Assessment of Health Needs and Living Conditions of Migrants in Jordan

2011–2012

International Organization for Migration (IOM)

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International Organization for Migration (IOM)
In collaboration with the
Jordanian Ministry of Health

Amman-Jordan

International Organization for Migration (IOM)

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Executive Summary

Background

The Sixty-first World Health Assembly (WHA) adopted Resolution No. 61.17 on the health of migrants in May 2008. This resolution calls for Member States, partner agencies and key stakeholders to promote migrant-sensitive health policies and practices and to promote equitable access to health promotion and care for migrants. World Health Organization (WHO) Member States have agreed to take action on the recommendations outlined in this resolution.

The estimated number of international migrants as of 2010 is about 214 million, which accounts for 3.1 per cent of the world population. Women constitute 49 per cent of migrants worldwide. Migrants' health is not the sole responsibility of either migrant-sending or migrant-receiving countries but is their joint responsibility, as migration flows benefit both societies.

Jordan is considered one of the countries with a high percentage of migrants. It faces the challenge of meeting the health demands of a vast number of migrants, including internal migrants, visitors from neighbouring countries, tourists extending their stay, refugees in both border and urban areas and numerous migrant workers from neighbouring countries or from South and South-East Asia. Migration health assessments are among the most well-established migration management services offered by the International Organization for Migration (IOM). Health assessments provide the opportunity to promote the health of migrants through the initiation of preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrants' health and/or on the public health of the host countries.

Jordan has expressed a clear interest to collaborate with IOM in the area of addressing the challenges of migrants' health. The demand for foreign labour is increasing to sustain economic growth and prosperity of the society. Moreover, most migrants have a lack of understanding of their own right to health, and little is known about their health conditions. Thus, the assessment of the situation of migrants' health is urgently needed to better understand their needs and vulnerabilities for the purpose of including them in the national health policies and strategies of Jordan.

The overall objective of this study is to provide baseline information about the health needs and challenges that affect different migrant groups in Jordan to assist the government and the relevant parties to develop policies and strategies to manage migrants' health.

Methods

The research was conducted using two designs:

- A cross-section study conducted on a sample representing a migrant population residing in Jordan.
- A focus group discussion to gather certain qualitative data from the national government and other migration health stakeholders.

The population frame of the cross-section study consists of the nationalities of the main migrants that are residing in Jordan for six months or more. This frame focuses on two main strata of migrants: the Arab migrants (predominantly Egyptians and Iraqis) and the non-Arab Asian migrants (i.e., Sri Lankans, Indonesians, Filipinos and other non-Arab Asians from Pakistan, Bangladesh, China, India and Nepal).

These two strata account for about 70 per cent of migrants in Jordan. Other nationalities were not considered in the frame of this study.

The estimated score of the irregular migrants does not appear in this frame as well because these migrants do not present themselves for visa renewal protocols at the Ministry of Health. Moreover, it is difficult to locate them and determine their size and location. Accordingly, they were not represented in our sample.

In summary, the segments of migrants that are excluded from the sample of this study are irregular migrants, Europeans, other Arabs and newcomers (i.e., migrants residing less than six months in the country).

The three most in demand Chest Diseases Centres in the country were selected to be the sites for sampling and interviewing migrants. These are as follows:

- Amman centre that represents the central region
- Irbid centre that represents the northern region
- Aqaba centre that represents the southern region.

The three selected centres examined about 72 per cent of the migrant population in 2010. Data collection was intended for six months to ensure a good representation of seasonal variation in migrant flow and health conditions.

A stratified random sampling technique was used. Two separate samples were selected, each from separate frame strata, that is, the Arab stratum and the non-Arab stratum.

The size of the Arab sample was 1200 and that for the non-Arab sample was 800. Thus, the total sample size selected from the two strata was 2,000. These two samples were further stratified according to the three geographical regions and nationalities.

The data collection period was undertaken in six months. Five teams of interviewers and four supervisors were trained and assigned. Each team worked for a minimum of four hours per day and for two to three days a week.

The subjects to be interviewed were selected as they appeared in the centre. The questionnaire was filled out by the interviewer after he/she received the written consent from the interviewee. Before ending the interview, the questionnaire was checked for completeness and errors in filling it out both by the interviewer and the supervisor.

Interpreters provided by IOM assisted those who had a language barrier in filling out the questionnaires. The collected data from the migrants include demographic information, socioeconomic data, mobility-related data, individual health concerns medical history, current medical complaints, reproductive health history, psychological complaints, living and working conditions, health-seeking behaviours and health services access, that is, availability, affordability and acceptability of migrant-sensitive services. These data were gathered through a structured interview questionnaire. A pilot testing of the questionnaire was conducted in three days in the three regions; 100 questionnaires were filled out. The questionnaires were coded, and the data were entered into the computer by well-trained data entry personnel. The Statistical Package for Social Sciences software was used for data entry, cleaning and analysis. Dummy tables, which consist of simple frequency tables and cross-tabulations, were developed. The chi-square statistical significant testing method was used in the analysis.

A focus group discussion was conducted over a one-day workshop to gather qualitative data from the national government and other migration health stakeholders. Around 30 persons participated in this workshop, representing concerned governmental ministries such as the Ministry of Health, Ministry of Interior (MOI), Ministry of Labour (MOL), Ministry of Foreign Affairs and the General Security Directorate. The other stakeholders who participated in this meeting were the representatives of WHO,

IOM, the United Nations High Commissioner for Refugees, embassies, private companies that employ a large number of migrants and local recruiting agencies for house workers.

At the beginning of the meeting, the participants were made to feel comfortable to facilitate the easy and open communication of ideas, views and opinions. After each participant introduced himself/herself and the institution he/she represents, a shared presentation was conducted by the Director of the Migration Health Department of the Ministry of Health and the IOM research consultant to give the participants an overview of the project, the research and particularly the objectives of the focus group and the manner it would be conducted.

Two discussion sessions at two hours each were conducted. Chairmen and rapporteurs were assigned for these sessions. Recording facilities were available and utilized.

The key issues raised and discussed during the sessions include the following: health impact of the movement of migrants across international borders, national policies, legislations and programmes that affect migrants' health, social and health problems faced by migrants in Jordan, existing policies in MOL and MOI on the human rights of migrants, health insurance policies for migrants, management of migrants in the public health sector when affected by any infectious disease and its cost, health-care access barriers that migrants may face, major challenges (i.e., political, legislative and financial) faced by different organizations in dealing with migrants and plans to overcome these challenges.

The consultant asked each question separately in both English and Arabic. He explained the aim of the question, the information required from it, how the question works and whether it catches the people's interest. Were the respondents talking about the topic or not? Was the information gained relevant to the topic? The consultant revised and clarified the questions to maintain their relevance to the topic.

The consultant made efforts to motivate all the participants to talk and create an environment of active interaction among them. He also summarized the ideas and information given by the respondents for each question.

All the responses, comments and recommendations of the participants were recorded by the rapporteurs. The notes taken by the rapporteurs included the key points in the discussion and the notable quotes. Observations such as silent agreement, obvious body language and contradictory statements, which might not be captured in the tape recording, were also noted. Immediately after and during the next few days of the meeting, the consultant and the rapporteurs wrote down the findings of the focus group discussion based on the notes and transcripts to decrease the recall bias.

Main findings

Literature review

International migration is on the rise. The estimated number of international migrants as of 2010 is about 214 million. Migrants account for 3.1 per cent of the world population. The integration of migrant health needs and rights into national plans and policies is deficient in most governments of the world. The present immigration legislation rules and regulations, which have been designed for regulated and accepted migratory movements, are less effective in addressing the challenges of new and emerging patterns of movements.

The migration process, due to conditions that may accompany it, may expose migrants to different health risks and vulnerabilities. Language and cultural barriers, high mobility of migrants, lack of cooperation from their employers and high cost of health care are among the most important challenges that may affect the accessibility of migrants to health-care services. Migrants' health is considered a joint responsibility of both migrant-sending and migrant-receiving countries.

The WHA Resolution No. 61.17 calls upon Member States to promote migrant-sensitive health policies, equitable access to health promotion and disease prevention. The Global Consultation on Migrant Health in Madrid convened by WHO in 2010 recommended four key priorities: monitoring migrants' health, establishing policy and legal frameworks, encouraging migrants' sensitive health systems and strengthening partnerships and networking. Many studies conducted in different parts of the world indicate that information is limited on migrant health status and their need for and use of medical services in the destination countries. A high percentage of migrants do not utilize the local health services for different reasons.

Jordan faces the challenge of meeting the health demands of a vast number of migrants. As of 2010, the total number of foreign-born individuals residing in Jordan is about 3 million, accounting for 46 per cent of the total population. The net migration rate (2005–2010) for Jordan is 8.3 migrants/1000 populations. As of 2010, women constitute 49 per cent of immigrants in Jordan.

Jordan is open to sharing its lessons learned in migrant health programmes within and beyond Jordan and is keen to collaborate with other countries to address migrants' health. The demand for foreign labour is increasing in Jordan, leading to the need for addressing migrants' health demands and for considering migrants in the existing national health strategies and policies.

The existing health policy in Jordan does not include a clear focus on migrants' health needs and specificities. All foreigners in Jordan, regardless of their legal status, have access to Jordan's public health-care system at rates subsidized by the government; the government covers 60 per cent of the total cost. Moreover, the Ministry of Health provides free vaccination services to all children living in Jordan including foreigners. Jordan's national health surveys do not collect data on migrant population. Therefore, identifying the major health needs of this population is difficult. The Jordanian Government endorses a special working contract for non-Jordanian domestic workers. It augments the coordination between the sending countries and Jordan and guarantees migrant workers' rights to life insurance, medical care, rest days and repatriation upon expiration of the contract. It also reiterates migrant women's right to be treated in compliance with international human rights standards. From 2007 to 2010, a total of 804 cases of tuberculosis, 944 cases of hepatitis B and 195 cases of HIV were discovered among 1,209,242 foreigners screened. The Ministry of Health conducts mandatory screening for tuberculosis, HIV and hepatitis B for foreigners who decide to stay in the country for more than 30 days.

Cross-section study

The study indicates the presence of a language barrier among nearly half of the non-Arab migrants. Family-related issues were the main causes of concern among migrants in Jordan. Almost all of the migrants (97%) characterized their quality of life in Jordan as very good, good, or fairly good. The majority of migrants (about 95%) were employed, and about half of them were entitled to additional employment benefits other than their regular salary. About 94 per cent of migrants were either very much satisfied or satisfied to a certain extent with their work. The majority of migrants (about 93%) perceived their health status as very good or good. Nearly half of the migrants lived in overcrowded conditions in which they shared one bedroom with three or more persons.

Although the Jordanian labour law determines the number of working hours, the annual holiday rights and the payment rights, a significant percentage of migrant workers still complained about such problems. This finding may be due to the lack of awareness to such information.

The prevalence of chronic illnesses was relatively low (about 7%), which could be due to the fact that the majority of the subjects were young and that only 6 per cent of the study population reported exposure to accidents in the past six months. The main psychological symptoms suffered by the subjects in the week preceding the interview were loneliness/missing their family, nervousness/tension, headache, worries and sadness/frustration.

All the women who became pregnant during their stay in Jordan received antenatal care. About 98 per cent of them received this care from physicians, and about 95 per cent had more than three antenatal visits during their pregnancy. Among the pregnant women, 95.5 per cent delivered in a hospital, and 95.5 per cent received a vaccination card for their babies.

As regards health-seeking behaviour, 35.6 per cent of the migrants sought health-care services in the last six months. The study population mainly used the private health sector. Among the subjects who had an acute illness or injury in the month preceding the interview, 80 per cent sought medical consultation and treatment. Among those who did not seek medical consultation, 84 per cent stated that the condition was not significant, and about 5 per cent could not afford the cost.

The subjects' health behaviour when suffering from common health conditions was positive. Medical treatment was widely available to them, with only 5 per cent of the study population reported being unable to receive medical treatment because they could not afford it. The geographical accessibility to health-care services in Jordan was high, the availability of these services was high or moderate for the majority of migrants. Most of the subjects were able to utilize the health services when they needed them; only about 10 per cent of them were not able to do so. Financial barrier (i.e., high cost and lack of health insurance) was the main reason for not using the services. The majority of the subjects reported no discrimination when availing of health-care services, and about 90 per cent of them were highly or moderately satisfied with the quality of health services provided to them.

The health insurance coverage rate of the study population was about 25 per cent. The coverage rate of non-Arabs was nearly five times more than that of Arabs. The employed migrants were more likely to have health insurance than the unemployed. The private sector accounted for 86 per cent of the source of health insurance. Health expenditure of the majority of the subjects was less than 10 per cent of their monthly income, which is considered acceptable and not a catastrophic health expenditure. This finding may be due to the relatively low prevalence of morbidity among this young population.

Health status was better among males and the younger age groups than among females and the older age groups. General health was expressed to be better as the level of education and income increased. Health status appeared to be better for Arabs than for non-Arabs. This finding is validated by the fact that the prevalence of chronic illnesses and the rate of occurrence of acute illnesses or injuries were higher among non-Arab migrants than among Arabs. Moreover, the rate of seeking health care in the last six months was higher among non-Arabs than among Arabs.

The rate of seeking health care increased as the migrants' length of stay in the country increased until the end of the first three years, declining afterward. The insured subjects were more likely to seek health-care services and to be admitted to hospitals than the non-insured were. The subjects who characterized their health status as fairly good or bad were more likely to be admitted to hospitals than those who characterized it as very good or good.

Focus group discussion

The presence of a relatively high number of migrants in Jordan causes a heavy burden on the limited national resources. Thus, the migrants are exposed to many unmet health and social needs. Moreover, many migrants do not know how to access health services. Others have issues that prevent them from gaining easy access to such services. Accordingly, most of the diseases contracted by migrant workers are discovered at the late stage, which can lead to disease transmission, complications and death.

The existing Jordanian health policy does not cover the needs and specificities of migrants' health. However, all foreigners in Jordan, regardless of their legal status, should enjoy the right to access the public health-care system at rates partially subsidized by the government. The Ministry of Health provides free vaccination services to all children living in Jordan including foreigners. So far, there is

no legislative provision that mandates the coverage of migrants by health insurance. However, MOL obligates the owners of companies and factories to provide treatment for work-related diseases and injuries when they occur. According to the Jordanian Labour Law, as of May 2011, every institution that has one or more employees must participate in the Social Security Programme to ensure the coverage of working migrants in health insurance against work-related diseases and injuries.

Jordan is considered one of the countries that respect the human rights of the population including those of migrants. Jordan has its own human rights organization that monitors the rights of the population including those of migrants. MOL has established a new unit to control human trafficking. It is tasked to monitor and preserve the rights of migrants including the right to health. A human rights department in MOI is mandated to receive and follow up on human rights abuse complaints from the whole population including migrants/non-Jordanians.

Jordanian embassies are not present in some labour-exporting countries. Nevertheless, when an embassy is present, no labour adviser is available.

Recommendations

The following are the recommendations of this study:

1. A formal and mandatory health insurance should be established for all migrant workers with a reasonable cost that is suitable to the employers' capability and to migrants' income and length of stay in Jordan. The costs can be borne by the employers or shared between the parties (employer–employee).
2. Strategies should be developed, and national policies that regulate the right and access to health care of migrants in Jordan should be instituted.
3. The Jordanian labour law that determines the rights of migrant workers, such as the number of working hours, the payment rights, their right to communicate with their home countries and the annual holiday rights, as well as raises the awareness of migrant workers to such information should be implemented. Migrant workers should be aware of these rights.
4. The roles of the newly established units in MOL should be enforced to control human trafficking, to provide guidance in monitoring and protecting the rights of migrants and to solve problems and issues related to them including health-related problems.
5. The level of awareness on the protection of and the psychosocial and psychological problems faced by migrant workers, especially domestic workers, should be increased to prevent mental health problems and suicide risk. Ways of monitoring progress and changes should be determined.
6. The strategic plan proposed by the Ministry of Health on conducting the following three medical examinations for migrant workers should be implemented:
   a. Pre-arrival examination by highly credible and accredited health centres in the country of origin.
   b. Entry examination to be conducted at the earliest time after the migrant worker enters the country.
   c. Post-entry periodical examination conducted after the migrant worker's entry to follow up on his/her health status.

   These examinations should be linked to care and treatment plans.
7. When a treatable health condition is determined during a medical examination, the migrant should have access to treatment and time off to recover. When a decision is taken to allow a foreign worker to have a follow up or treatment in the country of origin because of a particular untreatable disease or injury, the country of origin should be informed about the case.
8. The oversight role of IOM, Ministry of Health and MOL should be promoted to ensure the credibility of the medical examinations and the mechanism for issuing reliable health certificates in the country of origin that comply with international ethical practices, such as the informed consent by the migrant and the confidentiality of medical results, and to provide migrants with access to counselling, follow-up treatment and support services.

9. The health awareness of citizens and migrants on the importance of migrants' access and utilization of available health services when needed should be raised, and a mechanism to overcome the language and cultural barriers that prevent access to services should be developed. Health workers should be made aware of migrants' specific circumstances and needs.
10. The government should try to establish embassies or consulates in labour-sending countries that lack these services and ideally to appoint labour advisers to facilitate quickly the cooperation between the countries in terms of labour migration.
11. An information system in MOL or MOI on immigrant labour in Jordan that can be electronically linked to the relevant departments in the country should be established.
12. The Jordanian Government should sign agreements with labour-sending countries that ensure migrants' access to relevant pre-departure orientation and training such as on health issues, vocational training, language and other practical training. Having good knowledge and orientation of the new country is essential for the migrant worker to ensure healthy working and living conditions.
13. Bilateral agreements between migrant-sending countries and Jordan should strictly regulate the process of labour recruitment. Involved agents/agencies on both sides should be carefully selected and subject to accreditation on a yearly basis to ensure fair and consistent application of the selection policies and recruitment fees, including costs that are related to the pre-arrival health assessment. The tasks of recruitment agencies should include exchanging information and securing that migrant workers have access to health care.
14. National policies should be developed and instituted to monitor the adequate living and working conditions of migrant workers in Jordan. A governmental body to monitor and ensure they are followed in practice.
15. Relevant articles on the Jordanian health legislations and policies should be reviewed to address migrant issues, such as whether the rights of migrants to health care are lacking or not well defined in these legislations.
16. A national technical committee should be formed to develop a national migrant health strategy as a follow-up to this consultation and be made multisectoral.
17. Regular meetings with all stakeholders should be continuously held to solve problems that may arise and to protect the health of migrants and the hosting community.
18. Further in-depth research should be conducted on issues such as health insurance, living and health conditions of irregular migrants and awareness of migrants and their employers on migrant rights including their right to health.

Introduction

Migration in itself is not a risk factor to health. The circumstances surrounding the migration process increase migrants' vulnerability and expose migrants to various health risks. Most migrants have a lack of understanding of their own right to health; this is particularly true for workers with a low level of education and for those who are undocumented and marginalized.

The Sixty-first World Health Assembly (WHA) adopted Resolution No. 61.17 on the health of migrants in May 2008. This resolution calls for Member States, partner agencies and key stakeholders to promote migrant-sensitive health policies and practices as well as equitable access to health promotion and care for migrants. World Health Organization (WHO) Member States agreed to take action on recommendations outlined in this resolution.

Migrants' health is not the sole responsibility of either migrant-sending or migrant receiving countries but is their joint responsibility, as migration flows benefit both societies.

The estimated number of international migrants as of 2010 is about 214 million, which accounts for 3.1 per cent of the world population. Women constitute 49 per cent of migrants worldwide (IOM, 2011a).

Jordan is considered one of the countries with a high percentage of migrants. It faces the challenge of meeting the health demands of a vast number of migrants including internal migrants, visitors from neighbouring countries, tourists extending their stay, refugees in both border and urban areas and numerous migrant workers from the neighbouring countries or from South and South-East Asia.

Since the coalition invasion of Iraq in 2003, the humanitarian ripple effects have been felt in the surrounding countries. As of 2010, Iraqis have spread throughout the world, with the majority of Iraqis internationally displaced in Turkey, Iran, Egypt, the Syrian Arab Republic and Jordan. By far, the Syrian Arab Republic and Jordan have taken the humanitarian lead, accepting the majority of displaced Iraqis.

The Hashemite Kingdom of Jordan (HKJ) also hosts a large number of irregular migrants from neighbouring Egypt, some of whom migrate seasonally and some for prolonged periods of time. Based on the information from the Jordanian Ministry of Interior (MOI) and the Directorate of Chest Diseases and Migrant Health, the estimated number of Egyptian migrants residing in Jordan is 250,000.

Other migrant workers, originating mostly from Asia, generally work as domestic workers and assistants in the many private businesses in the country, such as beauty parlours, restaurants, hotels and so on. According to the Jordanian MOI and the Directorate of Chest Diseases and Migrant Health, these migrants are estimated at 150,000.
These three migrant groups put additional pressure on the public health-care system.

Migration health assessments are among the most well-established migration management services offered by the International Organization for Migration (IOM). Health assessments provide the opportunity to promote the health of migrants through the initiation of preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrants' health and/or on the public health of the host countries (IOM, 2011b).

The existing health promotion programmes do not cover migrants' health needs and specificities. The risk of introducing and/or reintroducing diseases that are no longer prevalent in the HKJ should migrants' health needs are not addressed is present. From a public health point of view, it is good practice to include the most vulnerable groups in the hosting community in the provision of health promotion and health-care services.

Jordan has expressed a clear interest in collaborating with IOM in addressing the challenges of migrants' health. The demand for foreign labour is increasing to sustain economic growth and prosperity of the society. Moreover, most migrants have a lack of understanding of their own right to health, and little is known about their health conditions. Thus, the assessment of the situation of migrants' health is urgently needed to better understand their needs and vulnerabilities for the purpose of including them in the national health policies and strategies of Jordan.

Review of Literature

Overview

Regardless of its causes or effects, international migration is on the rise. The estimated number of international migrants as of 2010 is 214 million, and 740 million are internal migrants. Migrants account for 3.1 per cent of the world population; however, the percentage of migrants varies greatly from country to country. Countries with a high percentage of migrants include Qatar (87%), United Arab Emirates (71%), Jordan (46%), Singapore (41%) and Saudi Arabia (28%). Countries with a low percentage of migrants include South Africa (3.7%), Slovakia (2.4%), Turkey (1.9%), Japan (1.7%), Nigeria (0.7%), Romania (0.6%), India (0.4%) and Indonesia (0.1%).Women constitute about 49% of migrants worldwide (IOM, 2011a).

Migration usually consists of a heterogeneous group of individuals. Each group has specific and different determinants, needs and vulnerabilities as regards health. The integration of migrant health needs and rights into the national plans and policies remains lacking in most governments.

The migration process, due to conditions that may accompany it, may expose migrants to different health risks and vulnerabilities. The lack of education, training and awareness of the host country's laws and working conditions is among the causes of the violation of migrants' human rights and their right to health in many places. This deficiency is particularly true for workers who are undocumented and marginalized. Other barriers that affect the accessibility of migrants to health-care services include language and cultural barriers, migrants' high mobility, lack of cooperation from their employers and high cost of health care.

Migrants' health is considered a joint responsibility of both migrant-sending and migrant-receiving countries, as their health is considered crucial and beneficial for both societies (IOM, 2011b).

The relationship between migration and disease has long been acknowledged. However, it is only in the last century, and as a result of advancement in medical sciences, that public health linked to mobility has been explored.

Mobility can take the form of a planned movement accepted by a host country, or it can be conducted in an irregular manner, as in the case of smuggling. A given country may be a country of emigration, immigration and transit and /or return at the same time.

The journey can be international, transnational or intra-regional, and it can also be permanent, temporary or seasonal. The legal status of migrants in the host country determines their access to health and social services (IOM, 2011c).

A major challenge that faces the world today that results from globalization is the management of irregular migration including the management of individuals' health and global public health. The current immigration legislation rules and regulations, which have been designed for regulated and accepted migratory movements, are less effective in addressing the challenges of new and emerging patterns of movements. Irregular migrants usually lack access to health services and healthy environments. Being "undocumented" indicates that migrants with irregular status are more exposed to various and significant health risks (IOM, 2011d).

Effective public health measures can prevent the introduction of infectious or communicable diseases associated with the mobility of people. Pre-departure migration health assessment is one way of addressing population mobility and public health concerns. Such assessments detect and treat communicable diseases as well as non-communicable diseases that may be carried by mobile people (e.g., migrants, refugees, tourists, business persons and students). Countries usually have a

legislative basis for immigration requirements that include a pre-departure health assessment. The primary rationale for a pre-departure health assessment is the protection of public health and safety. Health conditions that are of public health concern (e.g., tuberculosis) are screened and treated before departure. If treatment is required, a migrant is allowed to migrate to the hosting country once his/her health condition has been assessed as no longer posing a threat to public health (IOM, 2011e).

