0.2(0.0-1.3)
Staff was rude	2	0.5	1.3(0.2-2.2)
Couldn't afford user fees (wasn't free)	1	0.3	0.2(0.0-1.3)
Can't afford transport	1	0.3	0.2(0.0-1.3)
Don't know where to go	2	0.5	1.3(0.2-2.2)

4.5.2 Women health barriers

Among pregnant women 1.9% reported difficulties while getting antenatal care, the most reported difficulties that prevented them from getting care were affordability of user fees (1.5%) while other reasons had minimal impact with less than 1% among each barrier (**Table *4.10***).

Table 4.10 Antenatal care difficulties

	Total	Unweighted proportion or mean*, %	Weighted proportion or mean*, % (95% CI)
Women pregnant during the past two years	144	43.5	40.5(42.8-44.4)
Women faced difficulties while getting care	41	1.9	1.8(1.0-3.1)
Reasons prevented the pregnant HH member from getting antenatal care (n=39)			
Long wait	4	0.2	0.2(0.0-1.1)
Staff was rude:	3	0.1	0.2(0.0-1.5)
Couldn't afford user fees (wasn't free)	33	1.5	1.6(0.3-3.0)
Facility wasn't properly equipped	4	0.2	0.3(0.0-1.1)
Others (Specify).	4	0.2	0.3(0.0-1.1)

Among women who tried to obtain contraceptives (19.8%), 3.1% faced difficulties; the most frequent reported difficulties were user fees (2.6%) and minimally the staff behaviors at 0.8% (**Table *4.11***).

Table 4.11 Family planning difficulties

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Members tried to obtain contraceptives	76	19.8	19.5(18.4-20.6)
Faced difficulties obtaining the contraceptives	12	3.1	2.6(1.4-3.8)
Encountered difficulties while obtaining the contraceptives(n=15)			
Long wait	-	-	
Staff was rude	3	0.8	1.3(0.7-1.9)
Couldn't afford user fees (wasn't free)	10	2.6	2.6(1.4-3.8)
Don't know where to go	-	-	
Don't believe in contraceptives	1	0.3	0.3(0.0-1.2)
Fearing side effects	-	-	
Others (Specify)	2	0.5	0.5(0.0-1.7)

4.5.3 Chronic illnesses difficulties

Among the members with chronic diseases 23.0% of them had difficulties to access healthcare services for various reasons including not knowing where to go (22.0%), in addition to the long wait (3.3%) and mainly not being able to afford user fees (97.8%) (**Table *4.12***).

Table 4.12 Chronic disease access difficulties

	Total	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Members have Chronic condition	628	28.6	
Member unable to access health services	506	23.0	23.1(21.9-24.7)
Reasons for inability to access health services(n=506)			
Long wait	17	3.3	3.5(3.1-3.7)
Couldn't afford user fees (wasn't free)	497	97.8	98.1(97.3-97.9)
Don't know where to go	112	22.0	21.9(21.2-21.5)
Others (Specify)	8	1.5	1.8(1.0-1.9)

4.5.4 Monthly access barriers

Monthly regular access to healthcare shows minimal barriers with high uptake rate, only 7.9% couldn't access healthcare in past month due to many reasons including not knowing where to go (0.8%), not liking the health service/staff (2.1%), facility refuses to give care (2.1%), couldn't afford user fees (2.1%) or transport (0.3%). (**Table 4.13**)

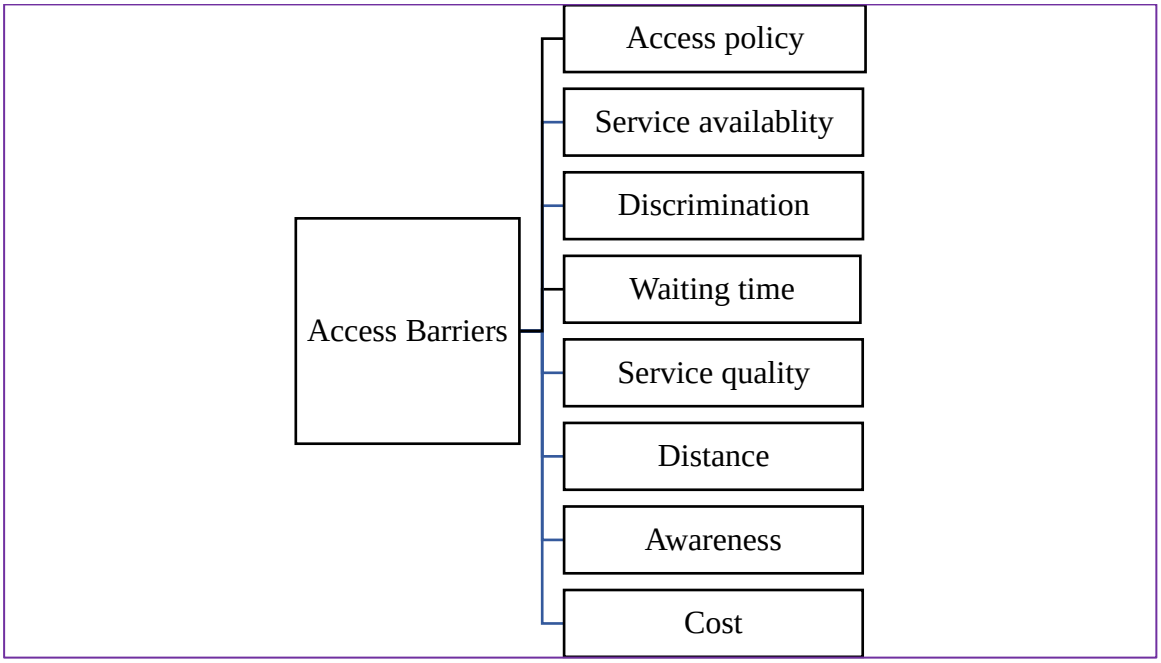
Table 4.13 Monthly access difficulties

	Total (n=383)	**Unweighted proportion or mean*, %**	**Weighted proportion or mean*, % (95% CI)**
Members needed access to healthcare services in past month	339	88.5	88.5(87.1-89.9)
Were not able to get healthcare	25	7.9	7.6(5.2-7.9)
Barriers faced to get needed care(n=25)			
Facility refuses to give care	8	2.1	2.6(1.2-3.9)
Couldn't afford user fees (wasn't free)	8	2.1	2.6(1.2-4.2)
Can't afford transport	1	0.3	0.3(0.0-1.5)
Don't know where to go	3	0.8	1.3(0.6-2.0)
Don't like the health service/staff	8	2.1	2.6(1.5-3.7)
Others(specify)	7	1.8	2.6(1.3-3.5)

On the other hand, the group of refugees participated in qualitative component reported several barriers to the healthcare, all 20 HHs reported at least one barrier when they were accessing the healthcare needed by one or more family members.

It is remarkable to observe the huge factors in participants' experiences and recognition of factors considered barriers to healthcare access. The most frequently cited factors included cost, access policies, service availability, discrimination, awareness, distance, quality of service and waiting time. However, several participants described different experience with these factors, some of which created barriers for one participant and might be perceived as a non-issue for others. The below figure illustrates domains associated with access barrier's theme (Figure 4-10).

Figure 4-10 Access barriers thematic map



4.5.5 Cost as barrier

Nearly all the participants mentioned the cost of healthcare as a main barrier to access needed healthcare services. For example, 19 out of 20 participants mentioned cost during some stages of interview as a barrier to get needed services, some were not able to get service due to affordability while other fall in debt due to a previous health event. The cost of services was classified into direct health expenditure and indirect expenditure; the direct health expenditure was those expenditure needed to cover cost of direct healthcare services such as cost of medication or hospitalization while the indirect expenditure mentioned were mainly due to transportation cost and some administrative cost related to the documentation.

An example, when the cost is high and not affordable was an issue for a 37 year mother (12-001) when she was asked about last health incidence she said:

> “Last time I went to Dr.Ahmad in Alsadeh st. because of my knees problem, he said you need x-ray as you have bone friction, I told him about both legs and my back, then

> he said, you need x-ray for both legs and your back. I went nowhere, I didn't undertake the x-rays" (12-001)

When she was asked why, she stated:

> "I don't have income to go and do x-rays, I need 100 JoDs and then go back to the doctor and pay another 50 JoDs. I went to another doctor, he prescribed an injection cost 300 to 400 JoDs to be injected in my knees, some people told me its good and some told me it's not. Even if it's good, from where I can bring 400 JoDs, 400 JoDs can cover 4 months' rent for my house"

Another example, when the cost seems very low but the financial capacity of HH be a real barrier, was among 60 years old male (Z11-001+002) when he was asked about last health incidence he said: "I used to go to normal doctors, those who take 3 to 4 JoDs, I went there since several months, as I told you I don't have any, even medication cost", then when he asked why, he said " I went for body balance problems because I stop medication as its costly, it cost 15 JoDs".

Additionally, the transportation and other administrative procedure cost were mentioned by some participants as a barrier to healthcare. For example, a 38 year women said:

> "The governmental health center is far, I live in Jabal Alhusien and the health center is in east Amman, I need two and a half JoDs transportation, photocopying of my papers and pay in the center so the total cost will be around five JoDs. No, I will bring the antibiotics and Revanin (antipyretic) from private pharmacy and no need to wait (31-001)

Finally, it was notable among those who detected cost as a barrier they faced the increased cost of needed services which prevented them from seeking services or due to their low financial capacity even if the needed care is within a low-cost category.

4.5.6 Healthcare access policy as barrier

Healthcare access policy as a barrier surfaced into two interviews, each interviewee has different reasons for the access requirements detected as barriers for healthcare. The first interviewee indicated the lack of access to subsidized healthcare at public healthcare due to their place of residence. The place of residency prevented them from getting that level of care and shifted their access to use private pharmacies to meet their health needs. One of the participants, when was asked about the places she goes to when she needed healthcare, said: "actually I have to go to health center (public center) but have a problem with our cards (Ministry of Interior registration card), our card issued from Marka and we live here (Nuzha)" (19-001).

Other participants indicated to their legal status that cause an access problem when they needed healthcare, this case left a camp without proper bail out, thus was not eligible for assistances at urban supported healthcare services at subsidized rate. said " my husband fall down from 4th floor, he had multiple fractures in his pelvis, he stayed in bed for about one year, now he improved and starts walking" when she was asked about place of care she stated:

> "we took him to Albasheer hospital, no one help us, neither Aloun (NGO) nor Albasheer hospital because of our legal status, it was a difficult situation, he had fracture so he cannot go back to the camp since I couldn't mobilize him at all, we obtain the treatment cost from people, we announce on Facebook and some people help us and we borrow money as well, we have 1500 JoDs left as debt" (22-001)

4.5.7 Service availability as barrier

Service availability was detected as barrier to get needed services, at least 7 participants directly mentioned their inability to get needed service due to its unavailability at healthcare facilities, most of the notes on unavailability come from those who accessed public healthcare facilities

while no significant association found among level of care weather at primary healthcare level of other advance level at hospitals side. The service unavailability presented in two ways; the first was when clients face shortages in provisions of services like lack of medical specialty or medication, while other shape of unavailability was the lack of space capacity to accommodate client needs like lack of vacant hospital bed due to full occupancy of available beds.

A 26 years mother when she was asked where she go when needed healthcare, she said: “I go directly to the pharmacy, I cannot afford doctor fees”. And when she was asked about her experience with governmental health center, she said: “I go there when needed vaccination when my children were young, I went one or two times and medication was not available, they give me one medication and I bought other from outside” (05-001).

Another mother when she was asked about her experience with last health incidence at governmental hospital, said:

> “My son needed admission some days ago to Albasheer hospital, there was no bed available, this was the problem. Two weeks ago, he needed admission another time, he searched at that time due to increase of infection level compared to previous time but again the bed availability was the reason, finally, he said I get bored, and I will not back to the hospitals again, I will take care of myself at home” (Z18-002).

4.5.8 Awareness as barrier

Awareness on available services and subsidies stand to be weather a facilitator for refugees’ access to health services when it was sufficient, while the lack of sufficient awareness on available services, policies and eligibilities seems to be one of thematic barriers detected throughout the interviews.

The group of participants who said they have awareness on services and subsidies available they have higher tendency to utilize health services when needed if they did not encounter other

access barriers such as availability of services. For example, an old male head of household, when he was asked about access policies and experience with public health services, he said:

> "I know the policy, I pay doctor fees with white card 0.4 JoDs, its good, I was paying 3.5 JoDs before, we were not taking the medication from there, we were pigging form my brother and sister to get 3.5 JoDs for fees and 3 to 4 JoDs for medication, I had no money, it will not work. Now, 0.4 JoDs for fees and take the medicine so it's all about 2 JoDs, its good" (Z04-003).

On the other hand, the group of participants who were not aware about access policies and available services show avoidance practice toward public healthcare services due perceived barriers, mainly due to the cost of services and if they left without options. A mother (12-001) she was always uses either NGO supported services or private provider to meet her, and her family health needs, this head of HH found not aware when she was asked about her awareness on healthcare access policy, and she never utilized public healthcare services.

4.5.9 Distance as barrier

More than half of participants (11 out of 20) mentioned the distance of healthcare provider as one of the difficulties they were facing when they needed healthcare services, the availability of transportation media was not the reason for almost all of those who indicated to the distance as a barrier, but rather it was the transportation cost and to a lesser extent the transportation time.

For instance, a 43 years old mother when she was asked about difficulties encountered when she needed healthcare, she stated: "all hospitals are far away from me, the money I will save, I have to pay it for transportation fees" (Z18-002).

4.5.10 Quality of care as barrier

Quality of healthcare services was mentioned by few participants, only five participants directly mentioned the quality of care as an area of concern for their healthcare access and needs. All those participants used to seek care in public healthcare providers including health centers and hospitals, only one participant showed satisfaction with his access to public hospital while the other four clearly stated the poor quality as a difficulty and perceived as barrier to get needed healthcare services.

A 60 years old male when he was asked about his regular access to get his chronic medication, he said, “I go to private pharmacy, I will never go to public health center” and when he asked why, he said:

> “it’s impossible, they will give me alternative medicine that is not appropriate for my health status, if I don’t get the same regimen, I will have complication. Long time ago, I went there but was not able to adapt, they give me pills in bag (with no instructions), I was not able to understand what it is or how to use it, it was 5 mg dose, I get worst (Z11-001+002)

4.5.11 Waiting time as barrier

Waiting time to receive needed services was one of the difficulties encountered by several participants and detected as a barrier to access health services when needed, among the 20 participants, 8 participant reported waiting time as a barrier. Most of those who reported long waiting were those who accessed ministry of health facilities. Only 2 reported delays in provision as a barrier among NGOs supported services. However, none reported the long waiting among those who accessed private providers.

