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The Impact of Jordanian Health Care Policy on the Maternal and Reproductive Health Care Seeking Behavior of Syrian Refugee Women

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Table of Contents

Acknowledgements	3
Abstract	4
Introduction	5
Literature Review	9
Methodology	17
Results	20
Characteristics of the Population	20
Health Seeking Behavior	21
Perceived Health	22
Maternal Health	27
Study Limitations	28
Conclusion	30
Future Studies	32
References	34
Appendix A: Questionnaires – English and Arabic	36
Appendix B: Interview Guide – English and Arabic	45
Appendix C: Informed Consent	47

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Abstract

On November 20, 2014, the Jordanian government rescinded the free health care it had provided to Syrian refugees living in the host community. Now, Syrians must pay the same amount as uninsured Jordanians when seeking health care in facilities run by the Jordanian Ministry of Health. Identified as a vulnerable and disadvantaged population, most of the Syrian community is not financially secure and has difficulty meeting the cost of living in Jordan. This study surveyed 36 Syrian women and interviewed 2 of them in order to determine the effects this policy has had on their maternal and reproductive health seeking behavior. It hypothesized that the new health care policy will increase the cost of living for Syrian refugees in the host community and therefore cause them to seek health care for maternal and reproductive health care services less frequently. The results showed that there was a decrease in the number of visits these women made for maternal and reproductive health services after the policy change due to financial stress, although the results are statistically insignificant.

Key words: health seeking behavior, maternal and reproductive health, refugees, women, healthcare policies, public health

Introduction

Refugee health care is an important point of focus for the Jordanian Ministry of Health. It is estimated that more than 500,000 registered Syrian refugees live in the Jordanian host communities (UNHCR 2015). These populations are concentrated in the governorates of Amman, Irbid, and Mafraq. More than 50% of the Syrian refugees in Jordan are women, of whom more than 50% are above the age of 18 years and a majority are in the reproductive ages (90,000+ between the ages of 18-25 years) (UNHCR 2015). Syrians in the host community are not allowed work permits and often work illegally and under harsh conditions, making a meager salary (UNHCR 2014). Recent research has shown that Syrian refugees in the host community have an average household income of 228JD although their monthly expenditures are an average of 472JD. These data also show that almost 70% of these families have sold assets or borrowed money and about 90% receive cash allowance from NGO's or the UN (UNCHR 2014). These data also show that almost one tenth of the monthly expenditures are on health services. The lack of financial opportunities for the Syrians and the recent health policy change could account for a very underserved population that must be looked at.

Due to limited resources, the nation must prioritize and allocate health care services to its citizens and the various refugee populations both in camps and in the host community. A lack of funding from foreign donors and a sharp rise in the demand for health care services by non-Jordanians, namely refugees from Syria, Palestine, and Iraq, recently pressured the Jordanian MOH to rescind free health care for Syrian refugees in the host community (Malkawi 2014).

It has been more than four months since this policy has been passed and no research has emerged to evaluate its impact on the health seeking behaviors (HSB) of this vulnerable and impoverished population. The author's personal interest in maternal and reproductive health, especially amongst refugee populations, led her to choose this topic and determine whether or not this change in policy has affected the maternal and reproductive health care seeking behaviors (MRHSB) of Syrians in the host community.

This preliminary study can provide insight on the financial situations of refugee women and how it affects their health and behavior. This research could potentially provide the Ministry of Health with valuable information on how its policies are influencing Syrian women.

Additionally, this topic was chosen because the author believes that since they are being directly influenced by any and all policies related to refugee health care, these individuals have a right to voice their opinions, concerns, and comments.

Due to time restrictions during the data collection period, the entire sample population was chosen at Al-Takkaful Clinic in Ramtha. The hypothesis of this study is that the recent health care policy that rescinds free health care services from Syrian refugees in the host population will increase the financial pressure on families and will be a reason that negatively affects the maternal and reproductive health care seeking behavior (MRHSB) of Syrian refugee women. It is expected that women now are visiting health clinics and comprehensive centers much less frequently than they were before the policy change. Additionally, it is predicted that their perceived overall and reproductive health will be more negative than was before. It is possible

that this new policy is preventing women from seeking the maternal and reproductive health care they believe they need to be healthy.

Literature Review

Throughout the designing and implementation of this study, a variety of literary works were studied in order to gauge what the research community has been focusing on in relation to maternal and reproductive health seeking behavior (MRHSB). It is pertinent to be well read on this topic and determine what types of questions to ask when determining the effects of finances on health seeking behavior. In order to generate reproducible, relevant, and reliable data, previously cited theories and research methodologies were examined.

Although there is no previous literature on this exact topic, research regarding the HSB of uninsured individuals was looked at (Bourne 2007). There also exist a variety of papers examining the results of socioeconomic status on the maternal and/or reproductive health care seeking behavior of women in countries like Ghana and Bangladesh (Aboagye 2013, Bosu 2007, Amin 2010). The findings, research methodologies, and theories stated in these studies provide valuable insight on how to conduct this study and view its results because there is a huge parallel between the two. Additionally, further probing was done into how the Jordanian government is attempting to balance the increasing demand for medical services and the lack of funding and resources.

The most recent report about the health care seeking behavior of Syrian refugees in the host community was conducted in 2014 by a collaborative group that included the UNHCR, the Johns Hopkins School of Public Health, the World Health Organization, and Jordan University of

Science and Technology. This report, however, occurred prior to the change in policy so the figures from this report will be used as a comparison to the results of this study. Although this study occurred while the Jordanian government provided free medical care to any Syrian with a refugee status, the perceptions of household access to medical care were very negative. For instance, the report showed that more than 50% of the participants did not believe that their households were able to get medical care or medical specialists when needed. They also did not believe they could always afford medical care or medication, or that they received enough health information to stay healthy (UNHCR 2014). Additionally, it should be noted that 61% of people reported not seeking adult health care due to financial reasons before the change in policy. This same holds true for why 18% of Syrian women did not seek antenatal care (UNHCR 2014). This is significant because shows that although the Ministry of Health worked to provide free primary health care to Syrian refugees, this was not substantial in meeting their health needs.

The Jordanian 2015 Response Plan for the Syrian Crisis does not mention specifically, or in detail, its response to the recent change in health policy – only that it has taken place in November 2014 and that it may affect the health budget. No specific comments were made on whether or not there were any measures taken after the implementation of the policy change to ensure that Syrian refugees in the host community will be able to afford health care services (The Government of Jordan 2015).

