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Continuous Care in Complex Contexts: Access to Health Services for Noncommunicable Diseases among Syrian Refugee Women in Jordanian Host Communities

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Continuous Care in Complex Contexts:

Access to Health Services for Noncommunicable Diseases among Syrian Refugee Women in
Jordanian Host Communities

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Key words: Public health, healthcare access, health policy

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Abstract

This study examines how, when and where Syrian refugee women living in a host community in central Jordan access health services related to noncommunicable diseases. Noncommunicable diseases are the leading cause of death and disability worldwide, but can be effectively managed through timely treatment. Examining access to care for these diseases in the context of humanitarian emergencies, such as war and displacement, is particularly important because they require continuous care, which may be interrupted during emergencies, and because they can cause acute complications, which may be exacerbated by emergencies (WHO, 2016).

Previous studies indicate a high burden of NCDs among Syrian refugees living in Jordan. They also confirm that many Syrian refugees living in Jordanian host communities have difficulties accessing health services, and identify cost as the most formidable barrier to access. The cost of medications has emerged as particularly significant. This study, which also identifies cost as the most significant barrier in accessing health services, supports previous findings.

By analyzing ten in-depth interviews with Syrian refugee women living in central Jordan, this study builds on previous research through qualitative descriptions of barriers in accessing health services. Specifically, this study analyzes the ways in which barriers to accessing health services interact, concluding that problems in physical accessibility and, to a lesser extent, acceptability, often exacerbate cost-related barriers.

By analyzing the barriers Syrian refugee women encounter in accessing health services for NCDs, this research contributes to a body of knowledge that may be useful to a variety of actors (policy maker, NGOs, health services providers, etc.) seeking to improve access to health services and address NCDs among refugees living in Jordanian host communities.

Key words: Public health, healthcare access, health policy

Introduction

Since unrest began in Syria in March 2011, over 4.8 million Syrians has fled their country (UNHCR, 2016). Of those, over 650,000 are currently registered with the UNHCR in Jordan, although some estimates indicate that as many as 1.3 million Syrian refugees are living in the country (Human Rights Watch, 2016). In fact, according to a 2016 Amnesty International Report, Jordan hosts more refugees than any other country, with approximately 2.7 million refugees as of December 2015. The large numbers of refugees living in Jordan places a large amount of strain on social services, including health services.

The provision of social services is further complicated by the fact that more than 80% of Syrian refugees in Jordan live in host communities, removed from the services provided in formal refugee camps (Al-Fahoum et al, 2015). As the conflict in Syria enters its sixth year and refugees find themselves living in Jordan for extended periods of time, it is important to ensure their access to good and affordable health services, which contributes to the integration of immigrants into the community and safeguards public health (Al-Fahoun et al, 2015). In efforts to ensure access to quality, affordable health services among refugees, noncommunicable diseases (NCDs) constitute a particular concern because they require continuous care, often including medications and other medical technologies, which can be difficult to maintain in the context of displacement. The importance of providing health services for NCDs is magnified by the fact that the burden of NCDs is increasing, in part because of lifestyle changes associated with urbanization, making urban refugee host communities particularly interesting. Moreover, if untreated, NCDs result in preventable increases in morbidity and mortality, in addition to increasing economic strain on refugee families and host communities (WHO, 2015).

Through a series of in-depth interviews with Syrian refugee women living in Karak, a host community in central Jordan, this study attempts to assess how, when and where refugee women access health services and medications for NCDs. In identifying and describing access to services, this study explores six broad categories: NCD status, household living conditions, financial conditions, changes in health status and services, access to services and demographic information. By examining these factors, this research attempts to answer the following questions:

- How, when and where do Syrian refugee women living in host communities access health services for NCDs, and what barriers do they encounter? Specifically:
 - o What barriers do Syrian refugee women encounter in accessing health services for NCDs in host communities? How do these barriers impact access to health services?
 - o Which barriers to accessing health services for NCDs are most prevalent among Syrian refugee women living in Jordanian host communities? Why are these barriers the most significant?

Examining health care access among women is especially important, because women's health has been shown to suffer disproportionality during conflict (Samari, 2016). Examining health in host communities is significant not only because of the association between urbanization and NCDs, but also because of the limited number of service providers working in host communities and, in particular in central and southern Jordan, as service providers and non-governmental organizations (NGOs) related to refugees are generally concentrated in northern Jordan, where most Syrian refugees have settled. As the Syrian conflict enters its sixth year, an increasing number of refugees are moving south, to communities like Karak, where, as of

December 2016, over 8,500 refugees are registered with UNHCR (UNHCR, 2016). This research thus explores the challenges of accessing health services in a community removed from northern Jordan's more established refugee regime of NGOs, government services and camps. By conducting in-depth interviews with refugee women and NGO employees in Karak, it aims to identify, describe and explain the unique challenges Syrian refugee women face in accessing health services for NCDs in host communities.

Hypothesis

From this research, I expected to find that, while most Syrian refugee women have some access to health services, a significant minority lack consistent access to appropriate services. Moreover, I anticipated a high incidence of NCDs, particularly among older women. Regarding barriers to care, I expected the most formidable barrier to be cost; that is, health services were too expensive to afford. Broadly speaking, this study supports that a high burden of NCDs exists among Syrian refugee women living in Jordanian host communities and that financial affordability was the main reason for insufficient access to services. However, among the participants who lacked sufficient access to health care, barriers tended to be not only financial, but also related to physical accessibility and acceptability, which may serve to exacerbate barriers in financial affordability. Therefore, while my hypothesis was generally correct, it failed to explain the interactions between barriers to care revealed by this study.

Terminology

As the conflict in Syria enters its sixth year and displaced Syrians move from place to place, defining a "refugee" can be complicated. For the purpose of this study, a refugee is defined a person fleeing conflict or persecution and, as such, is outside his or her home country. Although not exact, this definition is consistent with the definition of a refugee established in the

Geneva Convention (1951) and the 1967 Protocol. The participants in this study were Syrian refugees living in Jordan who, generally speaking, interview participants fled their homes in Syria three to five years ago.

Among refugees living in Jordan, this study examines access to health services, which is defined as the opportunity or ability to obtain necessary health services and to be protected from financial risk, per the World Health Organization (Evans, Hsu & Boerma, 2013). Notably, access can be broken down into three dimensions: physical accessibility, financial affordability and acceptability (Evans et al, 2013). This study further breaks “health services” into two categories: access to health care, such as doctors’ visits and emergency room access, and access to medications, including the ability to access to a pharmacy and obtain medications. In this study, financial affordability, or “people’s ability to pay for services without financial hardship,” was the most commonly cited barrier to health services access, particularly regarding access to medications (Evans et al, 2013). Physical accessibility, or “the availability of good health services within reasonable reach of those who need them,” was less commonly referenced by participants, but, when raised, proved to be a formidable barrier to health services access (Evans et al, 2013). Finally, acceptability, or “people’s willingness to seek services,” while rarely explicitly expressed by interview participants, was implied in their reported dissatisfaction with health services and perception that health services in Syria were better than those in Jordan.

In an attempt to better understand participants’ access to health services, this study examines household living conditions and financial conditions. For this purpose, a household is defined as a group of people living together and functioning as a single financial unit.

Regarding access to health services, this study specifically examines access to services for NCDs, which are chronic diseases that are not passed from person to person. They are

typically characterized by long duration and slow progression, and require the provision of continuous care (WHO, 2015). The four main types of NCDs are cardiovascular diseases, cancers, chronic respiratory diseases and diabetes (WHO, 2015). This study does not examine a specific type of NCD, but examines access to health services for NCDs in general. The specific NCDs discussed in by interview participants included hypertension, chronic pain, bone conditions, high cholesterol, respiratory conditions, heart conditions, endocrine disorders and autoimmune disorders.

Noncommunicable Diseases: A Growing Burden

NCDs are the leading cause of death and disability worldwide. Globally, they kill 36 million people annually, accounting for 63% of global deaths (WHO, 2013). The burden of NCDs is particularly acute in low- and middle-income countries (LMICs), where as much as 30% of the adult population is living with diabetes or hypertension (WHO, 2013). Importantly, a high burden of NCDs not only adversely impacts health outcomes, but also incurs economic costs. For example, LMICs currently bear 86% of premature death related to NCDs, resulting in cumulative economic losses of US\$ 7 trillion over 15 years (WHO, 2013). Moreover, the global burden of NCDs is increasing, and, in LMICs, NCD-related deaths are expected to increase by 50 percent by 2030 (Nikolic, Stanciole & Zaydman, 2011).

