

ARE THERE HEALTH DISPARITIES AMONG JORDANIAN OLDER ADULTS? PROPOSED INTERVENTIONS (PART II)

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Abstract

Several factors including access to health care, and the cost, and quality of that health care are varied among the population of Jordanian citizens, including older adults. Furthermore, there is a paucity of both formal instruments devoted to screening health outcomes relevant to older adults in Jordan, and also desired outcomes following proposed interventions to enhance health outcomes in older adults. Several strategies will be proposed for implementation as guidelines for healthcare providers in this paper. In addition to those strategies, myriad of interventions mentioned in this paper are driven by theoretical or conceptual models, and might eventually contribute to the promotion of healthcare. Finally, such interventions could also be useful in terms of their desired health outcomes at the end of the predetermined interventions targeting older adults in Jordan.

Keywords: Jordanian older adults, health disparities, interventions

Introduction

The Access, Use, Cost, and Quality of Healthcare

Historically, Jordanian older adults, in particular those who have chronic diseases, confront a myriad of health issues vis-à-vis access to and use, cost, and quality of healthcare. In common sense, proposed health strategies are regarded as successful when they are shown to make health coverage expansion, healthcare quality enhancement, and health cost minimization their high priorities.

Healthcare quality is defined as health services that are efficacious, effective, and efficient in terms of the most up-to-date clinical practices, which in turn achieve the clinical needs of patients and the goals of healthcare providers (Mosadeghrad, 2013). Aspects of the quality of health services in the Hashemite Kingdom of Jordan were addressed from the patients' standpoint in a 2012 Abu-Kharmeh study as follows: reliability, availability, assurance, empathy, responsiveness, efficacy, tangibility, and

communication. These terms were defined as the ability to, offer a desired health service, obtain appropriate services when and where patients need, feel safe about services provided, understand and recognize patients' needs promptly, provide health services in a timely manner, be efficient, offer any required physical facilities, and deliver comprehensive information about service to the receivers, respectively. Abu-Kharmeh also revealed that the highest dimensions of healthcare services ranked by participants were responsiveness and assurance, whereas reliability was the last. In the same study, Abu-Kharmeh classified the degree of the quality offered by Jordanian hospitals as moderate (2012). In the context of demographic and geographic distribution variables, significant differences were not found in healthcare services based on social status, but were found based on gender, age, and region. In other words, a male more than 55 years old and living in the south of Jordan might still have a lower quality of health services than a younger female counterpart in the north (Abu-Kharmeh, 2012). Although this provides a significant benefit for female Jordanian older adults living in the north, it also calls into question the quality of healthcare services offered to older adult patients in the southern regions of Jordan.

In regard to healthcare access, as previously mentioned, patients living in the south of Jordan have a lower quality of healthcare services (Abu-Kharmeh, 2012), and confront transportation issues while looking for better quality services in the north of Jordan. Based on the *Jordan Population and Family Health Survey 2007* showed by the Department of Statistics (2008), older adults who live in rural areas tend to have less education. The discrepancies between urban and rural areas are also shown through antenatal care, breast cancer screening, and Pap smear tests, which are most like to be offered to women living in urban areas compared to rural ones (Department of Statistics, 2008).

Although differences in the quality of health services are significant for female Jordanian patients (Abu-Kharmeh, 2012), 62% of Jordanian women face at least one issue vis-à-vis the healthcare access according to the *Population and Family Health Survey 2012* (Nsour, et al., 2013). These issues were listed under several categories as follows: knowing where to go, getting permission to go for treatment, getting money for treatment, distance to health facility, using means of transportation, not wanting to go alone, and no female provider. Many of these issues relate specifically to cultural influences, and play a crucial role in accessing healthcare for Jordanian women. For instance, getting permission to go for treatment, not wanting to go alone, and not having female providers available are all issues that are inherent in Jordanian culture. However, the other issues listed pertain to a lack of knowledge about appropriate health services, financial issues, and geographical and transportation options. Consequently, Jordanian older

adults, in particular women, are being impacted by the cultural norms and considerations as an influential cornerstone in the healthcare access.