Several goals were made in the Response Plan, which include increasing the availability of reproductive and maternal health care services to both the Syrian refugees and to vulnerable Jordanians, but no specific plan was laid out as to how these goals will be reached.

A very detailed financial outline was laid out in the Response Plan that stated that only about \$55.6 million has been set for the health response to the Syrian crisis. These funds are not only meant for all the refugees living in camps, but also to those living in the host communities, along with vulnerable Jordanian populations (The Government of Jordan 2015). The total Syrian refugee population in Jordan, according to UNCHR, remains at around 100,000 in camps and about 521,000 outside of camps (UNHCR 2015).

The report addresses that there are a lack of resources for Syrian refugees outside of camps; for instance, Amman only has one health clinic per 3,600 refugees. The goal is to have more than one per 1,000 people. The report states that support will be maintained in areas with high populations of refugees by providing medical supplies in clinics. Additionally, the government recognizes that secondary health services need to be funded to ensure affordability, but does not state how or if they will be funded (The Government of Jordan 2015).

Overall, the health care portion of this report was a bit vague in addressing health inequality amongst Syrians in the host community. It seems that though the Ministry of Health and international organizations are focusing more on providing health services to Syrians living in refugee camps. Although this is the case, there are other non-governmental organizations that are providing reduced-cost or free health care services for impoverished populations (UNHCR 2014). These are important notes to consider for this study as they may address the presence or absence of enabling factors apart from the health care policy that may affect the HSB of Syrian women.

Previous research has shown that impoverished women and uninsured individuals do not seek health care services as actively as those who have funds or are insured (Bourne 2007). They also show that these individuals have lower perceived health. Additionally, the report has shown that the lack of significant difference in medical care-seeking behavior between the social classes is a reflection of the removal of user fees in the health care system (Bourne 2007). This particular study is important because it was used as a model to determine MRHSB and perceived health in this study. The questions were tailored so that HSB can be compared to before and after the change in policy.

There also exist several studies that have been centered around determining the role of enabling factors, such as insurance, or subsidized health care, on potential and realized access in terms of HSB. One such study was conducted to measure the effects of a micro-health insurance program on the HSB of individuals residing in Karnataka, India (Savitha 2013). The findings of the study indicated that the micro-health insurance program removed financial barriers to increase access to quality health care. There was also a positive correlation between the insurance status of an individual and his/her use of formal health services (Savitha 2013). Although my study does not directly relate to health insurance, it will contribute to previous studies by addressing how reversing health care policies that provide financial benefits to individuals affect their HSB.

Another study was conducted on the HSB of insured versus uninsured individuals in Vietnam (Markiewicz & Baugh 2009). Results indicated that the effect of health insurance is stronger amongst lower income populations; that is, lower income populations are much less likely to

seek medical treatment if they are uninsured (Andersen 1995). This is an important fact to consider when studying vulnerable refugee populations that are more often than not placed at the lowest income tier.

One other study determined that increasing enabling factors, such as exempting fees, can improve HSB by increasing potential and realized access to health care and thereby improve maternal mortality and morbidity rates (Bosu 2007). This study was conducted in Ghana after a policy was established to eliminate deliver user fees. Another study in Ghana determined that maternal HSB by women is determined by: health facility, order of referrals, capacity of health facility, and financing of maternal health care through delivery exemption policy (Aboagye 2013). These studies prove that affordability plays a role in maternal health; in this study, perceived maternal health was measured in order to determine if it was affected by the policy change.

This study will also be focusing more on the health system to determine whether or not that affects the decision of women to seek care related to maternal and/or reproductive health. Although this study does not focus on the social structures that may affect the attitude of women, like other HSB determining studies have done, certain aspects of the survey or the interview may reveal insight into the attitude of women and how it has affected their health seeking behavior before and after the policy change. For instance, although my study will not be measuring the effectiveness or capabilities of health facilities, participants of the study will be asked whether or not they believe they received adequate care. This question has been added to probe whether or

not there may be other factors, other than the health policy change, that are affecting maternal and reproductive HSB amongst Syrian women.

Previously published literature shows that socioeconomic status is a major indicator of health-seeking behavior. It affects the frequency with which women use modern trained providers for antenatal care, birth attendance, post-natal care, and child health care. The decision making power of a woman has less of an influence on her health seeking behavior than does her socioeconomic status (Amin 2010). This is significantly important for this study because most Syrians who live in the host community face economic hardships due to an absence of economic opportunities (UNHCR 2014). Although an increase in accessibility of modern health care has been noted in Bangladesh, socioeconomic factors are a major barrier for women when they are seeking maternal health care (Amin 2010).

Additionally, some studies have been done on the health-seeking behavior of refugees or asylum seekers. One such study takes place in Florida and relates to Cuban and Haitian asylees (Markiewicz 2009). These individuals live in the host community, just like the Syrian refugees in this study, and are the least likely to seek health screenings for several reasons (Markiewicz 2009). Namely, because they are not eligible for free health screening until they are officially granted asylum after reaching the country. This is somewhat parallel to the situation Syrian refugees in the host community face. For instance, they are not eligible for free health care unlike the Syrian refugees residing in camps. The paper also discusses that many of the asylees in the United States do not receive health care because they are unaware that it is available to them (Markiewicz 2009). This may be an issue in this study because women may not be aware of free

health care services available to them through non-MOH clinics (for instance, they may not know about clinics that provide reduced health care, like the one where the surveys were conducted). Additionally, studies have shown that almost 5% of Syrian refugees in the host community are not receiving UNHCR benefits because most of them reported not knowing what UNHCR is or how to register (UNHCR 2014).

Methodology

According to the revised behavioral model of access to health care published by the Journal of Health and Social Behavior, there are several initial measures of access that assess whether or not an individual is utilizing health care services. In this study, we will be addressing the *potential* and *realized access*, which can be driven or impeded by “*enabling resources*.”

Generally, the “*enabling resource*” takes the form of health insurance; in this case, the *enabling resource* is that which has affected the *potential* and *realized access* of health care to the Syrian refugee women. Previous to the policy change, the *enabling resource* was the policy that had allowed free access to health care for Syrian refugees. We will make that the independent variable and measure the effects it has on the *potential* and *realized access* to health care before and after its removal by the new refugees.