Critically, the same regions that are facing the most substantial burden of NCDs—both in terms of current and projected numbers—are also the regions where the vast majority (80%) of refugees live (Guterres & Spiegel, 2012). Furthermore, the increasing incidence of NCDs has been linked to urbanization and increasing life expectancy—two trends that have been documented not only among the population at large, but among refugees specifically (Amara & Aljunid, 2014). As Antonio Guterres, the former United Nation High Commissioner for

Refugees, wrote in 2012, “the archetypal image of rows of tents stretching into the distance in refugee camps no longer captures [...] the daily reality for many refugees, a substantial proportion of whom live in urban settings” (673). Jordan, where upwards of 80% of Syrian refugees live outside of camps, is no exception (Al-Fahoum et al, 2015). At the same time, refugees’ demographic profiles are also changing: they are getting older and are increasingly from middle-income settings, such as Syria. This demographic transition is accompanied by a shift away from communicable diseases and an increase in the burden of NCDs, in part because urban lifestyles are frequently associated with NCD risk factors and because elderly people are more likely to be living with one or more NCD (Doocy et al, 2015). The changing burden of disease among refugees can be connected to the so-called “epidemiological transition” away from communicable diseases and toward NCDs, which have been associated with four main behavioral risk factors, including tobacco use, harmful use of alcohol, insufficient physical activity and unhealthy diet (Baldwin and Amato, 2012).

NCDs in the Context of Emergency and Displacement

Despite the increasing burden of NCDs and the changing features of refugee populations, NCDs have not traditionally been considered a priority in emergency response (Demaio et al, 2013). In addition to their increasing prevalence, the epidemiological qualities of NCDs suggest that their role in emergency response should be reevaluated. Most NCDs can be effectively managed through timely treatment, which significantly decreases morbidity and mortality and helps avoid significant healthcare costs. However, the management of NCDs in emergencies can be difficult because:

- *Persons with NCDs are more vulnerable in emergencies:* NCDs can incur substantial health costs and may limit function, reducing people’s ability to cope during

emergencies, both physically and financially (Demaio, 2013; WHO, 2016). Additionally, displacement may lead to degradation of living conditions (loss of shelter, shortage of water, lack of access to regular food supplies, reduced income, etc.) that are associated with risk factors for NCDs (poor nutrition, physical and psychological strain, etc.) (WHO, 2016).

- *Emergencies exacerbate NCD-related complications:* Increased stress and decreased access to care during emergencies may lead to acute complications among persons with NCDs (Demaio, 2013). For example, events such as heart attacks and strokes may be up to 2-3 times more common than in normal pre-emergency circumstances (WHO, 2016). These and other acute complications require medical care, incur health costs and may limit function, affect daily activities and reduce life expectancy (WHO, 2016).
- *NCDs require sustained interaction with health systems and providers:* Access to health services may be interrupted during emergencies due to displacement or the destruction of health infrastructure (WHO, 2016). Interruptions in access to healthcare contributes to the exacerbation of NCD-related complications in emergencies (Demaio, 2013).
- *NCDs often require ongoing treatment with medicines and other medical technologies:* Displacement may lead to a loss of access to medications, assistive devices, prescriptions and other services critical to the effective management of NCDs (WHO, 2016).
- *Morbidity and disability associated with NCDs is often lifelong:* Suboptimal management of NCDs during and after emergencies has long-lasting health ramifications (Demaio, 2013).

In emergencies, examining access to health services among refugee women is especially important because women are not only more vulnerable than men, but also tend to remain

displaced for longer periods of time (Samari, 2016). Additionally, women and girls may have a limited ability to move freely, often because they must obtain permission from or be accompanied by a male relative to travel outside their homes, including travel to access health services (Samari, 2016).

Finally, ensuring access to services for NCDs in refugee host communities is important because it is associated with stronger social cohesion and more robust local economies (Nikolic et al, 2011). Due to its increasing duration, the response to the Syrian conflict now demands a longer-term health delivery strategy (Samari, 2016). To be successful, such a strategy must address the management and prevention of NCDs among refugees. Access to affordable and effective health services contributes to the integration of immigrants into the community by preventing inequality and safeguarding the public health of the community at large (Al-Fahoum et al, 2015). Access to health services may be a source of tension in host communities, as health services providers have come under severe stress due to the increasing demands placed on them by the large influx of refugees (REACH, 2014). Addressing tensions related to health services should be “part of a wider agenda addressing social vulnerabilities in host communities” (REACH, 2014, p. 18).

As noted above, access to health services also relates to economics. According to a 2011 discussion paper published by the World Bank, the costs of NCDs to economies can vastly exceed their direct medical costs (Nikolic et al). Reasons for these costs include decreased productivity and competitiveness, increased fiscal pressures, increased poverty and increased inequality. In their global action plan for NCDs, the WHO further elaborates on this point, stating that the growing burden of NCDs “undermines social and economic development throughout the world” (2013, p. 7). However, when cost-effective preventive and curative

measures are implemented, the burden of NCDs, both in terms of human health and economic strain, can be substantially reduced (WHO, 2013).

NCDs among Syrian Refugees: Examining the Literature

Several studies have assessed access to health services, including access to services for NCDs, among Syrian refugees residing in Jordan. Although most studies tend to focus on the refugee response in northern Jordan, their findings are generally consistent with the opinions and descriptions given by interview participants for this study, which was conducted in central Jordan. In general, financial affordability is reported as the most important barrier impacting access to health services. Other important barriers include physical accessibility, such as location, transportation and availability. Acceptability is occasionally mentioned as a barrier to accessing services.

Previous research suggests a high burden of NCDs among Syrians. Prior to the beginning of the conflict in 2011, nearly three-quarters of mortality in Syria could be attributed to NCDs. This statistic is particularly concerning because many Syrians have since been displaced and, as described above, interrupted treatment and lack of access to medication associated with displacement leads to excess morbidity and mortality among persons living with NCDs (Rafique, 2015). As health systems in Syria have deteriorated and millions of Syrians have been displaced, an estimated 200,000 Syrians have died from chronic illnesses because of lack of access to treatment and medicines (Rafique, 2015).

Among Syrian refugees living in Jordan, approximately 40% to 50% of households report at least one adult with an NCD, most commonly hypertension or diabetes (UNHCR, 2014, December; UNHCR, 2015; Doocy et al, 2015). Not surprisingly, the proportion of refugees with one or more NCD increased with age, with a particularly marked increase in NCDs among

refugees aged 40 years and above (UNHCR, 2014, December). This relationship between age and NCD status is roughly reflected among participants in this study, among whom the two participants under the age of 40 *had not* been diagnosed with an NCD, while all but one of the eight other participants, all aged 40 years and above, *had* been diagnosed with an NCD. More specific statistics collected via a telephone survey of Syrian refugees living in Jordan indicate that 17% of Syrian refugees between the ages of 30 and 44 have been diagnosed with an NCD, compared nearly 40% of 45- to 59-year-olds and 54% of Syrian refugees over 60 years old (UNHCR, 2014, March). Notably, previous studies have generally examined a specific set of NCDs, typically including hypertension, diabetes, cardiovascular diseases, chronic respiratory diseases and arthritis. Although these conditions include the vast majority of NCDs, they risk slightly underestimating the burden of NCDs and ignoring less common NCDs, which may require more specialized and costly care, thereby creating a particular challenge for health services access. For example, one participant in this study (which examines NCDs in general, rather than a specific list of NCDs) had been diagnosed with Behcet's Disease, a rare autoimmune disorder, and faced significant barriers in accessing appropriate care.

Importantly, changing policies related to refugees in Jordan have had an ongoing impact on access to health services. Related to labor, most Syrian refugees living in Jordan are prohibited from working, limiting their incomes and making it difficult to afford the treatment of long-term illnesses (Rafique, 2015). Related to health policies specifically, free health care for Syrian refugees in Jordan was repealed in late 2014 (Rafique, 2015). Thus, Syrians residing in Jordan must now pay for healthcare and medications, except for services accessed through the UNHCR or other humanitarian agencies (such as some NGOs). At public health centers and hospitals, Syrian refugees now pay the same prices as uninsured Jordanians for both healthcare

and medications. While these prices are subsidized, and therefore cheaper than prices in the private sector, even relatively low fees could be a barrier to utilization, especially given the limited means of income generation available to refugees living in Jordan (UNHCR, 2014, December). Since the repeal of free health services for Syrian refugees, there has been a reported decrease in access to both curative and preventive health services among refugees living outside of camps in Jordan (UNHCR, 2015). Given the changing policies on refugee health and labor, it is important to continuously assess the access of refugees to health services.