Pertaining to healthcare cost, Jordanian older adults with chronic diseases and risk factors such as diabetes and obesity are faced with rising healthcare costs and healthcare professionals who pay little attention to preventive health care (Zindah, Belbeisi, Walke, & Mokdad, 2008). In addition, a tremendous burden has recently emerged from recent political difficulty in Syria, and the subsequent refugee influx that applies continuous pressure on the healthcare resources offered (Ministry of Planning, 2013), particularly in the northern region of Jordan. As reported by the Ministry of Planning in Jordan, the health services and resources such as medications, equipment, and specialists that were considered adequate have been undercut due such refugees' influxes (2013). These challenges, in turn, pushed the Ministry of Health to spend USD 53 million, including USD 20 million for vaccines, in 2013 (Ministry of Planning, 2013).

Generally, health costs are continuously rising, placing financial burdens on individual families (Abu Saif, n.d.), including Jordanian older adults with chronic diseases, who are looking for healthcare services. This situation is exacerbated in Jordanian people classified as low-income, and renders them vulnerable to health issues compared to those classified as high-income (Dinara Seijaparova & van Holst Pellekaan, 2004). In order to mitigate this limited healthcare access and high cost, specifically for the elderly, the Jordanian government and the private sector have partnered to broaden insurance coverage in an attempt to combat health disparities arising from poverty in rural or underserved areas in the Middle East and North Africa (Iqbal, 2006). For example, the Jordanian Ministry of Health (MOH) intends to offer minimum insurance coverage for all Jordanian people having no health insurance and for all Jordanian older adults aged 60 years and older (Abu Saif, n.d.) to confront the vulnerability to disease in later life.

Measurement and Data Collection Issues

It is not surprising that the measurement of health outcomes in older adults has not been addressed specifically within this segment of population in the Hashemite Kingdom of Jordan, and most of studies merely debate health outcomes as a whole in the Jordanian population, which are inadequate to unearth all pertinent health outcomes. The measures offering such outcomes are still derived from the information gleaned in national and governmental surveys, such as Behavioral Risk Factors Surveillance Surveys (BRFSSs) and Demographic and Health Surveys (DHSs). In an attempt to glean information relevant to the population's health variables, a small number of Jordanian BRFSSs and DHSs have been reported at either the level of governorates, such as *Jarash and Ajloun s' BRFSS* conducted by Al-

Nsour in 2012, or the level of the kingdom as a whole, such as *the Jordanian BRFSS 2007* and *Jordan: Population and Family Health Survey (JPFHS) 2012* (DOS, 2013). Therefore, health outcomes regarding older adults have been addressed as only a part of Jordanian population in such surveys. As known, such studies relied on surveys' use of questionnaires as cornerstone instruments. For instance, the JPFHS is comprised of two questionnaires; the Household Questionnaire and the Woman's Questionnaire. These questionnaires were accompanied by in-person interviews (DOS, 2013). According to NCFA, in 2008, there were only one PhD. and 20 Master's theses addressing issues relevant to Jordanian older adults. Thus, few of the studies targeting the health outcomes and behaviors in older adults as separate population segment, have been conducted in Jordan.

In addition, any pertinent information obtained about health behaviors and outcomes in Jordan's population relied on self-reporting and as such, the answers are influenced by personal judgment, subjectivity, and several other confounding variables, including social desirability, cultural norms, and the presence of required facilities. For instance, the participant classifies their physical activities as either vigorous or light physical activity depending on the extent to which their breathing becomes more difficult (Browning, Sims, Kendig, & Teshuva, 2009). In addition, conducting studies relying on self-reporting in older adults could foster potential for inaccurate findings as a result of illiteracy; especially, 50.7% of Jordanian older adults are illiterate (Department of Statistics, 2004 as cited in NCFA, 2008).