The Sixty-first WHA that convened in 2008 adopted Resolution No. 61.17 on the health of migrants that called upon Member States:

1. to promote migrant-sensitive health policies, equitable access to health promotion and disease prevention;
2. to establish health information systems to assess and analyse trends in migrants' health and to establish mechanisms for improving the health of all populations, including migrants, by identifying and filling the gaps in health service delivery;
3. to gather, document and share information and best practices to meet migrants' health needs in the countries of origin or return, transit and destination;
4. to raise health service providers' cultural and gender sensitivity to migrants' health issues and to train health professionals on health issues associated with population movements;
5. to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process.

WHO Member States agreed to take action on the recommendations outlined in this resolution (World Health Organization, 2008).

As a result of the 2008 WHA resolution on migrants' health, a global consultation was convened in Madrid in March 2010. This consultation recommended the following key priorities:

- Monitor migrants' health to ensure the standardization and comparability of data on migrants' health. The action points recommended are to develop health information systems, collect and disseminate data and assess migrants' health. Migrant health variables should be integrated into existing data collection systems.
- Establish policy and legal frameworks to adopt relevant international standards on the protection of migrants and to respect their right to health in national laws and practice.
- Encourage migrant-sensitive health systems to ensure that health services are delivered to migrants in a culturally and linguistically appropriate way, improve the capacity of the health and relevant non-health workforce to address the health issues associated with migration and deliver migrant services in a comprehensive, coordinated and financially sustainable way.
- Strengthen partnerships and networking to establish and support migration health dialogues and cooperation across relevant sectors and among countries of origin, transit and destination (World Health Organization, 2010).

Studies conducted on migrants

El-Sayed and Galea (2009, 9:272) conducted a systematic review of literature on the health of Arab-Americans living in the United States of America. They reviewed research articles published in the period of 1980–2008 and found that the health of Arab-Americans differs from that of the other ethnic and racial groups in the United States. Exposures such as immigration, acculturation and discrimination could be important in the aetiology of several diseases among them.

In their review of the health status of visitors and temporary residents in the United States, Yanni et al. (2009) concluded that these groups of people represent a considerable and increasing percentage of travellers to the United States. Information is limited with regard to their health status upon arrival and their need for and use of medical services in the United States. More information is required to

determine the public health issues as well as their health challenges and needs. After these issues and needs are clarified, intervention programs should be developed to increase access and decrease the disparities of care experienced by these populations.

Stirbu et al. (2006) studied the differences in avoidable mortality between migrants and the native Dutch in the Netherlands. Data were obtained from causes of death and population registries in the period of 1995–2000. They found a slightly elevated risk in total avoidable mortality for the migrant population (RR=1.13). A higher risk of death among migrants was observed from almost all infectious diseases and several chronic conditions including asthma, diabetes and cerebro-vascular disorders (RR>1.7). Migrant women experienced a higher risk of death from maternity-related conditions (RR=3.8).

Parry et al. (2007, 61:198–204) studied the health status of Gypsies (Roma) and travellers in England to provide the first valid and reliable estimate of their health status. Gypsies and travellers reported a poor health status in the last year. They are significantly more likely to have a long-term illness, health problem or disability that limits daily activities or work. They have more problems with mobility, self-care, usual activities, pain or discomfort, anxiety and depression. They also have a higher overall prevalence of reported chest pain, respiratory problems, arthritis, miscarriage and premature death of offspring. The researchers concluded that significant health inequalities exist between the Gypsy and traveller population in England and their non-Gypsy counterparts, even when compared with other socially deprived or excluded groups and other ethnic minorities.

Dias et al. (2008) studied the determinants of health care utilization by immigrants in Portugal. In their study, 20 per cent of the immigrant sample reported that they had never used the National Health Services. Among the participants that used the health services, 22.4 per cent reported to being unsatisfied or very unsatisfied with it. After adjusting all variables, the utilization of health services among immigrant men remained significantly associated with length of stay, legal status and country of origin. Among immigrant women, the use of health services was significantly associated with length of stay and country of origin. They concluded that there is a clear need to better understand how to ensure access to health-care services and to deliver appropriate care to immigrants. Barriers must be identified, and the approaches to remove them should be developed through coherent and comprehensive strategies.

Mou et al. (2009) examined the health care utilization of insured and uninsured migrant workers in Shenzen, South China, to compare their health needs, self-reported health and health care unitization. They found that among those who reported illness in the previous two weeks, about 62 per cent did not visit a doctor. Among the group who were referred for inpatient care, about half of them did not attend because of inability to pay. Around 55 per cent of the respondents were uninsured. The disease patterns were similar irrespective of insurance status. The uninsured were more likely to be female, single, young and less educated unskilled labourers with a lower monthly income compared with the insured.

A recent multi-country study on *Health Vulnerabilities of Asian Women Migrants in the Arab States* found that women who migrate through irregular channels and/or who have limited education and preparation are among the most vulnerable to abuse, extortion, sexual exploitation and increasing their health and HIV vulnerability (UNDP, CARAM Asia, UNAIDS, IOM, Caritas Lebanon, 2008).

In Sri Lanka, the Centre for Women's Research estimated that around 10 per cent of female migrant workers from Sri Lanka are victims of some form of physical, psychological or sexual abuse. The Ministry of Health raised concerns about the health and psychological impact of out-migration on families, especially the children left behind by their mothers who are often neglected, abused and demotivated (IOM, Sri Lanka, 2011).

Migration in Jordan

B.1 Role of IOM and the proposed research project

Jordan, as an IOM Member State since 1999, has requested IOM assistance in elaborating and supporting the roles and responsibilities of the Department of Migrant Health at the Ministry of Health. Jordan is open to share its lessons learned in migrant health programming within and beyond Jordan and is keen to collaborate with other countries to address migrants' health. This technical cooperation aims to establish a national framework towards migrant health programming and the inclusion of migrants in relevant national health policies. The IOM mission in Jordan has strong relations with the Ministry of Health, and it is capable of assisting Jordan in its efforts to implement the WHA resolution through the implementation of a 15-month project that aims to strengthen the capacity of the government to promote and address migrants' health. First, a comprehensive situational assessment and analysis on the health needs and vulnerabilities of the migrant population in Jordan will be conducted in coordination with the government and other relevant stakeholders. Second, a knowledge exchange visit will be organized for selected stakeholders from countries that send migrant workers to Jordan for an inter-ministerial working group meeting (including representatives from the Ministries of Health, Social Welfare and Labour). This exchange visit will enable Jordanian authorities to gain knowledge and facilitate joint discussions and information-sharing mechanisms for conducting programmes between migrant-sending and migrant-receiving countries. Moreover, these stakeholders from migrant-sending countries will be able to participate or at least give input to the National Conference on Migrants' Health to be convened in Jordan, where government agencies, partners and other key stakeholders will participate and agree on priority actions and strategies. Relevant government representatives from countries such as Egypt, Indonesia, Iraq, the Philippines and Sri Lanka (countries of origin of migrants in Jordan) will exchange information and identify good practices that ensure migrants' health for the benefit of the migrants, host countries and sending countries alike. Third, this project will support the newly established Department of Migrants' Health within the Ministry of Health of Jordan.

Based on the findings of the situation assessment study and the input from all concerned stakeholders during the national conference, the gaps and challenges in providing migrant-sensitive health services will be identified. This technical cooperation project, with full collaboration with the Ministry of Health and other concerned ministries of the Government of Jordan, will help IOM in future resource mobilization. The 1035 Facility (Line 2) will provide the funds required for this project (IOM, Amman, 2011).

B.2 History and general migration setting in Jordan

Jordan's strategic location at the crossroads of two major areas of instability and protracted conflict in the Middle East has caused it to be involved in major humanitarian emergencies and cope with massive influxes of refugees and migrant workers fleeing conflict areas. From the mid-1970s to the mid-1980s, hundreds of thousands of well-educated and highly skilled Jordanians migrated for employment mainly to oil-producing countries. During the same period, the country introduced policies favouring immigration. Thus, Jordan became a labour recipient of semi-skilled workers from Egypt, the Syrian Arab Republic and Asian countries to meet the needs of its agrarian, semi-industrial and service-oriented economy. The net migration rate (2005–2010) of Jordan is 8.3 migrants/1000 populations. Women constitute 49 per cent of immigrants in Jordan (2010).

Aside from receiving Palestinians, Jordan also hosted forced migrants from Lebanon during the 1975–1991civil war and from Iraq during and after the 1991 Gulf War. Since the coalition invasion of Iraq in 2003, the humanitarian ripple effects have been felt in the surrounding countries. As of 2010, Iraqis have spread throughout the world, with the majority of Iraqis internationally displaced in Turkey, Iran, Egypt, the Syrian Arab Republic and Jordan. By far, the Syrian Arab Republic and Jordan have taken the humanitarian lead, accepting the majority of displaced Iraqis.

The latest escalation of violence in Iraq after the 2003 Second Gulf War drastically raised the number of Iraqis fleeing to and residing in Jordan to about 750,000, increasing the pressure on the government authorities, economic and social infrastructures and local communities, and requiring the attention of the international community.

Jordan also hosts a large number or irregular migrants from neighbouring Egypt, some of whom migrate seasonally and some for prolonged periods of time. Based on information from the Jordanian MOI and the Directorate of Chest Diseases and Migrant Health of the Ministry of Health, the estimated number of Egyptian migrants residing in Jordan is around 250,000 as of 2010.

Other migrant workers, originating mostly from Asia, generally work as domestic workers and assistants in numerous private businesses in the country such as restaurants, hotels and so on. They are estimated to be around 150,000 as of 2010. These three migrant groups may be putting additional pressure on the public health-care system.

The situation in Jordan is further complicated by the different typologies of migrants. A marked difference exists between the two major migrant groups: the group of mostly non-Arabic-speaking female domestic workers mainly coming from the Philippines, Indonesia and Sri Lanka, and the group of mostly Arabic-speaking male construction workers coming from Egypt. Regardless of these differences, common to most of the migrants is their being invisible in the health-care platforms and certain levels of marginalization from available health-care services. Accordingly, Jordan faces the challenge of meeting the health demands of a vast number of migrants, including internal migrants, visitors from neighbouring countries, tourists extending their stay, refugees from both border and urban areas and numerous migrant workers from neighbouring countries or from South and South-East Asia (IOM, 2012).

The Population Division of the United Nations Department of Economic and Social Affairs estimates the total number of foreign-born individuals residing in Jordan to be about 3 million as of 2010, accounting for 46 per cent of the total population (UN,2009). This figure includes Jordanian citizens of Palestinian origin who are not technically migrants (i.e., those born in Jordan with Jordanian citizenship).

Palestinians represent the largest nationality of foreign-born residents. However, majority of them are naturalized Jordanians, with the exception of 150,000 Palestinians born in Gaza who hold two-year Jordanian travel documents that grant them residence in Jordan and partial access to social services and the labour market.

Although the number of Iraqis has been subject to controversy, they still represent the second-largest foreign-born community. The Egyptians represent the majority of labour migrants in Jordan. The rest of the labour migrants in Jordan come from Asian countries, mainly the Philippines, Sri Lanka and Indonesia. The females account for about 16 per cent of labour migrants in Jordan.

According to residency status for the year 2009, the number of immigrants in Jordan is comprised of those who have work visa (335,707), who are foreign students (26,736) and who are refugees and asylum-seekers (2,452,701) (Ministries of Labour and Higher Education, 2009, UNHCR, 2008).

The demand for foreign labour is increasing in Jordan, leading to the need to address migrants' health demands and to integrate migrants into the existing national health strategies and policies. The proportion of migrant workers of the total work force in Jordan increased from 11 per cent in 2000 to 24 per cent in 2009. Migrant workers registered in the governorates of Amman, Irbid, Zarqa and Balqa accounted for about 83 per cent of the total migrants officially registered in the country in 2009. About 90 per cent of registered migrants in 2009 were illiterate. Among the registered migrants in 2009, around 97 per cent worked in agriculture, manufacturing, construction, wholesale, retail trade, hotels, restaurants and social and personal services.

About 73 per cent of registered expatriates in the Ministry of Labour (MOL) in 2009 were Arabs (the majority were Egyptians), 26 per cent were non-Arab Asians and only about 1 per cent were of other nationalities. About one third of workers in the Qualified Industrial Zones were expatriates in 2009 (Ministry of labour, Jordan, 2009).

Note that these registered figures do not reflect the actual number of immigrant labour in the country because of the immense volume of irregular immigration into Jordan. These figures represent official figures of the work permits issued, and these are far from the unofficial figures that represent the actual number of immigrants of these nationalities in the country.

The term "migrant worker" does not appear in Jordanian legislation, but terms such as "foreign worker," "guest worker" and "non-Jordanian worker" are commonly used; any non-Jordanian residing in Jordan for a limited period of time to work is considered a "migrant worker" (Escoffier et al., 2008).

As regards their profile, foreign nationals in Jordan are a) mainly men (59.0%), b) young (mean age of 26.2), c) poorly educated (62.4% have less than secondary level), d) employed at low occupational levels (e.g., 43.9% are employed as craft and related trade workers and 27.8% are in elementary occupations) and e) mainly working in the manufacturing (26.6%), construction (22.5%), service (17.9%, of whom 82.6% are employed in private households) and agricultural sector (11.7%) (Bartolomeo et al., 2010).

B.3 Migration management in Jordan

B.3.1 National health policy

The Ministry of Health is responsible for the regulation of all health-related issues in the country, including the provision of health services and preventative and educational measures, aside from the regulation of health services from both private and public sectors. The Ministry is also responsible for encouraging all activities towards a healthy lifestyle for the public such as the promotion of physical exercise and correct diet, anti-smoking, maternal health, pre-marital health, childcare and other relevant campaigns.

The existing health policy does not cover migrants' health needs and specificities. However, all foreigners in Jordan, regardless of their legal status, have access to the country's public health-care system at rates subsidized by the government; the government covers 60 per cent of the total cost. Moreover, the Ministry of Health provides free vaccination services to all children living in Jordan including foreigners. Migrant workers who are covered by the Social Security Corporation have medical insurance for work-related injuries or diseases. However, some employers do not include their workers under the umbrella of the Social Security Corporation. Thus, these workers do not have any kind of health insurance, causing them serious problems when they are exposed to disease or injury. Regulation No. 42/1998 of the Preventive and Therapeutic Medical Care for the Workers in Establishments obligates employers to verify the fitness of a worker before the latter starts to work in the establishment. Each employer should appoint the required number of physicians and nurses or establish a medical unit appropriate for the number of workers (Escoffier et al., 2008).

The risk of introducing and/or reintroducing diseases that are no longer prevalent in the country should migrants' health needs are not addressed is present. According to the data from the Ministry of Health, infectious diseases with a possible impact on public health, such as multidrug-resistant tuberculosis, are found in the migrant population. National health surveys do not collect data on migrant population; therefore, identifying the major health needs of this population is difficult (IOM, 2012).

In August 2009, a decision was taken by the Minister of Health upon the request of the Embassy of Egypt to mandate all Egyptian migrant workers to have an annual insurance coverage certificate that covers compensation for death and accidents beginning in 2010. The worker pays about JD 10 a year, and he/

she receives about JD 11,000 as compensation for death and about JD 700 as maximum compensation for accidents (Ministry of Health, Jordan, 2009).

B.3.2 Migration policy and legal frameworks

The main governmental institution responsible for the administration of labour, both national and migrant, is MOL. The Ministry has evolved much over the last few years, with several departments having been created, some for the sole purpose of dealing with issues on migrant labour in the country. Moreover, several laws and regulations were drawn up to address specifically the issues related to migrant labour. Many efforts are being directed towards the improvement of the status of migrant labour in the country.

Not all immigrant labour is the same. Some belong to restricted nationalities, and some belong to the non-restricted. Egyptian, Syrian and Yemenite labour are non-restricted and residency fee-exempt, whereas all the other nationalities are non-exempt. Some nationalities are exceptions to the general rule because of treatment agreements, whereas others follow the standard operating procedures set for other countries. Politics plays an important role in determining this treatment so generalization causes inaccuracies in this respect.

Thus, the Department for the Recruitment of Immigrant Labour was established in MOL to ensure the application of the relevant rules and regulations to the relevant nationalities. This department is tasked to monitor the flow of labour within the work marketplace and to direct immigrant labour towards the sectors and areas that are not taken up by Jordanian labour. The objective is to obtain migrant/national labour quotas. Jordanians are trained where opportunities arise. However, if the vacancies remain, migrant labour is employed even in closed sectors.

The other main governmental institution that works in coordination with MOL is MOI, which grants the permission of entry before MOL grants the work permits. In this respect, MOI performs the security checks on immigrant labour and has the ultimate decision-making power in the entry of immigrant labour into the country. MOI has the authority to issue entry visas and security clearances as well as to conduct inspections in all sectors and all areas in the country concerned with migrant workers. Moreover, it is responsible for executing the relevant regulations and enforcing general law, such as residency laws and public security regulations and instructions. The Ministry also coordinates with the National Social Security Department, the National Organization for Vocational Training and the Ministry of Health, supervises and grants permits to recruiting agencies and cooperates with non-governmental organizations and labour unions.

In conclusion, as far as developing an intergovernmental dialogue and cooperation on labour migration policy is concerned, MOL is currently drafting new bilateral agreements with the main sending countries of foreign labour. At the same time, the Ministry is restructuring itself to specialize in the various issues related to labour. Most importantly, MOL's main source of information on migrant labour in the country remains to be the number of work permits it issues. Irregular labour migrant flows remain unseen in the Ministry's statistics. Little information is available from MOI on any current projects to coordinate the figures obtained from border entry points and those reflecting the volume of legal labour in the country. Although it is of Jordan's interest to replace the immigrant workforce with its own national workers and to improve the efficiency of Jordanian labour, international investments in the country cannot afford to be placed on hold until this is achieved. Therefore, the country continues to import foreign labour to maintain a favourable investment climate.

Much has changed over the last few years as far as the legislation relevant to migrant labour is concerned. Up to a few years ago, only a few Jordanian laws specifically targeted immigrant labour in Jordan. However, several laws and regulations are being drawn up specifically to address the targeted issues on migrant labour. The Civil and Criminal Laws are examples of laws that currently apply to

immigrant workers not covered by the Labour Law. These laws have not been changed specifically to suit migrant workers' needs, but they have been changed according to the needs of the Jordanian community. Certain articles of the Jordanian Labour Law refer to migrant labour within the larger context of regulating certain issues such as recruiting agencies, employment regulations, work permits and closed professions, among others. Several articles in Jordanian law are equally applicable to all individuals living on Jordanian soil, especially those presented under the Civil and Criminal Laws and in the Penal Code. No Jordanian laws are specifically targeted at migrant workers' health. In this respect, what are applicable to migrants in Jordan are general laws that apply to them in their capacity as persons living on Jordanian soil where Jordanian laws apply. In cases in which the migrant worker is covered by the Labour Law, the entitlements include social security, insurance for workplace injuries, right to equal pay, determined work hours, annual holiday rights, protection by trade unions, maternity rights and regulations for work safety. Any individual, whether Jordanian, migrant worker, tourist or foreign individual, on Jordanian soil who would like to file a complaint has the right to do so against any other person, party, or body who violates any of his/her rights, whether civil, criminal, labour, personal or otherwise, to local police stations or relevant authorities. He/She also has the right to report the violations of rights of others.

The Administrative Governor may also be involved in receiving complaints from migrant workers in case they are exposed to any kind of verbal or physical abuse, which the Administrative Governor will address by taking the necessary action (Ta'amneh, 2007).

The Jordanian MOL endorsed a special working contract for non-Jordanian domestic workers. The contract is the first of its kind in Jordan and is expected to become a model for other countries in the Arab region. It augments the coordination between the sending countries and Jordan as a receiving country to increase the number of migrant workers from Asia, guarantees migrant workers' rights to life insurance, medical care, rest days and repatriation upon expiration of the contract and reiterates migrant women's right to be treated in compliance with the international human rights standards (WHO, 2003).

The following are the key legislations and regulations related to migration management in Jordan:

- Nationality Law No. 6 of 1954, which regulates the conditions and procedures of granting nationality as well as the conditions of revoking it
- Residence and Foreigners' Affairs Law No.24 of 1973, which regulates entry and registration of foreigners, residence permits, exemptions and penalties
- Visa Regulation No. 3 of 1997, which specifies the types of visas, fees and exemptions
- Regulation no. 95 of 1998, which defines the place of residence issued according to article 40 of the Residence and Foreigners' Affairs Law
- Passport Law No. 5 of 2003, which specifies and regulates the types of passport to be issued
- Labour Code No. 8 of 1996, which regulates the function of the labour market such as subsequent regulations and instructions that specifically apply to foreign workers
- Law No. 48 of 2008, which amends the Labour Law to secure more rights for migrants and nationals workers in the domestic and agricultural sectors.

The key actors involved in migration management in Jordan are MOI, MOL and the Ministry of Foreign Affairs (Pitea, 2010).

B.3.3 Common health conditions/diseases among labour migrants

The Ministry of Health conducts mandatory screening for tuberculosis, HIV and hepatitis B for foreigners who decide to stay in the country for more than 30 days. Malaria screening is conducted for nationalities that come from endemic countries. Foreigners who test HIV positive are deported. From 2007 to 2010, a total of 804 cases of tuberculosis, 944 cases of hepatitis B and 195 cases of HIV were discovered among 1,209,242 foreigners screened. The following table shows the distribution of the three diseases discovered among three selected groups of migrants from 2007 to 2010. These groups are included in the present study.

Nationality	Tuberculosis cases and prevalence/ 100000	Hepatitis B cases and prevalence/ 100000	HIV cases and prevalence/ 100000	Number screened
Egyptian and Iraqis	84 (10.7)	10 (1.3)	13 (1.7)	783,381
Indonesian, Sri Lankan and Filipinos	402 (162.6)	846 (342.0)	97(39.0)	247,283
Other Asians	151 (123.0)	54 (44.0)	14(11.4)	122,656
Total	637 (55.2)	910 (79.0)	124(10.8)	1,153,320

Source: (Ministry of Health Statistics, 2007–2010).

As the table shows, the highest prevalence of the three diseases is in the group of Indonesians, Sri Lankans and Filipinos, followed by the group of other Asians. The lowest prevalence is in the Arab group.

Objectives of the Study

Overall objective

To overall objective is to provide baseline information on the health needs and challenges that affect different migrant groups in Jordan to assist the government and relevant parties to develop policies and strategies to manage migrants' health.

Specific objectives

The specific objectives are as follows:

1. to characterize the migrants' health status and utilization of local health services
2. to identify the availability and accessibility of health services to migrants
3. to understand the health-seeking behaviour of migrants
4. to determine certain aspects of their living conditions and social structure
5. to determine any association between the migrants' health and health-seeking behaviours with their sociodemographic characteristics and reported living and working conditions
6. to gather information on migrants from the perspectives of key stakeholders in Jordan
7. to collect information from the literature on migrants' health conditions and health-care access issues and information on national health and migration policy, legal frameworks and health system capacity to offer migrant-sensitive health services.

Methodology

The research was conducted using two designs:

1. A cross-section study conducted on a sample representing the migrant population residing in Jordan.
2. A focus group discussion to gather qualitative data from the national government and other migration health stakeholders.

A. Cross-section study

Population frame

The population frame consisted of the main migrant nationalities that reside in Jordan for six months or more. This frame focused on two main strata of migrants: the Arab migrants (i.e., Egyptians and Iraqis) and the non-Arab Asian migrants (i.e., Sri Lankans, Indonesians, Filipinos and other non-Arab Asians from Pakistan, Bangladesh, China, India and Nepal).

According to the statistics of the Ministry of Health, the size of the Arab stratum was about 236,000 and that of the non-Arabs Asians stratum was about 106,000 in 2010. These two strata account for about 70 per cent of migrants in Jordan. Other nationalities were not considered in the frame of this study.

The Egyptians accounted for 92 per cent of the Arab stratum, and the Iraqis accounted for 8 per cent of this stratum. The Indonesians accounted for 23 per cent of the non-Arabs stratum, and the Sri Lankans, Filipinos and other Asians accounted for 25 per cent, 18 per cent and 34 per cent of this stratum, respectively.

According to the statistics of the Ministry of Health, in 2010, the proportions of migrants screened for certain infectious disease to obtain work permits in Jordan in different Chest Diseases Centres in the three geographical regions of the country were 74.5 per cent, 13.5 per cent and 12 per cent in the central, northern and southern regions, respectively.

The irregular migrants were not included in this frame because they do not present themselves for visa renewal protocols at the Ministry of Health. Moreover, it is difficult to trace them and determine their size and location. Accordingly, they were not represented in our sample.