Previous studies reveal that the Syrian refugee population in Jordan is increasingly urban. While over 80% of registered Syrian refugees in Jordan live outside of camps, about 70% of these refugees live in urban centers (UNHCR, 2014, December; UNHCR, 2015). As noted previously, living in urban settings may predispose refugees to risk factors associated with NCDs, such as sedentary lifestyles. Nevertheless, most Syrian refugees living in non-camp settings *do* seek care for chronic conditions. Of Syrian refugees living with an NCD, nearly 85% reported receiving care in Jordan at some point (UNHCR, 2014, December). Importantly, the highest rates of care-seeking among refugees with NCDs were observed in northern Jordan, where most refugees reside, while the lowest rates of care-seeking were in central Jordan (Doocy et al, 2015). This difference suggests that more research is needed on access health services outside of northern Jordan, where numbers of Syrian refugees are substantially lower and, accordingly, the refugee response, including responses related to refugee health, has been considerably smaller. By examining access to services among refugees living in Karak, this study aims to contribute to a growing body of knowledge about refugees residing outside of northern Jordan.

While the majority of Syrian refugees living with NCDs reported seeking care in Jordan, a significant percentage reported difficulties in accessing care consistently. A 2015 survey of Syrian refugees living outside of camps revealed that 58% were sometimes unable to access medicines or health services (UNHCR, 2015). A survey conducted in December 2014, just after the free health services for Syrian refugees were discontinued, nearly 65% of households that lacked consistent access to care reported cost as a barrier to health services (UNHCR, 2014, December). Notably, even before the policy change, Syrian refugees seemed to struggle with access to health services for NCDs more so than for other health problems. According to a 2014 telephone survey of refugee households in Jordan, just 1% reported difficulty accessing vaccines and 4% reported difficulty accessing reproductive health services, while almost 25% reported difficulties accessing health services related to chronic illnesses (UNHCR, 2015). The perception of financial affordability as a substantial barrier to accessing health services is reflected in this study, as all ten interview participants mentioned cost as a barrier to access.

Both in previous research and in this study, access to medications has arisen as a particular problem. As a December 2014 report noted, out-of-pocket health services costs were “primarily associated with the purchase of medicines” (UNHCR, 2014, December, p. 39). Among survey participants with chronic conditions, nearly 90% were prescribed medications for their condition, either in Jordan or in Syria (p. 30). However, over 25% reported that medication use stopped or medication ran out for longer than two weeks in the past year (p. 31). The most common reason reported for stopping medication was cost. This paper aims to build on these statistics by better describing why Syrian refugees with NCDs face such barriers in financial affordability, and specifically in affording medications. Broadly speaking, many study participants reported that their medications were sometimes unavailable at public facilities,

forcing them to resort to paying higher prices at private pharmacies. As this example suggests, barriers in accessing health services may act in conjunction with one another. In this case, a barrier related to physical accessibility (a stock out of medicines at a public clinic) led to a barrier in financial affordability (purchasing medications at a private pharmacy for a higher price).

After financial affordability, physical accessibility is reported as the most formidable barrier in accessing health services. In a 2014 survey, just over 15% of Syrian refugees living outside of camps reported long waits at clinics, while just under 15% reported not knowing where to go for health services (UNHCR, 2014, December). Among the ten interview participants in this study, two reported lack of access to appropriate specialized care, while over half of interview participants reported long wait times.

Among existing research, acceptability was occasionally mentioned as a barrier to health services access, but not as frequently as financial affordability or physical accessibility. In a 2015 survey, about 15% of participants indicated that they perceived negative staff attitudes in health centers (UNHCR, 2015). While interview participants in this study were not explicitly asked about staff attitudes, comments related to their perceptions of health services implied that many participants were at least occasionally dissatisfied with health services, and felt that both health services in general and health professionals specifically had been better in Syria. Such dissatisfaction with health services and professionals could discourage persons living with NCDs from seeking care. However, more research is needed on acceptability before conclusions can be drawn.

Given the high prevalence of NCDs among Syrian refugees living in Jordanian host communities and the barriers they face in relation to health services access (especially financial

affordability and physical accessibility), it is perhaps not surprising that Syrians themselves have identified access to health services as a priority. In a 2013 participatory study conducted by CARE, almost every interviewee mentioned health as a key area of concern. Notably, “this was particularly so for families with preexisting physical health issues or disabilities requiring ongoing treatment and medication,” including NCDs (CARE, 2013, p. 5). Interviewees further elaborated that existing health services were “inadequate,” expensive, difficult to access (sometimes due to transport costs) and that medicines were “extremely expensive” (p. 34).

While previous research indicates that a significant proportion of Syrian refugees in Jordanian host communities are living with NCDs and face substantial financial and physical barriers to health services, my research is intended to describe and explain the barriers they encounter. In doing so, it aims to contribute to a body of knowledge that can be used to improve health system in Jordanian host communities, which Syrian refugees themselves have identified as a need.

Methodology

This study consists of a set of ten semi-structured interviews conducted with Syrian refugee women living in and around the city of Karak, Jordan (interview guide attached, Appendix A). Interviews were conducted over a period of two weeks in late November and early December 2016, during which I traveled to Karak a total of five times. In an effort to better understand access to health services, interviews included sections on NCD status, household living conditions, financial conditions, changes in health status and services since arriving in Jordan, current access to services and demographic information. Just under half of the interviews (4) were conducted at the facilities of a Jordanian NGO. The remaining interviews (6) were conducted in participants’ homes. Each interview was carried out with the assistance of an

Arabic translator. With the consent of the participant, interviews were recorded and later transcribed and analyzed for patterns.

Both oral and written consent was obtained from each interview participant (Arabic consent form attached, Appendix B). Prior to beginning each interview, the written informed consent form was read aloud to participants. The form, which details participants' privacy, confidentiality and other rights, includes the rights to decline to participate in any aspect of to study and to terminate participation altogether. After beginning the recording, participants were asked verbally whether they had read, understood and agreed to the contents of the form.

In addition to interviews with Syrian refugee women, two interviews were conducted with NGO employees, including one Syrian refugee who now works for the NGO and one long-time resident of Karak. These interviews were used to clarify information obtained during interviews, such as the locations of health centers in Karak, the services provided by various health centers and local perceptions about the number of Syrian refugees living in Karak.

Interviews were arranged through a Jordanian NGO working in Karak. I was connected with the NGO through my academic advisor, who has worked with the organization for several years. Interviewees were identified by an NGO staff member who, as a Syrian refugee herself, was well-connected to the local refugee community. Given this arrangement, participants were identified on the basis of convenience, rather than being randomly selected. As mentioned above, each interview was conducted through an Arabic translator. Translators were Jordanian community members, and included a university student, a teacher and an NGO employee. Because translators lived and worked in Karak, they were helpful in clarifying responses (for example, about distances from healthcare centers). However, participants may have also been hesitant to voice criticisms about Karak in front of other community members.

In order to gather both qualitative and quantitative information about access to health services, semi-structured interviews were carried out with each Syrian refugee woman. Interviews typically lasted 20-45 minutes, with the longest responses coming from the women with the most severe health issues. Initially, I planned to conduct both an interview (focused on qualitative responses) and a survey (focused on quantitative responses) among Syrian refugee women. However, because of a combination of time constraints (just four weeks to plan, collect, analyze and report data) and because of a high rate of functional illiteracy among older Syrian women (among whom the largest burden of NCDs can be assumed to exist), I ultimately decided to combine my interview and survey into a single document. Using this slightly more structured interview, I was able to collect qualitative and quantitative data for analysis from each participant using a single interview.

Initially, I hoped to gather data from several sites throughout Jordan. However, time restrictions and the establishment of a strong connection with the NGO located in Karak led me to focus exclusively on Syrian refugee women living in Karak. Although this decision means the study is limited in geographic scope, I felt that I was able to gather more in-depth information by interviewing a greater number of women from a specific community and meeting multiple times with staff members at a local NGO. Therefore, what this study lacks in geographic diversity, it at least partially compensates for in depth of knowledge about a specific local context.

Additionally, prior to beginning data collection, I had hoped to focus on collecting data about access to care among older women (greater than 55 years old), who previous research has identified not only as more likely to be diagnosed with an NCD, but also as more vulnerable in emergencies (Strong et al, 2015). However, because identifying and locating individuals fitting this profile proved impractical during the brief study period, my research ultimately includes

participants with a variety of ages. As described in the results section, they range in age from 18 to 65 years old and, although the majority (7) had been diagnosed with an NCD, three had not. I opted to interview these women regardless, in hopes that their perspectives would contribute to a broader understanding of access to health services among Syrian refugees living in Karak.