In regard to data collection procedures, geographical areas or settings could play a role in how accurate findings are pertaining to Jordanian studies. Jordan is partitioned into twelve governorates, in which surveys could target people in the north, central, and south areas of Jordan who live in either urban, rural, or Badia areas, or in refugee camps (DOS, 2013). Thus, it is important to bear in mind that the nature of participants living such geographical areas is taken into account while generalizing the findings at the level of the kingdom as a whole. In addition some research, such as Mohammad, Kassim, and Yasir s' 2013 study, addressed Jordanian older adults living in nursing homes. However, no other technology-based measures or tools are used to gain information relevant to older adults in Jordan. Statistical analysis is usually done to present findings pertaining to health behaviors based on a logistic regression and adjusted for several demographic and health variables such as age, sex, marital status, education, income, and employment; as was shown in Al-Nsour and colleagues' 2013 study. The participants in such studies could be recruited from outpatient clinics and community primary health centers as in Ammouri's study (2008). Some data related to health outcomes are extrapolated from global and local organizations that aim to compare health data between several

countries. For instance, a 2011 Boutayeb and Helmert study utilized data resources from World Health Organization (WHO), United Nations Development Program (UNDP), United Nations Children’s Fund (UNICEF), and the World Bank.

Pertaining to the instruments created originally in English, such as the Health Related Quality Of Life (HRQOL Short Form-36), have been translated into Arabic and validated in some Arab countries including Jordan. However, several different dialects exist between Arab countries, and could impact the translation process, whereby the some questions or items included in the translated instrument might not be appropriate to the Jordanian population. Based on a review of literature, few studies took linguistic issues such as this into consideration while translating the instrument from its resource language into Arabic (Khalaila, 2013), rendering the translated questionnaires incomprehensible by some Jordanian participants. Therefore, it is crucial to establish the reliability and validity of the translated instrument into Arabic using the trilingual translators’ method, that is, the translators are each familiar with Modern Standard Arabic, regional colloquial Arabic dialects, and the instrument-resource language (Khalaila, 2013).

Strategies for Delivering Culturally Sensitive Services

The strategies devoted to older adults should take into account Jordanian culture, so that healthcare providers can make a concerted effort to prevent miscommunication and culturally incompetent interventions. Jordanian culture dictates respectfulness toward individuals who have attained old age in society; a practice in line with all religions and social traditions pervasive among Jordanian people (NCFA, 2008). One of these strategies set out to target Jordanian elders was *The National Jordanian Strategy For Senior Citizens*, which was issued in 2008 by the National Council for Family Affairs (NCFA). The National Jordanian Strategy for Senior Citizens aims to enhance the quality of daily life for Jordanian senior citizens. This strategy is originally based on Arab and Islamic values, the principles of UN 1991 regarding older adults, regional and international action plans, and the Jordanian referential documents (NCFA, 2008). In order to approach holistic care in terms of older adults, NCFA has explored six directives: the citizens and their development, healthcare for senior citizens, physical environment that supports senior citizens, social welfare for senior citizens, scientific studies and research, and databases, and legislations (2008). Two of these are implicitly linked to culturally sensitive healthcare that professionals need to be aware about while dealing with older adults: healthcare for senior citizens and social welfare for senior citizens directives.

The healthcare of senior citizens has been made a high priority in the aforementioned strategy comprising preventive, curative and rehabilitation healthcare services. This in turn necessitates medical staff training in regard to delivering comprehensive healthcare services for older adults in Jordan (NCFA, 2008). Additionally, the implementation of social care for senior citizens is imperative in order to combat the negative social and psychological consequences arising from changes in social and family structures such as living alone after children leave the house as adults. These consequences entail feeling alone, financially unstable, and insecure (NCFA, 2008). The same strategy urges health decision makers to found social, cultural and recreation clubs as an alternative plan to mitigate the negative consequences which older adults face following staying alone at their homes.