In summary, the segments of migrants excluded from the sample of this study are the irregular migrants, Europeans, other Arabs and newcomers (migrants residing in the country for less than six months).

Study settings

The three most in demand Chest Diseases Centres in the country were selected to be the sites for sampling migrants and interviewing them. These centres are the Amman centre that represents the central geographical region of Jordan, the Irbid centre that represents the northern region and the Aqaba centre that represents the southern region. The selected three centres examined about 72 per cent of the migrant population in 2010. The remaining 28 per cent of migrants were examined by the other nine centres distributed in other governorates of the different regions in Jordan (i.e., central, northern and southern regions).

Clearly, focusing the study site in these three centres for conducting the survey is better than distributing the sample over the 12 centres located all over the country for different operational and logistical reasons.

The time intended for data collection was six months to ensure a good representation of seasonal variation in migrant flows and health conditions.

Sample and sampling techniques

A stratified random sampling technique was used. Migrants living in Jordan are considered to be part of heterogeneous groups that differ in sociocultural backgrounds. Thus, two separate samples were selected from each separate frame stratum, that is, the Arab stratum and the non-Arab stratum.

Sample size determination:

The formula $n = \frac{PqZ^2}{d^2}$ was used to calculate the minimum size of the statistically required sample for each stratum, where

n = the minimum sample size required
P = assumed proportion of migrants with health needs who use the local health services
q = 1-P
d = precision of the estimate or the allowed error
Z = standard normal deviant, which is 1.96 for an alpha of 0.05 if we assume that P is equal to 0.50 and the precision of estimate is 0.05.

Accordingly, the minimum sample size required was equal to 384 persons from each stratum. We multiplied this figure by 3 and 2 for Arabs and non-Arabs as the design effect factor, respectively, to obtain a more reasonable and sufficient size that permits further stratification of the sample according to the different nationalities of migrants and to adjust for expected non-responses that may be faced. The Arab sample size was expected to be higher than that of the non-Arabs, as there were more Arabs in the frame. The non-response rate among them was also expected to be higher.

The size of the Arab sample was 1,152, but it reached 1,200 after approximation. The size of the non-Arab sample was 768, but it reached 800 after approximation. Thus, the total sample size selected from the two strata was 2,000.

These two strata samples were further stratified according to regions and nationalities using the proportions of migrants screened in different geographical regions and the proportions of each nationality in each stratum according to the Ministry of Health statistics for the year 2010, which was mentioned previously under the population frame section.

The final distribution of the sample is presented in the following table:

Region / Nationality	Egypt	Iraq	Indonesia	Philippines	Sri Lanka	Others	Total
Central Region (Amman Centre)	822	72	137	107	149	203	1490
Northern Region (Irbid Centre)	149	13	25	19	27	37	270
Southern Region (Aqaba Centre	132	12	22	17	24	33	240
Total	1,103	97	184	143	200	273	2000

Operation of the study

The data collection period was six months. Five teams of interviewers and four supervisors were trained and assigned; three teams worked in Amman, one team in Irbid and one in Aqaba. A well-trained supervisor was assigned for each team in Irbid and Aqaba, and two supervisors were assigned for Amman. Each team worked for a minimum of four hours per day for two to three days a week.

The subjects to be interviewed were selected as they appeared in the centre. The questionnaire was filled out by the interviewer after he/she received the written consent from the interviewee.

Each of the three teams in Amman was assumed to finish a minimum of seven to eight questionnaires per day, and the teams in Irbid and Aqaba were expected to accomplish six questionnaires daily to complete the minimum of 248, 45 and 40 questionnaires per month from Amman, Irbid and Aqaba, respectively. Through this allocation, the sample size assigned for each region would be covered in six months' time.

During the day, different nationalities of migrants were interviewed to fulfil the requirements of the subsamples' typology mentioned in the previous table. Before ending the interview, the questionnaire was checked for completeness and errors in filling it out both by the interviewer and the supervisor.

Interpreters provided by IOM assisted those who had a language barrier in filling out the questionnaires.

Data collected and instruments of the study

The collected data from the migrants include demographic information, socioeconomic data, mobility-related data, individual health concerns medical history, current medical complaints, reproductive health history, psychological complaints, living and working conditions, health-seeking behaviours and health services access, that is, availability, affordability and acceptability of migrant-sensitive services. These data were gathered through a structured interview questionnaire.

Training of the study team and pilot testing

During the preparatory stage of the study, a one-day workshop was conducted in Amman to train the study teams on how to fill out the questionnaire and on the standardization of the study methods.

A pilot testing of the questionnaire was conducted in three days in the three regions; 100 questionnaires were filled out.

The pilot testing helped us to check the reliability and the validity of the questions and to discover the difficulties that might emerge during the execution. We made the necessary modifications on the questionnaire and prepared ourselves to face these difficulties before embarking on the actual study. The pilot testing also gave the interviewers the opportunity to be trained and become acquainted with the methods of data collection.

Data entry and analysis

The questionnaires were coded, and the data were entered into the computer by well-trained data entry personnel. The Statistical Package for Social Sciences software was used for data entry, cleaning and analysis. Dummy tables, which consist of simple frequency tables and cross-tabulations, were developed. The chi-square statistical significant testing method was used in the analysis.

Ethical consideration

Official clearance was obtained from the government of Jordan, represented by the Ministry of Health, on the performance of the study aside from a written consent from the designated national ethical board. An informed written consent was obtained from each participant of the study (i.e., participants were informed about the objectives of the study, importance of the information they provide and the harmless effect of the study on them).

Each subject was given the choice to participate in this study or not after the aims and the nature of the study were explained to him/her.

The obtained data would be kept confidential and used only for scientific purposes .The rights of the subjects and their employers would be reserved.

Any health problem or living condition problem that might emerge for any subject would be considered by having the relevant parties address it.

Quality control measures

The high quality of the collected data was ensured through the following:

1. The questionnaire was reviewed by a group of experts and modified accordingly.
2. A pilot study was conducted on a group of participants in the same study area. The required modifications in the methodology or questionnaire were performed accordingly.
3. Data were collected by experienced and well-trained interviewers using a standardized methodology to avoid inter-observer bias and to assure good quality data.
4. Each completed questionnaire was re-checked by the supervisors to ensure completeness and consistency of data.
5. While waiting, eligible participants were interviewed separately in an isolated place to ensure privacy.

Limitations of the study

1. As the mixed or irregular segment of migrants lives under the radar of the governmental institutions and is difficult to reach, it was not included in this study.
2. The language barrier for some ethnic groups and the setback in the recruitment of interpreters created delay and undercoverage of the proposed sample in certain areas. The difficulty in interviewing non-Arabic and non-English speaking migrants in the absence of Interpreters caused the interviewers to begin interviewing the Arabic-speaking migrants, who accounted for the majority of the sample, as well as the migrant groups that could communicate in English until interpreters could be recruited. Some employers and embassy staff lent their assistance during the interviews.
3. Some delay occurred in the preparation and execution of the study because of the fasting month (Ramadan) that began in early August 2011. To compensate for the delay of work due to Ramadan, we tried our best to expedite the work after Ramadan.

B. Focus group discussion

A focus group discussion was conducted over a one-day workshop to gather qualitative data from the national government and other migration health stakeholders. The focus group discussion was used as a substitute to the proposed key informant interview, which we expected to be of little value. We believed that bringing different stakeholders together in a discussion session would yield more valid information.

A total of 30 persons participated in the workshop, representing the concerned governmental ministries such as the Ministry of Health, MOI, MOL, Ministry of Foreign Affairs and the General Security Directorate. The other stakeholders who participated in this meeting were the representatives of WHO, IOM, the United Nations High Commissioner for Refugees, embassies, private companies that employ a large number of migrants and local recruiting agencies for house workers.

At the beginning of the meeting, the participants were made to feel comfortable to facilitate the easy and open communication of ideas, views and opinions. After each participant introduced himself/herself and the institution he/she represents, a shared presentation was conducted by the Director of the Migration Health Department of the Ministry of Health and the IOM research consultant to give the participants an overview of the project, the research and particularly the objectives of the focus group as well as the manner it would be conducted.

Two discussion sessions at two hours each were conducted. Chairmen and rapporteurs were assigned for these sessions. Recording facilities were available and utilized.

The following key issues were raised and discussed during the sessions:

- Health impact of the movement of migrants across international borders.
- National policies, legislations and programmes that affect migrants' health.
- Social and health problems faced by migrants in Jordan.
- Existing policies in MOL and MOI on the human rights of migrants.
- Health insurance policies for migrants.
- management of migrants in the public health sector when affected by any infectious disease and its cost.
- Health-care access barriers that migrants may face major challenges (i.e., political, legislative and financial) faced by different organizations in dealing with migrants and plans to overcome these challenges.

The consultant asked each question separately in both English and Arabic. He explained the aim of the question, the information required from it, how the question works and whether it catches the people's interest. Were the respondents talking about the topic or not? Was the information gained relevant to the topic? The consultant revised and clarified the questions to maintain their relevance to the topic.

The consultant made efforts to motivate all the participants to talk and create an environment of active interaction among them. He also summarized the ideas and information given by the respondents for each question.

All the responses, comments and recommendations of the participants were recorded by the rapporteurs. The notes taken by the rapporteurs included the key points in the discussion and the notable quotes. Observations such as silent agreement, obvious body language and contradictory statements, which might not be captured in the tape recording, were also noted. Immediately after and during the next few days of the meeting, the consultant and the rapporteurs wrote down the findings of the focus group discussion based on the notes and transcripts to decrease the recall bias.

Results of the Study

Main findings of the literature review

International migration is on the rise. The estimated number of international migrants as of 2010 is about 214 million. Migrants account for 3.1 per cent of the world population. The integration of migrant health needs and rights into national plans and policies is deficient in most governments of the world. The present immigration legislation rules and regulations, which have been designed for regulated and accepted migratory movements, are less effective in addressing the challenges of new and emerging patterns of movements.

The migration process, due to conditions that may accompany it, may expose migrants to different health risks and vulnerabilities. Language and cultural barriers, high mobility of migrants, lack of cooperation from their employers and high cost of health care are among the most important challenges that may affect the accessibility of migrants to health-care services. Migrants' health is considered a joint responsibility of both migrant-sending and migrant-receiving countries.

The WHA Resolution No. 61.17 calls upon Member States to promote migrant-sensitive health policies, equitable access to health promotion and disease prevention. The Global Consultation on Migrant Health in Madrid convened by WHO in 2010 recommended four key priorities: monitoring migrants' health, establishing policy and legal frameworks, encouraging migrants' sensitive health systems and strengthening partnerships and networking. Many studies conducted in different parts of the world indicate that information is limited on migrant health status and their need for and use of medical services in the destination countries. A high percentage of migrants do not utilize the local health services for different reasons.

Jordan faces the challenge of meeting the health demands of a vast number of migrants. As of 2010, the total number of foreign-born individuals residing in Jordan is about 3 million, accounting for 46 per cent of the total population. The net migration rate (2005–2010) for Jordan is 8.3 migrants/1000 populations. As of 2010, women constitute 49 per cent of immigrants in Jordan.

Jordan is open to sharing its lessons learned in migrant health programmes within and beyond Jordan and is keen to collaborate with other countries to address migrants' health. The demand for foreign labour is increasing in Jordan, leading to the need for addressing migrants' health demands and for considering migrants in the existing national health strategies and policies.

The existing health policy in Jordan does not include a clear focus on migrants' health needs and specificities. All foreigners in Jordan, regardless of their legal status, have access to Jordan's public health-care system at rates subsidized by the government; the government covers 60 per cent of the total cost. Moreover, the Ministry of Health provides free vaccination services to all children living in Jordan including foreigners. Jordan's national health surveys do not collect data on migrant population. Therefore, identifying the major health needs of this population is difficult. The Jordanian Government endorses a special working contract for non-Jordanian domestic workers. It augments the coordination between the sending countries and Jordan and guarantees migrant workers' rights to life insurance, medical care, rest days and repatriation upon expiration of the contract. It also reiterates migrant women's right to be treated in compliance with international human rights standards. From 2007 to 2010, a total of 804 cases of tuberculosis, 944 cases of hepatitis B and 195 cases of HIV were discovered among 1,209,242 foreigners screened. The Ministry of Health conducts mandatory screening for tuberculosis, HIV and hepatitis B for foreigners who decide to stay in the country for more than 30 days.

Results and conclusions of the cross-section study

Results

The findings of this study are presented in 92 tables, 71 of which are simple frequency distribution tables and 21 are cross tabulations. This section presents all the findings from the interviews conducted with the labour migrants included in this study. Simple frequencies for the key variables are presented. Some of the variables are further analysed to present findings disaggregated by sociodemographic variables (e.g., age, sex, education, insurance status, etc.) and health status variables.

Characteristics of the sample

The total number of study subjects was 2,035, accounting for 102 per cent of the proposed sample size. The response rate was 94 per cent for the other non-Arab Asians and 173 per cent for the Iraqis. The response rates in the central and northern regions were above the required rate, and that in the southern region was 79 per cent. The occurrence of the high response rate of the Iraqis in the study sample was intended to obtain a good number of married women who live with their husbands in Jordan to satisfy the collection of data on maternal care.

The relatively low response rate in the Southern region was compensated by increasing the response rates in the other two regions. This method is considered acceptable, as the geographical residence of migrants does not play a significant role in their health and living conditions in Jordan because of the wide distribution of health facilities and other health-related services all over the kingdom.

Based on the sociodemographic characteristics, the majority of the subjects were young, with their age ranging from 18 to 42 years (about 86%).

Males accounted for about 70 per cent of the study population and females about 30 per cent. For the year 2010, males accounted for 59 per cent of all migrants in the Migration Profile of Jordan (Bartolomeo et al., 2010).

The proportion of Arab migrants in the study sample was 61.7 per cent and that of non-Arab migrants was 38.3 per cent, compared with 60 per cent and 40 per cent in the proposed sample, respectively. According to MOL statistics in 2009, about 73 per cent of registered expatriates were Arabs (mostly Egyptians), 26 per cent were non-Arab Asians, and only 1 per cent of them were of other nationalities (Escoffier et al., 2008).

About 65 per cent of the subjects were married. Among the subjects, 82.5 per cent had a certain degree of formal education (about 30% had primary or intermediate level, 21% had secondary level and 32% had more than secondary level of education) and 17.5 per cent were illiterate or could only read and write. These findings indicate that 68 per cent of the sample was poorly educated (less than secondary level); this figure is close to that provided by the Migration Profile in Jordan for the year 2010 (62.4%) (Bartolomeo et al., 2010).

Among the subjects, 44.7 per cent had a monthly income of less than JD 200 (USD 282), 45.5 per cent had a monthly income of JD 200–JD 400 and 7.4 per cent had a monthly income of more than JD 400. The ownership of certain household items served as a rough proxy indicator for the migrants' status of living. About 5 per cent of the subjects owned vehicles, more than one third of them owned a TV set, around half of them owned a refrigerator and about 14 per cent owned a computer. Nearly half of the subjects (47.5%) owned two or more of these items, and about 17 per cent did not own anything. More than half of the study sample (about 52%) had been staying in Jordan for more than three years, 19 per cent for two to three years, 20 per cent for one to two years and 9 per cent for 6 to 12 months.

These periods of stay do not necessarily indicate continuous residence inside Jordan, as migrants may leave the country for a home visit and then come back.

When non-Arab migrants were asked about their language skills, more than half (about 53%) and about 45 per cent of the respondents reported fairly good or good ability in speaking or understand Arabic and English languages, respectively, and 46 per cent and 54 per cent indicated very poor or poor ability in speaking or understanding Arabic and English languages, respectively.

These findings indicate the presence of a language barrier among nearly half of the non-Arab respondents (Tables 1-4, 6, 7).

Living conditions

About one third of the migrants lived in the central region (i.e., Amman, Zarqa, Balqa and Madaba), 14 per cent lived in the northern region (i.e., Irbid, Mafraq, Jarash and Ajloon) and 9 per cent in the southern region. The majority of them lived in cities (94%), and the rest lived in villages or moved between cities and villages.

When the migrants were asked about their causes of concern during their stay in Jordan, family-related issues were their main causes of concern. They reported very low concern for the other issues outlined in Table 8. About 86 per cent of the sample perceived their quality of life to be very good or good, and 11 per cent considered it to be fairly good. About 80 per cent of the migrants lived with families or friends, and 20 per cent lived alone. Among those living with families or friends, 45 per cent of them shared the same bedroom with three persons or more, 40 per cent shared it with one or two persons and 15 per cent did not share it with anyone.

When the migrants were asked about experiencing problems during their stay in Jordan, the majority of them reported no problems regarding living and sleeping in overcrowded rooms, lack of access to basic hygiene provisions, lack of access to clean toilets, inadequate water for drinking, inadequate water for cleaning, poor quality of food or lack of adequate food, inadequate ventilation and lack of direct sunlight and lack of clean clothes. Although 45 per cent of them reported sharing the same bedroom with three or more persons, 76 per cent reported no problems regarding living and sleeping in overcrowded rooms. This finding may be related to their lack of awareness of the danger of this practice (Tables 8–13).

Employment conditions

Based on their occupational skill, 44 per cent of the migrants were unskilled and worked as manual workers, 30 per cent of them were skilled or highly skilled and 22 per cent were semi-skilled. However, this classification is considered subjective because it depended on the interviewer's evaluation of the occupation of the concerned person.

About 95 per cent of the study population were employed. When distributed according to the main sectors of employment, one third of these employed migrants worked in the private sector, 20 per cent in households and 2 per cent in the public sector. About 23 per cent, 16 per cent, 15 per cent, 15 per cent, 9 per cent and 3 per cent of the subjects worked as housemaids, in industries, construction, services, farming and business and trade, respectively, and about 21 per cent worked in other types of employment. It should be noted that a person may work in one field or more, especially the manual workers. The pattern of work was characterized mainly by a low occupational level similar to that identified in the Migration Profile in Jordan for the year 2010 (Bartolomeo et al., 2010).

When the employed subjects were asked about receiving additional employment benefits other than their regular salary, about 45 per cent of them reported a positive response, and more than half did not receive any additional benefits from work.

As regards the work location, 31 per cent of them performed their jobs in workshops, 27 per cent inside houses, 9 per cent in the field, 4 per cent on the streets and 30 per cent in other places.

About 60 per cent of the population was very satisfied with their work, and 34 per cent was satisfied to a certain extent.

Long work hours, heavy work load, low payment and night shifts were the four main problems that migrants faced at work. This finding indicates that, although the Jordanian Labour Law has determined the number of working hours, the annual holiday rights and the payment rights, a significant percentage of migrant workers still complain about such problems, which may be due to their lack of awareness of such information and inactivation of the law. Moreover, about one fourth of the respondents reported exposure to occupational hazards in the workplace such as cold, heat, dust, bad smells and noise, and about 12 per cent was exposed to work-related illnesses or injuries. Nevertheless, the Labour Law includes entitlements for safety and ensures good environmental conditions at work.

The degree of severity of illness or injury among those exposed to occupational hazards was medium or severe in 46 per cent and mild in 40 per cent of the respondents (Tables 5, 14–23).

Health status and morbidity

About 93 per cent of migrants classified their health status as very good or good, 5 per cent as fairly good and 1 per cent as poor. The men (96%) characterized their health status better than did the women (89%). The difference was statistically significant, with a chi-square of 34.8 and a p-value of 0.000.

The perception of very good or good general health was more prominent among the younger age groups, with the rate of this perception declining as age increased. The rate of fairly good or poor general health increased as age increased. This result is due to the increase in the incidence of non-communicable diseases with aging. The difference was statistically significant, with a chi-square of 14.8 and a p-value of 0.005.

The perception of very good or good general health is associated with the level of education. Thus, as the level of education increases, the better general health is expressed. The level of education is considered one of the important social determinants of health. The reason is that, aside from their behaviour of seeking medical advice when sick, more educated people are better aware of the causes of these diseases and what constitutes a healthy lifestyle to prevent the occurrence of such diseases. The difference was statistically significant, with a chi-square of 7.834 and a p-value of 0.005.
As the subjects' monthly income increased, the status of their health characterized as very good or good improved. This association was statistically significant, with a chi-square of 11.9 and a p-value of 0.003.

Income is considered to be important in determining one's health status because it gives the ability to pay for the high cost of health services.

Arab migrants (i.e., Egyptians and Iraqis) appeared to perceive their health status better than did the non-Arab migrants (i.e., Sri Lankans, Filipinos, Indonesians and other non-Arab Asians). About 96 per cent of the Arabs considered their health as very good or good, but only about 91 per cent of the non-Arabs did so. This difference was statistically significant, with a chi-square of 19.35 and a p-value of 0.000.

The admission rate to hospitals of migrants who characterized their health status as fairly good or poor (23.3%) was double that of those who characterized their health status as very good or good (11.4%). The difference was statistically significant, with a chi-square of 15.2 and a p-value of 0.000.

The prevalence of chronic illnesses as reported by the subjects was about 7 per cent, which could be due to the low percentage of older persons in the sample (less than 7% was over 48 years). Respiratory diseases, hypertension, diabetes, bone and muscular diseases and gastrointestinal diseases were the most common chronic morbid conditions that were reported by the study population. More than one third of the affected subjects suffered from one disease, 15 per cent from two diseases and 6 per cent from three diseases or more. The prevalence of chronic illnesses was higher among non-Arab migrants (8.2%) than among Arab migrants (6.6%). However, the difference was statistically insignificant, with a chi-square of 1.707 and a p-value of 0.19.

Among the study population, 6 per cent reported exposure to accidents in the past six months, with only 2 per cent of them reporting the existence of their current physical disability. About 26 per cent of the subjects who suffered from a physical disability reported a moderate-to-severe impairment as a result of this disability, 48 per cent reported mild impairment and 17 per cent reported no impairment. In the month preceding the interview, 16.5 per cent of the subjects reported suffering from acute illness or injury. Among those who reported suffering from acute illness or injury, the non-Arab migrants accounted for 23.5 per cent, and the Arab migrants accounted for 12.9 per cent. The difference was statistically significant, with a chi-square of 37.61 and a p-value of 0.000. About one fourth of the affected subjects reported refraining from leading their usual lives because of their illness or injury. When the subjects who refrained from living their usual lives were asked about who cared for them during their illness, 28 per cent did not receive care from any person, 56.5 per cent received care from a family member and 14 per cent received care from friends or others.

About 18 per cent of the respondents missed going to work because of their illness or injury. Among them, 56 per cent missed one to two days, 17 per cent missed three to five days and 25 per cent missed more than five days.

The most prevalent psychological symptoms reported by the subjects in the week preceding the interview were loneliness/missing their family, nervousness/tension, headache, worrying, feeling tired or having little energy and sadness/frustration.

The majority of the study population reported no problems or complaints about mobility, self-care, usual activities, pain/discomfort and anxiety on the day of the interview.

Among the various morbid conditions reported on the day of the interview, respiratory problems ranked the highest, followed by teeth problems, chest pain/discomfort, vision problems and arthritis in descending order (Tables 24–38, 72–78, 86).

Reproductive health of married women

Among the 79 married women who lived with their husbands in Jordan in our sample, 56 per cent stated that they became pregnant during their stay in Jordan, and 44 per cent of them did not become pregnant.

According to some antenatal characteristics, all pregnant women reported receiving antenatal care, 98 per cent received care from physicians and 95 per cent had more than three antenatal visits during their pregnancy. As regards the place of delivery, 95.5 per cent of the pregnant women delivered in a hospital (59.1% in private and 36.4% in public hospitals). The majority of women who delivered (95%) reported receiving a vaccination card for their babies after delivery, which is in accordance with the high and universal vaccination coverage of children in Jordan. After excluding the missing data from the

calculation, we found that about 68 per cent of the women reported three years or more as a suitable period of spacing between two successive pregnancies, and 26 per cent considered two years as a suitable period (Tables 39–43).

Health-seeking behaviours

After excluding the missing data from the calculation, we found that 35.6 per cent of the study population sought health-care services in the last six months. This rate of health-seeking behaviour was higher among the non-Arab migrants (41%) than among the Arab migrants (31.6%). The difference was statistically significant, with a chi-square of 22.09 and a p-value of 0.000. This finding may be partly due to the incidence of acute illnesses and injuries and the prevalence of chronic illnesses are higher among the non-Arab migrants than among the Arab migrants and partly due to the higher coverage of health insurance among non-Arab migrants than among Arab migrants, which enables them to use the health services more. Although the rate of seeking health care was higher among males (36%) than among females (34.7%), this difference was not statistically significant, with a chi-square of 0.29 and a p-value of 0.594.