A 45 years old single women had previous experience with governmental hospital where she used to seek care for her parents, when she was asked about last health incidence, she stated:

> "I am tired, I have 90 problems but don't go to doctors. I had B12, ferritin deficiency and anemia but I treated myself on my expenses" and when she was asked why on her expenses and didn't access the public health center, she said "I can't wait, I did investigation and brought treatment from a pharmacy known to us" (Z11-001+002)

Another mother used to go to private pharmacy to get her family medication and when she was asked about her daughter needs, she stated:

> "For my little daughter, I don't go to health center or Caritas clinic. Some people whom I know they went there and wait from 8:00 to 14:00 clock then back, I mean lots of people and waiting, that's why I don't go there, and they told me not all medication available as well (19-001)

4.5.12 Discrimination as barrier

The last domain that detected from interviewees responses was the discrimination experienced by some. Specifically, those who accessed public healthcare services providers, some interviewees perceived some administrative procedures or individual's behaviors as a discriminatory behavior directed toward refugees. Those perceived behaviors were contributing to the decision of families to avoid accessing services as they were perceived as a barrier to the services.

A 46 years old mother used to access NGO clinic, stated that:

> "I tried to access public healthcare center, they told me it helps Syrians, I tried to obtain health card for me and my children but unfortunately there was a bad treatment. I stopped because the employee contempt us as a Syrians while I didn't do anything for him, I was shocked and stopped going there" (31-002).

However, one case (19-001) perceived the service provided by public healthcare provider as an excellent service when she accessed them for a reproductive health issue, and clearly stated that there was no problem to be Syrian and received an equal treatment like others.

4.6. Adaptation Strategies

An estimated 53% of questioned HHs have noticed an increase in healthcare cost over the past 6 months (**Table 4.14 Adaptation strategies - HH questions**). The impact of that increase varied, it included not being able to visit a doctor/hospital (93.5%), can't afford medication (92.6%), can't afford other medical procedures (57.6%), and reduce the ability to meet other livelihood requirements (9.1%) (**Table 4.14**). In seeking adaptation, HHs adopted some strategies including soughing for NGO free services (55.9%), reduce or stop medication use (49.5%), using alternative medicine (49.0%) and spending savings/ borrowing money (77.6%). An estimated 86.9% of the HHs was reported to spend money on any healthcare during the past month (**Table 4.14**).

Table 4.14 Adaptation strategies - HH questions

	Total (n=383)	**Unweighted proportion or mean, %**	**Weighted proportion or mean*, % (95% CI)**
HHs noticed increase in healthcare costs over last 6 months	203	53	
Reported impact of healthcare cost increase on family(n=204)			
No impact	1	0,4	0.3(0.0-1.0)
Not able to visit a doctor or hospital when needed	190	93.5	93.2(93.1-93.6)
Not able to afford required medication	188	92.6	92.1(92.7-50.5)
Not able to afford required other medical procedures (e.g., investigation, devices, consumables)	117	57.6	57.9(57.-57.9)

Reduce ability to meet family's other livelihood requirements (shelter, food, education. etc.)	185	90.1	90.5(90.1-90.8)
Adaptation strategies HH adopted to meet healthcare needs(n=383)			
No coping strategy adopted	10	2.6	2.6(0.9-3.9)
Sought for NGO free services	217	55.9	57.2(56.0-59-0)
Reducing number of visits to healthcare providers	-	-	
Reduce or stop medication use	192	49.5	49.4(47.9-50.4)
Use alternative medicine or traditional healers	190	49.0	49.4(47.8-50.3)
Spent saving or Borrow money	301	77.6	78.1(77.0-79.3)
Plan for repatriation or leave to a third country	-	-	
Others	30	7.7	7.7(5.0-9.01)

From the multiple response analysis on impact (Table 4.15), it is clear that the impact of increase in healthcare costs on refuges family cause inability to visit doctor or hospital when needed among 25.6%, 25.3% were not able to afford required medication, 25.2% were not able to afford required other medical procedure (e.g. investigation, devices, consumables) while 25.9% reported no impact.

Table 4.15 Multiple responses analysis for the impact of increase in healthcare costs on refugees' family

The impact of increase in healthcare costs on refugees' family	N	Percent	Total
No impact	190	25.9%	93.6%
Not able to visit doctor or hospital when needed	188	25.6%	92.6%
Not able to afford required medication	171	23.3%	84.2%
Not able to afford required other medical procedure (e.g., investigation, devices, consumables)	185	25.2%	91.1%
Total	734	100.0%	361.6%

The Multiple response analysis for adaptation strategies (Table 4.16) shows that the most adaptation strategies used by refugees to meet healthcare need were; use alternative medicine or traditional healers at 26.5% which mean 80.7% from respondents indicate to this strategy, (19.1%) answered no coping strategy adopted. While (16.9%) responded reducing number of visits to healthcare providers, (16.8%) Sought for NGO free services and (16.8%) reduce or stop medication use as adaptation strategies.

Table 4.16 Multiple responses analysis for the adaptation strategies HH adopted to meet healthcare need

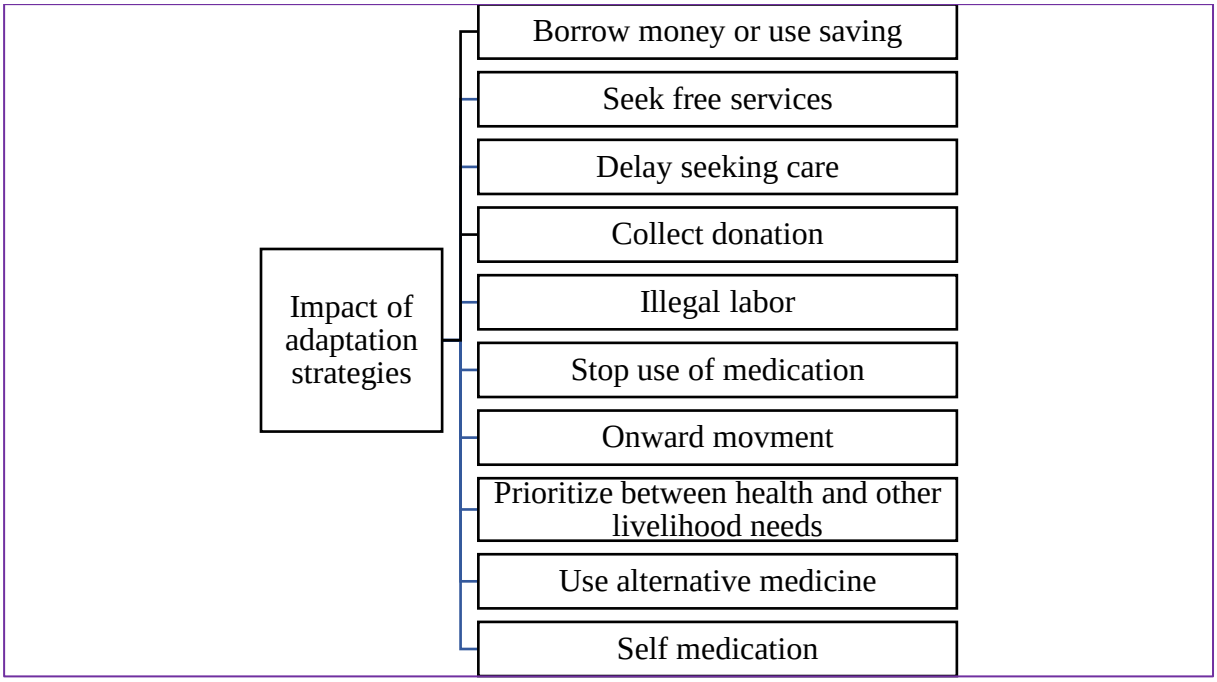
Adaptation strategies	N	Percent	Total
No coping strategy adopted	217	19.1%	58.2%
Sought for NGO free services	190	16.8%	50.9%
Reducing number of visits to healthcare providers	192	16.9%	51.5%
Reduce or stop medication use	190	16.8%	50.9%
Use alternative medicine or traditional healers	301	26.5%	80.7%
Spent saving or Borrow money	14	1.2%	3.8%
Plan for repatriation or leave to a third country	30	2.6%	8.0%
Total	1134	100.0%	304.0%

The researching on adaptation strategies using the qualitative tool was one the major objectives that meant not only to triangulate the quantitative findings, but also to better understand the wide spectrum of adaptations that refugees use in urban setup when a long-term barrier encountered over long period in a such protracted crisis.

As almost all the interviewed HH faced one or more difficulties over their access experience to the healthcare services, there was a wide set of adaptation strategies detected during the semi

structured interviews that utilized in order to meet the demanded healthcare. Those group of adaptation strategies ranged from extreme negative to a positive strategy. The thematic analysis revealed 11 domains under the adaptation strategies that have been utilized by one or more families (Figure 4-11).

Figure 4-11 Adaptation strategies thematic map



It classified as a health-related adaptation strategies includes self-medication, use alternative medicine, delay seeking care, stop or reduce medication and seek free services. other set of non-health related strategies included, reduce consumption of basic livelihood, borrow money, or use saving, collect donation, illegal labor, use other livelihood assistances or plan for onward movement. However, the detected adaptation strategies focus on two paradigms; one was aiming to reduce healthcare cost, which was classified as health-related strategies, and other focus on increase the financial capacity of HH to improve their capacity to meet healthcare demands and seen as non-health related strategies.

4.6.1 Self-medication

Self-medication or incomplete use of healthcare cycle happened when the healthcare seeker decides to use medication without going through proper medical consultation and appropriate clinical examination or investigation. The self-medication theme reported by 9 participants, when they decided to go directly to the down street private pharmacies and pick up their treatment. The group decided to use this strategy to reduce healthcare cost by eliminating consultation fees and transportation cost.

A mother describes her impression on health services utilization as the following

> "For private care, its available but need money, I don't have money, if I have enough money, I will treat her in private clinics. There are competent doctors and Jordan is well known and having best doctors and best treatment, but it needs money and its high cost, and I don't have. I gain 200 to 300 JoDs a month, how I will treat my children if they have flu? I go to the pharmacy directly and not to the doctor in order not to pay doctor fees, I pay for medicine only" (Z25-001)

4.6.2 Use alternative medicine

Use alternative medicine has been raised by 5 interviewees as an adaptation strategy to reduce healthcare cost or delay medical care. The participants indicated to two main strategies; some participants used the pain killers in order to delay care or auto solve health issue, while other used traditional herbals to minimize or solve experienced health problems.

A mother lives in Zarqa governorate, when she was asked about how she dealt with health needs burden, she stated:

> "In such time of the year, you feel there are a lot of diseases, I mean there are viruses in the air because of low raining rate -may God bless us-, I might need antibiotic syrup but

> because there is no income to help so I use things available at home (natural) and try to treat by it" (Z18-002)

Another 50 years old female was asked on times when she or her family needed healthcare and was not able to grant, she said "many occasions happened this year but didn't went, I took analgesics and don't go" (06-001)

4.6.3 Delay seeking care

Some head of HHs mentioned delay in seeking care as a strategy used when they do not have money to seek the needed healthcare. The duration of delay varies from one family to another depend on their perception toward needed healthcare. Some delay the care until it reaches an emergency, some others skip doctor visit for a chronic condition, and some delayed it until they find alternative support. For example, a case with multiple chronic conditions said: "When we need healthcare, we wait until get worst, may some good people help us and send me to a hospital when I reach a point where I need hospital care" (31-002)

4.6.4 Stop or reduce medication intake

Stopping or reducing medication intake was associated with those who suffer from long-lasting conditions requiring regular care and continuous medication. However, this adaption strategy mentioned by two participants as a way to adapt and reduce healthcare cost to a tolerable level. A 50 years old mother with multiple chronic diseases, including respiratory condition, said:

> "I have chronic bronchitis; it impacts my chest. I can't breathe and found to have shortage in oxygen and vitamin deficiency. He told me (the doctor) according to the investigation that I suffer from lung rheumatism, I went there one time then I stop because of financial depletion and bad situation. This inhaler (medication), I have to take and not to stop at all as it clean the secretions. Honestly, I ceased it, it's my hope…, I ceased it, from where I can get money!" (Z18-001)

4.6.5 Borrow money

Borrow money or use saving have been extensively utilized by more than half of participants as an adaptation strategy to meet basic livelihood needs including healthcare. 11 interviewees mentioned borrow money as a way to meet their basic needs; most of those participants (8 participants) directly mentioned emergency health conditions or chronic conditions as the major reason behind borrowing money. A mother asked about times when she was not able to pay for needed services; said "sometimes needs raised up, and we are obliged to meet; something that break the back but nothing available (money). For anything urgent, I have to go and borrow money" (12-001). Finally, just one participant (19-002) mentioned use of saving as a strategy used to cover some urgent health needs faced, of which may indicate the refugees exhaust all resources available with longevity of their stay at COA.

4.6.6 Seek free services

Seeking free services was mainly contextualized over the interviews as a seeking behavior, but some participants clearly stated that as an adaptation strategy used to meet healthcare needs. Specifically, when refugees find themselves left with minimal financial capacity or left without options. Over the interviews, six participants mentioned seeking NGO-based care provided on a free basis as a strategy to meet their health needs when the care was not affordable for several reasons but mainly due to financial capacity.

A 38 years mother was in need for radiological investigation that cost about 100 JoDs, she was waiting for long time and avoided to borrow money as she was afraid about her ability to reconcile and fall in debt. She was asked about possible strategies that she may use to get needed service and said "I have to apply for a center to support and wait until my turn come. However, even if I get 50% discount, I will not be able to pay and make it" (31-001)

4.6.7 Prioritize between health and other livelihood needs

Reprioritization was another significant domain detected in 11 interviews, the participants adapted several reprioritization strategies between health and other livelihood needs in order to maintain balance between them. Some participants prioritize health over other livelihood needs while some others prioritize other livelihood needs over health. The group of livelihood needs mentioned ranged from food, clothes, sanitation materials and learning materials.

The prioritization modes detected were either use other livelihood assistances to cover health needs such as monthly cash assistance or food coupons, cancel or reduce consumption of the quantities required, select a lower quality food or other products, or sell home assets.