Results

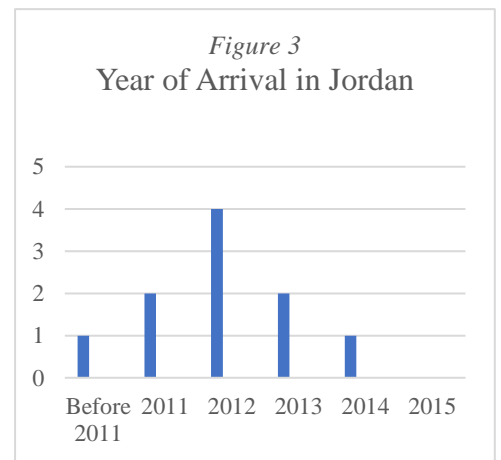
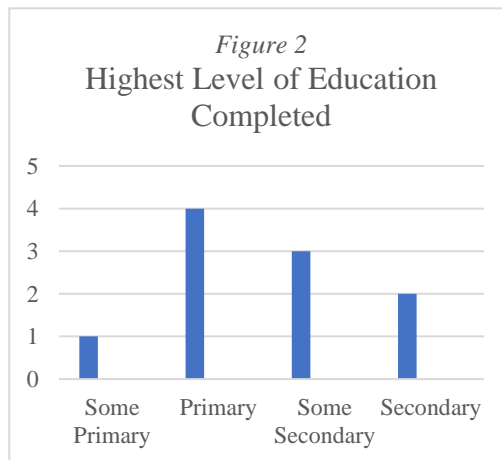
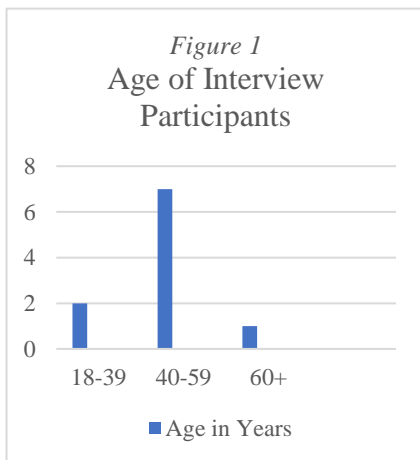
Among the ten women interviewed, all participants expressed difficulty accessing health services at some point. The most common barriers to access were related to financial affordability, which is consistent with existing literature. The most common barrier related to financial affordability was not accessing healthcare itself, but maintaining consistent access to medications, which participants often had to purchase from private pharmacies. Several participants also mentioned physical accessibility as a barrier to services. Although it was not mentioned as frequently as financial affordability, physical accessibility appears to be a more severe barrier, barring women from accessing care even when they can afford to pay for services. For example, two interview participants reported that they could not receive necessary specialized care in the governorate where they lived, forcing them to travel several hours to Amman, the national capital, for health services. Acceptability was not so much expressed as a barrier to care, but as a reason for dissatisfaction with existing services. For example, a few interview participants expressed frustration with what they considered a “poor quality” health system, in which they considered wait times too long and referral systems inadequate.

Participant Characteristics

Interview participants were Syrian refugee women living in Karak Governorate in central Jordan. The total population of the governorate, located about 130 kilometers southwest of Amman, is approximately 300,000, with about 70,000 people living in the city of Karak itself

(Ministry of Interior, 2015). All participants lived within thirty minutes (by bus or car) of the city of Karak. UNHCR has registered 8,500 persons of concern in Karak Governorate, but unofficial estimates given by community members and NGO employees suggest that as many as 15,000-20,000 Syrian refugees are living there (UNHCR, 2016). The reasons for this large discrepancy could be that many Syrians living in Karak either are not registered with the UNHCR or registered in another governorate before coming to Karak. All participants in this study, however reported being registered with the UNHCR in Karak.

Additional characteristics of interview participants (depicted in figures 1, 2 and 3 below) include their ages (18 to 65 years old), their marital status (all were married) and their level of education (half had received at least some secondary education). The majority of participants had arrived in Karak in the past three to five years, although one arrived in Jordan some twelve years ago and registered as a refugee after the conflict began and it became impossible for her to return



to Syria.

Areas of Focus

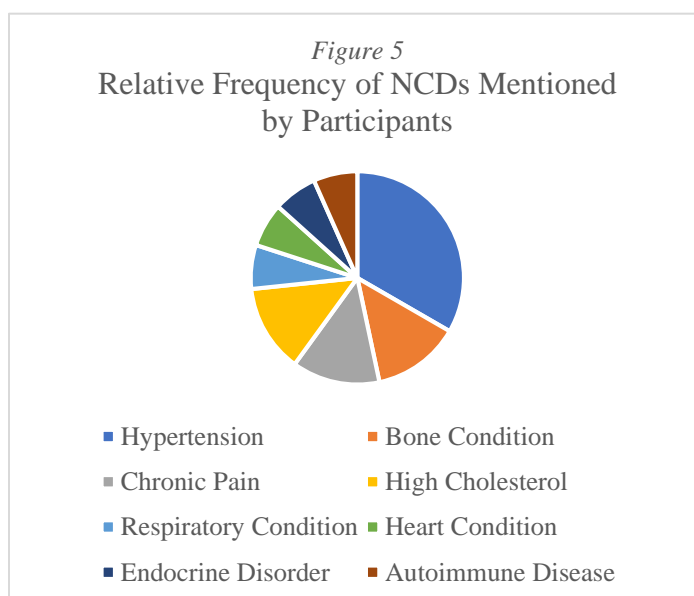
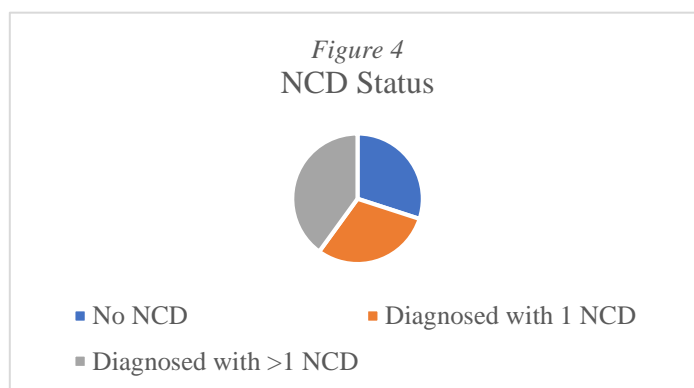
In assessing access to health services, Syrian refugee women were asked about five areas:

- *NCD status*, in which women were asked whether they had been diagnosed with an NCD and, if they had, about its impact on their lives;
- *Household living conditions*, in which women were asked about the size of their household, their ability to leave their homes unaccompanied and the location of their home relative to health services;
- *Financial conditions*, in which women were asked about their household's income, employment status and changes in health-related expenses since arriving in Jordan;
- *Changes in health status and services*, in which women were asked to describe their health in general and how it had changed since arriving in Jordan;
- *Access to services*, in which women were asked more detailed questions about where, when and how they accessed health services.

The results from each section are discussed below.

NCD Status

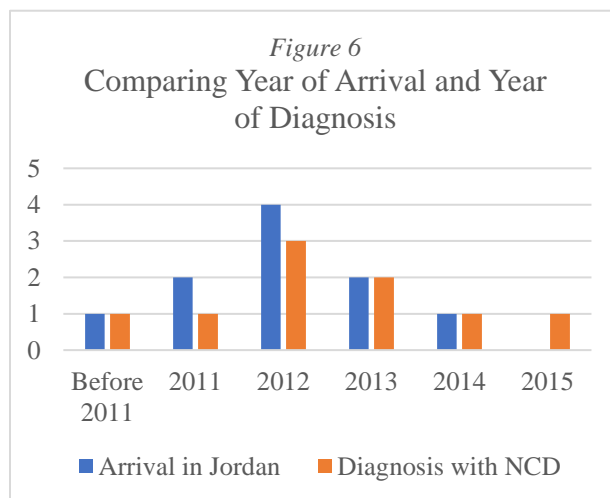
Of the ten women interviewed, seven had been diagnosed with one or more NCD, including hypertension, bone conditions, chronic pain, chronic respiratory infections, endocrine disorders, high cholesterol and autoimmune disorders (figures 4 and 5). Among the three participants who had not been diagnosed with NCDs, two were the primary caretakers for individuals living with



NCDs, including heart conditions and hypertension. Among all participants, hypertension was mentioned the most frequently, coming up in five of the ten interviews. Bone conditions, chronic pain and high cholesterol were each mentioned by two interview participants, while the remaining NCDs were each mentioned by one participant. Broadly speaking, these findings support previous research, in which hypertension was found to be the most common NCD among Syrian refugees living in Jordan (UNHCR, 2014, December). Given the small sample size (10 interviews), it is not possible to draw more precise comparisons.