The rate of health-seeking behaviour among the less educated (36%) was slightly higher than that among the more educated (34.7%). However, the difference was not statistically significant, with a chi-square of 0.767 and a p-value of 0.38. As regards income, the rate of health-seeking behaviour was the highest among migrants whose income was JD 200–JD 399 J.D, followed by those whose income was JD 400 and then by those whose income was less than JD 200. However, the difference was not statistically significant, with a chi-square of 3.85 and a p-value of 0.146.

The rate of health-seeking behaviour increased as the length of stay of migrants in the country increased until the end of the first three years, declining afterward. The highest rate was among those who stayed for 19–36 months, and the lowest was among those who stayed for 36 months and more. The difference was statistically significant, with a chi- square of 31 and a p-value of 0.000. This finding can be explained by the barriers in accessing health care in the early months of stay (i.e., financial, geographical, lack of information and awareness and language-related barriers). When these barriers are overcome, the pattern of health-seeking improves until the conditions settle and the disease is managed. Afterward, the need for health-care services decline.

In their study on the determinants of health-care utilization by immigrants in Portugal, Dias et al. (2008) found that the utilization of health services among immigrant men and women remains significantly associated with the length of stay.

The rate of health-seeking behaviour was much higher among insured migrants (61.8%) than among non-insured migrants (26.6%). The difference was statistically highly significant, with a chi-square of 205.99 and a p-value of 0.000. Health insurance coverage usually encourages the seeking of health-care services because the cost will be subsidized and shared, and the information on the availability and distribution of different health services and specialties are easier. In some cases, health insurance may lead to excessive or inappropriate use of health services.

The four main types of health services sought by the subjects were general physicians, hospitals, medical specialists and pharmacies in descending order. The respondents mainly used the private health sector (76%), and only 22 per cent used the public health sector.

The study population did not seem to use the health services frequently. After excluding the non-responses from the calculation, we found that only 58 per cent of the subjects who sought care did so once per six months. This finding indicates the low need for health service utilization among migrant workers because of general good health or of the presence of barriers in utilizing health services.

After excluding the missing and the non-response data from the calculation, we found that, among the subjects who had acute illness or injury in the month preceding the interview, 80 per cent sought medical consultation and treatment. The most common types of health services or personnel to be consulted by the subjects who sought medical consultation were general physicians, specialist doctors, pharmacists and hospitals in descending order.

When the subjects who did not seek medical consultation were asked about their reasons for doing so, 84 per cent stated that their condition was not significant, 11 per cent gave reasons related to cost, lack of time and not having anyone to take them to the health facility, and 6.5 per cent gave other reasons. Only 8 per cent of the migrants sought health care outside Jordan, such as in their home countries, in the year preceding the study.

The rate of admission to hospitals in the six months preceding the interview was about 12 per cent. After excluding the non-responses and unknown data from the calculation, we found that accidents/trauma, respiratory diseases and diarrhoea were the primary reasons for the admission of about 42 per cent of the subjects.

As regards the health behaviour of the subjects when they suffer from common health conditions, 57 per cent consulted and ask for a prescription from a health professional, 40 per cent consulted a pharmacist, 27 per cent relied on obtaining medicines from their home countries, friends or other family members and less than 2 per cent coped with the disease and let it pass without receiving any treatment. This finding indicates three conclusions: 1) migrants have a positive health-seeking behaviour, 2) medical treatment is available to the subjects and 3) migrants try to obtain medicine without medical consultation (Tables 44–53, 79–84).

Access to health care (i.e., services, drugs and health information)

Only about 8 per cent of migrants sought health care in the last year outside Jordan. The majority sought this care from their home countries during their vacation or before coming to Jordan. Social factors and cost were the main reasons for this behaviour.

When the subjects were asked about receiving medications in the two months preceding the interview, 46 per cent reported receiving these medications. Painkillers/fever reducers and antibiotics are the most common drugs the respondents used. Physician's prescription and direct purchase from a private pharmacy are the two major methods of obtaining these medications. Among the subjects, 50 per cent obtained the medicines through a physician's prescription and 35 per cent through direct purchase from a private pharmacy without consulting with a physician. After excluding the missing and non-response data from the calculation, we found that 5 per cent did not receive medical treatment because they could not afford it, and 95 per cent were able to afford it.

When the subjects were asked about the barriers that prevent them from obtaining information about diseases and health, more than one third of them reported no barriers. Those who faced barriers reported cost as the most common, followed by language barrier and other minor barriers.

The three most common sources of health information used by the subjects are TV (69%), family, friends, neighbours and colleagues (33%) and health workers (20.5%).

After excluding the missing data from the calculation, among the study population, we found that 84 per cent lived within a 5 km distance of health services, 11.7 per cent lived within a 5–10 km distance and 4.6 per cent lived more than 10 km. This finding indicates that the geographical barrier is not a main obstacle for accessing health-care services.

The geographical accessibility of health services was further explored by asking the subjects about the mean they use to reach the service. Half of them reported that they go on foot and the others use private car or public transport. When the cost of transportation was investigated (after excluding the missing and non-response data from calculation), about 58 per cent of the subjects indicated that the cost was fair and affordable, about 17 per cent received free transport, 16.5 per cent found the transportation as expensive.

These findings reflect the high geographical and financial accessibility of health services to the study population in Jordan (Tables 54–63).

Availability and utilization of health services

After excluding the missing and non-response data from the calculation, we found that health services were highly or moderately available for 91.4 per cent of the study population and were poorly or not available for less than 1 per cent. When the rate of migrants' perception of the availability of health services was cross tabulated with health insurance status, length of stay in Jordan, educational categories and nationalities, the differences were very small and not statistically significant, with p-values of 0.48, 0.76, 0.08 and 0.76, respectively.

The study population was asked about their inability to utilize health care services despite their needs. After excluding the missing and non-response data from the calculation, we found that 10.5 per cent of them were unable to use the services despite their needs, and 88 per cent of them were able to do so. Dias et al. (2008) studied the determinants of health care utilization by immigrants in Portugal and found that 20 per cent of the immigrant sample had never used the National Health Services.

The two most prevalent reasons why the subjects did not use the health care services despite their needs are the absence of health insurance (82.5%) and the high cost of health care (81%). This finding indicates that the financial barrier is the main cause for not accessing the health services.

After excluding the missing data from the calculation, we found that 88.8 per cent of the subjects never encountered discrimination during their visits to the health care services and 11.2 per cent encountered such sometimes, always or often.

After excluding the missing and non-response data from the calculation, we found that 90 per cent of the study population was highly or moderately satisfied with the quality of health services provided to them, and 2 per cent were either not satisfied or poorly satisfied. In the study of Dias et al. (2008), among the migrants in Portugal that used the health services, 22.4 per cent of them were unsatisfied or very unsatisfied (Tables 64–68, 87-90).

Health insurance

The health insurance coverage rate of the study population was 25 per cent. Mou et al. (2009), who studied the health care utilization of Shenzhen migrant workers in South China, found that 55 per cent of the respondents were uninsured (13). Insurance coverage rate among non-Arab migrants (49.5%) was nearly five times more than that among Arab migrants (10.3%). This difference was highly statistically significant, with a chi-square of 388.39 and p-value of 0.000. This finding may due to the high number of non-Arab migrants who are employed as clusters of large groups in some factories where private health insurance is mandatory. Moreover, migrant female domestic workers who work with families are usually provided with informal health insurance by paying the cost of health care provided to them by these families when needed. The employed migrants (26.1%) more likely had health insurance than did the unemployed (11.4%). The difference was statistically significant, with a chi-square of 11.3 and a p-value of 0.001. This finding can be explained by Regulation No. 42/1998 of the Preventive and Therapeutic Medical Care for the Workers in Establishments, which states that employers should

appoint the required number of physicians and nurses or establish a medical unit appropriate for the number of workers. Moreover, workers, including migrant workers, in these establishments are usually covered by the Social Security Corporation that provides medical insurance for work-related injuries or diseases (Escoffier et al., 2008).

The insured subjects (30%) were more likely to be admitted to hospitals than were the non-insured (6%). The difference was highly statistically significant, with a chi-square of 209 and a p-value of 0.000. The uninsured migrants may not be able to afford the cost of hospital admission so they may ignore their health and refuse admission.

As regards the type of insurance, about 86 per cent of the insured subjects had private sector insurance, 4 per cent had public sector insurance and 10 per cent had insurance from other sources. This finding is expected, as the majority of the sample works in the private sector.

Generally and after excluding the missing and non-response data from the calculation, two thirds of the subjects spent less than 10 per cent, 7 per cent spent 10 per cent to 15 per cent and only 3.6 per cent spent more than 15 per cent of their monthly income on health. This finding is acceptable and is not a catastrophic health expenditure. It may be due to the relatively low prevalence of morbidity among the study population (Tables 69–71, 85, 91–92)**.**

Conclusions

The study indicates that nearly half of the non-Arab migrants had a language barrier. Family-related issues were the main cause of concern among migrants in Jordan. Almost all migrants (97%) characterized their quality of life in Jordan as very good, good, or fairly good. The majority of migrants (95%) were employed, and about half of them received additional employment benefits other than their regular salary. About 94 per cent were either very much satisfied or satisfied to a certain extent with their work. The majority of migrants (93%) perceived their health status as very good or good. Nearly half of the migrants lived in overcrowded conditions in which they share one bedroom with three persons or more.

Although the Jordanian Labour Law determines the number of working hours, the annual holiday rights and the payment rights, a significant percentage of migrant workers still complained about such problems, which could be due to their lack of awareness of such information.

The prevalence of chronic illnesses was relatively low (7%). This finding may be due to the fact that the majority of the subjects were young, and only 6 per cent reported exposure to accidents in the past six months. The subjects suffered the following main psychological symptoms in the week preceding the interview: loneliness/missing their family, nervousness/tension, headache, worrying and sadness/frustration.

All the women who became pregnant during their stay in Jordan received antenatal care, with about 98 per cent of them receiving this care from physicians. About 95 per cent had more than three antenatal visits during their pregnancy, 95.5 per cent delivered in a hospital and 95.5 per cent received a vaccination card for their babies.

As regards health-seeking behaviour, 35.6 per cent of migrants sought health care services in the last six months. The study population mainly used the private health sector. About 80 per cent of the subjects who had acute illness or injury in the month preceding the interview sought medical consultation and treatment. Among those who did not seek medical consultation, 84 per cent of them did not do so because their condition was not significant, and 5 per cent did not because of cost.

When the subjects suffered from common health conditions, their health-seeking behaviour was positive. Medical treatment was widely available to them, with only 5 per cent of the study population being unable to receive medical treatment because they could not afford it. The geographical accessibility to health-care services in Jordan was high. The availability of these services was high or moderate for the majority of the migrants. Most of the subjects were able to use the health services whenever they needed it, with only 10 per cent not being able to do so. Financial barrier (i.e., high cost and lack of health insurance) was the main reason for not utilizing the services. As regards facing discrimination during their visits to health-care services, the majority of the migrants reported no discrimination. About 90 per cent of them were highly or moderately satisfied with the quality of health services provided to them.

The health insurance coverage rate of the study population was 25 per cent, with the coverage rate among non-Arabs being nearly five times more than that among Arabs. The employed migrants were more likely to have health insurance than were the unemployed. The private sector (86%) was the main source of health insurance. Health expenditure for the majority of the subjects was less than 10 per cent of their monthly income. This finding is considered acceptable and is not a catastrophic health expenditure. This result may be due to the relatively low prevalence of morbidity among this young population.

Health status was better among males and the younger age groups than among females and the older age groups. General health was expressed to be better as the levels of education and income increased. Health status also seemed to be better for Arabs than for non-Arabs. This finding is validated by the prevalence of chronic illnesses and the rate of occurrence of acute illnesses or injuries being higher among non-Arab migrants than among Arab migrants as well as by the rate of health-seeking behaviour in the last six months being higher among non-Arabs than among Arabs.

The rate of health-seeking behaviour increased as the length of stay of migrants in the country increased until the end of the first three years, declining afterward. The insured subjects were more likely to seek health-care services and to be admitted to hospitals than were the non-insured. The subjects who characterized their health status as fairly good or bad were more likely to be admitted to hospitals than those who characterized it as very good or good.

Results and conclusions of the focus group discussion

Results

Health impact of the movement of international migrants across international borders

All the respondents reported that Jordan, similar to other countries, faces the challenge of meeting the demands of migrants' health and that the movement of migrants across borders can cause health burdens on both the host communities and on the migrants themselves. Migrants constitute an additional burden on the host communities because they increase the pressure on the already limited national resources such as water, food, health and education. Migration in itself, whether it is forced or voluntary for the purpose of study, work or tourism, is a risk factor. It has implications on the physical and psychological aspects of the migrants because of their presence in communities with circumstances different from those of their home countries. According to the Ministry of Health, many cases of infectious diseases have been discovered among migrants such as HIV and drug-resistant tuberculosis (90% of drug-resistant tuberculosis was found among migrants, who were treated for 24 months for free and not deported). This occurrence has a negative effect on public health. In the period of 2007–2010, about 804 tuberculosis cases, 944 hepatitis B cases and 195 HIV cases were detected among 1,209,242 screened migrants. Another challenge raised by the participants is the existence of a good percentage of migrants working on a daily basis and in an unorganized work environment as well as another segment of migrants that is unemployed and unproductive so they lack any form of

health insurance coverage. The fact that the primary concern of migrant workers is to look for work and earn money, and thus they do not prioritize their health, poses another challenge. This situation is exaggerated by the reality that, as a number of migrants stay in the country irregularly and are not easily accessible for medical screening and follow-up, they may expose themselves and their host community to certain health risks. These conditions usually occur to migrants from countries that are exempted from the obligation of obtaining an entry visa. Another social factor that may affect migrants' health is the low socio-economic class of the majority of migrants. As a high percentage of migrants comes from poor areas of the world, they are more susceptible to malnutrition and a high prevalence of epidemic and endemic diseases. The sexually transmitted diseases that migrants may have may pose a serious health problem to the members of the host communities.

Among the problems that affect migrants' health are the lack of knowledge on how to access health services, the existence of barriers that prevent them from gaining easy access to such services and the discovery of most cases of infectious diseases at the late stage, which can lead to disease transmission, complication and death. Migrants are a high-risk source of disease because some cases are not detected, some migrants refuse to receive treatment and others deny that they have a disease. The participants raised the issue that the migrants' circumstances could increase the probability of contagious disease transmission because many foreign workers enter the country in groups and in a mixture of nationalities, their residency may not be regulated, and they work in factories in groups and live in crowded conditions.

Jordan's health policy provides free treatment for all detected cases of infectious diseases if they are curable and discovered after entering the country. Thus, more financial burden is brought on the country in terms of increased health care expenditure.

IOM, in cooperation with the concer□ned authorities, can develop strategies to raise the migrants' awareness about the importance of undergoing primary and periodic medical examinations and seeking health services when needed. Some participants pointed out the lack of health control strategies for foreign workers, especially for the irregular migrants and for those who work in hazardous occupations and places. The mental and psychological problems and disorders among migrant workers, especially domestic workers, should be given attention.

Social and health problems faced by migrants in Jordan

The participants reported many problems in this area such as exposure of some migrants to many forms of violence, culture shock resulting from the differences in language, religion, customs, traditions and weather, family separation (home sickness) and living in unhealthy conditions such as lack of ventilation, poor lighting, heat, overcrowding and contaminated water. Another serious problem is the violation of certain migrants' rights identified by Labour Law, such as delay in paying the monthly salary, giving incomplete salary (breaching the contract), failing to secure suitable housing conditions, withholding of the migrants' passports and disallowance of communicating with their families. Some participants emphasized the problems related to workers' leaving their original work without proper notice, the difficulty of following them to their new addresses, especially those working in large factories and communities, and the social and health problems resulting from workers' sex-mix (both sexes living in the same house), especially those working in large industrial clusters and factories.

National policies, legislations and programs that affect migrants' health

The Ministry of Health established a Directorate of Migrants' Health within the structure of the ministry to develop health policies and programs for migrants. However, the existing Jordanian health policy does not cover the needs and specificities of migrants' health. Nevertheless, foreigners in Jordan, regardless of their legal status, have the right to access the public health-care system at rates partially subsidized by the government. A large segment of the migrants' children who are under 6 years of age

is treated for free in all MOH centres and hospitals similar to other Jordanian children. Vaccination is provided free of charge to all Jordanian and non-Jordanian children and pregnant women. The Ministry of Health provides free primary maternal and child health-care services, such as family planning and school health services, to all migrants.

According to the Public Health Law, the Ministry of Health provides free treatments for communicable diseases for all Jordanians and non- Jordanians through both preventive (vaccination) and curable methods.

The health regulations in Jordan obligate all migrants who intend to stay in Jordan for 30 days or more to undergo a medical screening for tuberculosis, HIV and hepatitis B. Screening for malaria is conducted for some nationalities that come from Malaria-endemic countries. The Ministry of Health must inform MOI about migrants discovered to have hepatitis B or HIV for deportation.

The Ministry of Health has proposed a strategic plan that involves conducting three medical examinations for migrants. The first examination is the pre-arrival examination by highly credible and accredited health centres in the country of origin. This medical examination is required for migrants prior to entry into Jordan. An agreement exists between the Ministry of Health and IOM offices in different exporting countries for migrant workers to undergo such tests. IOM, in coordination with MOL, the Ministry of Health and labour recruitment agencies, can assume an important oversight role for ensuring the credibility of the medical examinations, for issuing health certificates for migrants in the country of origin within the strict conditions and for guaranteeing the high level of transparency of the testing results. The second examination is the entry examination to be conducted at the earliest time after the migrant worker enters the country. The third one is the post-entry periodical examination conducted after the migrant worker's entry into Jordan to follow up on his/her health status. According to the strategy, the Ministry of Health will provide free treatment for the disease provided it is discovered after entry and is curable.

Another issue related to health regulations is the proposed plan developed by the Ministry of Health in collaboration with private insurance companies to establish a health insurance system for migrants for a reasonable fee. A pregnancy test for married migrant women should be included in the package of medical screening examinations for foreign workers. Modern tests that are highly accurate and quick should be provided by the Ministry of Health to save both time and money. These tests are for investigating certain diseases among migrants and raising the awareness level of both employers and employees on the importance of conducting medical examinations.

The Jordanian Labour Law obligates all workers, whether Jordanian or non-Jordanian, in establishments to perform periodic medical examinations (every six months), including laboratory tests and X-ray, to screen for occupational diseases. Moreover, Regulation No. 42/1998 of the Preventive and Therapeutic Medical Care for the Workers in Establishments obligates employers to appoint the required number of physicians and nurses or to establish a medical unit appropriate for the number of workers. A doctor should be assigned in any facility with a number of employees exceeding 50.

According to the Jordanian Labour Law, since May 2011, every institution must have one or more employees participating in the Social Security Program to ensure the health insurance coverage of employed migrants against work-related diseases and injuries. The Social Security Program allows both Jordanians and non- Jordanians to participate and receive the full package of benefits obtained by Jordanian citizens.

Some embassies use the medical centres from the migrants' place of origin to conduct medical examinations before the migrants leave.

Although according to the Jordanian Labour Law there is no discrimination between Jordanians and non-Jordanians as regards employment, some professions are closed to non-Jordanians. However, these professions become open when there is no Jordanian labour to fill these jobs.

MOI prepares and distributes brochures in different languages to migrants at points of entry along all Jordanian borders to encourage them to report their problems in their own language and refer to the concerned persons, parties or MOI to solve these problems. These brochures contain the necessary phone numbers the migrants may need. Any individual, whether Jordanian or non-Jordanian, living in the Jordanian territory can report a complaint to police stations or local authorities against a person, a party or an entity that violated his/her civil, criminal , personal or other work-related rights.

Some participants especially those representing the recruitment agencies, complained of the absence of workers' advisers in the Jordanian embassies of certain labour-sending countries such as Sri Lanka and the Philippines.

Existing policies in the Ministry of Labour and Ministry of Interior on the human rights of migrants

Policies of the Ministry of Labour

Jordan is considered one of the countries that respect human rights including those of migrants. Jordan has its own human rights organization that monitors the rights of the population including those of migrants. However, migrants' awareness of their rights that are included in the Labour Law is limited. MOL has established a new unit to control human trafficking. It is tasked to monitor and uphold the rights of migrants. MOL has established a guidance unit to solve problems and issues related to the barriers faced by migrants such as language and cultural barriers.

The Jordanian MOL endorsed a special working contract for non-Jordanian domestic workers. The contract is the first of its kind in Jordan and is expected to become a model for other countries in the Arab region. It augments the coordination between the sending countries and Jordan, as a receiving country, to increase the number of migrant workers from Asia, guarantee migrant workers' rights to life insurance, medical care, off days and repatriation upon expiration of the contract and reiterate migrant women's right to be treated in compliance with international human rights standards.

Policies of the Ministry of Interior

The representatives of MOI reported many policies and regulations that are either in place currently or in the works. These policies and regulations are as follows: implementing a national project that includes providing every migrant a special number that enables national authorities to follow him/her up from the time of entry until the time of departure, establishing a human rights department in MOI to receive and follow up complaints and problems from the whole population including non-Jordanians, ensuring that, before departure, migrants did not violate the national regulations and they received their financial and other affairs and implementing policies that will overcome the language barrier of expatriates such as the agreement with the recruitment offices to hold language and awareness courses for expatriates before being exported and the distribution of booklets that contain important information needed by newcomers upon arrival in border crossings.

Health insurance policies for migrants

The participants agreed that, to date, there is no governmental legislation or policy on the health insurance of migrants in Jordan and that there is no legislative provision in MOL that mandates companies to provide health insurance to migrant workers. However, there is a provision for life insurance. Some companies voluntarily provide health insurance to their workers. Once they do so, the health insurance becomes part of the workers' rights. MOL obligates business owners to continue this provision of insurance. It also compels owners of companies and factories to provide treatment for work-related diseases and injuries when they occur. In August 2009, a decision was taken by the Minister of Health, upon the request of the Embassy of Egypt, to mandate all Egyptian migrant workers to obtain an annual insurance coverage certificate that covers compensation for death and accidents beginning 2010. The

worker pays about JD 10 a year, and he/she receives about JD 11,000 as compensation for death and about JD 700 as maximum compensation for accidents.

Management of migrants in the public health sector when affected by infectious disease and its cost

The Jordanian health legislations state that the treatment of communicable and infectious diseases at the Ministry of Health is free for all residents including non-Jordanians. Free vaccinations are provided for children for the prevention of infectious diseases at the Ministry of Health facilities for Jordanians and non-Jordanians.

Barriers that may affect migrants' accessibility to health care services

The participants indicated that there is an inappropriate health awareness of the citizens and migrants on the importance of migrants' access to and utilization of available health services as well as on the lack of a universal health insurance system for migrants. Aside from poverty and unemployment, these issues can complicate their access to health services. Language and cultural barriers can also add to the problem of inaccessibility.

Major political, legislative and financial challenges faced by different organizations in dealing with migrants

The participants representing different organizations reported the following challenges: the lack of Jordanian embassies in some labour-exporting countries as well as the lack of a labour adviser even when an embassy is present, the lack of guaranteed mechanism for the protection of funds transferred from Jordan to the recruitment offices abroad for the recruitment of workers, the mandatory payment of the work permit fee before the worker's arrival to the country putting a financial burden on the Jordanians in case the worker do not arrive as this fee is non- refundable, the absence of an active national mechanism to protect the original employer in case the foreign workers leave their original employer either for their embassies or for another job in another place and with another employer in Jordan without an official work permit as well as from being forced to receive the worker when found, usually after a long time, and assume all the legal responsibility of his/her fleeing.

Conflicting results sometimes arise in the medical and laboratory examinations of the same migrant when entering the country and renewing his/her permit between the results of the examinations conducted by the Ministry of Health and those conducted in the private sector, leading to confusion in the diagnosis of cases. Given the nature of some diseases, the first examination may be negative and then become positive after a time. The migrant can also be free of infection at entry and then acquire the infection inside Jordan.

Conducting pregnancy tests for married migrant women is not included in the mandatory examinations performed by the Ministry of Health.

The denials of recruitment agency owners of the existence of a particular disease among the workers they recruit create many problems and debates between the employers and the staff of the Ministry of Health.

Conclusions

The relatively high number of migrants in Jordan constrains the limited national resources. The migrants themselves are exposed to many types of health and social unmet needs. Moreover, most migrants do not know how to access the health services, and they face many barriers that prevent them from gaining easy access to such services. These circumstances may lead to the discovery of diseases among migrants, causing disease transmission, complications and death.