A mother of five children when she asked about inability to meet her family needs and how it impacts them, she said: “It reduces nutrition especially after suspension of monthly assistances (food coupon) I get from United Nation, it will be utilized for many other things, and I will not keep it only for food”. Another mother of three minors said: “frankly, I might select anything in the week when we bay medication for my daughter, we eat anything in order to meet our needs” (31-001)

Another participant (Z18-003) who rely on monthly assistance and used to borrow money to meet her health and other needs said “swear, in a previous occasion I sold some of home assets to meet more important things” (Z18-003)

4.6.8 Collect donation

Collect donation was mentioned as a temporary strategy to meet health needs when there was no other way to do so, or when refugees fall in debt due to previous health incidence. Among those who use donation collection to get needed services, they utilized it to secure medication that is not affordable either by collecting money to bay medicines or collect medicines themselves as a donation. For instance, a chronically ill female refugee suffers from

hypertension, rheumatoid disease and vascular disease needs for multiple medication that are not affordable for her, said:

> "I go to a doctor I know him since a while, one of them is Syrian and he give me as a donation. Frankly, I can't bay them as they are expensive. Sometimes, I got it from a neighbor, they have health insurance and sometimes they have the same hypertension medication I use, they give it to me if they have sufficient stock" (Z18-003)

Another refugee family fall in debt due to catastrophic health expenditure due to a work injury, said "I have 2,200 JoDs debt, swear, I collect some from my brothers and neighborhoods" (22-001)

Additionally, illegal labor surfaced through a different shape during the interviews. The illegal work shapes detected were homebased business, informal labor and unskilled labor or child labor. The group of interviewed participants who fall into illegal labor activities has utilize it to gain some income to cover their basic livelihoods needs including health demands. However, there is one case experienced catastrophic health event and expenditure due to work related injury that was not covered under labor health insurance due to illegality of activities.

4.6.9 Child labor

Child labor was a prominent shape of illegal work that presented by three families as a way to gain some income to meet family's basic needs including health. For instance, a 50 year old mother when she was asked about her family life, she said:

> "We live in a simple house with simple furniture that took us long time to secure, last piece I brought was refrigerator, I am UNHCR registered. My son work, he is the only one, he was in the school and was at higher rank with 86% averages, he left the school at 10^{th} grade in order to work and meet our needs" (05-002)

Another lady (22-001), her family lost their income due to a work-related injury impacted her husband ability to gain income while he was working in informal labor market (construction worker) said:

> "due to my husband status I made a small minor's nursery for the neighbors where female workers put their children, I gain about 200 JoDs a month, but 200 JoDs what they will do? 150 for home rent, still I have the water and electricity bills and my little daughters are studying and need milk, diapers, and others" (22-001)

4.6.10 Onward movement

The last adaptation strategy that was reported by one participant only was onward movement (plan to leave to a 3rd country or be resettled), the case suffers from multiple livelihood challenges including big debt for home rent and multiple health conditions that is not properly managed, said:

> "Frankly, I need to go outside, even if I live for two days. I am psychologically tired, I feel desperate, I heard from those who went out, if I leave there, I will receive financial support, they will treat me and others, I wish I can leave outside. (Z11-001+002)

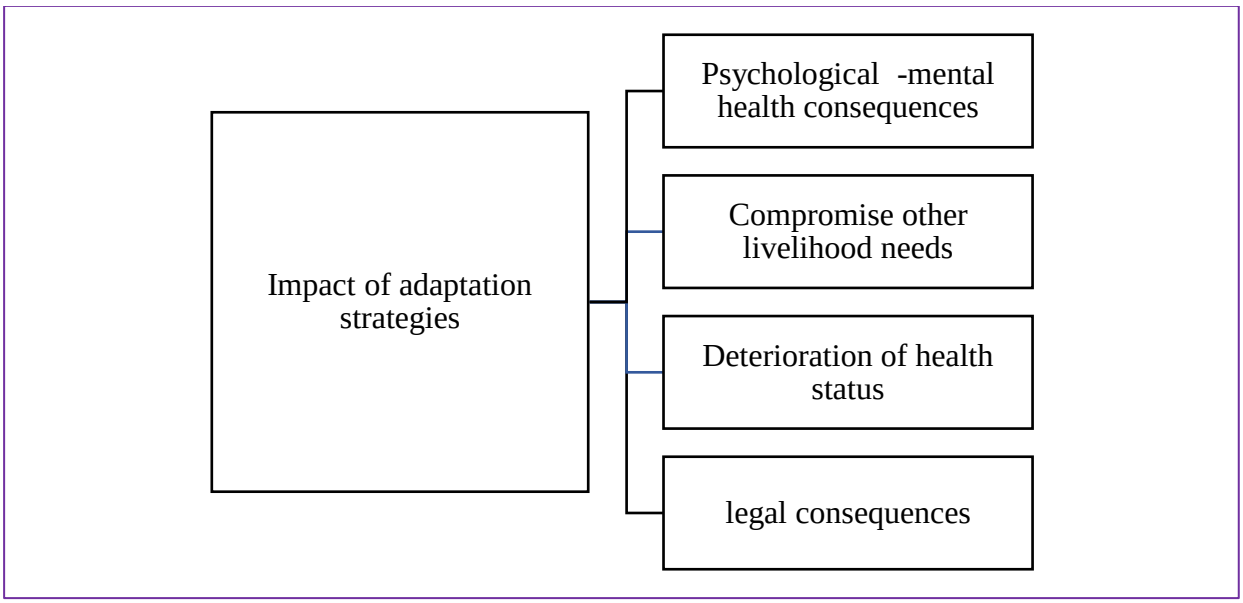
4.7. Impact on health

The impact of adopted strategy was a specific question tackled through qualitative method only. Research subjects were asked about their feeling toward adaptation strategies and additional risks encountered due to adaptation behaviors adopted to minimize or eliminate healthcare access barriers.

The participants have detected many risks and presents its direct impact on their individual health status as well as the indirect impact that resulted from a consequence connected to their health needs or previous health events. Four themes have been detected throughout most of the

interviews that included psychological-mental health consequences, deterioration of health status, legal consequences and finally the impact on another livelihood needs (Figure 4-12)

Figure 4-12 Impact of adaptation strategies thematic map



4.7.1 Psychological -mental health consequences

A long list of psychological and mental health disorders has been detected as a prominent theme over the interviews. The list of those disorders was exhaustive, and it included most of psychological and mental health disorders that is globally defined. The reported group of psychological impact disorders were depression, anxiety disorders, addiction and substance abuse, and stress disorder.

The participants described the psychological impact of facing unmet livelihood and health needs using wide range of verbal expressions. The verbal expression used to reflect the impact of continuous unmet needs included fear, stress, social isolation, feeling of helpless, anxiety, frustration, depression, angriness, substance abuse and suicide thoughts or attempts.

A total of 18 interviewees (90%) mentioned one or more type of psychological symptoms that impacted one or more family member. The majority of psychological consequences were

related to unmet health needs and reported by twelves participants. Additionally, five participants connected the psychological consequences to non-medical needs such as livelihoods needs, education requirements and recreation needs. However, most of serious psychological impact including substance abuse, suicide thought, and attempts developed as a result of non-medical needs while other symptoms of psychological stress, anxiety and depression were more prominent among those who reported unmet health needs.

Among those who reported non-medical needs as source of psychological consequences; a father of 16 years old boy when he asked about time when he needed healthcare and was not able to afford said:

> "Some time ago, my son gets stressed and swallow pills to poison himself (suicide attempt), it happened at mid night and I transferred him to Albasheer hospital, he took five pills and hospital provided first aid" when he asked why he did that, he said "I am stressed and don't have any one here, living alone without friends at all" (16-002)

Another mother when she was asked about her concern toward her children, she said:

> "If some children invite my children to go out, I prevent them, you know why, if the children are deprived then they will look outside and go with others (she feel unsafe). For example, all neighboring children plays in the next play yard, I prevent my children in order not to see others and hear their talk about their recreation activities and what their families offer them and then come back and ask me for things that I can't afford" (Z25-001)

Among those who reported health needs as a source of their psychological consequences a 50 years old lady when she was asked about consequences of her inability to afford medical needs, she said:

> "I am suffering from everything if situation will continue like this…. I swear, I am frustrated, if I need anything I don't have money, if I need medicines, I don't have money. I am stressed, if my children get sick and need treatment and can't afford it all" (Z18-001)

Additionally, mother of 12 years old sick girl who is in desperate need for medical care said:

> "it's difficult, this daughter is tired, I don't know where I should go to get help and obtain someone to pay 600 JoDs. It's difficult, where I can go to get care! My husband work for 4 to 5 days a week for 5 JoDs daily, he works at vegetables market for 5 JoDs, we collect them to pay house rent. I was on monthly cash assistant program but suspended, it's difficult to have a sick member, its difficult life. I mean, any surgery requires a lot of money, like thousands and we don't have them, this daughter I just mention to you caused me insomnia (unable to sleep at night) because of the needed 600 JoDs" (08-001)

Another 60 years old head of HH answered a follow up question on consequences of faced unmet health need and said:

> "I don't know what to say! I mean… I would say, I am bored out of everything in this life" with more elaboration from interviewer, said "everything happened caused me psychological dilemma, because of difficulties we are facing, our situation was different, it was not expected to reach such time and face these difficulties. Everything in our life impacted, sometimes I have thoughts to finish my life" (Z11-001+002)

4.7.2 Compromise other livelihood needs

The impact of adopted strategies found to be extended to other livelihoods needs. The interviewed families who found themselves dealing with shortages in one or more aspect of life

needs tried to maintain balance between those group of needs. Apparently, they were obliged to compromise some. Several shapes of compromises found and mainly lead to reduced consumption of basic needs like food, prioritize some needs over other such as health over food or rent over food, and utilize assistances for one to cover other such as food to cover health or rent. These practices have direct impact on family's food security and safety. Hence, the risks associated with reduction of food consumption or food quality due to inability to cover these needs directly or prioritize other over it was highlighted by some participants. For instance, a mother of anemic girl (08-002) who was facing a big challenge due to her economic situation, used to borrow money to cover her health needs said:

> "I have many children with many requirements, we need daily expenses and winter clothes (Jackets), but I don't have, this drive me tired. They all go to the school with minimal food support. My daughter Ghufran suffered from Anemia and was diagnosed as malnutrition case (08-002)

4.7.3 Deterioration of health status

Other prominent outlook of impact revealed through interviews was deterioration of health status among refugee's families who were not able to meet their members health needs. The negative impact on health status found to be directly impacted by adaptation strategies aim to reduce healthcare expenditure, adaptation strategies aim to reduce other livelihood expenditures or harmful adaptation strategies.

The group of adaptation strategies aim to reduce expenditure on health and lead to a negative impact were delayed diagnosis or seeking care of which led to long term or irreversible health damage such as disabilities. For example, a woman with a hand broke and was in cast for 2 months said:

> "My hand stayed in cast for 2 months, after 2 month they release it and made X ray for it. They told me it can't be casted anymore and need to stay in bandage only. later, when I visited them, they released the bandage, and I was not able to move my hand, so they advise me to do rehabilitation session, but I have not done any" (Z18-001)

Other mother of one and a half month baby who was a product of caesarean section, who passed away due to premature discharge from a private hospital due to cost, said:

> "I gave birth at Aqila hospital on my expenses because I left the camp illegally, my delivery cost 350 JoDs and they asked for 250 JoDs per night for the newborn. I kept him for 2 days then I was not able to continue paying, I ask the hospital to discharge him on my responsibility and committed to take him to Albasheer hospital, but I took him to a doctor not Albasheer hospital. Later, he had complications, his temperature went up to his brain, he was to be at a hospital… later when we took him to Albasheer, they told us that temperature increase caused brain damage and later he passed away" (22-001)

Additionally, reduce healthcare provider visit and medication intake were other strategies used to reduce health expenditure of which led to poor control of health conditions especially among those who were suffering from chronic diseases. A 50 year old mother who suffer from joint problem and was not able to seek care due to inability to pay said "I have joint problem, I have continuous pain in my legs and my back hurt me as well, I take analgesics only and don't go to doctors" (06-001).

The other group who reduced the other livelihood requirements in order to control their monthly expenditure exposed their families to an indirect impact on health status. A good example is among those families who reduced the food consumption or food quality in order to meet the other needs including health where some of their children fall into malnutrition.

The last group of families who faced negative impact due to a direct negative adaption strategy adapted. This included a group of members used self-harm behaviors such drug abuse and suicide attempt of which has a great direct impact on health status of respondents and their families.

4.7.4 Legal consequences

The last impact domain was the legal consequences, the legal consequences originated by two main reasons; the first was due to legal claims raised against refugees' individuals as a result of debt induced by uncovered health expenditure or through illegal work that led to uncovered work-related injuries.

For instance, borrowing money was common adaptation strategy to cover family's basic livelihood needs including health. Some of refugee's families when they found themselves unable to cover their health events expenditures, they weather left an unpaid bill at healthcare facilities or borrowed money to cover those commitments. This behavior led to a raising of legal claims against refugees at courts and led to detention of a family members as per local laws and regulations. For example, a head HH of a refugee's family who used to borrow money to cover their family health expenses was detained due to a big debt claimed by landlord through a local court.

The other group of refugees who faced legal consequences were those who used to work at unorganized or illegal labor market, this group faced a big risk especially when they suffer from work related injuries as there will be no insurance coverage for treatment and livelihood compensation. Some members of interviewed families faced a great impact on their health due to illegal work where they end up with improper or incomplete treatment that impacted their health status negatively. For example, a refugee had work related injury and his wife during the interview said:

> "My husband during working in constructions failed down and had a leg fracture, work owner took him to Albasheer hospital, casted his leg and discharge him. Frankly, he needed operation with nails but was not done as the work owner refuse to pay a big amount of money. He is now good but not normal, he is better than before now". (31-001)

4.8. Other themes

There are three general themes have been detected in many interviews that is not related to the research questions. Those themes come toward the end of interview at the stage of challenges and adaptation strategies questions; those themes included a general vulnerability theme, social isolation, and bullying.