Another aspect of Jordanian culture is that the older adults tend to accept health information without hesitation, and this is especially true of female older adults who often do not like to argue with decisions made by male older adults (Al-Makhamreh, 2005 as cited in Al-Makhamreh, Hasna, & Al-Khateeb, 2011). Therefore, healthcare providers should confirm that the female older adults concur with what has been taught. In addition, health professionals should involve other family members if at all possible in the health teaching process for older adults in order to cultivate their beneficial support and ascertain the sustainability of their interventions. The reasoning behind this strategy include the idea that family is the basic unit of the Jordanian community and that older members in families are appreciated and cared for by other younger members (Al-Makhamreh et al., 2011).

Interventions Project Targeting Jordanian Older Adults

Few issues have been addressed about Jordanian older adults in the context of interventions tailored to their population. As previously mentioned, the NCFA reported that only one PhD. dissertation and 20 Masters theses were conducted until 2008 vis-à-vis older adult issues. Thus, there is an urgent need to create interventions aimed at enhancing the health and life conditions that these older adults live within. Based on Sidani and Braden (2011), the interventions are designated and divided into three main categories: the method relied on theory, the empirical approach, and the experiential approach. In regard to this paper, the proposed interventions will be grounded using some components from a conceptual framework called the *Commission on Social Determinants of Health*. Following this foundational grounding, two intervention components, two intervention variables, and three outcomes variables will be presented throughout the paper.

Commission on Social Determinants of Health (CSDH)

In order to combat healthcare inequity and health disparities between older adults and other age groups, between groups living in urban and rural areas, and between males and females in Jordan, the Commission on Social Determinants of Health (CSDH) framework will address the issue and guide the proposed interventions specifically targeting the latent health disparities in Jordanian older adults. The World Health Organization defines health equity as the absence of preventable differences among categories of people as they are defined based on social, economic, demographic, or geographic characteristics (2014).

It is noteworthy to elaborate on the CSDH framework prior to using some of its components to direct the proposed interventions. The framework of the Commission of Social Determinants of Health (CSDH) purports to assist policy makers in making appropriate decisions (Figure 1). This model has been shown by Solar and Irwin (2007) to actually contribute to narrowing gaps in health equity in developing countries, rather than merely focusing on diseases (CSDH, 2008). This model depicts the reciprocal pathways between diseases and social factors in terms of social and political context that result in unequal socioeconomic classes (Solar & Irwin, 2007). As shown in Figure 1., social position is comprised of several variables, including income, education, occupational status, gender, and ethnicity, and contributes to social inequality (Solar & Irwin, 2007). As a result, the final outcomes of social position and its variables directly yield social determinants of health among individuals, and then social position of those individuals indirectly influences their well-being and general health. This in turn, feeds back to political and socio-economic contexts and social locations (Solar & Irwin, 2007).

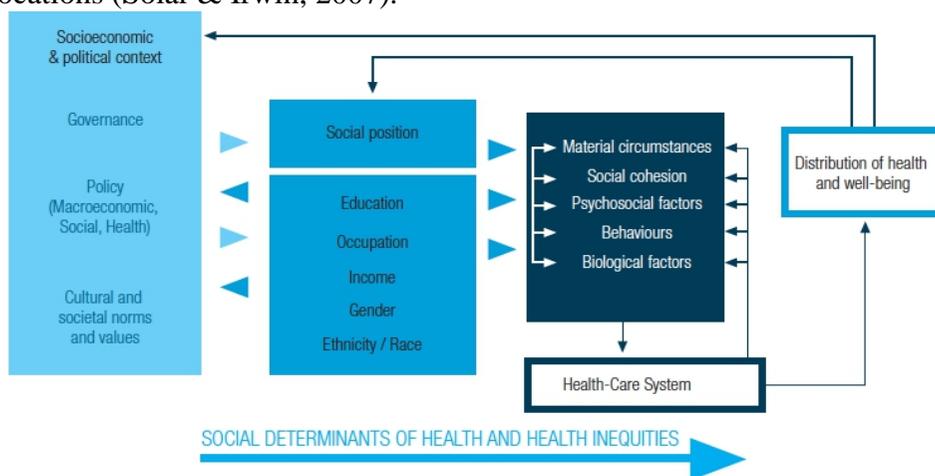


Figure 1. The Social Determinants of Health by Solar and Irwin (2007) as cited in WHO-CSDH 2008.