Of the women diagnosed with one or more NCD, most were diagnosed within the past three to five years. In their interviews, many women drew a connection between the conflict in Syria, displacement and their diagnosis with an NCD. As participant who was diagnosed with hypertension four years ago described, “there was a lot of bombing around me and I was very scared. It was very stressful and I was diagnosed after that.” Another woman, recalled that “when I was in Syria, I wasn’t feeling fatigue or anything like that,” but went on to say that “I don’t feel comfortable [in Jordan],” where she has since been diagnosed with hypertension. As a third participant described, “I suffered from

nothing while I was in Syria. All of my problems, I got them [in Jordan].” Although the sample size is not large enough to draw statistically significant conclusions, participants’ comments and the graph comparing year of arrival and year of



diagnosis (figure 3) suggest a relationship between displacement and diagnosis with an NCD among Syrian refugee women living in Jordan. This could be because weakened health systems

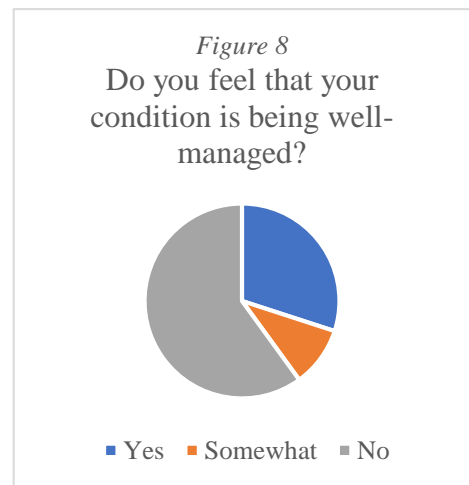
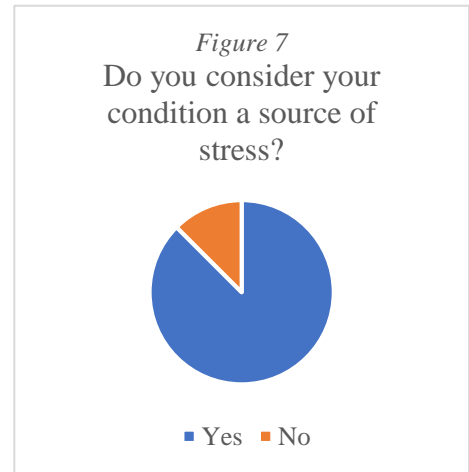
in Syria prevented earlier diagnosis, or it could be because, as suggested by the WHO in a 2016 report, displacement exacerbates the risk factors, such as stress and poor nutrition, that are associated with NCDs.

Nearly all participants identified their NCD as a source of stress that negatively impacts their daily activities (figure 7). Many women describing feeling tired, fatigued or frustrated because NCDs limited their activities. As one woman stated, “I can’t achieve what I want to achieve, because I get tired.” Another described feeling frustrated, “especially because of the many kinds of medications,” which she found difficult to manage.

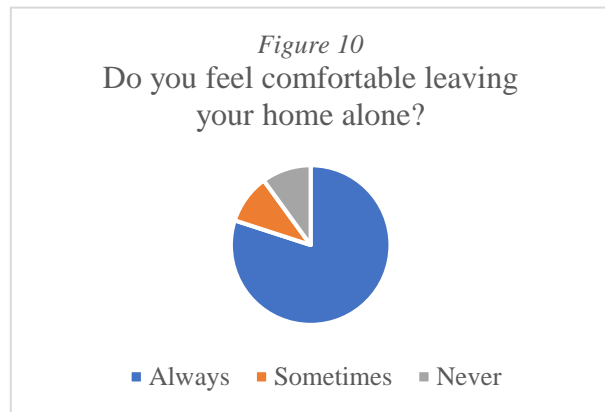
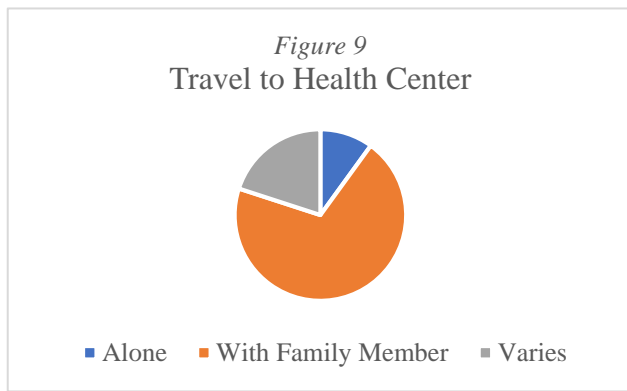
Finally, most women felt that their NCDs were not being well-managed (figure 8), despite the fact that most of them reported going to the doctor and taking medications. Reasons for feeling that NCDs were not well-managed included a perceived lack of specialized care in Karak and the 2014 repeal of free health services for Syrian refugees in

Jordan (and subsequent increase in health costs for Syrian refugees). Due to the lack of specialized care in Karak, two participants reported traveling several hours to Amman for healthcare. These two complaints (increased costs and lack of specialized care) support my hypothesis that the two most important barriers to care relate to financial affordability and physical accessibility.

Household Living Conditions



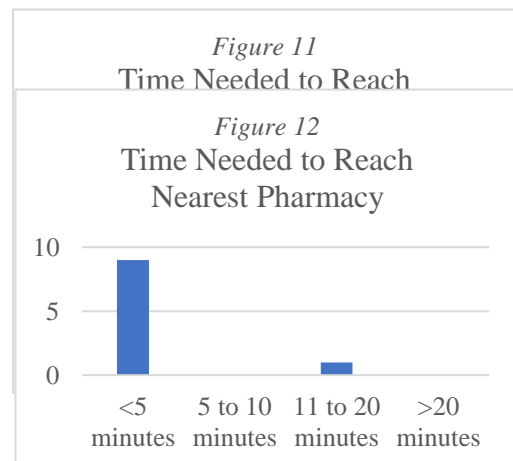
Household size among interview participants varied from two to eleven people, and household members typically included immediate family members. Most women traveled to health centers with family members, however, when asked, nearly all women stated that they felt comfortable leaving their homes alone when necessary (figures 9 and 10). This response undermines the relevance of the assumption that women face particular challenges in health services access because they may not be able to



leave home without a male relative (Samari,

2016).

Importantly, most women lived relatively close to healthcare centers and pharmacies. In general, women lived fewer than ten minutes away from a healthcare center and fewer than five minutes away from a pharmacy (figures 11 and 12). However, many women also reported that the healthcare center nearest to their home was not their preferred healthcare center. Generally, they preferred healthcare centers located farther away because of differences in cost. As one woman stated, “the nearest health center is ten minutes away [walking], but we don’t go there because it has fees.”

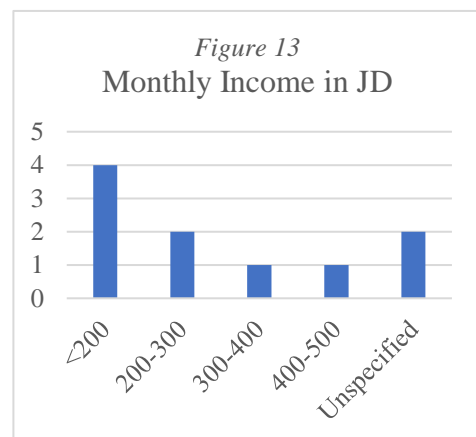


Instead, the woman and her family opt to visit a UNHCR-run clinic, which is located about twenty minutes away by bus, but has fewer fees. Additionally, two women reported that they could not access appropriate specialized care near their homes, and thus travelled to Amman for care, which is both time-consuming and expensive.

Similar barriers were mentioned regarding access to medications: despite the fact that private pharmacies were located near participants' homes, many women could not afford the medications, and opted instead to travel to government- or NGO-run health centers where medications were sold at lower prices. As one woman expressed, "pharmacies are very close, but the medications are expensive, so we don't go there." These examples demonstrate the relationship between financial affordability and physical accessibility in creating barriers to health services: inability to afford private clinics and pharmacies effectively creates a barrier in physical accessibility, because participants must travel greater distances to access healthcare and medications at prices they can afford. These types of situations help explain why cost has consistently been considered the most important factor impacting access to health services among Syrian refugees living in Jordan: cheaper services are more difficult to access because they tend to be farther away.