The existing Jordanian health policy does not cover the needs and specificities of migrants' health. Nevertheless, all foreigners in Jordan, regardless of their legal status, have the right to access public health-care system at rates partially subsidized by the government. Moreover, the Ministry of Health provides free vaccination services to all children living in Jordan including foreigners. So far, there is no legislative provision that mandates the health insurance coverage of migrants. However, MOL obligates owners of companies and factories to provide treatment for work-related diseases and injuries in the event they occur. According to the Jordanian Labour Law, as of May 2011, every institution must have one or more employees participating in the Social Security Program to ensure the health insurance coverage of employed migrants against work-related diseases and injuries.

Jordan is considered one of the countries that respect human rights including those of migrants. Jordan has its own organization for human rights that monitors the different rights of the population including those of migrants. MOL has a new unit for controlling human trafficking that monitors and preserves the rights of migrants. MOI has a human rights department that receives and follows up on complaints and problems of the whole population including non-Jordanians. Jordanian embassies are not present in some labour-exporting countries. Nevertheless, even when an embassy is present, no labour adviser is assigned to that embassy.

1. **Recommendations of the study**A formal and mandatory health insurance should be established for all migrant workers with a reasonable cost that is suitable to the employers' capability and to migrants' income and length of stay in Jordan. The costs can be borne by the employers or shared between the parties (employer–employee).
2. Strategies should be developed, and national policies that regulate the right and access to health care of migrants in Jordan should be instituted.
3. The Jordanian labour law that determines the rights of migrant workers, such as the number of working hours, the payment rights, their right to communicate with their home countries and the annual holiday rights, and raises the awareness of migrant workers to such information should be implemented. Migrant workers should be aware of these rights.
4. The roles of the newly established units in MOL should be enforced to control human trafficking, to provide guidance in monitoring and protecting the rights of migrants, and to solve problems and issues related to them including health-related problems.
5. The level of awareness on the protection of and the psychosocial and psychological problems faced by migrant workers, especially domestic workers, should be increased to prevent mental health problems and suicide risk. Ways of monitoring progress and changes should be determined.
6. The strategic plan proposed by the Ministry of Health on conducting the following three medical examinations for migrant workers should be implemented:
    a. pre-arrival examination by highly credible and accredited health centres in the country of origin
    b. entry examination to be conducted at the earliest time after the migrant worker enters the country
    c. post-entry periodical examination conducted after the migrant worker's entry to follow up on his/her health status.

    These examinations should be linked to care and treatment plans.
7. When a treatable health condition is determined during a medical examination, the migrant should have access to treatment and time off to recover. When a decision is taken to allow a

foreign worker to have a follow up or treatment in the country of origin because of a particular untreatable disease or injury, the country of origin should be informed about the case.

8. The oversight role of IOM, Ministry of Health and MOL should be promoted to ensure the credibility of the medical examinations and the mechanism for issuing reliable health certificates in the country of origin that comply with international ethical practices, such as the informed consent by the migrant and the confidentiality of medical results, and to provide migrants with access to counselling, follow-up treatment and support services.
9. The health awareness of citizens and migrants on the importance of migrants' access and utilization of available health services when needed should be raised, and a mechanism to overcome the language and cultural barriers that prevent access to services should be developed. Health workers should be made aware of migrants' specific circumstances and needs.
10. The government should try to establish embassies or consulates in labour-sending countries that lack these services and ideally to appoint labour advisers to facilitate quickly the cooperation between the countries in terms of labour migration.
11. An information system in MOL or MOI on immigrant labour in Jordan that can be electronically linked to the relevant departments in the country should be established.
12. The Jordanian Government should sign agreements with labour-sending countries that ensure migrants' access to relevant pre-departure orientation and training such as on health issues, vocational training, language and other practical training. Having good knowledge and orientation of the new country is essential for the migrant worker to ensure healthy working and living conditions.
13. Bilateral agreements between migrant-sending countries and Jordan should strictly regulate the process of labour recruitment. Involved agents/agencies on both sides should be carefully selected and subject to accreditation on a yearly basis to ensure fair and consistent application of the selection policies and recruitment fees, including costs that are related to the pre-arrival health assessment. The tasks of recruitment agencies should include exchanging information and securing that migrant workers have access to health care.
14. National policies should be developed and instituted to monitor the adequate living and working conditions of migrant workers in Jordan. A governmental body to monitor and ensure they are followed in practice.
15. Relevant articles on the Jordanian health legislations and policies should be reviewed to address migrant issues, such as whether the rights of migrants to health care are lacking or not well defined in these legislations.
16. A national technical committee should be formed to develop a national migrant health strategy as a follow-up to this consultation and be made multisectoral.
17. Regular meetings with all stakeholders should be continuously held to solve problems that may arise and to protect the health of migrants and the hosting community.
18. Further in-depth research should be conducted on issues such as health insurance, living and health conditions of irregular migrants and awareness of migrants and their employers on migrant rights including their right to health.

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Annex 1: Tables of the Cross-section Study

Table 1: Comparison between the studied sample and the proposed sample according to nationality and region

Nationality	Proposed sample	Studied sample	Response %
Egyptians	1,103	1,086	98.5
Iraqis	97	168	173.0
Sri Lankans	200	194	97.0
Filipinos	143	151	105.6
Indonesians	184	180	97.8
Other non-Arab Asians	273	256	93.8
Total	2,000	2,035	101.8
Region	**Proposed sample**	**Studied sample**	**Response %**
Central	1,490	1,552	104.2
Northern	270	293	108.5
Southern	240	190	79.2
Total	2,000	2,035	101.8

Table 2: Socio-demographic characteristics of the sample

Age in years	Number	%
18–22	179	8.8
23–27	499	24.5
28–32	472	23.2
33–37	340	16.7
38–42	262	12.9
43–47	148	7.3
48–52	69	3.4
53–57	48	2.4
58–62	12	0.6
More than 62	6	0.3
Gender		
Male	1,422	69.9
Female	613	30.1
Nationality		
Egyptian	1,086	53.4
Iraqi	168	8.3
Sri Lankan	194	9.5
Filipino	151	7.4
Indonesian	180	8.8
Other non-Arab Asians	256	12.6
Marital status		
Single	667	32.8
Married	1,320	64.9
Divorced	21	1.0
Widowed	8	0.4
Separated	7	0.3
Missing	12	0.6

Educational level		
Illiterate	228	11.2
Read and write	129	6.3
Primary school	341	16.8
Intermediate	266	13.1
Secondary	420	20.6
Diploma	460	22.6
Bachelor's degree	152	7.5
Beyond bachelor's degree	38	1.9
Missing	1	0.0
Monthly Income in JD		
Less than 100	50	2.5
100–149	364	17.9
150–199	494	24.3
200–249	419	20.6
250–299	302	14.8
300–349	161	7.9
350–99	47	2.3
400–449	39	1.9
450–499	32	1.6
500 and more	79	3.9
Missing	48	2.4
Total	2,035	100.0

Table 3: Sample according to ownership of household items, n =2035

Item owned	Frequency	%
Vehicle	98	4.8
T.V.	1,594	78.3
Computer	286	14.1
Refrigerator	983	48.3

Table 4: Sample according to the number of owned items

Number of items	Number	%
One item	720	35.4
Two items	731	35.9
Three items	169	8.3
Four items	68	3.3
None	347	17.1
Total	2,035	100.0

Table 5: Sample according to the degree of occupational skill

Status of skill	Number	%
Unskilled	895	44.0
Semi-skilled	440	21.6
Skilled	409	20.1
Highly skilled	200	9.8
Missing	91	4.5
Total	2,035	100.0

Table 6: Sample according to the length of current stay in Jordan

Length of stay in months	Number	%
6–12	191	9.4
>12–18	252	12.4
.>18–24	150	7.4
>24–30	213	10.5
>30–36	175	8.6
>36–42	133	6.5
>42–48	97	4.8
More than 48	822	40.4
Missing	2	0.1
Total	2,035	100.0

Table 7: Ability to speak or understand Arabic and English languages among non-Arab respondents

Arabic	Number	%
Very poor	143	18.3
Poor	217	27.8
Fairly good	308	39.4
Good	109	14.0
Missing	4	0.5
Total	781	100.0
English		
Very poor	216	27.7
Poor	207	26.5
Fairly good	190	24.3
Good	164	21.0
Missing	4	0.5
Total	781	100.0

Table 8: Distribution of the sample according to their concerns about different issues during their stay in Jordan

Family-related issues	Number	%
Never	995	48.9
Sometimes	595	29.2
Often	196	9.6
Always	232	11.4
Do not know	4	0.2
No response	9	0.4
Missing	4	0.2
Discrimination issues		
Never	1,695	83.3
Sometimes	226	11.1
Often	15	0.7
Always	33	1.6
Do not know	3	0.1
No response	8	0.4
Missing	55	2.7
Personal safety and security in the surroundings		
Never	1,857	91.3
Sometimes	87	4.3
Often	19	0.9
Always	54	2.7
Do not know	3	0.1
No response	8	0.4
Missing	7	0.3
Socio-religious aspects		
Never	1,910	93.9
Sometimes	70	3.4
Often	7	0.3
Always	17	0.8
Do not know	2	0.1
No response	10	0.5
Missing	19	0.9
Other concerns		
Yes	43	2.1
No	1,991	97.8
Missing	1	0.1
Total	2,035	100.0

Table 9: Sample according to how they characterize their quality of life in general

Quality of life	Number	%
Very good	858	42.2
Good	895	44.0
Fairly good	232	11.4
Bad	40	2.0
Do not know	4	0.2
No response	6	0.3
Total	2,035	100.0

Table 10: Sample according to governorate and place of residence i n Jordanian sites of study = Amman, Aqaba and Irbid

Governorate	Number	%
Amman	1,403	68.9
Zarqa	114	5.6
Balqa	23	1.1
Madaba	1	0.0
Irbid	274	13.5
Mafraq	5	0.2
Jarash	2	0.1
Ajloon	2	0.1
Aqaba	181	8.9
Ma'an	5	0.2
Karak	3	0.1
Tafilah	1	0.0
Moving between many provinces	18	0.9
Missing	3	0.1
Place of residence		
City	1,915	94.1
Village	110	5.4
Moving between city and village	4	0.2
Missing	6	0.3
Total	2035	100.0

Table 11: Sample by living status

Status of living	Number	%
Alone	410	20.1
With family	500	24.6
With friends	1,121	55.1
Alone but sometimes with others	3	0.1
No response	1	0.0
Total	2,035	100.0

Table 12: Subjects who live with family or friends according to number of persons who share the same bedroom

Number of persons	Number	%
None	236	14.6
One person	348	21.5
Two Persons	300	18.5
Three persons	270	16.7
More than three persons	463	28.6
No response	2	0.1
Missing	2	0.1
Total	1,621	100.0

Table 13: Subjects according to whether they experienced certain problems during their stay in Jordan

Problem	Number	%
Living and sleeping in overcrowded rooms		
Never	1,550	76.2
Sometimes	200	9.8
Often	71	3.5
Always	210	10.3
Missing	4	0.2
Lack of access to basic hygiene provisions such as hand washing soap and clean water supply		
Never	1,905	93.6
Sometimes	103	5.1
Often	16	0.8
Always	8	0.4
Missing	3	0.1
Lack of access to clean toilets		
Never	1,899	93.3
Sometimes	107	5.3
Often	20	1.0
Always	6	0.3
Missing	3	0.1
Inadequate drinking water		
Never	1,939	95.3
Sometimes	75	3.7
Often	14	0.7
Always	5	0.2
Missing	2	0.1
Inadequate water for cleaning		
Never	1,928	94.7
Sometimes	82	4.0
Often	18	0.9
Always	5	0.2
Missing	2	0.1
Poor quality of food or lack of adequate food		
Never	1,949	95.8
Sometimes	73	3.6
Often	10	0.5
Always	1	0.0
Missing	2	0.1
Inadequate ventilation, lack of direct sunlight		
Never	1,900	93.4
Sometimes	70	3.4
Often	37	1.8
Always	25	1.2
Missing	3	0.1
Lack of clean clothes		
Never	1,961	96.4
Sometimes	55	2.7
Often	9	0.4
Always	2	0.1
Missing	8	0.4
Total	2,035	100.0

Table 14: Subjects according to current employment

Current employment	Number	%
Employed	1,928	94.7
Unemployed	107	5.3
Total	2,035	100.0

Table 15: Employed subjects by main sector of employment

Sector	Number	%
Private sector	1,467	76.1
Households	392	20.3
Public sector	41	2.1
Other	18	0.9
NGOs	1	0.1
International organizations	4	0.2
Missing	5	0.3
Total	1,928	100.0

Table 16: Employed subjects by type of employment, n=1928

Employment	Number	%
Housemaid	441	22.9
Industries	312	16.2
Construction	291	15.1
Services	286	14.8
Farming	176	9.1
Business and Trade	65	3.4
Other	397	20.6

Table 17: Employed subjects according to whether they have employment benefits other than regular salary (e.g., free housing, meals and health insurance)

Having other employment benefits	Number	%
Yes	875	45.4
No	1,039	53.9
Missing	14	0.7
Total	1,928	100.0

Table 18: Employed subjects according to place of work, n=1928

Place	Number	%
In a workshop	598	31.0
In a house	519	26.9
In the field	174	9.0
On the street	84	4.4
Other	579	30.0

Table 19: Employed subjects according to perceived level of work satisfaction

Level of satisfaction	Number	%
Very much satisfied	1 152	59.8
Satisfied to a certain extent	661	34.3
Not satisfied	45	2.3
Missing	70	3.6
Total	1 928	100.0

Table 20: Employed subjects according to how they characterize their work in terms of different issues

Issues	Yes	No	Do not know	No response	Total
Much heavy work	688 35.7%	1,226 63.5%	9 0.5%	5 0.3%	1,928 100.0%
Long working hours	775 40.2%	1,143 59.3%	6 0.3%	4 0.2%	1,928 100.0%
Low pay	391 20.3%	1,501 77.8%	30 1.6%	6 0.3%	1,928 100.0%
Physical abuse	55 2.9%	1,854 96.1%	13 0.7%	6 0.3%	1,928 100.0%
Being insulted often	66 3.4%	1,838 95.3%	17 0.9%	7 0.4%	1,928 100.0%
Night shifts	333 17.3%	1,569 81.3%	19 1.0%	7 0.4%	1,928 100.0%
Delayed payment	84 4.4%	1,814 94.1%	18 0.9%	12 0.6%	1,928 100.0%

Table 21: Employed subjects according to exposure to occupational hazards

Hazard	Yes	No	Do not know	Missing	Total
Cold	516 26.8%	1,406 72.8%	3 0.2%	3 0.2%	1,928 100.0%
Heat	541 28.1%	1,381 71.5%	3 0.2%	3 0.2%	1,928 100.0%
Dust	550 28.5%	1,375 71.3%	2 0.1%	1 0.1%	1,928 100.0%
Smells	409 21.2%	1,512 78.4%	3 0.2%	4 0.2%	1,928 100.0%
Noise	445 23.1%	1,477 76.5%	3 0.2%	3 0.2%	1,928 100.0%
Other	30 1.6%	1,891 98.0%	6 ,0.3%	1 0.1%	1,928 100.0%

Table 22: Exposure of subjects to work-related illnesses or injuries

Exposure	Number	%
Exposed	243	11.9
Not exposed	1,748	86.0
Do not know	6	0.3
No response	1	0.0
Missing	37	1.8
Total	2,035	100.0

Table 23: Degree of severity of the illness or injury among those exposed

Degree of severity	Number	%
Severe	17	7.0
Medium severity	95	39.1
Mild severity	97	39.9
Inconsiderable	33	13.6
Do not know	1	0.4
Total	243	100.0

Table 24: Perception of general health status

Perception	Number	%
Very good	1,038	51.0
Good	863	42.4
Fairly good	98	4.8
Poor	22	1.1
No response	1	0.0
Missing	13	0.6
Total	2,035	100.0

Table 25: Currently suffering from any long-term chronic illness

Suffering	Number	%
Yes	145	7.1
No	1,862	91.5
Do not know	6	0.3
No response	10	0.5
Missing	12	0.6
Total	2,035	100.0

Table 26: Types and proportions of long-term chronic illnesses among affected subjects, n=145

Illness	Number	%
Respiratory disease	41	28.3
Hypertension	33	22.8
Diabetes	27	18.6
Illness realted to bones and muscle	23	15.9
Gastro-intestinal diseases	20	13.8
Cardiovascular diseases	9	6.2
Psychological diseases	3	2.1
Kidney diseases	2	1.4
Cancer	2	1.4
Brain stroke paralysis	1	0.7
Other	25	17.2

Table 27: Affected subjects by number of illnesses

Number of illnesses	Number	%
One illness	115	79.3
Two illnesses	21	14.5
Three illnesses	7	4.8
More than three illnesses	2	1.4
Total	145	100.0

Table 28: Exposure of subjects to accidents in the past six months

Exposure	Number	%
Exposed	123	6.0
Not exposed	1,907	93.7
Do not know	2	0.1
No response	3	0.1
Total	2,035	100.0

Table29: Subjects according to whether they currently suffer from any physical disability

Physical disability	Number	%
Yes	42	2.1
No	1,984	97.5
Do not know	2	0.1
No response	7	0.3
Total	2,035	100.0

Table 30: Subjects who suffer from disability according to whether they have any impairment resulting from it

Impairment	Number	%
No impairment	7	16.8
Mild impairment	20	47.6
Moderate impairment	8	19.0
Serious impairment	3	7.1
Do not know	1	2.4
No response	3	7.1
Total	42	100.0

Table 31: Subjects according to whether they suffered from any acute illness or injury in the past month

Suffered	Number	%
Yes	336	16.5
No	1,653	81.2
Do not know	6	0.3
No response	30	1.5
Missing	10	0.5
Total	2,035	100.0

Table 32: Subjects who suffered from acute illness or injury in the past month according to whether they refrained from leading their usual lives because of that illness

Refrained	Number	%
Yes	85	25.3
No	216	64.3
Do not know	29	8.6
No response	6	1.8
Total	336	100.0

Table 33: Subjects who refrained from leading their usual lives according to whether people cared for them during their illness

Person who cared for them	Number	%
Other family members living in the same house	42	49.4
No one cared for me	24	28.2
Friends	7	8.2
Other family members not living in the same house	6	7.1
Other	5	5.9
No response	1	1.2
Total	85	100.0

Table 34: Employed subjects according to whether they missed one or more work days because of illness or injury

Missed days of work	Number	%
Yes	346	17.9
No	1,315	68.2
Do not know	40	2.1
No response	30	1.6
Missing	197	10.2
Total	1,928	100.0

Table 35: Subjects who missed work days according to the number of days missed

Number of days	Number	%
One day	90	26.0
Two days	105	30.3
Three to five days	59	17.1
Six to seven days	28	8.1
Eight to fourteen days	20	5.8
More than 14 days	38	11.0
Do not know	3	0.9
No response	3	0.9
Total	346	100.0

Table 36: Subjects according to whether they suffered from certain symptoms in the past week

Symptom	Very much	To some extent	Rarely	Not suffering	Missing	Total
Loneliness/Missing family	210 10.3%	312 15.3%	155 7.6%	1,346 66.2%	12 0.6%	2,035 100.0%
Nervouseness/Tension	155 7.6%	291 14.3%	239 11.7%	1,342 65.9%	8 0.4%	2,035 100.0%
Headache	123 6.0%	310 15.2%	298 14.6%	1,296 63.7%	8 0.4%	2,035 100.0%
Sadness/Frustration	72 3.5%	181 8.9%	163 8.0%	1,609 79.1%	10 0.5%	2,035 100.0%
Worries	70 3.4%	239 11.7%	139 6.8%	1,581 77.8%	6 0.3%	2,035 100.0%
Tiredness or having little energy	70 3.4%	218 10.7%	136 6.7%	1,603 78.8%	8 0.4%	2,035 100.0%
Poor appetite or overeating	67 3.3%	119 5.8%	107 5.3%	1,734 85.2%	8 0.4%	2,035 100.0%
Little interest or pleasure in doing things	57 2.8%	103 5.1%	86 4.2%	1,781 87.5%	8 0.4%	2,035 100.0%
Trouble falling or staying asleep, sleeping too much or insomnia	42 2.1%	137 6.7%	129 6.3%	1,717 84.4%	10 0.5%	2,035 100.0%
No hope for the future	24 1.2%	53 2.6%	55 2.7%	1,893 93.0%	10 0.5%	2,035 100.0%
Feeling that life is not worth living	22 1.1%	48 2.4%	54 2.7%	1,893 92.9%	18 0.9%	2,035 100.0%
Feeling of fear	22 1.1%	79 3.9%	64 3.1%	1,862 91.5%	8 0.4%	2,035 100.0%

Table 37: Description of health regarding certain conditions on the day of the interview

Mobility	**Number**	**%**
No problem	1,989	97.8
Some problem	41	2.0
Missing	5	0.2
Total	2,035	100.0
Self-care		
No problem	2,013	98.9
Some problem	12	0.6
Missing	10	0.5
Total	2,035	100.0
Usual activities		
No problem	2,004	98.5
Some problem	23	1.1
Missing	8	0.4
Total	2,035	100.0
Pain/Discomfort		
No Pain	1,905	93.6
Moderate Pain	106	5.2
Exterme Pain	6	0.3
Missing	18	0.9
Total	2,035	100.0

Anxiety		
Not anxious	1,809	88.8
Moderatly anxious	168	8.3
Extremly anxious	24	1.2
Missing	34	1.7
Total	2,035	100.0

Table 38: Illnesses/problems reported on the day of the interview, n=2035

Illness/Problem	Number	%
Respiratory problems	236	11.6
Teeth problems	165	8.1
Chest pain/Discomfort	63	3.1
Vision problems	50	2.5
Arthritis	49	2.4
Gastro-intestinal problems	39	1.9
Hypertension	33	1.6
Diabetes	17	0.8
Hearing problems	11	0.5
Other	43	2.1

Table 39: Married women in child-bearing age who live with their husbands in Jordan according to whether they became pregnant during their stay in Jordan

Pregnancy	Number	%
Yes	44	55.7
No	35	44.3
Total	79	100.0

Table 40: Distribution of pregnant women according to their antenatal characteristics

Characteristic	Number	%
Received antenatal care		
Yes	44	100.0
No	0	0.0
Person consulted		
Doctor	43	97.7
Other	1	2.3
Number of antenatal visits		
Once	1	2.3
Twice	0	0.0
Three times	1	2.3
More than three times	42	95.4
Total	44	100.0

Table 41: Pregnant women according to their place of delivery

Place of delivery	Number	%
Private hospital/Clinic	26	59.1
Government hospital	16	36.4
Other	2	4.5
Total	44	100.0

Table42: Delivered women according to whether they received vaccination cards for their babies

Received the card	Number	%
Yes	42	95.5
No	2	4.5
Total	44	100.0

Table 43: Perception of married women in child-bearing age who live with their husbands in Jordan on the suitable period of spacing between two successive pregnancies

Period of spacing	Number	%
Two years	16	20.3
Three years	27	34.2
More than three years	15	19.0
Do not know	4	5.1
Missing	17	21.4
Total	79	100.0

Table 44: Subjects according to whether they sought health-care services in the last six months

Seeking	Number	%
Yes	720	35.4
No	1,302	64.0
Missing	13	0.6
Total	2,035	100.0

Table 45: Subjects who sought health care according to type of service used, n=720

Type of service	Number	%
General physician	248	34.4
Hospital	175	24.3
Medical specialist	132	18.3
Pharmacy	91	12.6
Dentist	65	9.0
Health centre	64	8.9
Nurse	8	1.1
Mental health worker	5	0.7
Other	11	1.5

Table 46: Subjects who sought care according to the sector of health-care service used, n=720

Health sector	Number	%
Private	547	76.0
Public	161	22.4
International	12	1.7
NGOs	4	0.6
Other	11	1.5

Table 47: Subjects who sought health care according to the frequency of using health-care services

Frequency	Number	%
Once per week	20	2.8
Once per month	82	11.4
Once per two months	28	3.9
Once per three months	66	9.2
Once per six months	361	50.1
Do not know	64	8.9
No response	99	13.8
Total	720	100.0

Table 48: Subjects who had acute illness or injury in the last month according to whether they sought medical consultation and treatment

Sought medical consultation	Number	%
Yes	264	78.6
No	67	19.9
No response	1	0.3
Missing	4	1.2
Total	336	100.0

Table 49: Subjects who sought medical consultation and treatment according to who they consulted first for advice or treatment

First consulted	Number	%
General physician	119	45.1
Specialist doctor	46	17.4
Pharmacist	44	16.7
Hospital	39	14.8
Dentist	6	2.3
Nurse	3	1.1
Traditional healer	3	1.1
Other	4	1.5
Total	264	100.0

Table 50: Subjects who did not seek medical consultation or treatment according to reasons, n*=62

Reasons	Number	%
The condition was not significant	52	83.9
I could not afford the cost of the treatment	3	4.8
I had no time to go for a medical consultation	3	4.8
I did not have anyone to take me	1	1.6
Other	4	6.5

Note: *Five persons did not respond.