The general vulnerability theme touch upon unmet needs and mainly touch two specific livelihood needs that most of refugees were facing challenges to access. Most of participants indicated to housing/rent challenges where most of them fall in debt due to inability to pay rent then fall into legal consequences, and some utilized food assistances or winterization assistances to cover those needs. For example, a 28 year mother said:

> "I keep stressed every month because of home rent, I keep borrowing money, recently I received winterization assistances for 390 JoDs for the whole year. The nearby market where I used to take my food and baby diapers was asking me for 290 JoDs, I gave it to him obligatory to keep giving me, and 100 JoDs I gave them to landlord for water and electricity bill. Currently I left without any, I signed debt docs for the landlord with 600 JoDs for unpaid rent" (22-001)

Some other families indicated to the education and its requirements as a challenging need, those requirements ranged from food, daily wages, clothes, and transportation cost.

On the other hand, some refugees mentioned social isolation as a challenge for them. However, the refugees seems that they have selected this approach as an adaptation strategy to reduce interaction with local community due to recognized risks, mainly on their children.

Finally, some of refugees' families (3 families) mentioned bullying or some harassment against children at schools or in neighboring environment as a concern for them. A father of 16 years old child said:

> "There are a group of adolescence in front of Prince Muhammad School sent a little boy to harass my son, this boy has many cousins. My child can beat them, but I ask him to avoid them, currently he sees any youth in the street he avoided them, this has impacted him psychologically (Z04-003).

CHAPTER 5 . DISCUSSION AND CONCLUSION

This research thesis aims to identify and explore Syrian refugees' access and utilization of healthcare services by assessing their knowledge of healthcare services, identifying their normal access behaviors, and identifying of healthcare needs of primary groups, including children, women and chronically ill, the most impacted at any refugee crisis. The study of healthcare access barriers also aimed at identifying adaptation strategies to limited options to meet their health needs. Finally, the access limitations and strategies adapted to minimize access barriers and meet basic healthcare needs have been explored to identify their impact on refugees and host communities.

The study's questions were investigated using the Mixed convergent method, a globally recognized quantitative questionnaire modified and validated to fit the study context and applied to over 383 participants selected randomly from three community centers. In addition, semi-structured interviews were done independently among 20 Syrian refugee adults who were conveniently selected from the quantitative pool. The aspects of the Gelberg-Andersen Behavioral model are used to understand the dynamics of healthcare utilization and seeking behaviors.

Quantitative data was collected in digitalized form using Open Data Kit (ODK) software and analyzed through SPSS software. The semi structured interviews were recorded and transcribed in the language in which they were conducted (Arabic) and then thematic analysis was utilized.

This chapter discusses the outcomes for the various study themes, following the findings flow through integrating both quantitative and qualitative findings. It also compares the quantitative results to the qualitative themes related to the global literature findings. Finally, it triangulates the findings of both data sets with a specific focus on adaptation strategies and their impact on refugees and host communities to illustrate more on those aspects that are under-studied by global literature, specifically in low and middle-income countries (Jallow et al., 2022).

A substantial consideration for the context of refugees' integration into Jordan's healthcare system was factored in throughout the discussion aiming to connect the outcome of access needs and behaviors, access barriers, adaptation strategies and impact to the specifications of the healthcare system in the country of asylum.

5.1 Summary of findings

Our demographic finding suggests that the Syrian refugees in Jordan have large families with an average household size of 5.7 individuals with almost equal gender distribution between males and females. However, the female-headed household constituted almost one quarter (24.5%) of surveyed households. Furthermore, the age distribution shows a young community structure, with more than 70% of individuals below the age of 30. Additionally, a significant proportion (57%) were found to be with no education and a minimal percentage (2.3%) were found at the diploma or university level. Most of the refugees (77.6%) came from four governorates (Damascus, Aleppo, Dara'a and Homs), and most of them were living in rural areas in Syria (36.2%) and currently settled in an urban center in Jordan (96.1%).

The analysis found an excellent awareness among refugees about their eligibility for subsidized access (100%) and a satisfactory awareness of places they have access to (79.4%). For example, 86.1% of refugees know that their children have free access to immunization services, while 61.1% received vaccines in Jordan; most of them (97%) received them at public health centers.

Among women of reproductive age, 43.5% were found to be pregnant during the previous two years. The antenatal care uptake rate was found at average, with a low level of full antenatal at 21%, the level of knowledge on family planning service availability was below average, with a low uptake rate, with only 19.8% trying to obtain it.

The chronic condition's prevalence was high among the surveyed group at 28.6%, and the most prevalent diseases were hypertension, asthma, and diabetes.

Healthcare services were found to be highly demanded, where more than 88% of surveyed households needed healthcare the previous month. The private providers (hospitals, clinics and pharmacies) were the most accessed by more than 50%, followed by a public healthcare provider, with only 20.4% accessing either a governmental clinic or hospital. Almost 85% of refugees paid for received services, and most of them paid less than 100 JoDs.

On the other hand, the participants in the qualitative part identified their health needs under a broad set of services, including chronic diseases, emergency healthcare, hospitalization or in-patient care, psychological-mental health, rehabilitation- disability, childcare, vaccination, elderly care and women health needs. Additionally. The analysis of needs corresponded with the analysis of seeking behaviors and suggested a group of sub-themes including access policy, financial capacities, practices, knowledge, and beliefs.

The analysis of access barriers identifies several barriers among care recipients with wide variations depending on the availability and affordability of services for each group of recipients, including child vaccination, women's health and family planning needs, chronic

disease needs and monthly household health needs. However, the most reported access barrier was cost and was more significant among those with chronic conditions (23%). On the other hand, the interviewed household identified several thematic barriers, including cost, access policies, service availability, discrimination, knowledge, distance, quality of service and waiting time.

The data suggest that 53% of survey participants noticed an increase in healthcare costs; most identified an inability to visit a doctor, inability to afford required medication and reduced ability to meet other livelihood needs as a significant impact on the healthcare cost increase. Additionally, borrowing money or using savings was detected as a primary adaptation strategy (77.6%) and, to a lower extent, seeking NGO -free services, reducing or stopping medication, and using alternative medicine were utilized by almost half of the participants. On the other hand, the qualitative analysis identifies a group of 11 domains under the adaptation strategies theme that was utilized by one or more families, including self-medication, use of alternative medicine, delay seeking care, stopping, or reducing medication and seek free services. Another set of non-health related strategies included, reducing consumption of basic livelihood, borrowing money or saving, collecting donations, illegal labor, using other livelihood assistance or planning for onward movement.

Finally, the impact of the adopted strategies was a specific question tackled through the qualitative method only. The interviewed HHs have detected many risks and presented their direct impact on their health status, an indirect impact that resulted from a consequence connected to their health needs or previous health events surfaced as well. Four themes have been detected throughout most interviews that included psychological-mental health consequences, deterioration of health status, legal consequences, and the negative influence on other livelihood aspects.

5.2 Demographic characteristics

The demographic findings revealed many results that match other surveys and research findings. For instance, the average family size among Syrian refugees was high at 5.7, comparable to the previous UNHCR health surveys and 2017 DHS findings (Department of Statistics/Jordan & ICF, 2019; UNHCR, 2019c). Additionally, the high average family size corresponds to the high fertility rate reported among Syrian refugees in Jordan at 4.7 compared to 2.7 among Jordanians (Department of Statistics/Jordan & ICF, 2019). Furthermore, the low level of education found to be dominant where a lower school attendance level confirms it in DHS findings (Department of Statistics/Jordan & ICF, 2019). Gender distribution was equalized and matched with global statistical reports, while age distribution shows a wide base hierarchy with the youth nature community, which matches with other Syrian population statistical reports (Nations, 2019).

Furthermore, the proportion of female-headed HHs reported high at 24.5 %, but it is still comparable to what has been reported by other protection survey findings (Krafft et al., 2018). The high level of female headed HHs is thematic among women fleeing from conflict areas. However, being a separated woman and head of household is considered an additional protection risk and required special protection services for these vulnerable groups.

A considerable shift was reported in the area of living between Country of Origin (COO) and Country of Asylum (COA). Two third of Syrians refugees were living in rural areas in Syria, and most of them (96.1%) moved to urban centers in Jordan. This change in living conditions from rural to urban life poses new challenges for refugee families and the healthcare system. The refugees' families will face a challenging environment within political, social and economic aspects that require additional efforts from civil society organizations to improve community capacities to integrate their needs into the new configuration (Norman, 2021), as

well as the ability of urban healthcare system to absorb sock and meet the increasing demands. (Tuncay et al., 2022).

5.3 Health access and utilization behaviors

Refugees showed excellent knowledge on available services and privileges they have as a refugee when 100% confirmed that the possession of a UNHCR certificate and MOI card allow subsidized access to public health services, while about 80% of them knew where the nearest clinic is. However, this excellent knowledge of access policy and health services availability is connected to the extended stay of refugees, where the vast majority (97.6%) were in Jordan for more than two years (Schober & Zocher, 2022). On the other hand, some interviewed refugee families were unaware of the reversal of subsidized healthcare policy for refugees; thus, they avoided accessing public healthcare services due to non-awareness of which require targeted campaigns to reconnect refugees to public healthcare systems at all levels of care.

This study did not capture the Vaccination coverage. However, children immunization as a blanket need for all children was assessed, and the level of awareness for the freeness of vaccine services among families was high at 86.1%; thus, most the refugees (97%) families used governmental health Centre to get their free vaccine. On the other hand, the qualitative findings showed little addressed needs for children immunization, but families rather raise their concern on acute conditions and nutrition of their children. Although, it seems that families address less concern due to the freeness of services compared to other services that need to be paid out of their pockets, this optimal access behavior when the services are provided free was common among refugees in several contexts and was supported by other studies finding in Iran and Turkey (Kiani et al., 2021; Tuncay et al., 2022).

The antenatal care assessment and family planning uptake were utilized to assess women's healthcare needs and behaviors. The findings showed a high proportion of pregnant women

among those of reproductive age. This finding corresponds to the high fertility rate reported among the Syrian population in Jordan (Department of Statistics/Jordan & ICF, 2019; Sieverding et al., 2019). Additionally, the findings from family planning uptake data, showed sub-optimal knowledge of family planning availability with deficient uptake among those who tried to obtain contraceptives during the past year. These findings are directly connected to the increased fertility rate among refugees. Over the qualitative findings, women's healthcare was not an eminent domain under the theme of the need and was addressed by few women. Again, the freeness of preventive antenatal care services had reduced the concern of refugee women when it was less addressed as a need through the interviews.

On the other hand, the freeness of family planning services does not correspond with the low uptake rate reported by refugee women, suggesting an additional barrier may be found beyond only the cost of services. In this sense, a cross-sectional study conducted among refugees in Germany brought up a concern beyond the availability of services and suggested that more should be done beyond the provision of free service (Inci et al., 2020). Additionally, Çelikkanat and Güngörmüş found that Syrian refugees women do not have the freedom to choose due to cultural barriers, partner pressure or being powerless to choose (Çelikkanat & Güngörmüş, 2022).

The chronic disease needs were assessed separately as it was one of the prominent healthcare needs among Syrian refugees due to its high prevalence (Naja et al., 2019). The quantitative data suggested high chronic disease prevalence among Syrian refugees (28.6%) and was comparable with other studies' findings (Rehr et al., 2018). Additionally, the most prevalent chronic condition reported was comparable to other surveys and studies (Rehr et al., 2018; UNHCR, 2021b) and included Hypertension, Diabetes, Asthma, and Ischemic heart diseases. Furthermore, the quantitative findings speak to the qualitative findings where most interviewed

HHs addressed chronic conditions as one of the most pressing needs that require continuous support and a wide range of healthcare services.

The qualitative assessment for healthcare needs among HH revealed much more needs beyond standard quantitative assessment findings that focused on three aspects (women's health, child health and chronic condition). For instance, emergency healthcare and hospitalization are addressed as a pressing need as it was experienced suddenly and encompassed catastrophic expenditures. This finding matches other research findings that detected emergency medical care and acute occasions requiring hospitalization as one of the main healthcare needs that impacted a significant portion of the refugee community (Assi et al., 2019; Ay et al., 2016).

Among refugee children, the findings from quantitative and qualitative correspond to the global literature where most of the children's health needs are directed toward vaccination services and communicable diseases treatment, and to a lesser extent, the chronic conditions connected with early childhood disabilities such as physical and visual impairment (Ay et al., 2016; Harkensee et al., 2021; Hjern & Kling, 2019)

Another significant need captured by study tools was mental health and psychosocial needs. The reported number of mental health disorders among surveyed families found low at less than 1%, considered very low compared to findings of other surveys (UNHCR, 2019c, 2021b). On the other hand, the quantitative analysis raised significant concern among refugee families toward psychological issues considered an obvious need for most of the refugees (17 out of 20 families). The high level of psychological and mental disorders was found to be high among refugees in general, specifically those who arrive from a conflict-induced context (Hunter, 2016); this high vulnerability has magnified the need for mental health and psychosocial healthcare services. However, the gap between those who reported mental health issues and

those who expressed several psychological challenges may suggest that the stigma around mental disorders is still a barrier and hinders better-seeking behaviors (Al-Soleiti et al., 2021).

Even though a small number of elderly refugees were found among interviewed families, their health needs have been addressed with particular attention to their needs for the management of chronic health conditions and unique personal care needs. However, many other kinds of literature detected the elderly refugee's health issues as neglected needs that require more attention from humanitarian health actors since they found them are more disadvantage, more vulnerable, and have more barriers that impact their seeking behaviors (Kristiansen et al., 2016; Strong et al., 2015).

Disability prevalence was found to be high (22.9%) among Syrian refugees in Jordan due to the conflict nature of the crisis (Humanity et al., 2018). This finding is consistent with our findings as 20% of interviewed families were found to have at least one disabled person living among HH. However, refugees' families see disability as a pressing need due to the longevity of need and excessive health and other livelihood demands (Polack et al., 2021).

The monthly health access assessment under the quantitative component aims to identify health-seeking behaviors among refugee HHs. The monthly access assessment has estimated the proportion of HH who needed healthcare in the previous month and identified the most accessed places by refugees. The data supported the high demand for healthcare among refugees when 88.5% of surveyed HHS needed healthcare during the past month. This high demand for healthcare reflects a high utilization rate found among refugees compared to non-refugees communities (Kiss, Pim, Hemmelgarn & Quan, 2013) and a high uptake rate as well that is supported by other studies and surveys (Doocy et al., 2016; UNHCR, 2019c, 2021b). The high health-seeking behavior reported by refugees is highly connected with contextual and individual characteristics are supported by the Andersen model (Andersen, 2008).