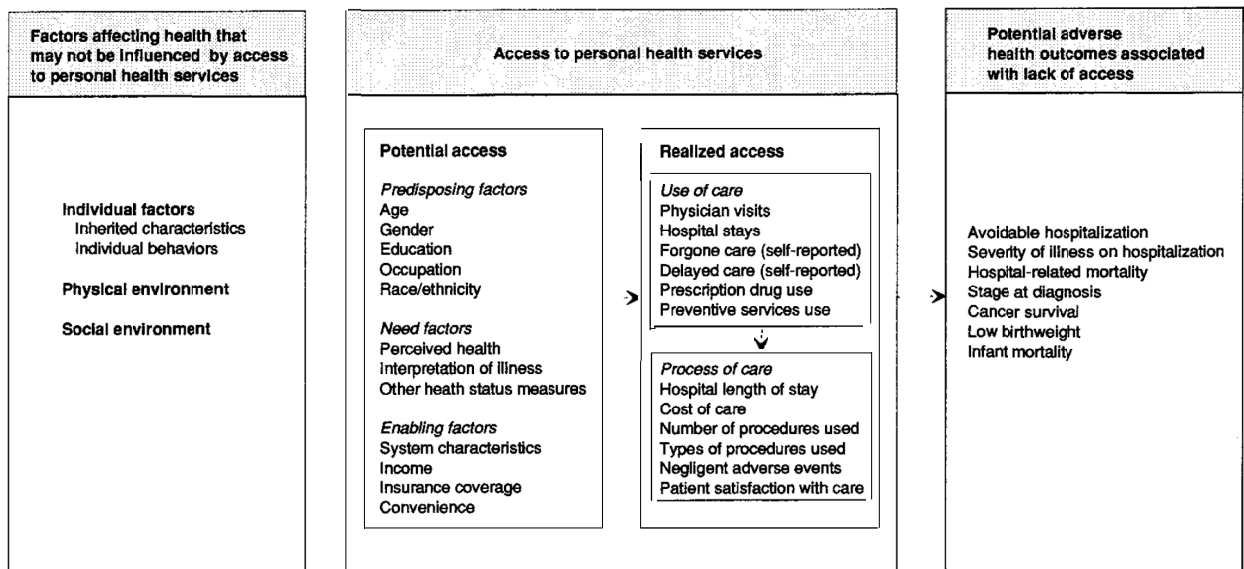


Figure 1:

SOURCE: Office of Technology Assessment, 1992, based on Warner and Murt, 1984; Andersen, et al., various years; Weissman and Epstein, 1992; Mechanic, 1979, Mechanic, 1989b; and studies reviewed for the interim report.

In this case, we are looking at the *potential* and *realized access* to health care in relation to the new policy change, which can be

*considered the removal of an **enabling factor** since Syrians are now to pay as uninsured Jordanians*

This research was done based on the behavioral model of access that is often referred to in literature that measures the effects of a variety of variables on HSB. The questions in the surveys and interviews of this study measured variables that are indicators of HSB; although there is not a specific or established scale to measure the effects of economic status on MRHSB, previous literature was used to identify important questions to be included in the surveys and interviews (Bourne 2007, Margaret & Glewwe 2000, Anderseon 1995). For instance, in order to measure potential access, working status and number of children were recorded. In order to measure need factors, women were asked in the questionnaires to describe their perceived overall health and health during any pregnancy that occurred during their time in Jordan and rate it as either excellent, great, good, or not healthy. The effect of the health policy on realized access was measured by asking women how often they visited health service providers before and after the policy change. Two women also volunteered to participate in a semi-structured interview during which similar questions were asked and expanded on in order to gain additional perspective on the effects of the recent policy on the MRHSB of Syrian refugee women in the host community. Questions that measured the potential access in terms of predisposing factors, need factors, and enabling factors were asked in order to determine the realized access. Additionally, the participants were asked if there were any adverse health outcomes that had arisen because they no longer receive free health care services.

In this study, the independent variable remains as the change in health care policy. The dependent variable will be the MRHSB of Syrian refugee women, which will be assessed based on

the aforementioned survey questions and interview guidelines, which have all been attached in the appendix of this report. The questions in the surveys will be measuring the various aspects of *potential access*, including *predisposing factors* such as number of children, occupation, and nationality. They will also measure *need factors* by measuring perceived health. *Realized access* will be measured by asking the women questions about physician visits, hospital stays, contraceptive use, and self-reported forgone or delayed care due to economic restraints.

Data collection was conducted from the hours of 10am to 1PM on the dates of April 6th through 8th, 2015 at Altakkaful Health Clinic in Ramtha, Jordan. Women were recruited for surveys by being asked if they were married Syrian refugee women. Two women were selected by random this way for the interviews as well. The women were given their rights as participants and given information about the study both in writing and verbally. The interviews were recorded and the women signed the informed consent form and were informed of their rights as participants. All the women were ensured that their privacy and identities would be kept safe. The ethics of this project were approved by the board at the School for International Training. None of the research is particularly sensitive although it does call for interviewing and surveying a vulnerable population. Women were given the freedom to not answer any questions they did not feel comfortable answering.

There were some difficulties regarding the survey distribution. Many participants were asked to participate in the study while waiting for a health professional to see them. Mid-way through the surveys, some women were called to being seen. Some came back to complete the survey while others did not. This significantly reduced the amount of completed surveys available for the

study; while around 50 surveys were collected, only 36 were considered for this research because the others were incomplete. Additionally, none of the women were compensated with anything so many did not feel the need to fill out the surveys completely or accurately. Many thought that the researchers and translators were aid workers from the government and expected some sort of compensation. In the future, some sort of small monetary compensation, or gift, for the participants should be considered.

Figure 2: The following dependent variables and their definitions were used to measure the overall maternal and reproductive health seeking behavior of participants.

Dependent Variable	Definition
POTENTIAL ACCESS	
Working Status	Yes, Working; No, not working
Number of Children	None; pregnant w/ first child; 1-2;3-4;5+
Marital Status	Married; widowed; separated; single
Experienced Pregnancy in Jordan	Yes; no
NEED FACTORS	
Perceived health for pregnancy	Excellent; great; good; not healthy
Perceived overall health	Excellent; great; good; not healthy
ENABLING FACTORS	
Travel time to health center	<10 minutes; 10-15; 15-20; 20+
Not visiting health center due to finances	Yes; no
Affordability, accessibility of contraceptives (before and after the policy change)	Yes; no
Number of visits for health services per month (before and after the policy change)	Never; 1-2; 3-4; 5+

Results

Characteristics of the Population

Most of the participants were married, with only 8% widowed. More than 1/3 of them had five or more children, and most had at least one child – only one woman reported to having no children. This suggests that the potential access to maternal and reproductive health care is very high since these women are all at reproductive age and have at least one child. More than 60% of the women are not using contraceptives, which suggests that they have a high likelihood of becoming pregnant and being in need of MRHS. Additionally, 40% of these women have been pregnant in Jordan, of which, 14% gave birth after the change in health policy, which means that they are prime candidates for determining any difference in MRHSB.