Table 51: Admission to hospital in the last six months

Admission	Number	%
Yes	246	12.1
No	1,782	87.6
Missing	7	0.3
Total	2,035	100.0

Table 52: Primary reason for admission among admitted subjects

Primary reason	Number	%
Accident/Trauma	31	12.6
Respiratory illness	24	9.8
Diarrhoea	23	9.3
Skin infection	17	6.9
Chronic condition (e.g., diabetes, heart disease, asthma, etc.)	14	5.7
Routine check-up	14	5.7
Other febrile illnesses	12	4.9
Labour/Delivery	10	4.1
Gynaecological problem	2	0.8
Mental health problem	2	0.8
Violence	1	0.4
Other	33	13.4
Do not know	3	1.2
No response	60	24.4
Total	246	100.0

Table 53: Subjects' behaviour when suffering from common cough, colds, fever, stomach discomfort or diarrhoea, n= 2035

Behaviour	Number	%
I consult with and ask prescription from a health professional	1,168	57.4
I ask the pharmacist	816	40.1
I ask for medicines from other members of the family	216	10.6
I have home remedies	198	9.7
I ask for medicines from friends, co-workers and neighbours	137	6.7
I buy over-the-counter medicines/remedies without consulting anyone	50	2.5
I just hold on, cope with it and let it pass	35	1.7
Other	8	0.4
Do not know	4	0.2

Table 54: Subjects according to whether they sought health care in the last year outside Jordan

Sought health care	Number	%
Yes	166	8.2
No	1,862	91.5
Missing	7	0.3
Total	2,035	100.0

Table 55: Subjects according to whether they received medications in the last two months

Took medications	Number	%
Yes	936	46.0
No	1,085	53.3
Do not know	5	0.2
No response	6	0.3
Missing	3	0.1
Total	2,035	100.0

Table 56: Subjects who received medications in the last two months according to the types of these medications, n=936

Type of medication	Number	%
Painkiller/Fever reducer	767	81.9
Antibiotic	373	39.9
Vitamins/Tonics	70	7.5
Anti-allergy	55	5.9
Anti-diarrhoeal	40	4.3
Other	32	3.4
Antihypertensive/Heart medications	30	3.2
Anti-nausea and vomiting	25	2.7
Antidiabetic medication	20	2.1
No response	5	0.5
Do not know	4	0.4

Table 57: Subjects who received medications in the last two months according to the method of obtaining these medications, n=936

Method of obtaining medication	Number	%
Through a physician's prescription	466	49.8
Directly from a private pharmacy	330	35.3
From family	99	10.6
From friends	78	8.3

Table 58: Subjects according to whether they did not receive treatment because they could not afford it

Did not receive treatment	Number	%
Yes	102	5.0
No	1,838	90.3
Do not know	16	0.8
No response	45	2.2
Missing	34	1.7
Total	2,035	100.0

Table 59: Obstacles encountered by subjects in obtaining information on diseases and general health in Jordan, n=2035

Obstacles	Number	%
Have no obstacles	1,593	78.3
Cost	306	15.0
Language	72	3.5
Distance	34	1.7
Fear of losing my job if I find out I have a disease	33	1.6
Fear of the doctor	15	0.7
Cannot go to the clinic or hospital	9	0.4
Other	17	0.8

Table 60: Most effective sources used by subjects to obtain health information, n= 2035

Source of information	Number	%
TV	1,411	69.3
Family, friends, neighbours and colleagues	667	32.8
Health workers	418	20.5
Newspapers and magazines	355	17.4
Radio	315	15.5
Internet	207	10.2
Brochures, posters and other printed materials	52	2.6
Billboards	46	2.3
Religious leaders	18	0.9
Other	30	1.5

Table 61: Subjects according to distance of health services to their place of residence

Distance	Number	%
Within 5 km	1,691	83.1
5–10 km	236	11.6
>10– 15 km	50	2.5
15–20 km	17	0.8
More than 20 km	25	1.2
Missing	16	0.8
Total	2,035	100.0

Table 62: Modes of transportation used by the subjects to access health service centres, n=2035

Modes of transportation	Number	%
On foot	1,020	50.1
By public transport	840	41.3
By private car	398	19.6
Other	6	0.3

Table 63: Subjects' views on the cost of transportation

Views	Number	%
Fair and affordable	1,099	54.0
Free	325	16.0
Expensive but affordable	253	12.4
Expensive and not affordable	59	2.9
Do not know	155	7.6
No response	123	6.0
Missing	21	1.0
Total	2,035	100.0

Table 64: Subjects' evaluation of the availability of health services to them

Evaluation	Number	%
Highly available	1,317	64.7
Moderately available	468	23.0
Mildly available	56	2.8
Poorly available	8	0.4
Not available	7	0.3
Do not know	97	4.8
No response	74	3.6
Missing	8	0.4
Total	2035	100.0

Table 65: Distribution of the sample according to the inability to utilize health-care services despite their needs

Response	Number	%
Yes	212	10.4
No	1,776	87.3
Do not know	31	1.5
No response	14	0.7
Missing	2	0.1
Total	2,035	100.0

Table 66: Reasons for the users' inability to utilize health-care services despite their need, n=212

Reasons	Number	%
I have no health insurance	175	82.5
Hight cost	172	81.1
Services are far from my place	15	7.1
I have no time	11	5.2
Do not trust the health service	8	3.8
Do not have anyone to take me	5	2.4
I was getting better on my own	5	2.4
Do not know where to go/who to ask	2	0.9
Do not have anyone to take care of the children or house while I am gone	1	0.5
Issues with documentation	1	0.5
Language and cultural barriers	1	0.5
Other	3	1.4
No response	1	0.5

Table 67: Whether the subjects faced discrimination during visits to health-care services

Faced discrimination	Number	%
Never	1,759	86.4
Sometimes	173	8.5
Often	15	0.7
Always	34	1.7
Missing	54	2.7
Total	2,035	100.0

Table 68: Subjects' satisfaction with the quality of health-care services provided to them

Satisfaction	Number	%
Highly satisfied	1,165	57.2
Moderately satisfied	535	26.3
Mildly satisfied	46	2.3
Poorly satisfied	17	0.8
Not satisfied	20	1.0
Do not know	106	5.2
No response	124	6.1
Missing	22	1.1
Total	2,035	100.0

Table 69: Subjects according to whether they have health insurance coverage

Health insurance	Number	%
Yes	512	25.2
No	1,510	74.2
Do not know	6	0.3
Missing	7	0.3
Total	2,035	100.0

Table 70: Insured subjects by the main type of health insurance

Main type	Number	%
Private insurance	441	86.1
Public insurance	19	3.7
Other insurance	51	10.0
Missing	1	0.2
Total	512	100.0

Table 71: Sample according to health expenditure as a proportion of monthly income

Proportion spent	Number	%
Less than 10%	1,101	54.1
10–15%	116	5.7
>15–20%	31	1.5
>20–25%	18	0.9
More than 25%	12	0.6
Do not know	400	19.7
No response	349	17.1
Missing	8	0.4
Total	2,035	100.0

Table 72: Perception of general health status by gender

Perception	Gender		Total
	Males	Females	
Very good, Good	1,356 96.1%	545 89.3%	1,901 94.1%
Fairly good, Bad	55 3.9%	65 10.7%	120 5.9%
Total	1,411 100.0%	610 100.0%	*2,021 100.0%

Chi- square=34.8,df=1, p=0.00

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 73: Perception of general health status by age in years

Perception	Age groups					Total
	18–27	28–37	38–47	48–57	58 and above	
Fairly good, Bad	637 94.9%	772 95.3%	374 91.9%	104 89.7%	14 82.4%	1,901 94.1%
Fairly good, Bad	34 5.1%	38 4.7%	33 8.1%	12 10.3%	3 17.6%	120 5.9%
Total	671 100%	810 100%	407 100%	116 100%	17 100%	*2,021 100%

Chi- square=14.8,df=4 , p=0.005.

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 74: Perception of general health status by education

Perception	Education		Total
	Intermediate school level and less	Secondary school level and more	
Very good, Good	890 92.5%	1,010 95.5%	1,900 94.1%
Fairly good, Bad	72 7.5%	48 4.5%	120 5.9%
Total	962 100%	1,058 100%	*2,020 100%

Chi square=7.834, df=1, p=0.005

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 75: Perception of general health status by income

Perception	Income			Total
	Less than JOD 200	JOD 200–JOD 399	JOD 400 +	
Very good, Good	834 92.3%	881 95.6%	144 97.3%	1,859 94.2%
Fairly good, Bad	70 7.7%	41 4.4%	4 2.7%	115 5.8%
Total	904 100%	922 100%	148 100%	*1,974 100%

Chi -square=11.9, df=2 , p=0.0

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 76: Perception of general health status by nationality

Perception	Nationality		Total
	Egyptians and Iraqis	Sri Lankans, Filipinos, Indonesians and other non-Arab Asians	
Very good, Good	1,191 95.9%	710 91.1%	1,901 94.1%
Fairly good, Bad	51 4.1%	69 8.9%	120 5.9%
Total	1,242 100%	779 100%	*2,021 100%

Chi square=19.35, df=1, p=0.000

Note: * * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 77: Prevalence of long-term chronic illness by nationality

Nationality	Presence of illness		Total
	With illness	No illness	
Egyptians and Iraqis	82 6.6%	1,155 93.4%	1,237 100%
Sri Lankans, Filipinos, Indonesians and other non-Arab Asians	63 8.2%	707 91.8%	770 100%
Total	145 7.2%	1,862 92.8%	*2,007 100%

Chi square=1.707, df= 1 , p=0.19

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 78: Subjects on whether they suffered from any acute illness or injury in the past month by nationality

Suffered	Nationality		Total
	Egyptians and Iraqis	Sri Lankans, Filipinos, Indonesians and other non- Arab Asians	
Yes	160 12.9%	176 23.5%	336 16.9%
No	1,081 87.1%	572 76.5%	1,653 83.1%
Total	1,241 100%	748 100%	*1,989 100%

Chi square=37.61, df= 1 , p=0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 79: Subjects on whether they sought health-care services in the last six months by nationality

Nationality	Sought care		Total
	Yes	No	
Egyptians and Iraqis	393 31.6%	849 68.4%	1,242 100%
Sri Lankans, Filipinos, Indonesians and other non-Arab Asians	327 41.9%	453 58.1%	780 100%
Total	720 35.6%	1,302 64.4%	*2,022 100%

Chi square=22.09, df=1, p=0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 80: Subjects on whether they sought health-care services in the last six months by gender

Gender	Sought care		Total
	No	Yes	
Males	Yes	No	1,409 100%
Females	507 36.0%	902 64.0%	613 100%
Total	213 34.7%	400 65.3%	*2,022 100%

Chi square= 0.29, df= 1 , p=0.594

Note: * Persons who had no response or missing or don't know answers were not included in this analysis.

Table 81: Subjects on whether they sought health-care services in the last six months by education

Education	Sought care		Total
	Yes	No	
Intermediate school level and less	350 36.6%	606 63.4%	956 100%
Secondary school level and more	370 34.7%	695 65.3%	1,065 100%
Total	720 35.6%	1301 64.4%	*2,021 100%

Chi square= 0.767, df= 1, p=0.38

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 82: Subjects on whether they sought health-care services in the last six months by income

Income	Sought care		Total
	Yes	No	
Less than JOD 200	300 33.2%	603 66.8%	903 100%
JOD 200–JOD 399	346 37.6%	575 62.4%	921 100%
JOD 400	55 36.7%	95 63.3%	150 100%
Total	701 35.5%	1,273 64.5%	*1,974 100%

Chi square= 3.85, df= 2, p=0.146

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 83: Subjects on whether they sought health-care services in the last six months by length of stay in Jordan

Length of stay	Sought care		Total
	Yes	No	
6–18 months	149 33.8%	292 66.2%	441 100%
19–36 months	243 45.3%	293 54.7%	536 100
>36 months	327 31.4%	716 68.6%	1,043 100
Total	719 35.6%	1,301 64.4%	*2,020 100%

Chi square= 31, df= 2, p= 0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 84: Subjects on whether they sought health-care services in the last six months by health insurance

Health insurance	Sought care		Total
	Yes	No	
Insured	316 61.8%	195 38.2%	511 100%
Not insured	399 26.6%	1,099 73.4%	1,498 100%
Total	715 35.6%	1,294 64.4%	*2,009 100%

Chi square=205.99, df= 1, p= 0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 85: Admission to hospital in the last six months by health insurance

Insurance	Admission		Total
	Admitted	Not admitted	
Insured	154 30.1%	357 69.9%	511 100%
Not insured	90 6.0%	1,414 94.0%	1,504 100%
Total	244 12.1%	1,771 87.9%	*2,015 100%

Chi square=209, df=1,p= 0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 86: Admission to hospital in the last six months by perception of health status

Health status	Admission		Total
	Admitted	Not admitted	
Very good, Good	215 11.4%	1,678 88.6%	1,893 100%
Fairly good, Bad	28 23.3%	92 76.7%	120 100%
Total	243 12.1%	1,770 87.9%	*2,013 100%

Chi square=15.2, df= 1 , p=0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 87: Availability of health-care service by health insurance

Insurance	Availability		Total
	Highly and moderately available	Mildly, poorly and not available	
Insured	480 96.8%	16 3.2%	496 100%
Not insured	1,297 96.1%	53 3.9%	1,350 100%
Total	1,777 96.3%	69 3.7%	*1,846 100%

Chi square= 0.494, df=1, p=0.482

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 88: Availability of health-care service by length of stay in Jordan

Length of stay	Availability		Total
	Highly and moderately available	Mildly, poorly and not available	
6–18 months	378 96.7%	13 3.3%	391 100%
19–36 months	466 96.5%	17 3.5%	483 100%
>36 months	940 95.9%	40 4.1%	980 100%
Total	1,784 96.2%	70 3.8%	*1,854 100%

Chi square=0.558, df=2, p=0.756

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 89: Availability of health-care service by education

Education	Availability		Total
	Highly and moderately available	Mildly, poorly and not available	
Intermediate school level and less	838 97%	26 3%	864 100%
Secondary school level and more	946 95.5%	45 4.5%	991 100%
Total	1,784 96.2%	71 3.8%	1 855 100%

Chi square=2.94, df= 1, p=0.086

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 90: Availability of health-care service by nationality

Nationality	Availability		Total
	Highly and moderately available	Mildly, poorly and not available	
Egyptians and Iraqis	1,138 96.3%	44 3.7%	1,182 100%
Sri Lankans, Filipinos, Indonesians and other non-Arab Asians	647 96.0%	27 4.0%	674 100%
Total	1,785 96.2%	71 3.8%	*1,856 100%

Chi square=0.094, df= 1, p=0.76

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 91: Health insurance coverage by nationality

Nationality	Insurance		Total
	Insured	Not insured	
Egyptians and Iraqis	129 10.3%	1,120 89.7%	1,249 100%
Sri Lankans, Filipinos, Indonesians and other non-Arab Asians	383 49.5%	390 50.5%	773 100%
Total	512 25.3%	1,510 74.7%	*2,022 100%

Chi square=388.39, df=1, p=0.000

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Table 92: Health insurance coverage by employment

Employment	Insurance		Total
	Not insured	Insured	
Employed	1,417 73.9%	500 26.1%	1,917 100%
Not employed	93 88.6%	12 11.4%	105 100%
Total	1,510 74.7%	512 25.3%	*2,022 100%

Chi square=11.3, df= 1 , p=0.001

Note: * Subjects who had no or missing responses or did not know the answers were not included in this analysis.

Annex 2 : Migrant Interview Questionnaire

RESPONDENT ID: _____

Serial number: _____

Governorate: _____

Date: _____ /_____/_____

Name of interviewer: _____

Signature: _____

Name of supervisor: _____

Signature: _____

Entered by: _____

Note 1: This questionnaire is intended for migrants residing in Jordan for six months and more.

Note 2: Please circle the selected choice or choices for each question.

I. Demographic Information

Q.1 Age in years

1. 18–22	3. 28–32	5. 38–42	7. 48–52	9. 58–62
2. 23–27	4. 33–37	6. 43–47	8. 53–57	10. More than 62

Q.2 Gender

1. Male 2. Female

Q.3 Nationality

1. Egyptian	3. Sri Lankan	5. Indonesian
2. Iraqi	4. Filipino	6. Other non-Arab Asian from Pakistan, Bangladesh, China, India and Nepal

Q.4 Marital Status:

1. Single	3. Divorced	5. Separated
2. Married	4. Widowed	

II. Socioeconomic data

Q.5 Educational Level (Choose one)

1. Illiterate
2. Read and write
3. Primary school
4. Intermediate
5. Secondary
6. Diploma
7. Bachelor's degree
8. More than bachelor's degree

Q.6 Average Monthly Income in JOD (Choose one)

1. Less than JOD 100
2. JOD 100–JOD 149
3. JOD 150–JOD 199
4. JOD 200–JOD 249
5. JOD 250–JOD 299
6. JOD 300–JOD 349
7. JOD 350–JOD 399
8. JOD 400–JOD 449
9. JOD 450–JOD 499
10. JOD 500 and more

Q.7 If you are employed, do you have other employment benefits aside from your regular salary?
(e.g., free housing, meals and health insurance)
1. Yes 2. No

Q.8 Do you own any of the following? (Mark all relevant items)
Vehicle
TV
Computer
Refrigerator

Q.9 Status of occupation (Choose one and indicate the occupation)
Unskilled
Semi-skilled
Skilled
Highly skilled

III. Mobility-related data

Q.10 Length of stay in Jordan (Choose one)

1. 6–12 months
2. >12–18 months
3. >18–24 months
4. >24–30
5. >30–36
6. >36–42 months
7. >42–48 months
8. More than 48 months

Q.11 Prior to entering Jordan, what was your country of residence?

_____

Q.12 If you are a non-Arab respondent, how would you rate your ability to speak or understand Arabic and English languages?

Arabic:
1. Very poor
2. Poor
3. Fairly good
4. Good

English:
1. Very poor
2. Poor
3. Fairly good
4. Good

Q.13 Since your migration to Jordan and during your stay in Jordan, how frequently have you been concerned about the following?
(Choose one for each item)

1. Family-related issues

1. Never 2. Sometimes 3. Often
4. Always 5. Do not know 6. No response

2. Discrimination issues

1. Never 2. Sometimes 3. Often
4. Always 5. Do not know 6. No response

3. Personal safety and security in the surroundings

1. Never 2. Sometimes 3. Often
4. Always 5. Do not know 6. No response

4. Socio-religious issues

1. Never 2. Sometimes 3. Often
4. Always 5. Do not know 6. No response

5. Any other concern (specify): _____

Q.14 Since your arrival and stay in Jordan, how would you characterize your quality of life in general?
(Choose one)

1. Very good
2. Good
3. Fairly good
4. Bad
5. Do not know
6. No responce

Please explain: _____

IV. Living and working conditions

Q.15 Place of residence in Jordan (Choose one)

1. Amman 2. Zarqa 3. Balqa 4. Madaba
5. Irbid 6. Mafraq 7. Jarash 8. Ajloon
9. Aqaba 10. Ma'an 11. Karak 12. Tafilah
13. Moving between many provinces

Q.16 Are you living in a city or a village?

1. City
2. Village
3. Moving between city and village

Q.17 How do you live? (Choose one)

1. Alone 2. With family 3. With friends 4. Alone but sometimes with others
5. No Response

Q.18 If you live with family or friends, with how many people do you share your bedroom?
(Choose one)

1. None
2. person
3. Persons
4. persons
5. More than 3
6. No response

Q.19 Since your arrival at <u>your place of residence in Jordan</u>, how frequently have you experienced the following?
(Choose one for each)

		Never = 0	Sometimes = 1	Often = 2	Always = 3
A	Living and sleeping in overcrowded rooms				
B	Lack of access to basic hygiene provisions such as hand-washing soap and clean water supply				
C	Lack of access to clean toilets				
D	Inadequate water for drinking				
E	Inadequate water for cleaning				
F	Poor quality food or lack of adequate food				
G	Inadequate ventilation or lack of direct sunlight				
H	Lack of clean clothes				

Q.20 Are you currently employed?
1. Yes
2. No
3. No response

If yes, please answer questions from (Q.21–Q.26)

Q.21 In what industry do you work? (Mark all relevant items)
1. Farming
2. Industries
3. Construction
4. House maid
5. Services
6. Business and Trade
7. Student
8. Other (specify) _____

Q.22 What is the main sector of your employment? (One option)
1. Public sector
2. Private sector
3. NGOs
4. International Organization
5. Households
6. Other (specify): .....

Q.23 Where do you perform your work?
(Mark all relevant items)
1. In the house
2. Workshop
3. On the streets
4. In the field
5. Other (specify): ……..

Q.24 Are you satisfied with your work?
(Choose one)
1. Yes, very much
2. Yes, to a certain extent
3. No

Q.25 Is your work characterized by the following?
(Mark all relevant items)

Much (heavy) work:	1. Yes	2. No	3. Do not know
Long working hours*:	1. Yes	2. No	3. Do not know
Low payment:	1. Yes	2. No	3. Do not know
Physical abuse:	1. Yes	2. No	3. Do not know
Constant insulting:	1. Yes	2. No	3. Do not know
Night shifts:	1. Yes	2. No	3. Do not know
Delayed payment:	1. Yes	2. No	3. Do not know

*More than 10 hours a day, more than 5 days a week.

Q.26 In the place where you work, are you often bothered by/exposed to the following?
(Mark all relevant items)

Cold	1. Yes	2. No	3. Do not know
Heat	1. Yes	2. No	3. Do not know
Dust	1. Yes	2. No	3. Do not know
Smells	1. Yes	2. No	3. Do not know
Noise	1. Yes	2. No	3. Do not know
Other (specify): _____	1. Yes	2. No	3. Do not know

Q.27 Have you ever been exposed to illness or injury because of work?

1. Yes 2. No 3. Do not know 4. No response

Q.28 If yes, what was the degree of severity of the illness or injury? (Choose one)

1. Severe 2. Medium severity 3. Mild severity
4. Inconsiderable 5. Do not know

V. Individual Health Concerns: Medical History, Current Medical Complaints, Psychological/Mental Health Complaints, Reproductive Health History (for certain women)

Q.29 Perception of general health status: How would you characterize your general health status?
(Choose one)

1. Very good 2. Good 3. Fairly good 4. Poor
5. Very poor 6. Do not know 7. No response

Q.30 Do you currently suffer from any long-term chronic illness?

1. Yes 2. No 3. Do not know 4. No response

Q.31 If yes, what is the illness?
(Mark all relevant items)

1. Diabetes
2. Cancer
3. Cardiovascular disease
4. Hypertension
5. Illness realted to bone and muscle
6. Respiratory disease
7. Kidney disease
8. Brain stroke
9. Psychological disease
10. Gastrointestinal disease
11. Other (specify) _____

Q.32 Have you had (been exposed to) any accidents in the past six months?

1. Yes 2. No 3. Do not know 4. No response

Q.33 Do you currently suffer from any physical disability?

1. Yes 2. No 3. Do not know 4. No response

Q.34 If yes, how would you characterize your impairment?
(Choose one)

1. No impairment 2. Mild impairment 3. Moderate impairment
4. Serious impairment 5. Do not know 6. No response

Q.35 Have you suffered from any acute illness or injury in the past month preceding this interview?

1. Yes 2. No 3. Do not know 4. No response

(N.B: If there has been more than one illness or accident, choose the latest one.)

Q.36 If yes, was the illness or injury so serious that you had to refrain from leading your usual life?

1.Yes 2. No 3. Do not know 4. No response

Q.37 If yes, who cared for you during your illness?
(Choose one)

1. No one. I took care of myself.
2. Other family member living in the household
3. Other family member not living in the household
4. Neighbour
5. Paid person
6. Friend
7. Other *(specify)* _____
8. Do not know/Do not remember
9. No response

For those who work,

Q. 38 Did you miss one or more days of work because of illness or injury?

Yes
No
Do not know/Do not remember
No response

Q.39 If yes, how many days were you not able to work because of this illness or injury?

(Choose one)

1. 1 day
2. 2 days
3. 3–5 days
4. 6–7 days
5. 8–14 days
6. More than 14 days
7. Do not know/Do not remember
8. No response

Q.40 In the past week, did you suffer from any of the following symptoms?