Despite this proposed conceptual framework that elaborates the role of social context in terms of the prevalence of diseases, challenges have emerged that involve both a paucity of evidence pertaining to gaps shown in health equity and also which types of interventions should be implemented to best close that gap (CSDH, 2008). However, the WHO has endeavored to address health inequity as it pertains to individuals’ early life experiences, their physical and social environment, and their job satisfaction, as well as to whether or not there is a significant relationship between social satisfaction and bias, socio-cultural habits, global and local economics, and governmental strategies to tackle health inequity (CSDH, 2008).

The components of CSDH utilized to tailor the interventions that target health disparities among Jordanian older adults are as follows: socio-economic position such as gender, income, and education, psychosocial and behavioral factors such as social circumstances, the interventions provided by their healthcare system, and finally their health related quality of life, which is an indicator of the distribution of health and well-being (Figure 2). Based on the CSDH framework in figure 1, socio-economic position comprises social and economic factors that facilitate, promote, or impede the health status of people. Also, the underlying social and economic processes determine the variant positions that individuals employ in social context (Solar & Irwin, 2007).

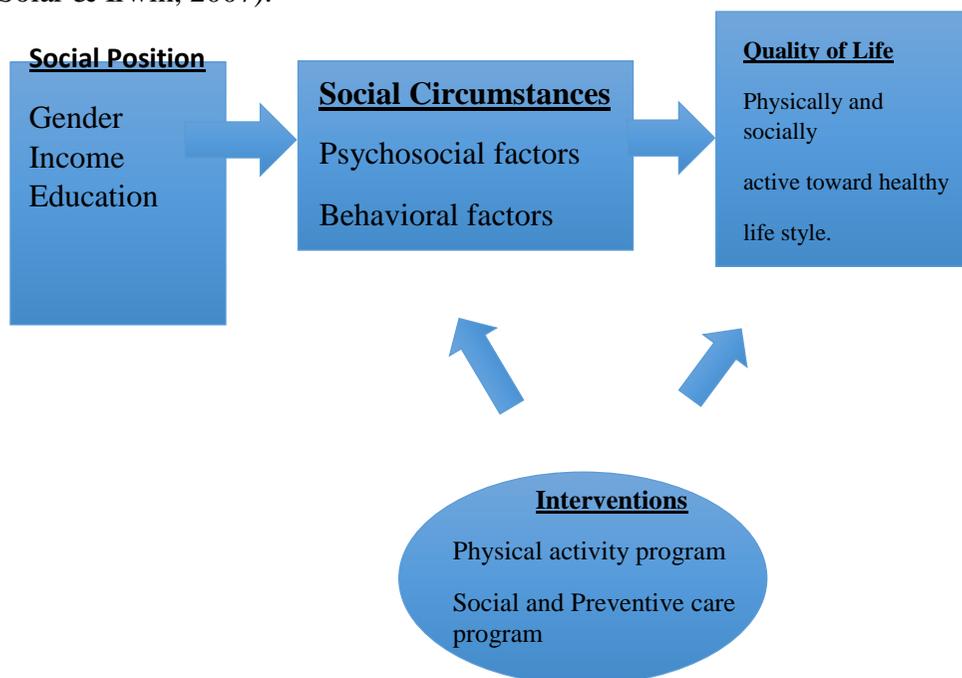


Figure 2. The adopted CSDH model of Jordanian older adults.

Thus, the demographic and health variables of older adults as well as their psychological and behavioral variables play a crucial role in determining their health status and their well-being. The proposed interventions in this paper are used in place of the healthcare system component in the CSDH and the phrase health related quality of life is used in lieu of the term well-being regarding older adults as well (Figure 2).