It should also be noted that none of these women work. Occupation is considered a predisposing factor that can either facilitate or hinder an individual towards realized access to health care and thereby affecting HSB (Andersen 1995). This statistic suggests that even if these women have husbands who work, there is strong chance that none are economically independent, which may play a role in their MRHSB. Past research on HSB of Syrians in the host community has shown that most do not seek adult health care services due to financial reasons, even though health services were provided for free (UNHCR 2014). One interviewee claimed that it was very difficult for her to hear about the new policy change because it increased her cost of living in Jordan, especially because one of her children was deaf and so she had to pay for his treatment (Participant 2, personal communication, April 8, 2015).

Perceived Health

Women had a wide range of perceived health status depending on what aspect of their health they were asked about. For instance, most women (36.1%) believed that they were not healthy in terms of overall health and 33% of these women believed their overall health to be “good.”

When women were asked how healthy they believed they and their babies were after delivery in Jordan, the response was almost equally weighted between “excellent”, “great”, and “good”.

None of these women believed they were unhealthy after the delivery in Jordan. Most of these women, when asked about their health during pregnancy, said they believed it to be “good”, while an equal amount (23.1%) believed it to be “excellent” and “not healthy”.

There may be several reasons for these results. Namely, because these women may be provided sufficient and adequate health care during their delivery and pregnancy; data from the survey suggests that 63% of women believed that the health care they received during their pregnancy was adequate. Another reason for these data may be that perhaps their overall health declined after pregnancy due to a decrease in health services available to them due to the policy change. The findings from the perceived health questions suggest that many women do not feel that their health is “excellent” or “great” and that this indicates that there is a great need factor amongst these women to seek out and access health care services.

Table 1: Perceived health; women were asked questions about what they believed their health to be overall, after their pregnancy, and during their pregnancy.

	Excellent	Great	Good	Not healthy
Overall health	11.1% (n=4)	19.4% (n=7)	33.3% (n=12)	36.1% (n=13)
Health of mother and baby after delivery in Jordan (n=13)	30.8% (n=4)	30.8% (n=4)	38.5% (n=5)	0% (n=0)
Health during pregnancy	23.1% (n=13)	7.7% (n=1)	46.2% (n=9)	23.1% (n=13)

Health-Seeking Behavior

Survey questions asking women about their visits to health care providers before and after the policy change revealed that the policy change had the greatest effect on the women's reproductive and maternal self-reported health care seeking behavior. For instance, there was a 13.9% increase in the number of women who never visited a healthcare provider for reproductive/maternal purposes after the policy change. Around 8% less women visited 1-2 times per month and 3-4 times per month, respectively.

General visits showed a similar pattern, but to a lesser extent. After the policy change, less women sought out specialist care 3-4 times per month while more women sought it out 1-2 times per month. These data could possibly be a result of women not prioritizing maternal or reproductive health and therefore seeking health services for it less than general or specialist health services. Although the previous data set shows that the perceived health for women is low and that they show a need for seeking health care, their actual HSB and MRHSB decreased after the policy change, possibly due to financial burdens. It should be noted that statistical

significance tests, such as chi-square, were not done on any of these data because of the low sample size.

Table 2: HSB; women were asked how many times, per month, they made visits for general health services, specialist care, or for maternal/reproductive health services before and after the policy change.

Type of Visit	Policy Change	Never	1-2 times	3-4 times	5 or more times	N/A
General (n=36)	Before	30.6% (n=11)	61.1% (n=22)	2.8% (n=1)	5.6% (n=2)	
	After	36.1% (n=13)	50.0% (n=18)	0% (n=0)	8.3% (n=3)	5.6% (n=2)
	% Change	+5.5	-11.1	-2.8	+2.6	
Specialist (n=36)	Before	30.6% (n=11)	55.6% (n=20)	8.3% (n=3)	5.6% (n=2)	
	After	25.0% (n=9)	61.1% (n=22)	0% (n=0)	5.6% (n=2)	8.3% (n=3)
	% Change	-5.6	+5.5	-8.3	0	
Reproductive/ Maternal (n=36)	Before	25.0% (n=9)	55.6% (n=20)	8.3% (n=3)	2.8% (n=1)	8.3% (n=3)
	After	38.9% (n=14)	47.2% (n=17)	0% (n=0)	0% (n=0)	13.9% (n=5)
	% Change	+13.9	-8.4	-8.3	-2.8	

Table 3: Women were asked if they believed more health visits would make them feel healthier.

		Yes	No
Do you think you would feel healthier if you visited a health clinic more often? (n= 36)		80.6% (n=29)	19.4% (n=7)
Do you think you would have felt healthier if had visited a healthier clinic more often during your pregnancy? (n=1)	Pregnant before policy change (n=11)	100% (n=11)	0% (n=0)
	Pregnant after policy change (n=2)	50% (n=1)	50% (n=1)

Additional data suggest that most women believe that they would improve in overall health if they visited a health clinic more often (80.6%). The data also suggest that women who gave birth before the policy change also believe that they would have felt healthier if they had visited a health care provider more throughout their pregnancy (100%). The data for the women who gave birth after the policy change was included as well, although it is insignificant because the sample size was considerably small. These data suggest that although free health care was provided before the policy change, there may have been another barrier that prevented them from accessing the health care needed for their pregnancy. This may include the time it takes to arrive to a clinic for MRH services; for instance, for 70% of women, it took more than 20 minutes to get to a health care provider for pregnancy-related services. Cost of transportation could have been a hindering factor that prevented them from accessing health services despite them being free. Almost 70% of women confirmed at least one instance during their pregnancy in Jordan when they did not seek professional health care due to financial reasons. These findings suggest that women have identified their need to visit a health professional, however they realize that

they are unable to afford such visits. This in turn is affecting their perceived overall health and their health status for pregnancy.

One pregnant interviewee specifically mentioned the impact of the policy change on her health status; she claimed that due to the cost of health services, she does not see the doctor for her hypertension or for the pain in her legs due to her pregnancy. She said this was especially stressful because along with the healthcare policy change, the value of the food coupon distributed amongst Syrian refugees in the host community has also decreased, contributing to the rise in the cost of living. This pregnant woman said that the policy change has affected how much she is willing to visit the doctor for health services; she claims that she is 8 months pregnant and has only visited the doctor twice for her pregnancy and for checking up on the baby's health. She said she would visit more often if the care provided was free (Participant 1, personal communication, April 9, 2015).