The utilization behaviors over the quantitative sample per type of service provider showed high utilization for private providers. More than half of the refugees decided to utilize self-paid private clinics/hospitals or private pharmacies as the first option to obtain needed health services. On the other hand, the qualitative findings explain some of these directions when some interviewees mentioned their awareness of subsidized access policy to public healthcare as a driver to seek services there, the awareness factor found to be matched with Tomkow and his colleagues' findings in their mixed method assessment (Tomkow et al., 2020). Additionally, the drug access policy was another driver for seeking behaviors since the refugees could get their medication from private pharmacies directly using a self-medication approach. Both, non-awareness about public healthcare access policy and drug access policy contributed to high utilization rate for private providers, thus increasing the expenditure on health, and made the cost one of the major barriers that impacted refugees' accessibility to the health services.

The high proportion of those who paid for health services and its reflections of HH financial capacity was another factor drive health-seeking behaviors. With compromised financial capacities, some refugees sought free or subsidized healthcare. This finding match Douangmala's findings as the refugees refrained from using services if it is not free (Douangmala et al., 2012); and some other utilized self-medication, delayed care or used traditional medicine to reduce the cost of healthcare of which is consistent with results of other research (Ojeleke et al., 2020).

Furthermore, the previous experiences with healthcare and facing barriers were driving the seeking behaviors, Tomkow supports this and his team's product as they found that health access and seeking behaviors could be impacted and compounded by access barriers experienced (Tomkow et al., 2020).

Finally, beliefs as an individual characteristic play an important role in defining ones health-seeking behaviors. For instance, recognizing the benefit of seeking healthcare or the seriousness of not seeking care for a condition was an additional driver for seeking behaviors, this assumption is well established through Andersen behavioral model and health belief model (Andersen, 2008; Champion & Skinner, 2008). The analysis of individual responses shows that the perceived seriousness of health conditions bush refugees to seek healthcare even if there was limited potential or resources to get needed services. On the other hand, due to adapted-seeking behaviors that are pushed by encountered barriers, some refugees might fall into harmful adaptation mechanisms that impact their health stability and extend to other means of livelihood such as education, food and shelter (Nabulsi et al., 2020).

5.4 Healthcare access barriers

The findings showed wide set of access barriers experienced by Syrian refugees, similar to those reported by many other research and systematic reviews among refugees globally (Antonipillai et al., 2017; Parajuli & Horey, 2019). However, the quantitative findings show a significant variation in barriers prevalence among different targeted groups. For example, the proportion of access barriers was minimal among children for vaccination access (2.99%), and among pregnant women for antenatal care (1.9%) and family planning (3.1%). While were significant among chronically ill patients (23%) and those who require monthly access (7.9%).

However, the barriers reported among children and women were all minimal. Clearly, the free access policy adopted for vaccination, preventive antenatal care and family planning positively impacted access and utilization among refugee women. Several other literatures have already reported the cost as a major significant barrier for many refugees (Mangrio et al., 2018). The findings of free access impact on eliminating access barriers supported by Kohlenberger and his team findings as the cost was not reported as barrier due to freeness of healthcare (Kohlenberger et al., 2019).

On the other hand, the more significant barriers faced by those who require monthly access were mainly due to cost of service, patient preferences when they do not like service providers and awareness of where to go. The need for regular access among those who require continuous medical needs, like those with chronic illnesses, and frequent family visits every month that is not free required families to pay out of their pockets. The increased demand for healthcare due to frequent access increases the expenditures on health, thus making the cost a primary barrier among this group as cited by Strong and her colleagues (Strong et al., 2015) and was supported by our qualitative findings as well . To a lesser extent, the patient preferences were the second access barrier detected and this raised the issues related to the quality of care detected by qualitative findings and supported by Parajuli & Horey in their systematic review (Parajuli & Horey, 2019). Additionally, refugees' awareness of where to go was detected by quantitative finding and qualitative findings as another access barrier. The refugees' low awareness and knowledge of their privileges corresponded to UNHCRs HAUS findings (UNHCR, 2021b). However, with long-stay reported by most of the refugees in Jordan, it is unexpected to have a low level of awareness and knowledge on access policies, but this could be explained by frequent fluctuations on access policy that underwent four changes over Syria crisis, where the last was only 18 months before data collection stage.

Additionally, the qualitative findings clearly supported the barriers reported by quantitative findings, but also brought up a new set of barriers faced when they needed healthcare services. The additional barriers detected by qualitative findings were found to be context specific and comparable to those detected by other researchers (Correa-Velez et al., 2005; McKeary & Newbold, 2010). However, its controversial that some access barriers detected by other research were not an issue for Syrian refugees in Jordan due to sociocultural proximity to the COO, such as linguistic and cultural barriers (Asgary & Segar, 2011; Kohlenberger et al., 2019).

The set of additional barriers detected through the qualitative method was either context related, such as access policy. The access policy exclusions created by the system have extended effect on health access. For instance, if the refugees change their area of residence (move from one governorate to another or leave camps without a permit) or have their documents invalid, they will automatically lose their access at the subsidized rate. Another group of access barriers detected was related to the health services structure, including service availability, discrimination in provisions, and waiting for time or proximity of providers. However, this group of barriers were detected by several researchers (Parajuli & Horey, 2019).

Finally, there was a controversial finding related to the access barriers when some refugees described some facilitators to their access to healthcare like the affordability of healthcare cost, the excellent quality of services received, and equal treatment. These findings may suggest the proportionality of barriers encountered by some refugees due to facilitators encountered by some groups.

5.5 Adaptation strategies

The adaptation strategies identified in the quantitative assessment were found to be connected to the increase in healthcare cost reported by more than half of surveyed refugees, the impact of raising healthcare cost have to be taken into account when explaining the context of adaptation strategies. Lack of financial resources has had a direct impact on the need to visit a doctor or obtain medication or medical procedures; thus, it has an extended impact on the non-medical needs such as shelter, food, or education.

Detecting adaptation strategies that extend beyond meeting the health needs to another means of livelihood was one of the main research questions that sought answers. The literature minimally supported the cluster of adaptation strategies reported in the quantitative assessment. For instance, only one assessment carried out by International Rescue Committee (IRC) in 2018

identified use of over counter medication, traditional medicine, home deliveries, borrow money, reduce expenditure on food or sell food coupons as a strategies to reduce expenditure on health or meet their health needs with minimal costs (IRC, 2019). Some of the IRC findings were supported by our quantitative findings, when spending saving or borrowing money was the most utilized strategy followed by sought for free services, reducing or stopping medication or using alternative medicine.

On the other hand, our qualitative analysis revealed deeper direct and indirect adaptation strategies and supported all findings detected in quantitative analysis. The new thematic adaptation strategies detected in qualitative analysis supported the group of another six standard adaptation strategies.

The adaptation strategies found were classified as direct if they directly affect the health domain. While those classified as indirect if their impact is connected to other dimensions of refugees' lives. The direct adaptation strategies detected were seeking free healthcare, delaying care seeking, stop medication use, using alternative medicine and self-medication. The indirect adaptation strategies included borrowing money or saving, collecting donations, illegal labor, onward movement, or prioritizing health and other livelihood needs.

The adaptation strategies detected were all found to be negative and/or have a negative impact on health and other means of livelihood. Nabulsi and his team supported some of our findings in their qualitative assessment conducted among Syrian refugees in Lebanon; they found informal employment, child labor, accruing debt and poor living conditions were adapted by refugees to meet their family's needs including health (Nabulsi et al., 2020).

As the refugees have a low health promotion scale and poor health outcomes compared to local nationals who have established welfare systems (Alzoubi et al., 2021), it is more important to understand how refugees behave when they face shortages in their means of livelihood

including health. The causal analysis for the root causes revealed that no clear reasoning or connection between health and other livelihood shortages. Additionally, the causal relationship seems challenging to detect. However, the shortages faced in basic needs brought many interrelated adaptation strategies when the families decide to deprioritize something over another, shift resources from one need to another, or utilize negative indirect strategies such as child labor to meet needs. On the other hand, the common reason found to be trans across all livelihoods needs including health was financial hardship. The financial hardship correlation was studied by Torlinska and his team in their longitudinal study among refugees, confirming that financial hardship is correlated with poor physical and mental wellbeing (Torlinska et al., 2020).

In conclusion, three scenarios found to be conductive to negative decision making when refugees population face a challenge to meet their health needs. The first; when the head of HH have a health condition limit their ability to gain income to cover their health and other livelihoods needs like those who have disability or limiting condition. The second scenario was among those suffering from health conditions requiring additional financial resources to stabilize their health condition, such as those with a family member or members suffering from chronic or long-lasting conditions. And the third is those groups with other pressing basic needs that are prioritized over health needs such as shelter, food, and education requirements, so that health-related needs are minimized and neglected.

5.6 Impact of adaptation strategies

The impact of adaptation strategies was the last research question aimed at estimating the impact of adaptation behaviors followed by refugees to meet their health needs, which was tackled through qualitative methods. However, most of adaptations found to have negative impact, and lead to an extended direct or indirect impact on individuals' and family’s health status.

The general deterioration of refugee's health status who experienced a limited care option. Among those who moved to a risky-seeking behavior like using traditional medicine, reducing the care-seeking frequencies by reducing visits to the care provider, reducing utilization of medicine in order to reduce healthcare cost, or prioritizing other needs over health were major predisposing factors. Syrian refugees in Jordan as per access policies have less access privileges compared to the local national as most of Jordanians have certain type of health insurance (Department of Statistics/Jordan & ICF, 2019), this discrepancies in access magnify the impact on health status. This assumption was supported by Schneider and others, who found that asylum seekers are less accessing the service provider and have a significant likelihood of reporting poor health status compared to nationals (Schneider et al., 2015).

However, when the refugees find themselves cornered or trapped in a situation where medical needs are deprioritized, they believe this strategy could reduce the cost of care; this is not always the case. For instance, Wal confirmed that the early detection for chronic disease is undoubtedly more cost-effective for both refugees and the hosting healthcare system (Wal, 2015). This has been confirmed as well by Daynes, who found that not addressing noncommunicable disease (NCDs) needs in European refugees is more likely to magnify human and economic needs (Daynes, 2016).Another peer review study from an economic perspective confirmed that improving immigrant access to healthcare might reduce cost through improvement of primary prevention (Nandi et al., 2009). In conclusion, addressing refugees' healthcare needs will improve health outcomes and reduce social and health demand costs, protect public health gains locally and globally, and contribute to long-term development outcomes (Gushulak et al., 2009).

Psychological and mental consequences appear as a significant theme. Most the studies that looked at psychological aspects among refugees found that refugees suffer from a higher level of psychological distress and disorders, either because of their refuge journey (Van Loenen et

al., 2018) or because of poor living conditions and poverty they live, displacement and being a victim of violence in the country of asylum (Daynes, 2016). Limited access to healthcare, increased barriers encountered by refugees, and compromised quality of care compounded by many other livelihood barriers they face increase the stress on resources available and make more refugees fall under the poverty line (Brown et al., 2021). In addition, the disadvantage of refugees when it comes to healthcare services increases the impact of inequalities (Lima Junior et al., 2022). However, available literature suggests that suffering from financial hardship due to multiple livelihood needs is associated with increased stress among refugees (Lund et al., 2010; Torlinska et al., 2020). In conclusion, the deprivileged refugees and limited access to essential services increase the fragility of refugees' families, increase their stress levels, and make them more susceptible to stress and mental disorders. On the other hand, the increased mental health disorders prevalence among refugees groups with limited access option to mental healthcare (Hjern & Kling, 2019) may trap refugees in a situation where the need for healthcare increased combined with limited accessibility will have a detrimental consequences on mental health non-resolvable and extensive.

Putting other livelihood needs in a critical situation, weather to make some savings to meet health needs or the other way around, will have an extended significant impact on the unmet needs under the other livelihood components. Our findings found to be corresponded to a mixed-method assessment conducted Syrian refugees living in Lebanon where poor living condition, limited access to healthcare and food insecurity found to be a theme impacted refugees (Nabulsi et al., 2020). Another finding from longitudinal study supports our findings as they found that the financial hardship has a crossing impact on all livelihoods including health with some variations at level of impact. The level of impact detected may indicate the variation in adapted adaptation strategies and the way families prioritize the needs among each other (Torlinska et al., 2020). In conclusion, the refugees found it very difficult to meet health

needs, even though it is one of many other basic needs they have to meet. The limited access to health made them incur more expenses and increase the pressure on financial requirement (Bozorgmehr & Razum, 2015), that situation make them reprioritize between health and other livelihood needs; therefore the eternal consequences may extend to other means of livelihoods on the one hand, and will make the impact unpredictable with extended effect to all livelihoods such as food, shelter and education.

The final recurring theme in the discourse of several refugees interviewed was the legal consequences that refugees faced due to unsettled debts. The debt originated from medical needs such as unsettled hospital bills or other housing needs such as rent, and sometimes originated from illegal work injuries that are not covered by insurance schemes.

The legal consequences that refugees might face included subject to a detention due to unsettled debt. This complicated situation may extend refugees' suffering as it will affect the family's ability to secure necessary resources due to the detention of income generator members who normally commit to resettle incurred debt that originated from several livelihood needs.

Additionally, falling in debt and being subject to legal disciplinary action including detention may bush some refugees to accept working in very poor labor condition or illegal works. On the other hand, the vulnerable members such as women may subject to additional protection risks such as, increased violence and trafficking and increased poor work conditions (Murray, 2018). Furthermore, for those who left without support and found themselves trapped in a huge debt that is impossible to settle, a subsequent migration might be the only option. The refugees have the option to leave the country of asylum either to the country of origin or largely to a third country. However, the debt driven migration has become one of growing migration modality. The adaptation of such behaviors by some refugees could increase the risks on refugees themselves as well as their families and lead to a family separation as well as other

type of protection risks for most vulnerable members such as women and children (Heidbrink, 2019).

Other couple of themes were detected throughout the interviews and were not specifically addressed by any other research question, these issues arose may reflect the compelling nature of these issues, of which may directly affect the refugee community in Jordan.

For instance, the general vulnerability theme that was connected mainly to the increased financial demands on refugees' families with limited economic opportunities, with specific indication to the shelter cost and education needs as a major gap. The urban nature of our sample has a direct impact on this vulnerability as the refugees have to pay for shelter rent which is not the case among camps residents who have free shelters. In addition, living in Amman as almost double the cost of shelter compared to all over Jordan (Brown et al., 2021) is another factor that exacerbated the vulnerability encountered by shelter. However, this finding supported by VAF assessment findings as one third of refugees found incurred debt due to rent while a strong correlation found between rent level and debt level, so as the rent increase the debt level increase (Brown et al., 2021). In conclusion, refugees' integration in local networks considered a best way to enhance refugees' resilience on long run but with limited support available then living in organized camp setting with safe affordable housing could be a better solution for refugees than living in urban side (Kikano & Lizarralde, 2019).