Intervention Components

Encouraging physical activity

In Jordan, risk factors such as obesity, unhealthy diet, and low physical activity get in the way of desired health outcomes and make people more vulnerable to chronic diseases, impeding the seamless function of healthcare services system over time (Zindah, et al., 2008). As reported in Ammouri 's 2008 study, Jordanian older adults are less likely to partake in physical activity, stress relieving behaviors, and behaviors aiming to ameliorate the health as a whole. In concordance with Jordanian culture, health behaviors could not be explicitly shown as distinct behaviors on a regular basis. For instance, physical exercise is not an essential component of the daily activities of Jordanian people (Gallagher, Gebhard, Nash, Occhipinti, & Walker, 2008). Zindah and colleagues (2008) reported that less than a half of the Jordanian population takes part in physical activity on a continuous basis, which predisposes them to obesity, and thus diabetes.

The strategy of combating diabetes in Jordan implies a holistic approach and recommends eating healthy food, increasing physical activity, controlling hyperglycemia, improving diabetes management, and minimizing the modifiable risk factors of diabetes ("MENA Diabetes Leadership," 2010). The most impactful feature of Jordanian culture in terms of causing poor health outcomes such as high ratio to diabetes is its citizens not taking preventive healthcare into consideration (Kamel Ajlouni, Personal Interview, February 25, 2008 as cited in Gallagher, et al., 2008), thereby predisposing them to several health issues. This point necessitates combined efforts to increase the level of awareness regarding the vital role of preventive healthcare. As a result, the intervention components are directed to encourage physical activity and promote social and preventive healthcare through a positive influence on psychosocial and behavioral factors resulting in a higher quality of life among Jordanian older adults.

Promoting social and preventive healthcare

According to the Solar and Irwin framework (2007), psychosocial factors include life, social, and living condition stressors. Jordanian older adults confront psychosocial conditions and life stressors in later life that are attributed to living alone, particularly when other family members leave to

build their own lives (NCFA, 2008). Thus, this group is most likely to have unequal opportunities to receive healthcare in comparison to other age groups. Such stressors could be triggers for complicated consequences that could result in somatic diseases, and in turn social inequalities in health (Solar & Irwin, 2007).

Behavioral factors can be referred to as either health promoting, which include behaviors such as exercise and eating well, or health harming, which include behaviors such as smoking and obesity (Solar & Irwin, 2007). In Jordan, physical inactivity alongside smoking, obesity, and unhealthy diet have become significant risk factors for non-communicable diseases such as cardiovascular diseases, cancer, and diabetes (Al-Nsour, et al., 2012; Zindah, Belbeisi, Walke, & Mokdad, 2008). As a member of the Jordanian culture, older adults do not take regular exercise or physical activity into account while living their daily life, and consider their past activity level or their current job as adequate exercise for someone their age. This in turn places Jordanian older adults at higher risk for social and health-related inequalities compared to other age groups, particularly those much younger. In light of the aforementioned explanation of psychosocial and behavioral factors in Jordanian older adults, the following intervention components contribute directly to the complicity and mitigation of factors related to a high quality of life. As social influence and subsequently social support increases, they will serve to replace the subjective cultural norms (Courneya, Plotnikoff, Hotz, & Birkett, 2000) that the older-age Jordanian population has toward not engaging in physical activity. NCFA (2008) posts a myriad of vital points enforcing the role of preventive healthcare, including conducting educational sessions about preventive care and healthy living to senior citizens, involving family members in preventive care education activities, and training healthcare professionals to offer preventive services to older adult citizens.