The second woman who was interviewed claimed that the policy change did not affect her that much because she never felt the need to seek healthcare and delivered her last baby before the policy had changed. Even while she was pregnant, she made a total of 3 visits to the doctor: one before her pregnancy, one during, and one for the delivery. She was also one of the women who claimed to not be satisfied with the services she was provided with. This woman did claim that the new policy change was affecting the health of her pregnant friend who, instead of visiting a professional, preferred to use traditional treatments for her pregnancy complications, such as drinking the yogurt-based drink called *shaneenah* (Participant 2, personal communication, April

9, 2015). Both women said that they visit Emirati Camp for refugee women for some health services.

Table 4: Self-reported feeling of hesitation to visit a health professional for reproductive/maternal health services due to financial reasons (before and after the policy change)

Policy Change	Yes	No	N/A
Before	25% (n=9)	69.4% (n=25)	5.6% (n=2)
After	77.8% (n=28)	16.7% (n=6)	5.6% (n=2)
% Change	+52.8	-52.7	

Data from questionnaires and the results from the interviews hint that women now feel much less comfortable seeking health care for maternal/reproductive health due to financial reasons. There was a 52.8% increase in the number of women who felt less comfortable going to a healthcare provider for such services after the policy change. This proves that self-reported realized access is very low compared to the need factors demonstrated above.

These data also hint that the use of care amongst these Syrian refugee women has declined since the implementation of the health care policy because most women claimed to not seek a health care provider at least once due to financial reasons, both for their pregnancy related issues or for their overall health care. But data also suggest that the need factors are high because many women do not believe that they are healthy either over all, or in terms of being healthy enough to be pregnant. Typically, high need factors would result in a correspondingly high realized access; however, in this case, the retraction of free health care services to Syrian refugees may be what is deterring them from needed access.

Table 5: participants who were pregnant before and after the policy change were asked how many visits per month they made to a health professional for prenatal and postnatal care. Note: these data are not conclusive, nor are they statistically significant because of the low sample size.

	Before or after policy change	Never	1-2 visits	3-4 visits	5+ visits
Prenatal visits	Before (n=11)	16.7% (n=2)	33.3% (n=4)	8.3% (n=1)	41.7% (n=5)
	After (n=2)	0%	0%	50% (n=1)	50% (n=1)
Postnatal visits	Before (n=11)	27.3% (n=3)	55.6% (n=5)	18.2% (n=2)	9.1% (n=1)
	After (n=2)	50% (n=1)	50% (n=1)	0%	0%

According to the UNCHR Health Access Survey Report that was written in 2014, Syrian women made an average of 6.2 visits for antenatal services. The statistics from this study are slightly different since more than half of the surveyed women only made 0 to 4 antenatal visits, which indicates that antenatal visits have decreased slightly, although this number is not statistically significant. This number is also for women who were pregnant before the policy change, so these data do not provide any information about how this change has led to any effect on the MRHSB of Syrian women. Additionally, the women who gave birth and were pregnant after the policy change were included separately in the data chart but the sample size is too small to consider it significant.

Study Limitations

It should be noted that this study was done in a very limited period of time. The author did not have sufficient time to revise and edit the questionnaire after the initial round of survey distribution, or get a large and diverse sample size that was more representative of Syrian refugee women living in the host community. Due to these restrictions, the participants of the questionnaire and interview were all recipients of the health services provided by AlTakkaful Health Clinic in Ramtha. These women paid a small fee for the services they received. Although the data could be possibly skewed for these reasons, it should not play a major role in affecting it because these women claimed to seek maternal and reproductive health care at facilities run by the Ministry of Health as well. Additionally, the questions in the survey were only based on several studies conducted on HSB in the past and do not follow a specific scale. The answers to the questions are what the author believes are indicators of perceptions of health amongst the participants and their health seeking behavior. Another obvious limitation is the sample size, which was only 36 women and 2 women who were interviewed. These numbers are not representative of the Syrian refugee host population and so the data from this study should be looked at critically. Due to these limitations, this study should simply be noted as a preliminary to a potentially larger project aimed at determining the HSB of Syrian refugee women after the health policy change. More time should have also be given between the change in policy and this research to allow for the manifestation of the impact, if any, of the policy change on MRHSB of refugees.

Additionally, there is the issue of self-reporting, especially amongst refugees. It is common that refugees will report their situations much worse than in reality because they are seeking help (A.

Othman, personal communications, April 27, 2015). Many of the refugee women in this study wrote pleas for financial help at the end of the surveys. Although their financial situation is deplorable, their self-reported data in this study should be looked at with a critical lens, particularly because the sample size is so low.

Conclusion

Overall, the data reports that there is a decrease in the number of maternal health care related visits, possibly due to the new health care policy that rescinds free health care from Syrian refugees in the host community. The greatest change in HSB was seen in services that relate to maternal or reproductive health; there was almost a 14% increase in the percentage of women that chose never to visit a professional for such services after the change in health care policy. There was a 53% increase in the number of women who now hesitate going to the doctor for reproductive/maternal health care services than there were before the policy change. These data somewhat support the initial hypothesis that the change in policy will place a greater financial burden on the Syrian refugee women, who will seek out reproductive and maternal health services much less and therefore have a reduced realized access because of this hindering financial factor. Additionally, the hypothesis was also supported because interview and survey data suggest that the women now have a lower perceived health status.

The women in this community have a relatively negative perception of their overall health and their health related to pregnancy. They believe that a greater number of visits to a health care provider, both for general health care needs and for maternal health care related needs, would allow them to feel much healthier. The interviewed women emphasized that cost is the main barrier preventing them from accessing antenatal and postnatal health care services. These women said that the cost of living for them in Jordan is very high, making it impossible to maintain access to shelter, food, and health care. They resorted to natural/at-home remedies for any issues related to pregnancies instead of visiting a health care professional.

Although the data give plenty of information about the womens' HSB, it must be noted that due to time restraints, the sample size was very small and the data for HSB differences during pregnancy before and after the health care policy change were inconclusive. More research needs to be done in order to produce statistically significant data that proves a correlation between policy change and any change in maternal and reproductive health care seeking behavior.

Future Studies

Since this study was done only several months after the implementation of the new health care policy, there may not have been enough time for significant changes to occur in the MRHSB of Syrian refugee women. As time passes, more issues or concerns may emerge or the situation may be dissipated so that there is no significant change in the MRHSB. More time should be allowed for these changes to occur. Future studies could perhaps replicate this research, with amendments, so that the impact of this health policy could be scrutinized after allowing potential time-sensitive issues or changes to arise.