(Choose one for each)

Nervouseness/Tension	1. Very much	2. To some extent	3. Rarely	4. No
Headache	1. Very much	2. To some extent	3. Rarely	4. No
Sadness/Frustration	1. Very much	2. To some extent	3. Rarely	4. No
Worrying	1. Very much	2. To some extent	3. Rarely	4. No
Fear	1. Very much	2. To some extent	3. Rarely	4. No
No hope in the future	1. Very much	2. To some extent	3. Rarely	4. No
Feeling life is not worth it	1. Very much	2. To some extent	3. Rarely	4. No
Loneliness/Missing family, etc.	1. Very much	2. To some extent	3. Rarely	4. No
Trouble falling or staying asleep or sleeping too much or insomnia	1. Very much	2. To some extent	3. Rarely	4. No
Little interest or pleasure in doing things	1. Very much	2. To some extent	3. Rarely	4. No
Feeling tired or having little energy	1. Very much	2. To some extent	3. Rarely	4. No
Poor appetite or overeating	1. Very much	2. To some extent	3. Rarely	4. No

Q.41 How would you describe your health regarding the following?
(Health on day of the interview; Choose one for 1–5)

A- Mobility:	1. No problem	2. Some problem	
B- Self-care:	1. No problem	2. Some problem	
C-Usual activities:	1. No problem	2. Some problem	
D- Pain/Discomfort:	1. No Pain	2. Moderate Pain	3. Extreme Pain
E- Anxiety:	1. Not anxious	2. Moderate anxiety	3. Extreme anxiety
F- Illness/Problems reported:	(Mark all relevant items)		

Chest pain/discomfort
Chronic cough.
Chronic Sputum
Bronchitis
Asthma
Arthritis
Vision Problems
Hearing problems
Diabetes
Hypertension
Teeth problems
Gastrointestinal Problems
Other (specify) _____

NOTE: The following questions (42–48) are intended for married women in the child-bearing age (15–49 years) who live with their husbands in Jordan.

Q.42 Have you been pregnant during your stay in Jordan?
1. Yes 2. No

Q.43 If yes, did you see anyone for antenatal care during this pregnancy?
1. Yes 2. No

Q.44 If yes, who did you see?
(Choose one)
1. Doctor
2. Nurse/Midwife
3. Traditional birth attendant
4. Other (Specify) _____

Q.45 If you received antenatal care, how many times did you receive it?
(Choose one)
1. Once 2. Twice 3. Three times 4. More than three times

Q.46 If you had been pregnant, where did you give birth?
(Choose one)
1. At home
2. Governmental hospital.
3. Private hospital/clinic
4. Governmental health centre
5. Other (Specify)
6. Do not know/Remember
7. No Response

Q.47 Was the baby given a vaccination card?
1. Yes 2. No 3. Do not know/ Do not remember 4. No response

Q.48 In your opinion, what is the suitable period of spacing between two successive pregnancies?
1. One year
2. Two years
3. Three years
4. More than three years
5. Do not know

VI- Health-seeking behaviours

Q.49 Did you seek any health-care services in the last six months?
1. Yes 2. No

If yes:
Q.50 Which type of service seek?
(Mark all relevant items)
1. General physician
2. Medical specialist
3. Health centre
4. Dentist
5. Hospital
6. Nurse
7. Pharmacy
8. Mental health worker
9. Traditional healer
10. Other (specify)_____
11. Do not know/Do not remember
12. No response

Q.51 Which sector of health service did you go to?
(Mark all relevant items)
1. Public
2. Private
3. International
4. NGOs
5. Other (specify)……

Q.52 How often did you seek health-care service?
(Choose one)
1. Once per week
2. Once per month
3. Once per two months
4. Once per three months
5. Once per six months
6. Do not know
7. No response

Q.53 If you had acute illness or injury in the last one month, did you seek medical consultation and treatment?

1. Yes 2. No 3. Do not know 4. No response

Q.54 If yes, who did you first consult for advice or treatment?

(Choose one)

1. General Physician
2. Specialist Doctor
3. Hospital
4. Nurse
5. Pharmacist
6. Dentist
7. Mental health worker
8. Traditional healer Treatment
9. Other (specify) _____

Q.55 If you did not seek medical consultation or treatment, what was your reason for doing so?

(Mark all relevant items)

1. The condition was not significant.
2. I could not afford the cost of the treatment.
3. I had no time to go for a medical consultation.
4. Health services were not available in my area.
5. I did not know where to go.
6. I did not have anyone to take me.
7. The location of the health service was too far to travel.
8. Language barrier
9. Other (specify)

Q.56 Have you been admitted to the hospital in the last six months?

1. Yes 2. No

Q.57 If yes, what was the primary reason for admission?

(Choose one)

1. Respiratory illness
2. Diarrhoea
3. Other febrile illness
4. Labour/Delivery
5. Skin infection
6. Accident/trauma
7. Chronic condition (diabetes, heart disease, asthma, etc.)
8. Mental health problem
9. Gynaecological problem
10. Violence
11. Routine check-up
12. Other (specify)
13. Do not know/Do not remember
14. No response

Q.58 For common cough, colds, fever, stomach discomfort and diarrhoea, what do you do?
(Mark all relevant items)
1. Consult and ask prescription from a health professional.
2. I ask the pharmacist.
3. I buy over-the-counter medicines/remedies without consulting anyone.
4. I have home remedies.
5. I ask for medicines from other members of my family.
6. I ask for medicines from friends, co-workers, and neighbours.
7. I just hold on, cope with it and let it pass.
8. Other (specify)
9. Do not know/Do not remember
10. No response

Q.59 Did you seek any health-care service in last year outside Jordan?
1. Yes 2. No

Q.60 If yes, why?.....

Q.61 Did you take any medication in the last two months?
1. Yes 2. No 3. Do not know 4. No response

Q.62 If yes, what medication?
(Mark all relevant items)
1. Antibiotics
2. Painkiller/Fever reducer
3. Antihypertensive/Heart medications
4. Antidiabetic
5. Anti-allergy
6. Antidiarrhoeal
7. Anti- nausea and vomiting
8. Vitamins/Tonics
9. Other (specify)
10. Do not know
11. No response

Q.63 If yes, how did you obtain these medications?
(Mark all relevant items)
1. Through a physician's prescription
2. Directly from a private pharmacy
3. From friends
4. From family

Q.64 Was there any treatment that you did not receive because you could not afford it?
1. Yes
2. No
3. Do not know/Do not remember
4. No response

VII. Access to Health Services

Q.65 What are the obstacles that you encounter when you want to obtain information about diseases and general health in Jordan?
(Mark all relevant items)
1. Cost
2. Language
3. Distance
4. Fear of the nurse
5. Fear of the doctor
6. Fear of losing my job if I find out I have a disease
7. Inability to go to the clinic or hospital
8. Other
9. I encounter no obstacles

Q.66 Which sources of health information do you think can most effectively reach people like you?
(Choose the three most effective sources)
1. Newspapers and magazines
2. Radio
3. TV
4. Billboards
5. Brochures, posters and other printed materials
6. Health workers
7. Family, friends, neighbours and colleagues
8. Religious leaders
9. Internet
10. Other (please explain):_____

Q.67 How far is the health service from your place of residence?
(Choose one)
1. Within 5 km
2. 5–10 km
3. >10–15 km
4. >15–20 km
5. More than 20 km

Q.68 What mode of transportation is generally used to go to the health-service centre?
(Mark all relevant items)
1. On foot
2. By private car
3. By taxi
4. By bus
5. By bicycle
6. By riding animals
7. Other (specify)

Q.69 How would you describe the cost of transportation?
(Choose one)
1. Expensive and not affordable
2. Expensive but affordable
3. Fair and affordable
4. Free
5. Do not know
6. No response

Q.70 How would you evaluate the availability of health services to you?
(Choose one)
1. Highly available
2. Moderately available
3. Mildly available
4. Poorly available
5. Not available
6. Do not know
7. No response

Q.71 Do you feel that you are in need of health-care service but cannot use it?
1. Yes 2. No 3. Do not know 4. No response

Q.72 If yes, why?
(Mark all relevant items)
1. I have no health insurance.
2. Hight cost
3. Services are far from my place.
4. I have no time.
5. Language and cultural barriers
6. I do not trust the health service.
7. I was getting better on my own
8. I did not have anyone to take me.
9. I did not have anyone to take care of the children or house while I was gone.
10. I did not know where to go/who to ask.
11. Issues with documentation
12. Other (specify): _____
13. Do not know/Do not remember
14. No response

Q.73 Do you face any discrimination when you visit the health-care services?
(Choose one)
1. Never
2. Sometimes
3. Often
4. Always

Q.74 During your visits to health-care facilities, how would you generally describe your satisfaction with the quality of services provided to you?
(Choose one)
1. Highly satisfied
2. Moderately satisfied
3. Mildly satisfied
4. Poorly satisfied
5. Not satisfied
6. Do not know
7. No response

Q.75 Do you have health insurance coverage?
1. Yes 2. No 3. Do not know 4. No response

Q.76 If yes, what is the main source of your health insurance?
(Choose one)
1. Public 2. Private 3. Other (specify)

Q.77 As a proportion of your income, how much do you spend on health care per month on average?
(Choose one)
1. Less than 10%
2. 10–15%
3. >15–20%
4. >20–25%
5. More than 25%
6. Do not know
7. No response

Q.78 Aside from the topics we discussed, do you have any special concerns or needs that you would like to share?

_____
_____
_____
_____

Thank you very much for participating in this interview.

Annex 3: Information sheet for the study subjects

Hello. My name is _____, and I am working with the International Organization for Migration on a study that aims to better understand health concerns and health-seeking behaviours of migrants such as you who are living in Jordan. With this study, the IOM hopes to obtain information that can be used to improve the health conditions for migrants.

If you agree to participate, you will be asked some questions. The interview will take about one hour only. All responses will be kept confidential. Your name or other identifying information will not be noted down anywhere on the questionnaire. Only the IOM study team will have access to the completed questionnaires. You will not be individually recognized in any of the study reports or other materials that are produced from this project. We ask you to answer our questions honestly and to the best of your ability. No information that you give us today will be shared with anyone else.

If you agree to participate, you can decide not to answer any or all of the questions in the interview. If at any time during the interview you wish to stop, you can do so. If you cannot understand any of the questions, you can ask for clarifications.

Your decision to participate in this study will not in any way affect your status in Jordan or on your living or working conditions.

If, in the future, you have any questions about this study or your participation, you may contact_____ at the International Organization for Migration, Amman, at the following address _____.

Annex 4: Informed consent form

I have been informed and fully understand the purpose for which the information I provide will be collected and used. I voluntarily and freely consent to participate in this interview.

_____
Signature of the interviewee

_____ Date: _____/_____/_____
Name and signature of the interviewer

تقييم الظروف الصحية والمعاشية للوافدين المقيمين في الأردن

2012-2011

المنظمة الدولية للهجرة

بالتعاون مع

وزارة الصحة الأردنية

عمان-الأردن

الملخص التنفيذي

خلفية عامة:

تبنت جمعية الصحة العالمية في قرارها رقم (61 / 17) الصادر في أيار لعام 2008 التركيز على صحة المهاجرين. دعا هذا القرار الدول الأعضاء والوكالات الشريكة وكافة المعنيين الرئيسيين إلى تعزيز السياسات الصحية والممارسات التي تعنى بصحة المهاجرين ، وكذلك تعزيز وصولهم العادل إلى مرافق الرعاية والسلامة الصحية ، هذا وقد وافقت الدول الأعضاء في منظمة الصحة العالمية على اتخاذ الإجراءات اللازمة لتنفيذ التوصيات الواردة في هذا القرار.

يقدَر عدد المهاجرين على المستوى الدولي في عام 2010 بحوالي 214 مليون شخص، وهذا يشكّل حوالي 3.1٪ من مجموع سكان العالم، تشكل النساء حوالي 49٪ من مجموع المهاجرين في جميع أنحاء العالم.

تعتبر صحة المهاجرين مسؤولية مشتركة تتحملها كل من الدول المصدرة للعمالة والدول المستقبلة لها، حيث أن تدفقات هذه الهجرة تعود بالفائدة على كلا المجتمعين.

يعتبر الأردن واحدا من البلدان التي لديها نسبة عالية من المهاجرين. وهي تواجه التحدي المتمثل في تلبية المطالب العديدة لصحتهم ، بما في ذلك المهاجرين الداخليين، والزوار من الدول المجاورة، والسائحين الذين يقومون بتمديد اقاماتهم، واللاجئين على الحدود والمناطق الحضرية بالإضافة إلى العديد من العمالة الوافدة من دول الجوار أو من جنوب شرق آسيا.

يعتبرتقييم الوضع الصحي للمهاجرين من أبرز الخدمات التي تقدمها المنظمة الدولية للهجرة حيث يوفر التقييم الصحي فرصة لتعزيز صحة الوافدين من خلال تقديم التداخلات الوقائية والعلاجية للحالات التي إذا تركت دون علاج، يمكن أن يكون لها أثر سلبي على صحة الوافدين و/ أو على الصحة العامة في البلدان المستضيفة.

أظهر الأردن رغبة واضحة في التعاون مع المنظمة الدولية للهجرة في مجال التصدي لتحديات صحة المهاجرين وحيث أن الطلب على العمالة الأجنبية في تزايد مستمر لمواصلة النمو الاقتصادي والازدهار في المجتمع، وبما أن معظم المهاجرين لديهم قصور في معرفةحقوقهم في الصحة ولا يعرفون إلا القليل عن ظروفهم الصحية، لذا يبدو أن هناك حاجة ملحة لتقييم وضعهم الصحي وفهم احتياجاتهم بهدف إدراجها على سلم أولويات السياسات والاستراتيجيات الصحية الوطنية في الأردن.

أهداف الدراسة:

الهدف العام: توفير قاعدة معلومات حول الاحتياجات الصحية والتحديات التي تؤثر على مجموعات الوافدين المختلفة في الأردن لمساعدة الحكومة الأردنية والجهات المعنية في رسم السياسات و تطوير الاستراتيجيات لإدارة صحة الوافدين.

الأهداف الخاصة:

1. وصف الوضع الصحي للوافدين وأنماط استخدامهم للخدمات الصحية في الأردن.
2. التعرف على مدى توفر الخدمات الصحية وسهولة وصول الوافدين إليها.
3. فهم سلوك الوافدين في السعي لطلب الخدمة الصحية.
4. التعرف على بعض جوانب الظروف المعيشية والتركيبة الاجتماعية للوافدين.

5. تحري وجود أي علاقة بين صحة الوافدين وأنماط سلوكهم في السعي للخدمة الصحية من جهة وخصائصهم الاجتماعية والديموغرافية وكذلك ظروفهم المعيشية وظروف عملهم من جهة أخرى.
6. جمع المعلومات المتعلقة بصحة الوافدين من وجهة نظر المعنيين الرئيسيين في الأردن.
7. جمع معلومات من الادبيات حول الأوضاع الصحية للوافدين وقضايا وصولهم وحصولهم على الرعاية الصحية وتلك المتعلقة بالصحة الوطنية وسياسة الهجرة، والأطر القانونية وقدرة النظام الصحي على تقديم الخدمات الصحية التي تراعي حساسية احتياجات الوافدين.

منهجية الدراسة:

تصميم الدراسة: تم تنفيذ البحث من خلال اتباع أسلوبين:

1. دراسة مقطعية أجريت على عينة ممثلة للسكان الوافدين والمقيمين في الأردن.
2. حلقة نقاشية مركزة بهدف جمع بيانات نوعية محددة من الشركاء المعنيين الممثلين للجهات الحكومية وغير الحكومية ممن لهم علاقة بصحة الوافدين.

منهجية الدراسة المقطعية العرضية:

تألف إطار العينة من الجنسيات الرئيسية للعمالة الوافدة الموجودة في الأردن والذين بلغت مدة إقامتهم في الأردن ستة شهور أو أكثر. شمل هذا الإطار طبقتين رئيسيتين للوافدين هما:

1. الوافدين العرب (المصريين والعراقيين).
2. الوافدين الآسيويين من غير العرب (سيريلانكا، واندونيسيا والفلبين وغيرهم من الباكستان وبنغلاديش والصين والهند ونيبال) .

شكلت هاتين الطبقتين نحو 70٪ من الوافدين في الأردن، علماً أنه تم استثناء الجنسيات الأخرى من الشمول في إطار هذه الدراسة. تجدر الإشارة هنا إلى عدم وجود تمثيل للوافدين غير المسجلين بطريقة شرعية (غير نظاميين) في إطار الدراسة حيث أنهم لا يسعون للتحري عن وجود المرض لديهم في مرافق وزارة الصحة، إلى جانب أنه من الصعب تعقبهم ومعرفة حجم عينتهم واماكن إقامتهم.

وبذلك يمكن القول بإن قطاعات الوافدين التي استبعدت من الظهور في عينة الدراسة هم الوافدين غير المسجلين بطريقة شرعية (غير النظاميين) والأوروبيون، والجنسيات العربية الأخرى من غير الجنسية العراقية والمصرية والقادمين الجدد (الوافدين الذين مضى على إقامتهم في الأردن فترة تقل عن ستة شهور).

تم اختيار أكثر ثلاثة مراكز للأمراض الصدرية تتبع لمديرية صحة الوافدين في وزارة الصحة والتي تعتبر الأكثر ازدحاماً في الأردن لتكون مواقع لسحب عينات الوافدين وإجراء المقابلات معهم عند حضورهم لهذه المراكز من أجل إجراء الفحوصات الطبية لغايت الحصول على إذن الإقامة أو تصريح العمل. كانت هذه المراكز هي: مركز عمان ليمثل إقليم الوسط ، مركز اربد ليمثل إقليم الشمال، ومركز العقبة ليمثل إقليم الجنوب. قامت هذه المراكز الثلاثة المختارة بفحص حوالي 72٪ من الوافدين خلال عام 2010. وقد تم تحديد فترة ستة شهور كوقت مقرر لجمع البيانات من أجل ضمان تمثيل جيد من المستجيبين لمراقبة التغيرات الموسمية في الظروف الصحية للوافدين ورصد تدفق نمط طلبهم للخدمة الصحية.

استخدم اسلوب العينة العشوائية متعددة الطبقات حيث تم اختيار عينتين منفصلتين، لكل منها إطار منفصل، (طبقة العرب وطبقة غير العرب).بلغ حجم العينة المختارة من طبقة العرب 1200 شخصاً، في حين بلغ حجم العينة المختارة من طبقة غير العرب 800 شخص وبذلك فقد وصل حجم العينة الكلية إلى 2000 شخصاً.

تم تقسيم عينة الطبقتين السابقتين إلى طبقات أخرى وفقاً للجنسيات والمناطق الجغرافية (الأقاليم الثلاثة: الوسط والشمال والجنوب).

تم تشكيل خمسة فرق من الباحثين الميدانيين ، تم تدريبهم على آلية تعبئة الاستبانات وإجراء المقابلات تحت إشراف أربعة مشرفين تم أيضاً تدريبهم على ذلك. عمل كل فريق مدة لا تقل عن أربع ساعات يوميا وبمعدل 2-3 أيام في الأسبوع، وبذلك فقد استغرقت عملية جمع البيانات حوالي ستة شهور.

تم إجراء المقابلات مع الوافدين ممن انطبقت عليهم معايير الاختيار أثناء مراجعتهم لمراكز الأمراض الصدرية في كل من عمان وإربد والعقبة وذلك حسب قدومهم إلى المراكز المختارة وظهورهم في العينة. تم تعبئة الاستبانات من قبل الباحث الميداني من خلال إجراء المقابلات الوجاهية مع الوافد/الوافدة بعد الحصول على الموافقة الخطية منه/منها على إجراء المقابلة. هذا وقد تم التحقق من اكتمال تعبئة الاستبانة وخلوها من أية أخطاء أثناء التعبئة من قبل الباحث الميداني الذي كان يجري المقابلة قبل مغادرة المستجيب ومن ثم تم مراجعة وتدقيق الاستبانات من قبل المشرف قبل أن تنتهي المقابلة، هذا وقد أوليت عناية خاصة للأشخاص الذين لديهم حاجز اللغة (لا يتكلمون اللغتين العربية والإنجليزية) أثناء تعبئة الاستبانات وإجراء المقابلات معهم من خلال الإستعانة بمترجمين فوريين عملت المنظمة الدولية للهجرة في الأردن على تأمينهم.

شملت البيانات التي تم جمعها من الوافدين المعلومات الديموغرافية والاقتصادية والاجتماعية وأخرى متعلقة بتنقلهم وأوضاعهم الصحية (التاريخ الطبي؛ الشكاوى الصحية والنفسية الحالية ، تاريخ الصحة الإنجابية ، ظروف السكن والعمل، وسلوكيات السعي لتلقي الخدمة الصحية والوصول لها من حيث توافرها والقدرة على تحمل تكاليفها، وتقبلها. وقد تم جمع هذه البيانات من خلال استبانة تم تصميمها وتعبئتها من خلال إجراء مقابلات وجاهية مع الفئات المستهدفة.

خلال المرحلة التحضيرية للدراسة، تم عقد ورشة عمل لمدة يوم واحد في مدينة عمان بهدف تدريب فرق البحث الميدانية على كيفية إجراء المقابلات وتعبئة الاستبانات وفقاً لدليل عمل ميداني تم تطويره بهدف توحيد آليات طرح الأسئلة وتصنيف الاستجابات بشكل موحد لتجنب اخطاء الانحياز. تم إجراء اختبار تجريبي للاستبانات لمدة ثلاثة أيام عمل في كل من الأقاليم الثلاثة تم من خلاله تعبئة 100 استبانة. تم اتخاذ التدابير الخاصة لمراقبة الجودة ومراعاة الإعتبارات الأخلاقية خلال كافة مراحل إجراء الدراسة.

تم ترميز الاستبانات وإدخال البيانات إلى الكمبيوتر من قبل مدخلي بيانات مدربين على عمليات إدخال وتحليل البيانات، تم استخدام برنامج SPSS الإحصائي لإدخال وتنظيف وتحليل البيانات (الحزمة الإحصائية للعلوم الاجتماعية). كذلك فقد تم إعداد خطة لتحليل البيانات تضمنت تصميم الجداول الصماء والتي كانت عبارة عن جداول التوزيع التكراري (simple frequency tables) وجداول دراسة العلاقات بين المتغيرات.

تم استخدام مربع كاي الإحصائي كطريقة اختبار إحصائي في عملية التحليل.

منهجية الحلقة النقاشية المركزة:

أجريت الحلقة النقاشية المركزة على شكل ورشة عمل لمدة يوم واحد بهدف جمع البيانات النوعية من الأشخاص المعنيين في الدوائر الحكومية المختلفة وغيرهم من أصحاب العلاقة بشؤون صحة الوافدين. شارك حوالي 30 شخصا في هذه الورشة مثلوا الوزارات الحكومية المعنية مثل وزارة الصحةووزارة الداخلية ووزارة العمل

ووزارة الخارجية ومديرية الأمن العام، بالإضافة إلى أصحاب العلاقة الآخرين مثل منظمة الصحة العالمية والمنظمة الدولية للهجرة و بعض سفارات الجنسيات التي تم شمولها في هذه الدراسة وكذلك شركات القطاع الخاص التي توظف عددا كبيرا من الوافدين والوكالات المحلية لاستقدام العاملات في المنازل.

في بداية الاجتماع، وبعد أن تم التأكد من جلوس المشاركين بشكل مريح يضمن سهولة التواصل وتبادل الأفكار والآراء ووجهات النظر، وبعد أن قدم كل شخص نفسه / نفسها والمؤسسة التي يمثلها، قام مدير مديرية صحة الوافدين في وزارة الصحة بتقديم عرض محوسب شارك في إعداده الباحث الرئيسي/ مستشار المنظمة الدولية للهجرة تم من خلاله تزويد المشاركين بلمحة عامة عن خلفية المشروع، وأهداف ومنهجية الدراسة وكذلك الأهداف الخاصة من جرّاء عقد هذه الحلقة النقاشية والطريقة التي سوف يتم اتباعها.

تم عقد جلستي حوار استغرق كل منها مدة ساعتين، بحيث تم تسمية رئيس وثلاثة مقررين لكل جلسة ، كذلك فقد تم تسجيل صوتي للنقاش بهدف الاستفادة من ذلك أثناء عمليتي التحليل والتوثيق.

أبرز القضايا الرئيسية التي أثيرت ونوقشت خلال جلستي العمل:

- الآثار الصحية الناجمة عن حركة الوافدين عبر الحدود الدولية.
- السياسات الوطنية والتشريعات والبرامج التي تؤثر على صحة الوافدين.
- المشاكل الاجتماعية والصحية التي يواجهها االوافدون في الأردن.
- السياسات الحالية الموجودة في وزارتي العمل والداخلية المتعلقة بحقوق الإنسان للوافدين.
- سياسات التأمين الصحي للوافدين.
- تعامل قطاع الرعاية الصحية العام مع الوافدين عند إصابتهم بأي مرض معد وتكلفة ذلك.
- معيقات الوصول إلى خدمات الرعاية الصحية التي قد تواجه الوافدين وطرق التغلب عليها.
- أبرز التحديات (السياسية والتشريعية والمالية) التي تواجه المؤسسات المعنية أثناء التعامل مع الوافدين وخطط التغلب عليها.