Financial Conditions

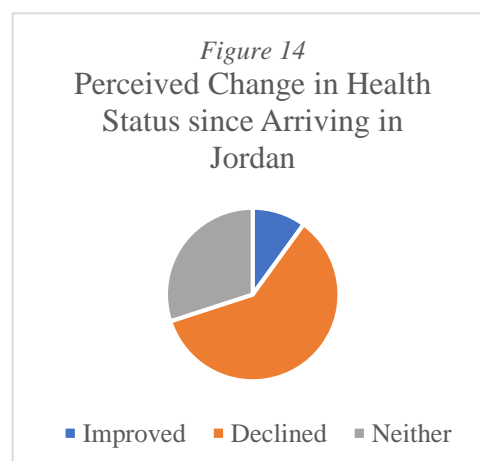
Given the fact that cost is the most frequently reported barrier to accessing health services, it is important to examine household financial conditions. As expected, incomes were generally low, often less than 300 JD per month (approximately 450 US\$, figure 13). Many households received financial support from humanitarian



organizations, most commonly UNHCR, although CARITAS and the Danish Refugee Council were also mentioned as providing seasonal assistance (for holidays, support for heating in winter, etc.). Despite Jordanian labor laws that typically prohibit Syrian refugees from working in Jordan, the majority of participants (8) reported that at least one member of their household was employed. Importantly, employment provides additional *regular* income to supplement the long-term costs of care and medications related to NCDs. Relatively low incomes, however, support the previous finding that Syrian refugee households are “under considerable financial stress,” which impacts their ability to pay for health services, especially for conditions that require continuous care (UNHCR, 2014, December, p. 38).

Changes in Health Status and Services

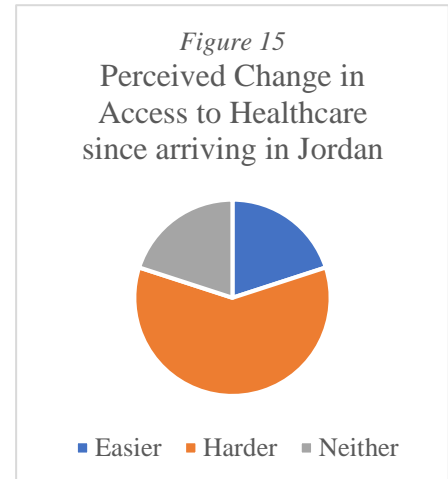
When asked about how their health had changed since arriving in Jordan, the majority of women (6) reported that their health had become worse, three reported no change in their health and just one felt that her health had improved (figure 14). Notably, when responding to these questions, most women did not discuss their NCDs, but their psychological health. Common comments described feeling uncomfortable because of being far away from family and friends, worrying about family and friends remaining in Syria and feelings of sadness and frustration about family members who had been killed or imprisoned as a result of the conflict. As one woman stated, “my psychological health is really bad because of the war and moving here. My son is still in Syria [...] so we are really sad and that affects my health.” Likewise, another woman described the death of one son and the imprisonment of a second son, stating “the situation, my, son, my family. It’s not easy.” Similarly, one woman reported that her health had gotten worse “psychologically, because [her] whole family is in Syria.”



The women who reported that their health had stayed the same or improved generally mentioned that their health had benefitted from “feeling more safe [and] more secure” in Jordan, despite the stress of displacement.

Notably, this section of the interview elicited the most emotional responses from participants. Several women cried while discussing family members and friends who had been killed or who were remaining in Syria. Their responses and reactions clearly demonstrate substantial psychological stress. While women did not directly discuss NCDs in their responses, psychological stress has been identified as a risk factor that may play a role in exacerbating NCDs and NCD-related complications during emergencies (WHO, 2016).

Women were also asked whether they felt healthcare and medications had become easier or more difficult to access since arriving in Jordan. Most women reported that accessing healthcare had become more difficult since arriving in Jordan (figure 15). Among the factors making access to care more difficult, several women noted that, as of the 2014 repeal of free health services for Syrian refugees, they had to pay for health services in Jordan, while government health services had been free in Syria. Several participants also expressed feeling more comfortable in health centers in Syria because of differences in communication and identity. For example, one woman stated that “there we communicate more easily with other people,” while another said, “there it’s different. It’s our country.” Respondents also mentioned that, because family income was higher or because they had had health insurance in Syria, they were able to afford private health services. Generally, women considered Syrian services, particularly private doctors, to be of higher quality than their Jordanian counterparts,



stating that in Syria, doctors “diagnose the person correctly,” “nobody [in Jordan] understands my condition correctly,” and “I’m more proud of the Syrian doctors than the doctors here.”

These responses relate to both financial affordability and acceptability: the women interviewed were less able to afford healthcare due to a combination of government policies, reduced incomes and lack of insurance. Simultaneously, they were less satisfied with healthcare in Jordan because of difficulties communicating and a perception that Syrian services were better (perhaps because they were able to afford private services, which is often perceived as higher quality than care in the public sector).

About half of women felt that medications had become more difficult to obtain in Jordan, citing cost and stock outs as the main barriers. This situation relates to the interaction between

financial affordability and physical accessibility because,

when medicines were out of stock at government or NGO facilities, women reported paying higher prices for

medications at private pharmacies. As one woman stated,

“the [UNHCR-run] clinic has helped a lot for getting medications, but they don’t always have the medications we

need.” Paying higher prices for medications at private

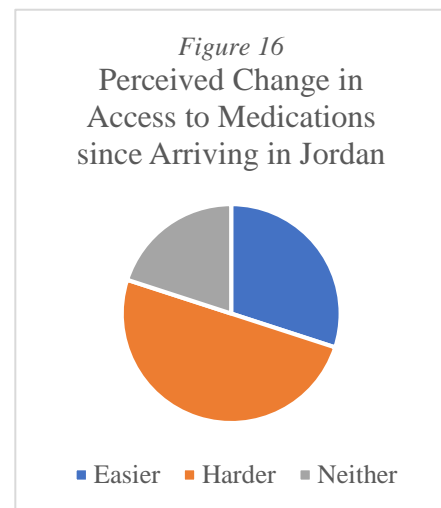
pharmacies, however, was difficult for most women. For

example, as one participant stated, “here medications are more expensive and more difficult to

get because our family income is so low.” The identification of cost as a significant barrier to

accessing medications supports existing research, which suggest that out-of-pocket costs for

medications are common, especially since the repeal of free health services for Syrian refugees

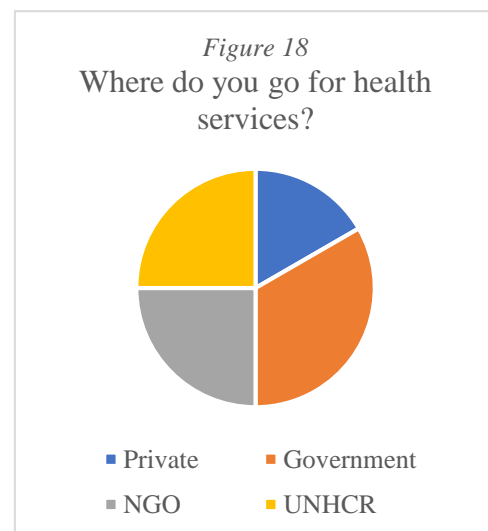
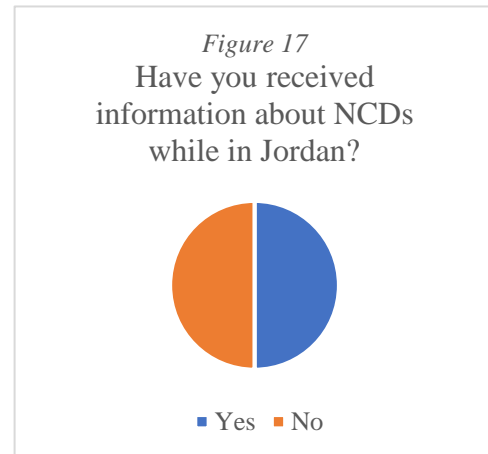


in 2014, and states that a significant proportion of health-related costs are due to medications for NCDs (Rafique, 2015; UNHCR, 2014, December).

Access to Services

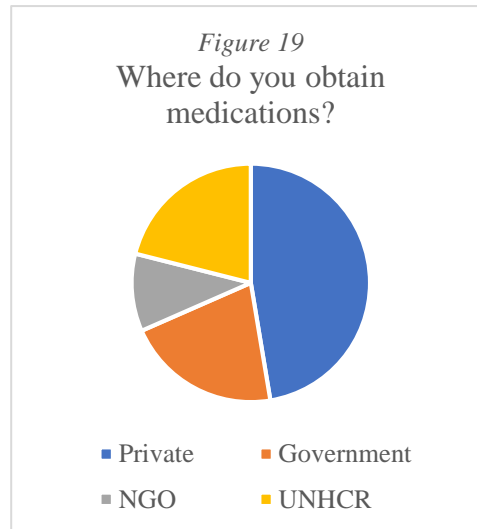
In the final portion of the interview, women were asked about a variety of factors directly related to health services in Jordan.

Since arriving in Jordan, approximately half of participants had received information about, such as a lecture or brochure, related to NCDs (figure 17). Of these women, one reported researching hypertension on the internet, while several others reported attending lectures on breast cancer. Information was typically distributed by NGOs, rather than the government. Given the importance of access to information in preventing NCDs, it is encouraging to see that a significant proportion of participants had received information about them.