Additionally, future studies could use the behavior of access model mentioned in this paper to probe into other factors that determine maternal and health seeking behaviors. These could include socioeconomic indicators amongst Syrian refugees, the decision-making power of Syrian refugee women and its effect on their MRHSB, and the efficacy of the services provided to refugees in the host community and its effect on their MRHSB.

This type of research on health-seeking behavior is not only limited to the Syrian refugee population, but can be done on vulnerable Jordanian populations as well. Womens' empowerment in the Jordanian community could be used as an indicator to determine MRHSB. Studies could be conducted on women-led households in both the Syrian refugee population in the host community and in vulnerable Jordanian communities.

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Questionnaire Introduction:

Hello, my name is Momina Mazhar and I am a student from the University of Maryland in the United States. I am here in Jordan studying health and community development at the School for International Training.

I am doing research on how the recent policy changes by the Jordanian government have affected the health care seeking behaviors of local Syrian refugees. These laws have resulted in the discontinuation of free health care for Syrian refugees, who now have to pay the same as uninsured Jordanians for health care. Your input is highly valuable to this research and I thank you for taking time out of your busy schedule to fill out this questionnaire.

This questionnaire will take approximately 10 minutes. You have the right to answer freely or to not answer at all if you do not wish to. I ensure you that the results of this study will be kept confidential and your identity will remain anonymous. If you have any questions, please do not hesitate to email me (mmazhar@terpmail.umd.edu) or call me (ph:0790218024) at any time.

Instructions:

Please circle or check the appropriate options. Write down the answer to any question if asked.

QUESTIONNAIRE ID:

Marital Status

- Married
- Widowed
- Separated
- Single
- Divorced

How many children do you have?

- Pregnant with first child
- None
- 1-2
- 3-4
- 5 or more

Are you working?

- Yes
- No

Have you ever been pregnant while living in Jordan?

- Yes
- No

If you are not pregnant, do you think that you are currently healthy enough to have a safe pregnancy?

- Yes
- No

How healthy do you feel?

- Very healthy
- Somewhat healthy
- Not very healthy
- Unhealthy

Do you believe that you would feel healthier if you could visit a health clinic more often?

- Yes
- No

How many visits did you make each month for a general check up prior to the recent policy change?

- 0
- 1-2
- 3-4
- 5+

How many visits did you make to see a specialist each month prior to the recent policy change?

- 0
- 1-2
- 3-4
- 5+

How many visits did you make to see a doctor for any reproductive health care services prior to the recent policy change ? (contraceptives, antenatal care, prenatal care, care during pregnancy, anything related to menstruation, etc.)

- 0
- 1-2
- 3-4
- 5+

How many visits do you now make each month for a general check up?

- 0
- 1-2
- 3-4
- 5+

How many visits do you now make to see a specialist each month?

- 0
- 1-2
- 3-4
- 5+

How many visits do you now make to see a doctor for any reproductive health care services? (Reproductive health services can include pre-pregnancy and pregnancy consultations, providing contraceptives such as birth control and

IUD's, prenatal care, care during pregnancy, antenatal care, addressing concerns about menstruation, and gynecology and obstetric visits)

- 0
- 1-2
- 3-4
- 5+

How much do you pay, on average, for a general visit to a health clinic?

How much do you pay, on average, for a visit related to your reproductive health?

How long does it take you to get to a clinic that provides reproductive health services? (Reproductive health services can include pre-pregnancy and pregnancy consultations, providing contraceptives such as birth control and IUD's, prenatal care, care during pregnancy, antenatal care, addressing concerns about menstruation, and gynecology and obstetric visits)

- Less than 10 minutes
- 10-15 minutes
- 15-20 minutes
- More than 20 minutes

Do you feel hesitant to visit the doctor for reproductive health services due to financial reasons?

- Yes
- No

Did you feel hesitant to visit the doctor for reproductive health services due to financial reasons when you were receiving free health care in the past?

- Yes
- No

Are you currently using any form of contraception?

- Yes
- No

Do you feel that contraceptives are accessible?

- Yes
- No

Do you feel that contraceptives are affordable?

- Yes
- No

Do you feel that contraceptives were affordable prior to the policy change?

- Yes
- No

PLEASE ANSWER THE FOLLOWING QUESTIONS IF YOU HAVE EVER BEEN PREGNANT IN JORDAN

What dates were you pregnant?

Approximately how many times did you see a doctor for prenatal health services?

- Never
- 1-2
- 3-4
- 5+

How long does it take you to get to the clinic that provided care during your pregnancy?

- Less than 10 minutes
- 10-15 minutes
- 15-20 minutes
- More than 20 minutes

Did you feel comfortable going to the doctor whenever you had any complications or felt sick during pregnancy?

- Yes
- No

Please explain:

Was there ever a time when you decided not to see a doctor during your pregnancy due to financial reasons?

- Yes
- No

Please explain:

Do you believe the care you received during your pregnancy was adequate?

- Yes
- No

Please explain:

How healthy did you feel during your pregnancy?

- Very healthy
- Somewhat healthy
- Not very healthy

Unhealthy

Do you think you would have felt healthier if you had more frequently visited a health care center or a clinic?

How healthy do you feel?

Yes

No

PLEASE ANSWER THE FOLLOWING QUESTIONS IF YOU HAVE EVER DELIVERED A CHILD IN JORDAN:

What date was the delivery?

Did the delivery occur under the supervision of a health care professional?

Yes

No

Did you feel as though the services provided to you during the delivery were adequate?

Yes

No

Not applicable

How many post-natal visits to a clinic did you make?

None

1-2

3-4

5+

How healthy do you think you and your baby were after the delivery?

Very healthy

Somewhat healthy

Not very healthy

Unhealthy

Any additional comments:

مرحباً. انا اسمي مؤمنة مزهر و انا طالبة من جامعة ماريلند في الولايات المتحدة الأمريكية. حالياً انا في الاردن لاقوم بدراسة تطور صحة المجتمع في مدارس التدريب الدولية.
 انني اقوم ببحث عن أثر تغير سياسة العلاج المجاني التي قامت بها الحكومة الاردنية على اللاجئين السوريين. هذه السياسات قامت بوقف العلاج المجاني للسوريين و اصبحوا يقومون بالدفع مثل غير المؤمنين من حاملي الجنسية الاردنية . اجابتك على هذه الأسئلة ستساعدني كثيراً، و أشكرك على الوقت التي اعطيتني اياه.
 هذه الأسئلة ستأخذ من وقتك ما يقارب العشر دقائق. لديك الحق في الاجابة او الاعتذار. اؤكد لك أن نتائج هذه الدراسة ستكون بأمان و اسمك سيبقى غير معروف. ان كان لديك اي اسئلة اتمني ان لا تتردد بالسؤال و يمكنك بعث ايميل على (mmazhar@terpmail.umd.edu) او الاتصال على ٠٧٩٢١٨٠٢٤

التعليمات:

ارجو وضع دائرة على اجابتك، و كتابة الاجوبة المطلوب فيها الشرح.