Although it was estimated that Syrian refugees could face a minimal social challenge due to culture proximity to Jordan, but some refugees mentioned social isolation as challenge. However, social isolation has been one of challenges regularly faced by refugees in different setting (Netto, 2011). As per participant feedback, the social avoidance has been practiced as an adaptation strategy due to harassment and bullying that refugees' children experienced in different setting. The harassment and bullying suggest that the social tension between refugees'

local community is remarkable (Ghreiz, 2020). This theme was supported by Çeri and his colleague finding when they detected an increased level of victimization and bullying among Syrian refugee children compared to local community (Çeri et al., 2021). By the way, the increased bullying level increases the probability of psychological problems, and those who experienced increased bullying are more prone to suffer from a higher level of stress like symptoms (Damra et al., 2022). Finally, the increased level of harassment and bullying against children, its impact on refugees' children and their families require an increased focus on creating safe environment as well appropriate psychosocial support to minimize its impact (Popham et al., 2022).

5.7 Limitations

This research revealed some weaknesses and limitations due to several contextual limitations. Ethical considerations arose during data collection phase that was mainly related to subjects' vulnerability and my identity as humanitarian worker of which in a way or another has impacted the consent process due to increased vulnerability of participants and their expectations.

As a humanitarian worker, managing my research identity and its impact on participant expectations, power distribution and freedom to participate in the study was challenging. However, the informed consent content clearly stated the role of research and researcher to manage expectations while freedom statements reconfirmed to minimize this impact. Some participants requested the researcher support to get some supports as they didn't recognize my role as a non-service provider, a clarification provided on my role as researcher and a referral pathway was used and refugees were either directed toward the local NGO clinic or provided with contact information of local partners.

Additionally, there was a focus on using simple random technique over quantitative sample, but the qualitative subjects were selected using purposive sample driven from quantitative

sample participants. Furthermore, the sample has been selected from three community centers that mostly receive urban refugees and were located in two governorates. This limited geographical coverage may limit the maximum variation we targeted for this study.

On the other hand, the simple random technique adopted for quantitative sampling, the sites selected were community centers but not a healthcare provider clinic of which enhanced the diversity of participants and supported the identification of all targeted variables when it came to the health-seeking behaviors, needs, barriers and adaptation strategies.

Finally, the interrelated nature of refugees' vulnerabilities including health vulnerability made it difficult to understand how the accumulation of vulnerabilities can be interpreted. Additionally, the facilitator to access health was captured partially by this study, which might have an impact on addressed needs, barriers, adaptation strategies, and general refugees' vulnerability status.

5.8 Implication and Recommendations

This thesis has an implication for healthcare professionals, providers, institutions, humanitarian organizations and hosting countries health policy makers. Given the current experience with multiple long term refugees crisis, the refugee crises are normally protracted, rather than short term; the average refugee remains a refugee for years (Loescher & Milner, 2006) and the integration within local community is a priority. Therefore, the understanding of refugee's health needs, utilization behaviors, barriers and identification of its impact on refugees themselves, hosting communities and countries is essential to have better health outcome, and minimize disparities that raised due to different contextual conditions (Lima Junior et al., 2022).

Healthcare practitioners normally deal with stabilized community with better health status, better health outcome, and connected to a well establish healthcare system. The refugees normally have a little deviated health needs normally driven by their specific vulnerabilities

and pre-departure health status such as lack of health insurance and increased level of violence. Identifying specific refugees' health needs and barriers will help healthcare practitioners better address refugees' healthcare needs and focus on specific health vulnerabilities among refugees.

On the other hand, the identification of refugees' health-specific needs will help the healthcare institution at local level to be better prepared in term of infrastructure, logistics and staffing. For instance, expanding the community health network could be an essential intervention to improve the attachment of refugees to healthcare services that are considered essential, like vaccination services for children and antenatal care for women.

Additionally, the international and humanitarian organization who are involved in short- and long-term interventions for refugees during the crisis will be able to construct evidence driven interventions that focus on the area of weakness in refugees' behaviors, minimize or eliminate barriers, advocate for better access to essential health services and mobilize resources as need be.

Furthermore, hosting countries still shoulder the big portion of any refugee crisis. The sudden eruption of the crisis made most countries rely on a standard contingency plan that might not fit the nature and background of a particular crisis.

The identification of a health response outlook that is built on identified needs and contextual variation will help the hosting countries to mobilize resources wisely, advocate for donor support, develop health access polices, and minimize the impact on the public healthcare system and public health indicators stability. In the long run, the refugee's healthcare utilization behaviors may be subject to change due to the longevity of crisis; thus, new healthcare needs may surface, a specific health risks may be minimized or escalated, and a modified response may become needed.

The dynamic nature of health-seeking behaviors besides a changing in refuge context as well as the protracted nature of refugee's crisis is recommended to study health-seeking behavior, refugees health needs and barriers identification. In addition to, Measuring the impact of those behaviors over systems, health indicators and economy has become a continuous practice for humanitarian organizations and local governments.

Finally, Gelberg-Andersen model has pointed a set of contextual and individual characteristics that interacts with health behaviors and shape the outcome of health-seeking among vulnerable groups (Andersen, 2008). This research has explored the context, individual characteristics, and behaviors from the angel of actual set up. However, understanding health-seeking behaviors in a context of enablers to healthcare where healthcare facilitators were not fully captured by this study such as socioeconomic condition or health insurance and were not correlated in one way or another to seeking behavior nor adaptation strategies. Therefore, it is recommended that future research focus on studying the impact of healthcare facilitators on refugees' access to health and healthcare outcomes, which might complete the picture and identify the best approaches to structure health responses for refugees. Some modifiable facilitators such as health insurance, health policies and behavior modification could have an efficient impact and enable a quick gain regarding health stability of refugees, hosting population and systems.

5.9 Conclusion

The proposed thesis focused on healthcare access and utilization among Syrian refugees living in an urban setting. It explored their needs, utilization behaviors, access barriers, adaptation strategies and impact.

The healthcare needs identified, including emergency healthcare, hospitalization, mental care, rehabilitation, vaccination, elderly care, childcare, chronic disease care and women's care were within the standards group of services that any human being needs. However, the variation

detected by refugees' community was slightly different from local community due to the predisposing factors that made some healthcare needs more pressing. The variation in needs come from two sources, weather it is because of increased demand such as mental and psychological health services due to increased levels of stress, or because of access barriers such as access to hospital care in catastrophic events, or sometimes because of a combination of both such as those among chronic condition when the prevalence is high, and access is not affordable.

The healthcare-seeking behavior was impacted by several factors as detected earlier by the Gelberg-Andersen model. Access policies, financial capacities, individual practices, knowledge, and beliefs were major drivers detected for seeking behaviors with no detection for its impact whether as a facilitator or barrier to healthcare seeking.

The identified barriers included the access policy, availability of services, discrimination, waiting time, quality of healthcare, distance, awareness and, majorly, the cost. The identified barriers had a varied impact on refugees depending on refugees' contextual and individual factors. The identified barriers obliged refugees to adapt several adaptation strategies to meet their health needs, some of those adaption strategies were non-harmful, but others were health harmful or had an extended impact on health, as well as other livelihood aspects. The variations in encountered barriers had led to a variation and massive extension in adaptation strategies adapted by refugees to meet their health needs. Those strategies included a group of balanced strategies such as seeking free healthcare or collecting donations; some others were harmful to health safety and stability, such as self-medication, delay seeking care, stopping the use of medicine, and using alternative medicine. At the same time, another group had an extended impact on other livelihoods, such as borrowing money, illegal labor, onward movement or re-prioritization between health and other livelihood needs.

The strategies adapted by refugees pose a new risk to refugees themselves and some have extended impact on the hosting community. For example, the increased level of psychological disorder and deterioration of refugee's general health status with poor health outcomes will impact the refugees' ability to meet their health needs and other livelihood needs. It will overburden the local healthcare system with increased preventable demands. On the other hand, compromising other livelihood needs or facing a legal consequence such as detention as part of refugee's effort to meet health needs or the other way around it may produce another set of risks, that extend impact to other aspects of life is unpredictable and may include uncontainable consequences.

Refugees' health access and utilization behaviors could be explored by defining their characteristics, pre refuge health outlook, and current needs, identifying seeking behaviors, access barriers, and adaptation strategies and measuring that impact on refugees themselves and hosting countries. However, understanding the interrelation between all health identifiers and other livelihoods still need more in-depth research and modelling. Additionally, the dynamic nature of this interrelation is still significantly impacted by the context of refuge that, is changing over time and requires continuous evaluation and monitoring.

Finally, leaving the refugees for a long-time facing shortages and barriers to access basic essential healthcare services and other livelihood needs will have interrelated and complex consequences, and it might bring many new and unpredictable adaptation strategies. Moreover, most new adapted adaptation strategies might be on opposing sides of behaviors and will have an extended impact on refugees' health stability, and their ability to live ordinary and resilient, and will have an extended impact on the hosting community where it might escalate a status of social tension between both communities.

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APPENDICES

Appendix I: Health Access Assessment Questionnaire

Study ID		(101-105)	Resp. No.		(106-109)
Interviewer No.		(113-116)	Interview Length		(117-118)
No. Of Queries		(119-120)	Reference No.		(121-124)

Q1	TERMINATE IF CODED 2 IF RESPONDENT DISAGREE TO PROCEED, PLEASE ASK FOR THE REASON Good morning/afternoon. I'm ..... from Granada University, Spain. I am currently conducting a study as part of university requirements for PhD degree. The purpose is to learn more about the experience of using healthcare services for refugees in Jordan. Your information will be kept confidential and will be used for the research proposes only. Could you spare us 15 to 20 minutes of your time? Thank you [SA] إذا لم يوافق المجيب على المتابعة فضلا اسأل عن السبب صباح /مساء الخير .أنا ..... من..... جامعة غرناطة اسبانيا, انا حاليا اجري دراسة كجزء من متطلبات الحصول على درجة الدكتوراه، الهدف من الدراسة هو معرفة المزيد عن تجربة استخدام اللاجئين لخدمات الرعاية الصحية في الأردن .ستبقى المعلومات الخاصة بك سرية وسيتم استخدامها لغايات البحث. هل يمكنك إعطائنا 15 إلى 20 دقيقة من وقتك؟ نشكرك[SA].	Code (125)	Route
	Yes نعم	1	
	No (Please specify) لا	2	

Q2	Would you please tell me your name? فضلا أخبرني ما هو اسمك؟

SECTION 1: FAMILY COMPOSITION

القسم :1 تركيب العائلة

Q3	Are you the head of the HH?[SA] هل أنت رب الأسرة؟ [SA]	Code	Route
	Yes نعم	1	
	No لا	2	

Q4	ASK ONLY IF CODED 2 IN Q3	Code	Route
	What is the gender of the HH head? [SA] ما هو جنس رب الاسرة؟[SA]	(165)	
	Male ذكر	1	
	Female أنثى	2	

Q5	ASK ONLY IF CODED 2 IN Q3		
	What is the age of the HH head (in COMPLETED years)? كم هو عمر رب الأسرة) بالسنوات المكتملة(؟		
(R1)	Age العمر		(166-167)

Q6	ASK IF CODED 2 IN Q3	Code	Route
	Which languages does the HH head speak? [MA] ما هي اللغات التي يتكلمها رب الأسرة؟ [MA]	(169)	

Arabic	اللغة العربية	1	
Kurdish	الكردية	2	
Turkish	التركية	3	
English	الإنجليزية	4	
French	الفرنسية	5	
Somali	الصومالية	6	
Other	أخرى	7	

Q7	ASK IF CODED 2 IN Q3	Code	Route
	What is the level of education of the HH head? [SA]	(171)	
	ما هو مستوى تعليم رب الأسرة؟[SA]		
	Knows how to read and write		
	يعرف القراءة والكتابة	1	
	Primary School		
	المرحلة الابتدائية	2	
	Intermediate/complementary school		
	المرحلة المتوسطة	3	
	Secondary school		
	المرحلة الثانوية	4	
	2 years Diploma		
	دبلوما 2 سنوات	5	
	University		
	الجامعة	6	
	None		
	لا شيء	7	

Q8	Can you please tell me your present age (in COMPLETED years)?		
	فضلا هل يمكنك إخباري عن عمرك الحالي) بالسنوات المكتملة(؟		
	Age		
(R1)	العمر الحالي		(130-131)

Q9	DON'T READ, POST CODE Record Gender [SA] لا تقرأ .سجل لاحقا سجل جنس المجيب [SA]	Code (133)	Route
	Male ذكر	1	
	Female أنثى	2	

Q10	Would you please tell me your place of birth? [SA] فضلا أخبرني عن مكان ولادتك؟[SA]	Code (135)	Route
	Allepo حلب	01	
	Idlip إدلب	02	
	Latakia اللاذقية	03	
	Tartus طرطوس	04	
	Hama حماة	05	
	Ar-Raqqah	06	

		الرقة	
		Al-Hasakah	
	07	الحسكة	
		Deir-ez-Zor	
	08	دير الزور	
		Homs	
	09	حمص	
		Damascus	
	10	دمشق	
		Damascus Rural	
	11	ريف دمشق	
		Quneitra	
	12	القنيطرة	
		Daraa	
	13	درعا	
		As-Suwayda	
	14	السويداء	
		Lebanon	
	15	لبنان	
		Turkey	
	16	تركيا	
		Iraq	
	17	العراق	

	Other اخرى		18	
Q11	Where were you living in Syrian في سوريا؟ [SA]	اين كنت تعيش	Code	Route
	Urban area	مركز حضري/ مدينة	1	
	Rural area	مناطق قروية/ ريفية	2	
	Desert or Mobile life	صحراء/ حياة متنقلة/ بدوية	3	
Q12	In which governorate do you live? [SA] الباحث اقرأ تعريف الأسرة :كل شخص يعيش تحت نفس السقف ويأكل من نفس وجبة الطعام في أي محافظة تعيش؟[SA]		Code (142)	Route
	Irbid إربد		01	
	Mafraq المفرق		02	
	Jerash جرش		03	
	Ajloun عجلون		04	
	Balqa البلقاء		05	
	Zarqa الزرقاء		06	

	Amman			
		عمان	07	
	Madaba			
		مادبا	08	
	Karak			
		الكرك	09	
	Tafileh			
		طفيلة	10	
	Ma’an			
		معان	11	
	Aqaba			
		العقبة	12	
Q13	Where are you living in Syrian? في الاردن ؟	اين كنت تعيش	Code	Route
			[SA]	
	Urban area	مركز حضري/ مدينة	1	
	Rural area	مناطق قروية/ ريفية	2	
	Desert or Mobile life	صحراء/ حياة متنقلة/ بدوية	3	
Q14	When did the first person in your family arrive in Jordan? [SA]		Code	Route
		متى وصل أول شخص من عائلتك إلى الأردن؟	(144)	
			[SA]	
	In the last year			
		في السنة الماضية	1	

	In the last 2 years في السنتين الماضيتين	2	
	More than 2 years أكثر من سنتين	3	
	DK/CS لا أعرف /لا استطيع القول	4	
Q15	What is the total number of individuals in your HH? [SA] كم هو إجمالي عدد الأفراد في أسرتك؟[SA]	Code (145)	Route
	1	01	
	2	02	
	3	03	
	4	04	
	5	05	
	6	06	
	7	07	
	8	08	
	9	09	
	10	10	
	11	11	
	12	12	

	13	13	
	14	14	
	15	15	
	16	16	
	17	17	
	18	18	
	19	19	
	20	20	

Q16 OPEN TEXT FIELDS ACCORDING TO NUMBER OF INDIVIDUALS CODED IN Q15

FILL THE NAMES OF ALL HOUSEHOLD INDIVIDUALS ACCORDING TO DESCENDING ORDER OF THEIR AGE

Would you please tell me the first name of each HH individual including yourself starting from the oldest to the youngest?