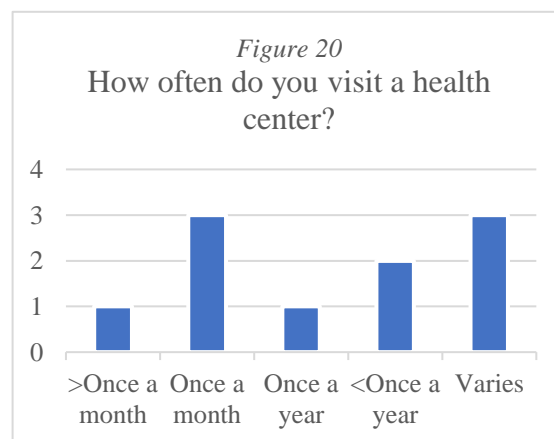
When asked where they go to access health services, nearly half of participants reported primarily going to government facilities, where Syrian refugees now pay the same subsidized fees as uninsured Jordanians (Rafique, 2015; figure 18). The second-most-common healthcare providers were NGOs and UNHCR, which sponsors a mobile clinic in Karak. Just one participant reported relying primarily on private services, which are generally more expensive than government or NGO services.

When asked about where they obtain medications, however, the proportion of women relying on the private sector increased to nearly half (figure 19). The reason for this increase appears to be stock outs at NGO clinics and government health centers. Although most women reported checking for medicines at a government or NGO facility first, they often had to purchase at least some medications at higher prices from private pharmacies. Common comments included, “If [medications] are available at the pharmacy, I get them there. Otherwise, I buy them from a private pharmacy” and “when medications are not available [at government hospital] I have to buy them.”



Among women diagnosed with one or more NCDs, all but one had been prescribed at least one medication, while several women had been prescribed more than one medication. This is consistent with previous reports, which note that NCDs are often managed with medication (WHO, 2016). This is important in assessing health care access because of the expense of purchasing medications, especially over long periods of time (often lifelong) (WHO, 2016; UNHCR, 2014, December).

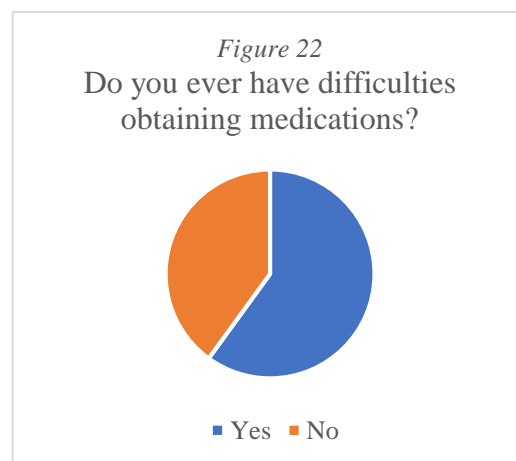
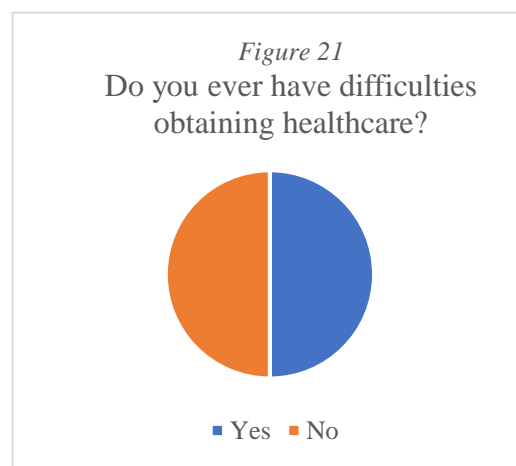
The frequency with which women visited a health center varied from 2-3 times per month to less than once a year. Importantly, several women noted that they had stopped regular doctors’ visits following the repeal of free health services for Syrian refugees in Jordan in 2014. While these women have stopped seeing the doctor



regularly, they continue to take medications to manage their NCDs. As one woman stated, she continues to purchase medications, but no longer goes to the government hospital for check-ups “now that they have stopped us for coming [to the hospital].” As her language implies, some participants seemed to feel a sense of entitlement to free health services, perhaps because they had also had access to free services in Syria. As a result, the lack of access to free services was a source of frustration. This supports the ideas that the repeal of free health services for Syrian refugees resulted in reduced access to services, as well as the theory that access to health services help immigrants adjust more easily (Rafiquie, 2015; Al-Fahoum et al, 2015).

Interestingly, when asked directly, only half of participants reported difficulties obtaining healthcare, while slightly over half reported difficulties obtaining medications (figures 21 and 22). However, in the course of their interviews, all interviewees referenced difficulty obtaining services at some point, most commonly related to financial affordability. This suggests that simple survey questions may underreport barriers to health services access, as most barriers to services only became clear through participants’ qualitative descriptions.

As noted above, cost is the most frequently mentioned barrier to accessing health services. High costs threaten to have a negative impact on health outcomes by causing interruptions to care and medications. For example, as one interview participant stated, “sometimes I don’t take [medicine] because it is too expensive,” even though she had been



prescribed medicine by a doctor. As mentioned in previous sections, high costs, especially related to medications, often relate to stock outs at NGOs and government facilities. As a result of these stock outs, women feel forced to pay higher prices to obtain medications from private pharmacies. For example, one participant reported that “sometimes the place where I go doesn’t have all the kinds of medicines I want, so I have to go to a private pharmacy and buy it.”

Interviewees also expressed frustration regarding long wait times and system inefficiencies at health centers. For example, when asked how long she speaks with a doctor during a typical visit, one woman responded that she speaks with a doctor for three minutes, but only after waiting “for a full two hours.” In addition to wait times in the clinic itself, several women reported waiting long periods of times for referrals for specialized care. As one woman described, “my husband needs an operation for his eye, and we have been waiting for a year.” Another woman expressed frustration with inefficient systems, saying that “the system is very long; you have to go there and come here and it’s a very long series of steps.”

Such long waiting times and systemic inefficiencies relate not only to the physical accessibility of healthcare, but also to its financial affordability. This is because, like medication stock outs, long wait times and slow referral systems may leave women with no options aside from paying out-of-pocket for healthcare from private providers. One woman who regularly puts her name on a waiting list at an NGO clinic reported that, if the wait time is too long, she feels forced to pay for care at a private clinic instead. Similarly, as one woman described, “if we get a transfer to the private sector or another hospital, you have to wait, but we can’t always afford the waiting and then we have to pay on our own with private spending.”

A few participants also mentioned a lack of specialized care in Karak as a barrier to health services. One woman, whose young son had a heart condition, had to travel to Amman for

care. In addition to a long journey, traveling to Amman for care incurred additional financial costs, because bus tickets had to be purchased and the boy's father had to take a day off work to accompany his son. Another woman, who arrived in Karak four years ago, spent three years traveling to and from Amman for care for a rare autoimmune disorder. However, one year ago she stopped making the trip because it was simply too expensive and time-consuming to continue. Although the woman continues to take medications, she is currently not receiving medical care for her illness. Although these examples relate to relatively rare cases (childhood heart condition, autoimmune disorder), they illustrate the way in location, although not mentioned as frequently as cost alone, can be a formidable barrier to accessing health services.

Several participants also mentioned barriers related to acceptability, mostly related to perceptions that the care provided failed to adequately address health problems. For example, as one woman stated in relation to her NCD, "they are able to control the pain, but I don't feel any progress or improvement in my health." Another woman expressed frustration about "moving from doctor to doctor to see if anyone could help" with an infection, but found that "no one could make the right diagnosis." A third woman told a story about her husband, who, after becoming sick, visited a UNHCR-run clinic, but did not obtain a referral for more advanced care. Because of this, when her husband's illness became worse, the woman felt forced to take him to a private doctor at her own expense. Perceptions that health services are ineffective are important to understand because they may discourage people from seeking care, potentially delaying diagnoses or exacerbating complications related to NCDs. Importantly, because they may lead women to seek care at higher prices in the private sector, barriers in acceptability also relate to affordability. As one interviewee struggling to manage an NCD that affected her eyesight stated after describing long referral periods at an NGO clinic (where she receives free care),

“sometimes I just have to go to a private clinic and pay myself. I have to get my eyes treated, because if I don’t my disease will cause me to lose my eyesight.”

Concluding Remarks

In support of previous studies, financial affordability clearly emerged as the most important barrier impacting access to health services among Syrian refugee women living in Jordanian host communities. A combination of factors, from limited employment opportunities to changing health policies have impacted the ability of Syrian refugees to pay for services (Rafique, 2015). Moreover, as employment among Syrian refugees in Jordan remains restricted and recent policy changes have resulted in increased health-related costs, difficulties in affording health services may become even more acute in the future.