الأسئلة:

١- الحالة الاجتماعية:

[] متزوجة [] ارملة [] منفصلة [] عزباء. مطلقة

٢- كم طفل لديك؟

[] حامل بأول طفل [] ليس لدي اطفال [] ١-٢ [] ٣-٤ [] ٥ و اكثر

٣- هل تعملين؟

[] نعم [] لا

٤- هل سبق لك ان حملت في الاردن؟

[] نعم [] لا

٥- ان لم تكوني حامل، هل تعتقدين انك في صحة جيدة كفاية لتحملين؟

[] نعم [] لا

٦- هل تشعرين انك في صحة جيدة؟

[] ممتازة [] جيدة جدا [] جيدة [] غير صحية

٧- هل تعتقدين انك ستكونين بصحة أفضل ان قمت بزيارة المركز الصحي أكثر؟

[] نعم [] لا

٨- كم مرة بالشهر كنت "قبل تغير سياسة العلاج المجاني" تقومين بزيارة المركز الصحي للقيام بفحوصات عامة؟

٠ [] +٥ [] ٣-٤ [] ٢-١ [] ٠

٩- كم مرة بالشهر كنت "قبل تغير سياسة العلاج المجاني" تقومين بزيارة د. متخصص ؟

٠ [] +٥ [] ٣-٤ [] ٢-١ [] ٠

١٠- كم مرة بالشهر كنت "قبل تغيير سياسة العلاج المجاني" تقومين بزيارة العيادة لسبب الصحة الانجابية (موانع حمل، رعاية قبل و بعد و خلال الحمل، و أي شيء متعلق بالدورة الشهرية)

٠ []+٥ []٣-٤ []١-٢ []

١١- كم مرة بالشهر تقومين بزيارة العيادة للقيام بفحوصات عامة الآن؟

٠ []+٥ []٣-٤ []١-٢ []

١٢- كم مرة بالشهر تقومين بزيارة العيادة لتقابلتيه د.متخصص الآن؟

٠ []+٥ []٣-٤ []١-٢ []

١٣- كم مرة بالشهر تقومين بزيارة العيادة بهدف الصحة الانجابية الان؟ (موانع حمل، عناية ما قبل و خلال و بعد الحمل، و أي شيء متعلق بالدورة الشهرية).

٠ []+٥ []٣-٤ []١-٢ []

١٤- ما هو متوسط المبلغ المالي التي تقومين بدفعه لزيارة العيادة للقيام بفحوصات عامة؟

١٥- ما هو متوسط المبلغ المالي التي تقومين بدفعه لزيارة عيادة لسبب الصحة الانجابية؟

١٦- ما المدة التي تستلزمك لتصلي إلى عيادة توفر لك كل ما يتعلق بالصحة الانجابية؟
[] أقل من ١٠ دقائق [] ١٠-١٥ دقيقة [] ١٥-٢٠ دقيقة [] أكثر من ٢٠ دقيقة

١٧- هل تشعرين بالتردد لزيارة دكتور نظرا للأعباء المادية؟
[] نعم [] لا

١٨- هل كنت تشعرين بهذا التردد عندما كنت مؤمنة صحيا؟
[] نعم [] لا

١٩- هل تستعملين أي من موانع الحمل؟
[] نعم [] لا

٢٠- هل تشعرين أن موانع الحمل سهل الحصول عليها؟
[] نعم [] لا

٢١- هل تعتقدين أن موانع الحمل يمكن تحملها ماديا؟

[] [نعم] [لا]

٢٢- هل تعتقد أن موانع الحمل كان يمكن تحملها ماديا قبل تغيير سياسة العلاج المجاني؟

[] [نعم] [لا]

الرجاء الاجابة عن هذه الاسئلة ان سبق و حملت في الاردن

١- ما التواريخ التي كنت فيها حامل؟

٢- تقريبا، كم مرة قمت بزيارة دكتور للقيام بفحوصات خلال الحمل؟

+٥ [] -٤ [] ٣ [] ٢-١ [] ٠ []

٣- ما المدة المستغرقة لكي تصلي لعيادة توفر لك العناية خلال حملك؟

[] [أقل من ١٠ دقائق] [١٠-١٥ دقيقة] [١٥-٢٠ دقيقة] [أكثر من ٢٠ دقيقة]

٤- هل كنت تشعرين بالراحة لزيارة الطبيب ان كنت تعانين من آلام او كنت متعبة خلال الحمل؟

[] [نعم] [لا]

"الرجاء التعليل"

٥- هل أتت عليك فترة رفضت زيارة الطبيب نظرا للاعباء المادية المترتبة على هذه الزيارة؟

[] [نعم] [لا]

"الرجاء الشرح أكثر"

٦- هل تعتقد أن العناية التي حصلت عليها خلال الحمل كانت كافية؟

[] [نعم] [لا]

"الرجاء التعليل"

٧- صحتك خلال الحمل كانت؟

ممتازة . جيدة جدا . جيدة غير صحية

٨- هل تعتقد انك كنت ستكوني بصحة أفضل ان قمت بزيارة العيادة أكثر "

[] [نعم] [لا]

الرجاء الاجابة عن هذه الاسئلة ان قمت بولادة احد اطفالك في الاردن

١- ما تاريخ ولادتك؟

٢- هل من قان بتوليدك شخص مرخص لتوليدك "طبيب . قابلة"؟

[] [نعم] [لا]

٣- هل تعتقد أن الخدمات و العناية التي قدمت إليك خلال الولادة كانت كافية؟
[] نعم [] لا

٤- هل تعتقد
[] نعم [] لا

٥- كم زيارة قمتي بها للعيادة بعد الولادة؟
٠ [] ١-٢ [] ٣-٤ [] ٥+

٦- كيف ترين صحتك و طفلك بعد الولادة؟
[] ممتازة [] جيدة جدا [] جيدة [] غير صحية

شكرا.

Semi-Structured Interview Guide

Introduction:

Hello, Ms./Mrs. _____, my name is Momina Mazhar and I am a student from the University of Maryland in the United States. I am here in Jordan studying health and community development at the School for International Training.