ملء اسماء جميع أفراد الأسرة وفقا للترتيب التنازلي لأعمارهم

من فضلك أخبرني بالاسم الاول لكل فرد من أفراد الأسرة بما فيهم نفسك بدءاً من الأكبر سناً إلى الأصغر سناً؟

(R1) Name

الاس

_____

_____

				(147-150)

HOUSEHOLD CLASSIFICATION

تصنيف الاسرة

INTERVIEWER: READ ALL OF THE FOLLOWING QUESTIONS TO THE SAME HOUSEHOLD INDIVIDUAL, POST CODE THEN REPEAT FOR THE REST

الباحث :اقرأ جميع الأسئلة التالية لنفس أفراد الأسرة، سجل لاحقا ثم كرر للباقي

Q17a PIPE IN NAMES CODED IN Q16

Would you please tell me the gender of **<NAME OF THE INDIVIDUAL>** ? [SA]

من فضلك أخبرني ما هو جنس>> اسم الفرد<<؟[SA]

Q17b PIPE IN NAMES CODED IN Q16

AGES SHOULD BE IN DESCENDING ORDER (AGE OF RESPONSE 2 CAN'T BE BIGGER THAN AGE OF RESPONSE 1, AGE OF RESPONSE 3 CAN'T BE BIGGER THAN AGE OF RESPONSE 2 ETC...)

Would you please tell me the age of **<NAME OF THE INDIVIDUAL>** ?

من فضلك أخبرني كم هو عمر>> اسم الفرد<<؟

Q17c PIPE IN NAMES CODED IN Q16

Would you please tell me the marital status of **<NAME OF THE INDIVIDUAL>**?[MA]

من فضلك اخبرني الحالة الزوجية ل>>اسم الفرد<<؟[MA]

Q17d PIPE IN NAMES CODED 'MARRIED', 'WIDOWED' OR 'DIVORCED' IN Q17c AND LESS THAN '50 YEARS' IN Q17 b

Was anyone of your female family members pregnant in Jordan during the last 2 years, say the names if the answer is **yes** ?

[SA]

Name:

اسأل عن" الإناث " اللاتي أعمارهن اقل من 50 سنة.

هل كانت احد افراد اسرتك الاناث حاملا في الأردن خلال السنتين الماضيتين, مع ذكر الأسماء في حال الاجابة **بنعم؟**

[SA]

الأسم:

Q17e PIPE IN NAMES CODED IN Q16

INTERVIEWER READOUT: A chronic disease is a long-lasting condition that requires regular clinical visits

Does **<INDIVIDUAL NAME>** have a chronic disease ? [SA]

الباحث اقرأ :المرض المزمن هو حالة مرضية تتطلب زيارات منتظمة إلى العيادة

هل> اسم الفرد <يعاني من مرض مزمن؟[SA]

Q17a		Q17b	Q17c					Q17d		Q17e	
Male ذكر	Female أنثى	Age العمر	Married متزوج	Single اعزب	Divorced مطلق	Widowed ارمل	Prefer not to answer افضل عدم الاجابة	Pregnant حامل	Not Pregnant ليست حامل	Yes نعم	No لا

	Name	(151)		(152 - 153)	(154)					(155)		(156)	
(R1)	الاسم	1	2	_ _	1	2	3	4	5	1	2	1	2

SECTION 2: KNOWLEDGE OF AVAILABLE HEALTH SERVICES

القسم :2 معرفة توفر الخدمات الصحية

General Knowledge

معرفة عامة

Q18	Code	Route
Do you know that all UNHCR registered Syrian refugees who hold a Ministry of Interior service card (security card) have subsidized access to governmental health services at primary healthcare centers and hospitals? [SA] هل تعلم أن جميع اللاجئين السوريين المسجلين لدى المفوضية السامية للأمم المتحدة لشؤون اللاجئين الذين يحملون بطاقة الخدمة الخاصة بوزارة الداخلية) البطاقة الامنية (بإمكانهم استخدام الخدمات الصحية الحكومية المخفضة في مراكز الرعاية الصحية والمستشفيات ؟[SA]	(176)	
Yes نعم	1	
No لا	2	

Q19	Do you know that all UNHCR registered refugees have free access to the immunization program in MoH healthcare centers? [SA] هل تعلم أنه بالإمكان تلقيح /تطعيم الأطفال اللاجئين مجانا في مرافق وزارة الصحة؟[SA] Yes نعم No لا	Code (172) 1 2	Route
Q20	هل تعرف أين تقع أقرب عيادة تابعة لوزارة الصحة؟[SA] Yes نعم No لا	Code 1 2	Route
Q21	Do you know where the nearest UN or NGO supported clinic is? [SA] هل تعرف أين تقع أقرب عيادة مدعومة من قبل الأمم المتحدة او المنظمات الدولية؟[SA] Yes نعم No لا	Code (173) 1 2	Route

SECTION 3: CHILD IMMUNIZATION

القسم :تلقيح الطفل

Q22	هل سبق أن تلقى أطفالك اللقاحات في الأردن؟[SA]	Code	Route
	Yes		
	نعم	1	
	No		
	لا	2	
	don’t have children ليس لدي أطفال	3	

Q23	ASK IF CODED 1 IN Q22	Code	Route
	أين تلقى أطفالك اللقاحات؟ [SA]		
	governmental health center مركز صحي حكومي	1	
	private clinic عيادة خاصة	2	
	mobile vaccination team فريق تطعيم متحرك	3	
	before arrival to Jordan قبل الوصول إلى الأردن	4	

Q24 ASK IF CODED 1 IN Q22

Were there any difficulties obtaining the vaccine? [SA]

هل كانت هناك صعوبات في الحصول على اللقاح ؟[SA]

Yes

نعم

No

لا

Don't Know

لا اعلم

Q25 ASK IF CODED 1 IN Q24

MULTIPLE ANSWER

What were the encountered difficulties while obtaining the vaccine? [MA]

ما هي الصعوبات في الحصول على اللقاح ؟

[MA]

Long wait

الانتظار الطويل

Staff was rude

الموظفون كانوا غير لطيفين

Couldn't afford user fees (wasn't free)

لم استطع تحمل الرسوم) لم تكن مجانا(

Can't afford transport

لا استطيع تحمل نفقات المواصلات

don't know where to go

لم أعرف إلى أين أذهب

Don't believe in vaccination

لا اؤمن في التطعيمات

Fearing side effects

خوفا من الاعراض الجانبية

Other (Please specify)

اخرى

ASK THIS SECTION IF 'PREGNANT' IS CODED TO ANY OF THE RESPONSES IN Q17d

INTERVIEWER READ OUT: I will be asking you questions about the antenatal care experience in Jordan, by Antenatal care we mean A visit where you receive healthcare during your pregnancy and may include physical exam, ultrasound, lab test for blood and urine, check your blood pressure, pill supplement, vaccine or/and health education on your lifestyle.

INTERVIEWER NOTE: ASK THE FOLLOWING QUESTIONS TO EACH PREGNANT FEMALE

SECTION 4: ACCESS ANTENATAL CARE

تعريف رعاية ما قبل الولادة :الرعاية ما قبل الولادة :زيارة تتلقين فيها الرعاية الصحية خلال فترة حملك ويمكن أن تشمل الفحص السريري، الموجات فوق الصوتية، فحص الدم والبول، فحص ضغط الدم، مقويات حبوب، لقاح و/أو التثقيف الصحي حول اسلوب حياتك.

ملاحظة للباحث :اطرح الأسئلة التالية لكل امرأة حامل.

القسم :4 الحصول على الرعاية قبل الولادة.

Q26 PIPE IN NAMES CODED 'PREGNANT' IN Q17d

Did **<INSERT NAMES CODED 'PREGNANT' IN Q17 d>** receive any antenatal care at any time during the pregnancy?

[SA]

هل تلقت> ادخل اسماء الذين اختاروا" حامل "أي رعاية ما قبل الولادة في أي فترة خلال الحمل؟

[SA]

		Yes نعم	No لا
(R1)	Name الاسم	(224) 1	2

Q27 ASK IF ANY RESPONSE CODED 'YES IN Q26

PIPE IN NAMES CODED 'YES' IN Q26

How many times did **<INSERT NAMES CODED IN Q26 >** visit the clinic and receive antenatal care? [SA]

كم مرة قامت> أدخل الأسماء المختارة في <Q45 بزيارة العيادة وبتلقي رعاية ما قبل الولادة؟[SA]

1-2 visits 1-2زيارات	3-4 visits 3-4زيارات	more than 4 visits أكثر من 4 زيارات
(225)		

	NAME			
(R1)	الاسم	1	2	3

Q28 ASK IF ANY RESPONSES CODED 'YES' IN Q26

PIPE IN NAMES CODED 'YES' IN Q26

Did **<INSERT NAMES CODED IN Q26 >** has any difficulties while getting that care? [SA]

هل واجهت> ادخل الاسماء المختارة في <Q45 أي صعوبات أثناء الحصول على هذه الرعاية؟[SA]

		Yes نعم	No لا
	Name	(226)	
(R1)	الاسم	1	2

Q29 ASK IF ANY RESPONSES CODED 'YES' IN Q28

INSERT NAMES CODED 'YES' IN Q28

MULTIPLE ANSWER, CHOOSE ALL THAT APPLY

What were those difficulties? [MA]

عدة إجابات، اختر كل ما ينطبق

ماذا كانت هذه الصعوبات؟[MA]

Q48a						
Long wait	Staff was rude	Couldn't afford	Can't afford	Don't know	Facility wasn't properly	Other (Please specify)

		الانتظار الطويل	الموظفون كانوا غير مهذبون	user fees لم استطع تحمل الرسوم	transport لا استطيع تحمل نفقات المواصلات	where to go لم أعرف إلى أين اذهب	equipped لم يكن المكان مجهز بشكل جيد	أخرى)ف ضلا حدد(
	Name	(227)						
(R1)	الاسم	1	2	3	4	5	6	7

Q30	Do you or any of your family members know that there are services available in Jordan to help prevent an unplanned or unwanted pregnancy? [SA] هل تعلم انت او اي من افراد الاسرة أن هناك خدمات متوفرة في الأردن للمساعدة في منع الحمل غير المخطط له أو غير المرغوب فيه؟[SA]	Code (234)	Route
	Yes نعم	1	
	No لا	2	

Q31	Have you or any of your family members heard any information about family planning in the past year? [SA] هل سمعت انت او اي من افراد الاسرة أي معلومات عن تنظيم الأسرة في العام الماضي؟ [SA]	Code (235)	Route

	Yes نعم No لا	1 2	
Q32	ASK IF CODED 1 IN Q31 MULTIPLE ANSWER, CHOOSE ALL THAT APPLY You said you/a family member have information about family planning, can you please tell us about the source of information? [MA] عدة إجابات، اختر كل ما ينطبق قلت أنك /احد افراد الاسرة سمعت معلومات حول تنظيم الأسرة، فضلا هل يمكنك إخبارنا عن مصدر المعلومات؟[MA] Community event الفعاليات المجتمعية TV, radio or other media source التلفزيون، الراديو أو مصدر إعلامي آخر Billboard لوحات إعلانية كبيرة في الشارع Brochure or other written material نشرات أو مواد مكتوبة أخرى Health center staff موظفي المركز الصحي Other (Please specify) أخرى) فضلا حدد(	Code (236) 1 2 3 4 5 6	Route

Q33	Have you or any of your family members tried to obtain contraceptives within the past year? [SA] هل حاولت انت او اي من افراد الاسرة الحصول على وسائل لمنع الحمل خلال السنة الماضية؟[SA] Yes نعم No لا	Code (237) 1 2	Route
Q34	ASK IF CODED 1 IN Q33 هل كان هناك أي صعوبات في الحصول على وسائل منع الحمل ؟[SA] Yes نعم No لا	Code 1 2	Route
Q35	ASK IF CODED 1 IN Q34 ما هي الصعوبات التي واجهتها أثناء الحصول على وسائل منع الحمل؟ [MA] Long wait الانتظار الطويل Staff was rude الموظفون كانوا غير لطيفين Couldn't afford user fees لم استطع تحمل الرسوم (لم تكن مجانا)	Code 1 2 3	Route

Can't afford transport	لا استطيع تحمل نفقات المواصلات	4	
Don't know where to go	لم أعرف إلى أين أذهب	5	
Don’t believe in family planning	لا اؤمن في وسائل منع الحمل	6	
fear from side effect	خوفا من الاعراض الجانبية	7	
other (specify)	اخرى	8	

ASK THIS SECTION ONLY IF 'YES' IS CODED TO ANY OF THE RESPONSES IN Q17e

INTERVIEWER NOTE: ASK THE FOLLOWING QUESTIONS TO EACH INDIVIDUAL WITH A CHRONIC DISEASE

SECTION 5: CHRONIC DISEASES

الباحث لاحظ:اطرح الأسئلة التالية لكل فرد يعاني من مرض مزمن

القسم :5 الأمراض المزمنة

Q36 PIPE IN NAMES CODED 'YES' IN Q17e

MULTIPLE ANSWER, SELECT ALL THAT APPLY

READ OUT RESPONSES

Does **<INSERT NAMES CODED 'YES' IN Q17e>** have any of the following conditions? [MA]

هل يعاني> ادخل الأسماء التي اختارت إجابة نعم في Q17e من أي الحالات التالية؟[MA]

		Q59a								
		DM سكر	HTN ارتفاع او انخفاض في ضغط الدم	IHD امراض القلب	Asthma or COPD الربو او الانسداد الرئوي	Cancer السرطان	Kidney disease امراض الكلى	Mental امراض نفسية و عصبية	Epilepsy صرع	other (please specify) أخرى (فضلا حدد)
(R1)	الاسم	(239) 1	2	3	4	5	6	7	8	9

Q37 PIPE IN NAMES CODED 'YES' IN Q17 e

For any reason, has **<INSERT NAME CODED 'YES' IN Q17 e>** been unable to access health services in the last three months?