قام الباحث الرئيسي بطرح الأسئلة كل على حدة بكلتا اللغتين الانجليزية والعربية، موضحاً الهدف من كل سؤال والمعلومات المطلوبة منه، كما قام بتشجيع المشاركين على النقاش وطرح المقترحات ذات العلاقة بالأسئلة المطروحة ومواضيع الحلقة النقاشية في محاولة للتحفيز والحفاظ على المسار الصحيح للنقاش وخلق جو من التفاعل النشط فيما بينهم، كما كان يقوم بتلخيص الموقف النهائي لجميع الأفكار والمعلومات والتوصيات المطروحة لكل سؤال.

هذا وقد تم توثيق كافة الملاحظات والردود والتعليقات والتوصيات للمشاركين عن طريق التدوين الفوري لها من قبل المقررين وفي الوقت نفسه تسجيلها صوتياً باستخدام أنظمة التسجيل الصوتي ، حيث شمل التدوين الفوري النقاط الرئيسية للنقاش بما في ذلك لغة الجسد والتأييد الصامت، والآراء المتناقضة التي قد لا تظهر في عملية التسجيل الصوتي. وبعد ذلك وخلال اليومين التاليين من الاجتماع ومن أجل تقليل انحياز التذكر تم تحليل البيانات من قبل الباحث الرئيسي والمقررين اعتماداً على الملاحظات المدونة خطياً والمسموعة صوتياً من خلال جهاز التسجيل الصوتي ، وتم استخلاص النتائج والخروج بتوصيات مجموعة حلقة النقاش.

نتائج الدراسة:

أولاً: أهم النتائج المستخلصة من أدبيات البحث

- يسير موضوع الهجرة الدولية بشكل متزايد حيث قدّر عدد المهاجرين عام 2010 بحوالي 214 مليون شخص. وشكل المهاجرون 3.1 % من سكان العالم.
- هنالك نقص في عملية دمج حاجات وحقوق المهاجرين في سياسات وخطط معظم دول العالم.
- تعرض عملية الهجرة المهاجرين نتيجة الظروف التي ترافقها لمختلف المخاطر الصحية.
- تشكل حواجز اللغة والحواجز الثقافية والتنقل المستمر وعدم تعاون أرباب العمل والكلفة العالية للرعاية الصحية أهم المعيقات التي تحول دون وصول المهاجرين لخدمات الرعاية الصحية.
- تعتبر صحة المهاجرين مسوؤلية مشتركة للدول المصدرة والمستقبلة لهم.
- تعتبر التشريعات الحالية والتي تم تصميمها للتعامل مع حركة المهاجرين المنتظمة والشرعية قاصرة على التعامل مع التحديات المستجدة لحركة المهاجرين حول العالم.
- حث قرار جمعية الصحة العالمية رقم 61.17 لعام 2008 دول العالم على تعزيز السياسات الصحية الخاصة بالمهاجرين والنهوض بصحتهم ووقايتهم من الأمراض.
- أوصت مشاورة مدريد الدولية حول صحة المهاجرين التي عقدتها منظمة الصحة العالمية عام 2010 الدول الأعضاء بأربعة أولويات؛ وهي مراقبة صحة المهاجرين وتصميم مصفوفة تشريعات وسياسات وتشجيع الأنظمة الصحية الصديقة للمهاجرين بالإضافة لتقوية الشراكات حول هذا الموضوع.
- بينت الدراسات التي تم تنفيذها في العديد من دول العالم شح المعلومات فيما يتعلق بوضع صحة المهاجرين وحاجاتهم واستخدامهم للخدمات الصحية في الدول المستقبلة. وتبين أن نسبة عالية من المهاجرين لا يستفيدون من الخدمات الصحية المحلية لأسباب مختلفة.
- تم تقدير معدل الهجرة الصافي في الأردن خلال السنوات 2005-2010 بحوالي 8.3% مهاجر لكل 1000 من السكان و شكلت النساء 49% من المهاجرين المتواجدين في الأردن لعام 2010.
- يواجه ألأردن تحديات لتلبية حاجات ومتطلبات الأعداد الكبيرة من المهاجرين الوافدين.
- قدر عدد الأشخاص المولودين خارج الأردن والمقيمين في الأردن لعام 2010 بحوالي 3 مليون وبما نسبته 46% من إجمالي السكان.
- يعتبر الأردن بلدا مستعدا للتشارك في الدروس المستفادة والتعاون حول التخطيط والبرمجة لصحة المهاجرين سواء داخل الأردن أو مع العالم الخارجي.
- بما أن حاجة سوق العمل للعمالة الوافدة تتزايد في الأردن فإن ذلك يتطلب مراعاة الحاجات الصحية لهولاء الوافدين وإدماجها ضمن السياسات الصحية الوطنية القائمة.
- لا تتضمن السياسة الصحية الوطنية الحالية في الأردن إشارات واضحة للحاجات الصحية التي تراعي خصوصية الوافدين.
- يتمتع جميع الأجانب القاطنون على الأرض الأردنية بغض النظر عن شرعية وجودهم بالحصول على خدمات صحية مدعومة جزئيا من قبل الدولة في القطاع الصحي العام ويحصل أطفالهم على المطاعيم ضد الأمراض السارية بالمجان كشأن الأطفال الأردنيين.

- لا تشتمل المسوحات الصحية الوطنية التي تنفذ في الأردن عادة على تجميع بيانات حول الوافدين ولذلك يصعب معرفة الحاجات الصحية الرئيسية لهم.
- أقرت الحكومة الأردنية عقد عمل خاص للعاملات الوافدات اللواتي يعملن في المنازل , يشتمل على تعزيز التنسيق بين الأردن والدول المصدرة لهذه العمالة ويضمن حقوقهن بالتأمين على الحياة والرعاية الصحية وأيام الراحة والتعويض عند إنتهاء العقد ويؤكد على حق النساء في معاملتهن حسب معايير حقوق الإنسان العالمية.
- تقوم وزارة الصحة الأردنية بإجراء فحوصات طبية إلزامية على الوافدين ممن ينوون الإقامة في الأردن لفترة تزيد عن الشهر(مع إستثناء بعض الحالات) للتحري عن أمراض التدرن والأيدز والتهاب الكبد الفيروسي البائي وذلك كمتطلب للحصول على تصريح العمل.
- تم فحص ما مجموعه 1,209,242 وافد خلال السنوات 2007-2010 وتم إكتشاف 804 حالات تدرن و 944 حالة التهاب كبد فيروسي بائي و 195 حالة إيدز بينهم.

ثانيا: نتائج الدراسة المقطعية العرضية

- أشارت الدراسة إلى وجود حاجز اللغة كمعيق للتواصل بين ما يقارب نصف عينة الوافدين من غير العرب.
- شكلت القضايا ذات الصلة بالعائلة السبب الرئيسي للقلق بين أوساط الوافدين في الأردن.
- وصف(97٪) من الوافدين نوعية حياتهم في الأردن بأنها جيدة جدا أو جيدة أو جيدة الى حد ما.
- عاش ما يقارب من نصف الوافدين في ظروف سكن مزدحمة ، حيث تشارك ثلاثة أشخاص أو أكثر في غرفة نوم واحدة.
- شكلت نسبة العاملين الغالبية العظمى من امستجيبين (95٪)، أشار نصف هذه النسبة تقريبا إلى امتلاكهم لفوائد إضافية من العمل إضافة إلى الراتب الشهري. بلغ مستوى الرضا الوظيفي بين فئة العاملين (راضي جدا أو راضي)حوالي 94٪.
- على الرغم من أن قانون العمل الأردني حدد عدد ساعات العمل، والحقوق الخاصة بالإجازات السنوية، واستيفاء الأجور، إلا أن هناك نسبة لا بأس بها من العمال الوافدين يعانون من مثل هذه المشاكل، قد يكون ذلك نتيجة لنقص وعيهم للمعلومات المتعلقة بحقوقهم.
- قيّم غالبية الوافدين (نحو 93٪) حالتهم الصحية بأنها جيدة جدا أو جيدة.
- كان معدل انتشار الأمراض المزمنة بين الوافدين منخفض نسبيا (حوالي 7٪) ، قد يعود ذلك إلى حقيقة أن فئة الشباب شكلت النسبة الاكبرمن المستجيبين.
- أفاد 6٪ فقط من عينة الدراسة تعرضهم لحوادث خلال الأشهر الستة الماضية.
- تمثلت أبرز الإضطرابات النفسية التي شكا منها المستجيبون خلال الأسبوع الذي سبق المقابلة؛ بالوحدة / الغربة وفقدان الأسرة، العصبية / التوتر، الصداع والقلق والحزن / الإحباط.
- تلقت جميع النساء تقريباً (اللاتي حصل معهن الحمل خلال فترة وجودهن في الأردن) رعاية ما قبل الولادة ،حوالي 98٪ منهن تلقين هذه الرعاية من أطباء وحوالي 95٪ أجرين أكثر من ثلاث زيارات أثناء الحمل. تمت ولادة 95.5٪ منهن في المستشفى وأيضاً حصل 95.5٪ منهن على بطاقة تطعيم

لأطفالهن.

• سعى35.6٪ من الوافدين لطلب خدمات الرعاية الصحية خلال ستة الأشهر التي سبقت إجراء المقابلة. وقد كان القطاع الخاص هو الأكثر استخداما بين القطاعات الصحية الأخرى من قبل مجتمع الدراسة.

• سعى 80٪ من الاشخاص الذين شكوا من وجود مرض حاد أو إصابة خلال الشهر الذي سبق إجراء المقابلة إلى طلب الاستشارة الطبية والعلاج. ذكر 84٪ من الذين لم يسعون لتلقي العلاج إلى أن الحالة الصحية لم تكن تستدعي العلاج ، بينما عزى حوالي 5٪ منهم فقط أن السبب هو كلفة العلاج.

• تميز سلوك الوافدين نحو سعيهم للحصول على الخدمة الصحية في حال تعرضهم لظروف صحية معينة بالإيجابية، حيث أشارت الغالبية العظمى إلى توفر الرعاية الصحية على نطاق واسع، في حين أفاد 5٪ فقط من مجتمع الدراسة بأنهم لم يتمكنوا من الحصول على العلاج الطبي بسبب عدم قدرتهم على الدفع .

• أثبتت الدراسة توفر تغطية جغرافية عالية في توزيع خدمات الرعاية الصحية في الأردن، حيث أفادت معظم العينة بأن توفر هذه الخدمات كانت عالية أو متوسطة.

• استطاع غالبية الوافدين استخدام خدمات الرعاية الصحية عند وجود حاجة إليها، .حوالي 10٪ منهم فقط لم يتمكنوا من القيام بذلك. هذا وقد كان الحاجز المالي (التكلفة العالية وعدم وجود تأمين صحي) هو السبب الرئيسي وراء عدم التمكن من الاستفادة من هذه الخدمات.

• لم تواجه الغالبية العظمى من المستجيبين أي نوع من أنواع التمييز خلال زياراتهم لخدمات الرعاية الصحية، هذا وقد أفاد حوالي 90٪ منهم وجود درجة عالية أو متوسطة من مستوى الرضا عن نوعية الخدمات الصحية المقدمة لهم.

• بلغ معدل التغطية بالتأمين الصحي في مجتمع الدراسة نحو 25٪، هذا وقد بلغ هذا المعدل بين الوافدين غير العرب خمس أضعاف المعدل بين الوافدين العرب. كما أثبتت الدراسة أن نسبة التأمين الصحي بين الوافدين العاملين تفوق النسبة بين العاطلين عن العمل ، هذا وقد شكّل القطاع الخاص المصدر الرئيسي للتأمين الصحي (86٪).

• لم يتجاوز معدل الإنفاق الشهري على الصحة لدى المستجيبون 10٪ من مجموع الدخل ، وهذا يعتبر من معدلات الإنفاق المقبولة والمعقولة ولا يصنف من ضمن النفقات الصحية الباهظة (الكارثية)، قد يعود ذلك إلى الإنخفاض النسبي في معدلات المراضة بين هذه الفئة الفتية من الوافدين.

• كان الوضع الصحي أفضل بين الذكور والفئات العمرية الأصغر سناً مقارنة مع الوضع الصحي بين الإناث والفئات العمرية الأكبر سناً.

• أثبتت الدراسة بأنه كلما ارتفعت مستويات التعليم والدخل، كلما كان التعبير عن مستوى الصحة العامة أفضل.

• قيّم الوافدون العرب وضعهم الصحي بشكل أفضل من غير العرب، تماشت هذه النتيجة مع ارتفاع معدلات انتشار الأمراض المزمنة ونسب حدوث الأمراض الحادة أو الإصابات بين الوافدين غير العرب وكذلك ارتفاع معدلات السعي للحصول على الرعاية الصحية خلال الأشهر الستة الأخيرة بين الوافدين غير العرب مقارنة مع العرب.

• تناسبت معدلات السعي للحصول على الرعاية الصحية طردياً مع مدة الإقامة للوافدين وحتى نهاية السنة الثالثة حيث بدأت بالتناقص بعد ذلك.

• أظهر الوافدون المؤمنون صحياً طلباً أكبر وسعياً للحصول على خدمات الرعاية الصحية، وكذلك سجلوا نسبة أعلى في معدلات الدخول إلى المستشفيات مقابل الفئة غير المؤمنة من الوافدين.

• بينت الدراسة أن الوافدين الذين وصفوا وضعهم الصحي بأنه جيد الى حد ما أو سيء، كانوا أكثر عرضة لدخول المستشفيات من أولئك الذين وصفوه بأنه جيدة جدا أو جيد.

ثالثا: نتائج الحلقة النقاشية المركزة:

• وجود عدد كبير نسبيا من الوافدين في الأردن يسبب عبئا كبيراً على الموارد الوطنية المحدودة، بالإضافة إلى تعرض الوافدين أنفسهم إلى عدة أنواع من الاحتياجات الصحية والاجتماعية غير الملباة.

• يجهل العديد من الوافدين آليات وطرق الوصول إلى الخدمات الصحية، بينما يعاني البعض الآخر من وجود حواجز ومعيقات تحول دون سهولة وصولهم إلى مثل هذه الخدمات.

• يتم اكتشاف غالبية الإصابات بين العمال الوافدين في مرحلة متأخرة من المرض، وهذا يمكن ان يؤدي الى انتشار العدوى وحدوث المضاعفات والموت.

• لا تركز السياسة الصحية الحالية في الأردن على احتياجات وخصوصيات صحة الوافدين. ومع ذلك، فإن جميع الأجانب في الأردن، بغض النظر عن وضعهم القانوني، يحق لهم الوصول إلى نظام الرعاية الصحية في القطاع العام وبأسعار مدعومة جزئيا من قبل الحكومة، فضلا عن ان وزارة الصحة تقدم خدمات التطعيم لجميع الأطفال الذين يعيشون على الأراضي الأردنية بما في ذلك الأجانب بشكل مجاني.

• على الرغم من عدم وجود نص تشريعي لغاية الآن بخصوص إلزامية تغطية الوافدين بأي شكل من أشكال التأمين الصحي، إلا أن وزارة العمل تلزم أصحاب الشركات والمصانع على توفير العلاج للأمراض المهنية وإصابات العمل في حال وقوعها.

• أوجب قانون العمل الأردني منذ أيار عام 2011 على كل مؤسسة تحتوي على عامل واحد فاكثر إلزامية المشاركة في برنامج الضمان الاجتماعي، بهدف ضمان تغطية العمالة الوافدة بالتأمين الصحي لعلاج الأمراض والإصابات ذات الصلة بالعمل.

• يعتبر الأردن من الدول التي تحترم حقوق الإنسان ، حيث يوجد منظمة لحقوق الإنسان في الأردن تعمل على رصد الحقوق المختلفة لكافة فئات المجتمع بما فيهم الوافدون.

• تم إنشاء وحدة جديدة لمكافحة الاتجار بالبشر في وزارة العمل بهدف رصد حقوق الوافدين والحفاظ عليها.

• هناك قسم حقوق الإنسان في وزارة الداخلية لتلقي ومتابعة الشكاوى والمشاكل لجميع السكان بما فيهم غير الأردنيين.

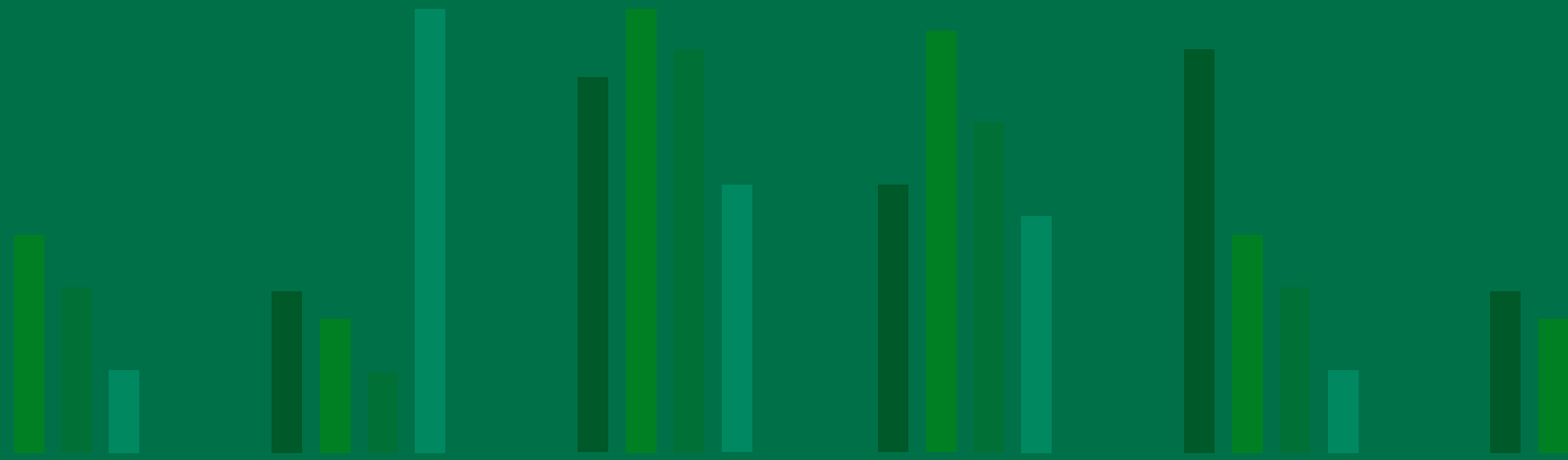
• يلاحظ عدم وجود سفارات أردنية في بعض البلدان المصدرة للعمالة الوافدة، وكذلك عدم وجود مستشارين عماليين في الدول التي يتوافر فيها سفارات.

• لا يتم إجراء فحص الحمل للنساء المتزوجات ضمن الفحوصات الإلزامية التي تجريها وزارة الصحة.

التوصيات:

1. هناك حاجة إلى إيجاد شكل من أشكال التأمين الصحي الإلزامي لجميع الوافدين المقيمين وبكلفة معقولة تناسب مستوى دخلهم ومدة إقامتهم داخل الأردن.
2. قيام المنظمة الدولية للهجرة بالتعاون مع الجهات المعنية بتنفيذ الاستراتيجيات الرامية إلى رفع درجة الوعي لدى الوافدين وأرباب العمل حول أهمية إجراء الفحوصات الطبية الأولية والدورية والسعي للحصول على خدمات الرعاية الصحية عند الحاجة إليها.
3. تفعيل تطبيق قانون العمل الأردني الذي يحمي حقوق العمال، مثل تحديد عدد ساعات العمل، ومقدار الأجر، وحقهم في التواصل مع أهاليهم في بلدانهم الأصلية والحصول على إجازة سنوية، وكذلك العمل على رفع وعي العمالة الوافدة بهذه الحقوق.
4. تعزيز أدوار الوحدات المنشأة حديثا في وزارة العمل بهدف مكافحة الاتجار بالبشر وتوعيه الوافدين بحقوقهم ومساعدتهم في حل مشاكلهم وقضاياهم.
5. إيلاء المزيد من الاهتمام للاضطرابات العقلية والنفسية للعمالة الوافدة من خلال تطوير عيادات للاستشارات النفسية، حيث ركزت حلقة النقاش على الحاجة لإيجاد هذا النوع من الرعاية وخاصة لخادمات المنازل، من أجل التغلب على محاولات الانتحار عندهن.
6. تبني الخطة الاستراتيجية التي اقترحتها وزارة الصحة، فيما يتعلق بالحاجة إلى إجراء ثلاثة فحوصات طبية للعمال الوافدين والتي تشمل:
   - فحص ما قبل الدخول: من خلال اعتماد مراكز صحية معينة في بلد المنشأ ذات مصداقية عالية بعد إجراء زيارات تقييمية لإعتماد هذه المراكز.
   - فحص الدخول: بحيث يجرى في أقرب وقت بعد دخول الوافد إلى الأردن.
   - فحص ما بعد الدخول: والذي يجرى بعد دخول الوافد إلى الأردن لمتابعة وضعه الصحي.
7. ضرورة إبلاغ بلد المنشأ بكافة الإجراءات التي تم اجراؤها عند اتخاذ قرار تسفير الوافد بسبب اكتشاف إصابته بمرض معين، بهدف مواصلة علاجه في وطنه الأم .
8. تعزيز الدور الرقابي للمنظمة الدولية للهجرة (IOM) ووزارة الصحة ووزارة العمل ومكاتب الاستقدام لضمان مصداقية الفحوصات الطبية وآلية إصدار الشهادات الصحية في بلد المنشأ ضمن شروط صارمة وكذلك التعامل بشفافية مع هذه النتائج ، وخاصة بالنسبة لغير العرب القادمين من المناطق الآسيوية والتي ترتفع بينهم معدلات الإصابة بالأمراض المعدية.
9. رفع مستوى الوعي الصحي لدى المواطنين والوافدين على أهمية وصول الوافدين وحصولهم على الخدمات الصحية عند الحاجة إليها، وتطوير الاستراتيجيات للتغلب على الحواجز اللغوية والثقافية التي تحول دون الوصول إلى هذه الخدمات.
10. استحداث السفارات أو القنصليات في الدول المصدرة للعمالة الوافدة والتي تفتقر إلى ذلك، وتوفير مستشارين عماليين فيها بهدف تسهيل آليات التعاون مع هذه الدول.
11. إنشاء مركز معلومات عن العمالة الوافدة في الأردن وربطه إلكترونيا مع الجهات المعنية ليتم تغذيته بالمعلومات بشكل دوري.

12. توقيع اتفاقيات بين الحكومة الأردنية والدول المصدرة للعمالة الوافدة تتضمن إجراء تدريب اجتماعي ومهني وعملي للعمال الوافدين قبل مغادرتهم لبلادهم وإعطاء الأولوية لتوظيف العمال القادرين على التواصل بلغة عالمية من أجل التغلب على حاجز اللغة.
13. توقيع الاتفاقيات الثنائية بين البلدان المرسلة للوافدين والبلدان المستقبلة لها لتنظيم عملية التعاون والتنسيق بين وكلاء ومكاتب توظيف العمالة في كلا البلدين، من أجل ضمان المساءلة فيما يتعلق بحقوق كل من الوافدين وأصحاب العمل في الدول المستقبلة للعمالة.
14. تفعيل الدور الرقابي للحكومة والمتعلق بضمان توفير ظروف معيشية ملائمة للعمال الوافدين.
15. تطبيق استراتيجيات صارمة بهدف الرقابة الصحية على العمال الأجانب، وخصوصا الوافدين غير الشرعيين وأولئك الذين يعملون في مهن وأماكن مشبوهة.
16. .تشكيل لجنة وطنية فنية لصياغة إستراتيجية وطنية لصحة الوافدين.
17. الاستمرار في عقد اجتماعات وحوارات وطنية دورية وبمشاركة كافة الجهات المعنية بهدف حماية صحة الوافدين وحل مشاكلهم التي ستنعكس ايجابا على صحة المجتمع المضيف.
18. إجراء المزيد من الدراسات المعمقة حول بعض المواضيع الهامة للمهاجرين كالتامين الصحي , الظروف الصحية والمعيشية للمهاجرين غير الشرعيين, قياس درجة وعي المهاجرين ومستخدميهم بحقوقهم وتقييم البيئة التشريعية الأردنية فيما يخص المهاجرين.



International Organization for Migration (IOM)