I am doing research on how the recent policy changes by the Jordanian government have affected the health care seeking behaviors of local Syrian refugees. These laws have resulted in the discontinuation of free health care for Syrian refugees, who now have to pay the same as uninsured Jordanians for health care. Your input is highly valuable to this research and I thank you for taking time out of your busy schedule to meet with me.

This interview will last approximately 15-20 minutes. You are free to get up and leave whenever you wish and you have the right to answer freely or to not answer at all if you do not wish to. I would also like your permission to record this interview, which will be kept safe and private. Thank you for your patience, we will now begin the interview.

Questions:

1. Recently a policy was been passed by the Jordanian Government stating that Syrian refugees in the country will be treated like uninsured Jordanians and will not receive free health care anymore. What were your initial thoughts when this law was passed?
2. How do you feel about your current health compared to how it was prior to the policy change?
3. How financially secure do you feel now compared to prior to the policy change?
4. Did you find yourself changing how often you visited a health professional before and after the policy change? If so, please elaborate.
5. What are your thoughts on the fees you have to pay now to receive healthcare and their affordability?
6. How healthy do you feel in terms of your reproductive health now in comparison to before the policy change?
7. How flexible do you feel now compared to how you did before the policy change when it comes to going to visit a professional healthcare provider for reproductive care?
8. (If applicable) Please elaborate on any sickness or illness related to reproductive health that you or a woman you know has gone through and how you accessed treatment.
9. (If applicable) Can you elaborate on your health and the services you sought throughout your pregnancy and/or delivery in Jordan?
10. Can you elaborate on your access to and affordability of contraceptives and if either of these has affected your decision to use them?

مرحباً. انا اسمي مؤمنة مزر و انا طالبة من جامعة ماريلند في الولايات المتحدة الأمريكية. حالياً انا في الاردن لاقوم بدراسة تطور صحة المجتمع في مدارس التدريب الدولية.

انني اقوم ببحث عن تغير سياسة العلاج المجاني التي قامت بها الحكومة الاردنية التي أثرت في اللاجئين السوريين. هذه السياسات قامت بوقف العلاج المجاني للسوريين و اصبحوا يقومون بالدفع مثل حاملين الجنسية الاردنية غير المؤمنين. اجابتك على هذه الأسئلة ستساعدني كثيراً، و أشكرك على الوقت التي اعطينتي اياه.

هذه المقابلة ستأخذ من وقتك ما يقارب الـ ١٥-٢٠ دقيقة. يمكنك اكمال المقابلة او لا كما تترين مناسب لك. و اود لو تأذني لي بتسجيل هذه المقابلة ستكون بامان معي. شكراً لصبرك، و الان سنبدأ بالمقابلة.

الاسئلة:

- ١- في الوقت الحالي الحكومة الاردنية قامت بتغيير السياسات المتبعة للاجئين السوريين بأن يعاملو مثل حاملين الجنسية الاردنية الغير مؤمنين. ما هي اول الافكار التي خطرت لك؟
- ٢- ما هو شعورك تجاه صحتك مقارنة بما كان قبل تغير السياسات؟
- ٣- هل تشعر انك بأمان مادي مقارنة بما قبل تغير السياسات؟
- ٤- هل تغيرت "قلت/زارت" زيارتك للعيادة مقارنة بما قبل تغير السياسات؟ لماذا؟
- ٥- ما رأيك بالرسوم التي تقوم بدفعها الان لترى المختصين الذين يقدمون لك الرعاية الصحية؟
- ٦- ما شعورك تجاه صحتك الانجائية الان مقارنة بما قبل تغير السياسات؟
- ٧- الرجاء الشرح، هل كنت او تعرفين شخص كان لديه مرض او كانت تعبة لشيء له علاقة بالصحة الانجائية و كيف وصلت للعلاج؟
- ٨- هل يمكنك التحدث اكثر عن صحتك و الرعاية الصحية خلال حملك/ ولادتك؟
- ٩- هل يمكنك التحدث اكثر عن امكانية وصولك لموانع الحمل و تكاليفهم، و ان كان هذا الشيء أثر على قرارك باستخدامهم؟

نموذج موافقة على المشاركة في بحثهدف البحث:

انني اقوم ببحث عن تغيير سياسة العلاج المجاني التي قامت بها الحكومة الاردنية التي أثرت في اللاجئين السوريين. هذه السياسات قامت بوقف العلاج المجاني للسوريين و اصبحوا يقومون بالدفع مثل حاملين الجنسية الاردنية غير المومنين.
ستعمل نتائج هذه الدراسة على توفير معلومات هامة من أجل رفع نسبة الوعي والتقبل لخدمات الصحة الانجابية
..يعتبر هذا البحث احدى متطلبات مؤسسة التعلم الامريكية في الأردن: دراسات عامه حول الصحة وتنمية المجتمع

الخصوصية والسريه:

كل المعلومات التي سيتم جمعها ستعامل بسرية ولست مضطراً لذكر اسمك على أي من صفحات الاستبانة وستعامل الاستبانات بسرية تامة من قبل الباحثه ولن يطلع على هذه الاستبانات إلا الباحثه نفسها. بالاضافه الى ذلك سيتم تدمير البيانات فور الانتهاء من الدراسة 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 الصحي و لن تؤثر في نوعية الرعاية الصحية المقدمة لك. كما انه لديك الحق بعدم المشاركة في البحث ان شئت، واذا ما غيرت رأيك وقررت الانسحاب بعد المشاركة فيمكنك الانسحاب كذلك. ومن حقك رفض السماح للباحثه باستخدام بيانات الدراسة في اي دراسات أخرى ستقوم بها الباحثه الرئيسيه

المعايير الاخلاقيه لمركز التدريب العالمي الامريكي:

- أ. الخصوصية - كل المعلومات سيتم تسجيلها وحمايتها كما ستعامل بسرية تامة, من حقك رفض تسجيل المقابلة 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 تماماً 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

إقرار موافقه 5:

من خلال التوقيع أدناه، فإنك توافق على استخدام إجاباتك في هذه الدراسة : نوعية خدمات تنظيم الأسرة في عيادات الأونروا. وعلاوة على ذلك، فإنك تقر فهم كامل حقوقك أثناء المشاركة في هذه الدراسة

-----:التاريخ توقيع المشـــــــارك-----

من خلال التوقيع أدناه فإنك توافق على استخدام نتائج هذه الدراسة لعمل مقارنه مع دراسه اخرى تعنى بنوعيه خدمات الصحة الانجابيه ولكن في اماكن مختلفه.

التاريخ ----- توقيع المشــــارك -----

6. اقرار 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:-----

التاريخ ----- توقيع المترجمه -----