[SA]

هل كان لأي سبب من الأسباب> أدخل اسم الذي اختار" نعم "في Q17e غير قادر للوصول إلى الخدمات الصحية الأخرى خلال الثلاث أشهر الماضية؟[SA]

		Yes نعم	No لا
	Name	(241)	
(R1)	الاسم	1	2

Q38 ASK IF ANY NAME CODED 'YES' IN Q37

PIPE IN NAMES CODED 'YES' IN Q37

What were the reasons for inability to access health services?

[MA]

ماذا كانت الأسباب لعدم قدرته على الوصول لخدمات الأخرى ؟[MA]

		Q63a						
		Long wait الانتظار الطويل	Staff were rude الموظفون كانوا غير لطيفين	was not available in facility لم تكن متوفرة في المرفق	Couldn't afford user fees لم استطع تحمل الرسوم	Can't afford transport لا استطيع تحمل نفقات المواصلات	don't know where to go لم أعرف إلى أين أذهب	Other: (Please Specify) أخرى (فضلا حدد)
	Name	(243)						
(R1)	الاسم	1	2	3	4	5	6	7

ASK ALL

Section 7: Monthly health access assessment

القسم :7 الحصول على تقييم صحي شهري

Q39 خلال الشهر الماضي، هل احتاج اي من افراد اسرتك الحصول على خدمات الرعاية الصحية؟[SA]

(اسال عن اخر شخص طلب رعاية صحية)

		Yes نعم	No لا	Don't know لا اعرف
Name		(252)		
(R1)	الاسم	1	2	3

Q40

		Yes نعم	No لا	Don't know لا اعرف
Name		(253)		
(R1)	الاسم	1	2	3

Q41 ASK IF CODED 1 IN Q40

أين هو المكان الأول الذي ذهب إليه من أجل الرعاية؟[SA]

Private Clinic / Hospital عيادة خاصة /	Government clinic\Hospital	Private Pharmacy صيدلية خاصة	NGO clinic عيادة المنظمات	other (please specify) أخرى)فضلا حدد(

		مستشفى خاص	عيادة \مستشفى حكومي		غير الحكومية	
	Name	(254)				
(R1)	الاسم	1	2	3	4	5

Q42 ASK IF CODED 1 IN Q40

هل كان قادر على الحصول على الرعاية الصحية هناك؟[SA]

		Yes نعم	No لا
	Name	(255)	
(R1)	الاسم	1	2

Q43 ASK IF CODED 2 IN Q42

MULTIPLE ANSWER, SELECT ALL THAT APPLY

What prevented **him** from getting care? [MA]

عدة إجابات، اختر كل ما ينطبق

ما الذي منعه من الحصول على الرعاية؟

[MA]

Q76a

		Health center refuse to provide services رفض المركز الصحي تقديم الخدمات	couldn't afford user fees لم استطع تحمل الرسوم	Too far / Transport issues المكان بعيد جدا / مشاكل في المواصلات	couldn't get time off work / Caring for other children لم استطع الحصول على إجازة من العمل / الاهتمام بأطفال آخرين	didn't know where to go لم أعرف إلى أين أذهب	Don't like the health services/staff لم تعجبني الخدمات الصحية / الموظفون	Other (Please specify) أخرى (فضلا حدد)
	Name	(256)						
(R1)	الاسم	1	2	3	4	5	6	7

Q44 ASK IF CODED 1 IN Q42

هل كان عليه الدفع للخدمات الصحية المتلقاة؟[SA]

		Yes نعم	No لا
	Name	(257)	
(R1)	الاسم	1	2

Q45 ASK IF CODED 1 IN Q44

ASK FOR EACH RESPONDENT WHO HAD TO PAY, POST THE AMOUNT IN JDs ACCORDING TO EACH RESPONDENT'S NAME

How much in Jordanian Dinars did you pay?

اسأل لكل مجيب كان عليه أن يدفع، سجل المبلغ بالدينار الأردني وفقا لكل اسم مجيب

كم هو المبلغ بالدينار الأردني الذي دفعه ؟

Name

(R1) الاسم (258-262)

DON'T ASK FOR EACH INDIVIDUAL, ASK ONCE FOR THE WHOLE HOUSEHOLD

HOUSEHOLD QUESTIONS

لا تسأل كل فرد، اسأل مرة واحدة لكل الأسرة

اسئلة الأسرة

Q46 Have you noticed any increase in healthcare costs over last 6 months? [SA] هل لاحظت اي ارتفاع في تكلفة الرعاية الصحية خلال الأشهر الستة التي مضت؟ [SA]	Code	Route
Yes نعم	1	
No لا	2	

Q47	ASK IF CODED 1 IN Q46 What was the impact of healthcare cost increase [MA] باعتقادك ما الأثر الذي سببه هذا الأرتفاع ؟	Code	Route
	no impact لا يوجد تأثير	1	
	Was not able to visit doctor or hospital when needed عدم القدرة على زيارة المستشفى او الطبيب عند الحاجة	2	
	Was not able to tolerate cost of medication عدم القدرة على تحمل تكاليف الأدوية المطلوبة	3	
	Was not able to tolerate cost of other medical procedures (investigation, equipment or consumables) عدم القدرة على تحمل تكاليف اي اجراءات طبية اخرى (مثل: الفحوصات الطبية, المعدات الطبية المستهلكات الطبية) ,	4	

Reduce ability to meet other livelihood needs such as food shelter or education تقليل القدرة على تلبية متطلبات الأسرة المعيشية الأخرى (المأوى ، الغذاء ، التعليم ، إلخ.)	5	
Other (specify) تأثيرات اخرى: يرجى التحديد	6	

Q48 What were the adaptation strategies your HH adopted to meet healthcare needs? [MA] [MA]؟ ما هي اساليب التكيف التي تبنتها اسرتك لتلبية احتياجات العائلة الصحية؟	Code	Route
No coping strategy adopted لم نتبنى اي اسلوب	1	
Sought for NGO free services بحثت عن خدمات مجانية تقدمها المنظمات و الجمعيات الغير حكومية	2	
Reducing number of visits to healthcare providers تقليل عدد الزيارات الى مزودي الرعاية بشكل عام	3	
Reduce or stop medication use تقليل او ايقاف استعمال الأدوية	4	
Use alternative medicine or traditional healers استخدام الطب البديل او المعالجين التقليديين	5	
Spent saving or Borrow money	6	

استخدام المدخرات و القيام بالاقتراض Plan for repatriation or leave to a third country	7	
العودة الى الوطن او المغادرة الى دولة اخرى Others: please specify	8	
اساليب اخرى: يرجى التحديد	9	

Q49	INTERVIEWER READOUT: healthcare includes consultations, investigations, pathology tests, medications, medical supplies Did the HH spend any money on healthcare in the previous calendar month? [SA] الباحث اقرأ :تشمل الرعاية الصحية الاستشارات، الفحوصات، الاختبارات، الأدوية والمستلزمات الطبية هل أنفقت الأسرة أي نقود على الرعاية الصحية في الشهر الماضي؟[SA]	Code (273)	Route
	Yes نعم	1	
	No لا	2	

Q50 ASK IF CODED 1 IN Q49

What was the total HH expenditure on health (in JDs) in the last month?

كم كانت مصاريف الأسرة على الصحة) بالدينار الأردني (خلال الشهر الماضي؟

JDs

(R1) دينار أردني | | | | | | (274-278)

Q51 In the previous calendar month what was the combined income for your HH?

خلال الشهر الماضي كم كان الدخل المشترك لأسرتكم) دخل كل أفراد الأسرة(؟

JDs

(R1) دينار أردني | | | | | | | (279-317)

THANK THE RESPONDENT AND END THE INTERVIEW

اشكر المجيب وأنهي المقابلة

Appendix II: Semi Structured Interview Topic Guide

Opening questions:

- When you arrive to Jordan?
- How older you?
- Are you living in a family?
- Are you the head of the HH?
- Who are in your family, please describe them (age, sex)?
- What is your education background?
- Are you employed? If yes, please describe your job?
- Can you please tell me about your living conditions?

Access and utilization of healthcare:

- Tell me about healthcare provider you are accessing in Jordan when you need care?
- Describe when you visited them?
- Tell me what you know about health services access policy in Jordan?
- Tell me about your impression about the clinics or hospitals you have visited or be to with other family member?
- Tell me about your last visit to any healthcare provider? When? Why?
- Tel me about your family members experience with healthcare providers in Jordan?

Access Barriers:

- How do you feel about healthcare you received in Jordan?
- Are you concerned about your or your family health needs? What are those concerns?
- Are you or have been concerned about health needs of women in your family like pregnancy? What is the concern?
- Are you or have been concerned about health needs of members with chronic condition in your family? What are the concern?
- Are you or have been concerned about health needs of minors in your family? What is the concern?
- Tell me about a time when you needed medical care but could not? What were the challenges?

Adaptation strategies:

- Do you think you have enough access to the healthcare services? Or receiving all needed care?
- Have you been able to meet all healthcare need for you and your family? If no, why?
- Have you ever used certain strategies to minimize healthcare burden on you and on your family?
- What were the strategies you used to overcome access barriers and minimize burden including cost?
- Have you felt those strategies prone you or your family for additional risks?
- In your opinion what were those risks?

- الاسئلة الافتتاحية:
- متى وصلت إلى الأردن؟
- كم عمرك؟
- هل تعيش في عائلة؟
- هل أنت رب الأسرة؟
- من هم أفراد أسرتك ، يرجى وصفهم (العمر ، الجنس)؟
- ما هي الخلفية التعليمية الخاصة بك؟
- هل تعمل؟ إذا كانت الإجابة بنعم ، يرجى وصف عملك؟
- هل يمكن أن تخبرني عن ظروف معيشتك؟
- الوصول إلى الرعاية الصحية واستخدامها:
- أخبرني عن مقدمي الرعاية الصحية الذين وصلت إليهم في الأردن عندما احتجت إلى رعاية؟
- صف متى زرتهم؟
- أخبرني بما تعرفه عن سياسة الحصول على الخدمات الصحية في الأردن؟
- أخبرني عن انطباعك عن العيادات أو المستشفيات التي قمت بزيارتها انت أو مع أحد أفراد الأسرة الآخرين؟
- أخبرني عن زيارتك الأخيرة لأي مزود رعاية صحية؟ متي؟ لماذا ا؟
- أخبرني حول تجربة أفراد عائلتك مع مقدمي الرعاية الصحية في الأردن؟
- حواجز الوصول:
- ما شعورك حيال الرعاية الصحية التي تلقيتها في الأردن؟
- هل تشعر بالقلق إزاء احتياجاتك الصحية أو احتياجاتك العائلة الصحية ؟ ما هي تلك المخاوف؟
- هل أنت حاليا او سابقا لديك تخوفات بخصوص الاحتياجات الصحية للنساء في أسرتك مثل الحمل؟ ما هي المخاوف؟
- هل أنت حاليا او سابقا لديك تخوفات بخصوص الاحتياجات الصحية للأفراد المصابين بأمراض مزمنة في أسرتك؟ ما هي المخاوف؟
- هل أنت حاليا او سابقا لديك تخوفات بخصوص الاحتياجات الصحية للاطفال في أسرتك؟ ما هي المخاوف؟
- أخبرني عن وقت كنت بحاجة فيه إلى رعاية طبية ولكنك لم تستطع ذلك؟ ما هي التحديات؟
- استراتيجيات التكيف:
- هل تعتقد أن لديك ما يكفي للوصول إلى خدمات الرعاية الصحية؟ أو تلقي كل الرعاية اللازمة؟
- هل تستطيع تلبية جميع احتياجات الرعاية الصحية لك ولعائلتك؟ إذا لا ، لماذا؟
- هل سبق لك استخدام استراتيجيات معينة لتقليل عبء الرعاية الصحية عليك وعلى أسرتك؟
- ما هي الاستراتيجيات التي استخدمتها للتغلب على حواجز الوصول وتقليل العبء بما في ذلك التكلفة؟
- هل شعرت أن هذه الاستراتيجيات عرضة لك أو لعائلتك لمخاطر إضافية؟

Appendix V: Consent form

Good Morning/Afternoon. My name is (Ibraheem Abu Siam) and I am PhD student from Granada University, Spain.

I am conducting a study among refugees. The purpose of the study is to learn more about the experience of using healthcare services for refugees in Jordan.

You are invited to take part in the survey. We expect to interview about 380 households who are registered with UNHCR. You are one of the selected households. We are asking you to be part of the interview. If you agree to do so, we will interview between 10 and 15 minutes.

From this and other interviews, we may gain a better understanding of challenges that refugees living outside the camps face when seeking healthcare in Jordan. The findings from these interviews may provide us with important information. The information we obtain will be used to assist refugees receive the healthcare services they need. All information will be kept confidential.

You are free to choose whether or not you want to take part in this survey. You can change your mind and stop at any time without penalty. This decision will not adversely affect you. It will not affect any benefits you may receive. It's your choice. If you have any questions about this study, please feel free to ask me.

Do agree to participate in the study?

Yes, I want to participate, and I confirm that I have all the information that I need	
No, I need more information	
No, I don´t	
Yes, with conditions….(explain)	