However, as women’s responses in this study indicate, barriers in financial affordability are not merely the result of low incomes and high costs. Barriers related to financial affordability appear to be exacerbated by barriers related to physical accessibility and acceptability. For example, due to stock outs at government and NGO facilities (a problem in physical accessibility), some women reported paying higher prices for medications at private pharmacies (creating a problem in financial affordability). Likewise, frustration with long referral periods and wait times for specialized care (a problem related to acceptability) left women feeling as though their only option was to pay relatively high prices for care at private facilities (creating another problem in financial affordability).

By describing how and why cost is such a significant barrier to access for services, particularly services related to NCDs, this research further suggests that it may be possible to address cost-related barriers by improving other aspects of health services access, such as physical accessibility and acceptability. For example, improving the availability of medicines at

NGO and government pharmacies could help reduce the sums refugee women spend on medicines at private pharmacies. Likewise, reducing waiting times and referral periods for specialized care could reduce the reliance of women on more expensive care at private sector facilities. Further research is needed to explore these implications.

Study Limitations

While the results of this study are similar to those of existing reports and publications, it had several important limitations. First and foremost, the small sample size (just ten participants) effectively renders all quantitative results insignificant and limits the extent to which qualitative results can be applied to refugees in general. Generalization is further limited by the limited geographic scope of the study, which examined access to health services specifically in the city of Karak. Limited geographic scope is particularly important because the majority of Syrian refugees in Jordan reside in the North. As a result, Jordan's refugee response has focused on northern Jordan, and the experiences of Syrian refugees living in northern Jordan could differ significantly from those of refugees living in central Jordan. Similarly, because NGOs working with Syrian refugees are also concentrated in the North, access to NGO health services described in this survey cannot be considered representative of access among all Syrian refugees in Jordan.

Additionally, as discussed in the methodology section, the selection of interview participants was not random. Participants were identified by employees from a Jordanian NGO working in Karak. Because all interview participants were connected to this NGO in some way, their access to services may be relatively higher than Syrian refugees who lacked such connections. This is especially true because the NGO that assisted with organizing interviews is the site of a mobile clinic (maintained in conjunction with UNHCR) and provides other services to refugees, such as assistance with heating costs and skills development courses.

Moreover, the study sample was concentrated in the city of Karak itself, meaning that Syrians working outside of the city (for example, in agriculture, an important sector in the local economy) were not included in the study. Notably, such individuals potentially face greater barriers related to accessing health services because their distance from service providers is considerably farther. Additionally, this study did not incorporate the opinions and observations of health services providers in Karak, who can likely provide further insights about the barriers to accessing health services encountered by Syrian refugee women living with NCDs.

Finally, in assessing financial conditions, the interview guide used in this study inquired about approximate monthly income, rather than monthly expenditures. Given the laws restricting employment among Syrian refugees in Jordan, Syrians may have underreported their income or employment status. For this reason, other surveys have used estimates of monthly expenditures to evaluate economic status. Reporting expenditures decreases sensitivities “related to refugees not being able to work legally and misconceptions that households reporting low income will be targeted for humanitarian assistance,” in addition to being more “likely to reflect household wealth, notably available savings” (UNHCR, 2014, December, p. 14). Estimated income was initially used in the interview because it was presumably easier for households to come up with an accurate estimate; however, in hindsight, this measure may have underestimated households’ financial resources.

Recommendations for Further Study

This research raises several topics for additional study, including the need for more comprehensive qualitative research on health services access, the need to further examine the relationships among barriers to health services, the need to develop and test potential interventions related to these barriers, and continued research on health awareness, prevention

and early detection of NCDs among Syrian refugees living in Jordan. Each topic of these topics is discussed briefly below:

- *Broader qualitative research* is needed to further describe and explain barriers to accessing health services, particularly services related to NCDs, among Syrian refugees throughout Jordan. Such research should include refugees living in northern Jordan and southern Jordan, as well as a more comprehensive survey of central Jordan.
- *Further examination of the relationships among barriers to health services* is needed to better understand the barriers to health services that Syrian refugees in the context of Jordan face, and to serve as a baseline for developing public health and policy interventions.
- *Research assessing interventions* is needed to help determine the most effective methods for reducing barriers to health services among Syrian refugees living in Jordan. Such research should examine the effectiveness of various schemes, from interventions targeting improved medication availability to interventions targeting improved referral systems among government and NGO health services providers.
- *Research on health awareness and prevention* is needed because prevention is the most effective means of reducing the financial, physical and psychological burden of NCDs, by almost completely eliminating the need to access NCD-related services. Health awareness, including public information campaigns, were examined only briefly in this study, but such campaigns are closely related to prevention. Prevention and awareness efforts should be examined more thoroughly among Syrian refugees living in Jordan.
- *Research on early detection* of NCDs among Syrian refugees living in Jordan is needed because it has the potential to reduce the physical, financial and psychological burdens

caused by NCDs. This is because, when detected early, it is possible to treat NCDs more effectively, thereby avoiding acute complications that have high costs, in terms of both health and finances.

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Appendix B

Consent Form – Arabic

نموذج موافقة على المشاركة في بحث

هدف البحث:

هدف البحث هذا هو فحص الحصول على الرعاية الصحية للأمراض غير السارية. بشكل خاص، سوف يبحث عن لاجئين يسكنون في مدن وقرى في الأردن وسوف يحلل المشاكل والصعوبات التي لاجئين يواجهون خلال الحصول على الرعاية الصحية للأمراض غير السارية. الأمراض غير السارية هي أمراض ليست معد، مثل الأمراض القلبية الوعائية والسرطان

والأمراض التنفسية المزمنة والسكري. نتمنى ان نتائج البحث سوف تساعد بتقديم الخدمات الصحية والحصول على الرعاية الصحية للاجئين يسكنون خارج المخيمات في الأردن.

الخصوصية والسريه:

كل المعلومات التي سيتم جمعها ستعامل بسرية تامة من قبل الباحثه ولن يطلع على البيانات إلا الباحثه نفسها. بالاضافه الى ذلك سيتم اتلاف البيانات فور الانتهاء من الدراسه وتحليل النتائج.

حقوق المشاركين:

المشاركة في البحث طوعية وبمحض اختيارك. لا يتطلب الاشتراك في البحث ذكر الاسم او ما يدل عليه ومهما كانت اجابتك او رأيك فان هذه الاجابات والآراء لن تؤثر بأي شكل كان على وضعك. كما انه لديك الحق بعدم المشاركة في البحث ان شئت، واذما ما غيرت رأيك وقررت الانسحاب بعد المشاركة فيمكنك الانسحاب كذلك. ومن حقك رفض السماح للباحثه باستخدام بيانات الدراسه في اي دراسات أخرى ستقوم بها الباحثه الرئيسييه.

المعايير الاخلاقيه:

أ. الخصوصية - كل المعلومات سيتم تسجيلها وحمايتها كما ستعامل بسرية تامه, من حقك رفض تسجيل المقابله وذلك من خلال الباحث الرئيسي.

ب. عدم الكشف عن الهوية - لا يتطلب الاشتراك في البحث ذكر الاسم او ما يدل عليه إلا إذا اختار المشارك خلاف ذلك.

ج. السرية - إن جميع الأسماء ستبقى سرية تماما ومحمية بالكامل من قبل الباحثه.

من خلال التوقيع أدناه، فإنك تعطي الباحثه المسؤولية الكاملة لحفظ هذا العقد ومحتوياته. كما سيتم توقيع نسخة من هذا العقد واعطائها للمشارك.

5. اقرار موافقه:

من خلال التوقيع أدناه، فإنك توافق على استخدام ردودك على أسئلة الاستطلاع في دراسة بحثية بعنوان (الحصول على الرعاية الصحية للأمراض غير السارية للاجئين في الأردن). كما أن توقيعك يعني أنك لا تمنع باستخدام ردودك على أسئلة الاستطلاع خلال هذه الدراسة في دراسات مستقبلية على مواضيع مماثلة . وعلاوة على ذلك ، توقيعك يعني فهمك الكامل لحقوقك أثناء المشاركة في هذه الدراسة.

توقيع المشـارك _____ التاريخ: _____

6. أقرار سريه:
من خلال التوقيع أدناه فانك ملتزم بحفظ المعلومات المقدمة من قبل المشاركين في الدراسة بسرية في جميع الأحوال. وهذا يشمل هوياتهم، اجوبتهم على الأسئلة، أو أي معلومات أخرى.

توقيع الباحثة _____ التاريخ: _____

توقيع المترجمه _____

التاريخ _____