Intervention Variables

Mode of Delivery: the most salient step in changing unhealthy behaviors to healthy ones in older adults is identifying those older adults who have the capability to make decisions under their health and social circumstances. Therefore, they decide what they perceive as important, what they can do based on their health conditions, and what they deem helpful to their health. Therefore, it is necessary to conduct health behavior assessment sessions to recognize the appropriate physical activities that older adults prefer as their conditions permit. In this paper, some of the proposed intervention components of physical activity enhancement are extrapolated from the 2011 Lee and colleagues' study, in which three health assessments and one in-person intervention in six months could be scheduled for

Jordanian older adults. This, in turn, purports to demonstrate value of working together as a team, and encourages participants to get involved in team activities, outdoor exercises, and supervised group-walk periods (Lee, et al., 2011). In regard to social and preventive healthcare promotion, the scheduled sessions will involve social meetings among older adult participants, allowing them the opportunity to talk to each other about their life experiences while performing exercises and walk-group sessions. In addition, the presence of key persons in these social meetings heartens the importance of physical activity and the role of preventive care in promoting their quality of life.

Intervention dose: Relied on 2011 Lee and colleagues' study, there could be six designated intervention sessions in as many months. The first three sessions are separated by a two week timeframe, and the final three sessions are separated by a 4 week timeframe. These sessions entail group physical activity and walk-group periods (15 minutes) to increase the physical activities among Jordanian older adults. Thus, at the end of each session, physical activity spent by each participant will be measured to evaluate the increase in her/his physical activity (Lee, et al., 2011).

Pertaining to social and preventive healthcare promotion, the Jordanian older adult participants attend a workshop at the end of each session discussing the importance of physical activity engagement and the acceptance of preventive care as a part of Jordanian cultural norms. In addition, interventions that are distributed through health education about preventive healthcare and the health benefits of exercise via brochures, poster, flyers, informational meetings, and surveys alongside getting family and peers involved in encouraging older adults to participate in walking sessions will vary according to the characteristics of Jordanian older adults themselves, in which age, educational status, and income predict to what extent an older adult engages in physical activity behavior (Browning et al., 2009).

The ultimate goal: On one hand, this six-month program aims to assist the older adult participants to meet their physical needs. The guidelines of physical activity, which will be used in this program, will be pulled from *2008 Physical Activity Guidelines for Americans*, in the publication *Healthy people 2020*, particularly the *Active Older Adults* chapter. Older adults who have no limitations can follow the same guidelines for adults, focusing on moderate intensive and vigorous aerobic exercises, such as "150 minutes (2 hours and 30 minutes) a week of moderate intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous intensity aerobic". They can also do regular exercises according to their conditions and tolerance (Physical Activity Guidelines for Americans, 2008). On the other hand, the target benchmarks of social and preventive healthcare promotion

are as follows: increasing the level of knowledge about social and preventive healthcare tolerated by older adults as well as their health benefits; changing the attitudes and intentions of older adults about preventive healthcare regardless of the nature of work that they are involved in, and enabling older adults to perceive regular physical activities as worthy of inclusion in their daily life.

Outcome Variables

Physical activity reporting using Jordan's BRFSS:

The utilized instrument in collecting the information about healthy behaviors including physical activity is BRFSS. The measurement of this health behavior could be conducted through the Ministry of Health and Ministry of Social Development planners, healthcare professionals, and faculty members who contribute significantly in evaluating the effectiveness, efficacy, and efficiency of the tailored interventions. The following definition to operationalize vigorous and moderate activity could be followed: vigorous activity was defined as any type of work that causes large increases in breathing or heart rate for at least 10 minutes continuously, while moderate activity was defined as any type of work that causes small increases in breathing or heart rate for at least 10 minutes continuously (Al-Nsour, 2012). As a result of a lack of health literacy tools measuring the comprehensive of the proposed question, using tools relied on self-reporting necessitates additional efforts to coach the participants how to use such instruments.

Social support measuring using older persons' utility scale (OPUS):

The older persons' utility scale (OPUS) reported in a 2006 Ryan, Netten, Skatun, and Smith study could be used to measure the domains that older adults need to meet for help and assistance. OPUS purports to measure social service interventions for older people integrated in defined domains (personal care, social participation, control over daily living, food and nutrition, and safety). Each domain could be operationalized as follows: all needs were met, there were low needs, and there were high needs. The last operational concept entails physical or mental health consequences if those needs are not met for a while (Ryan et al., 2006).

Therefore, Jordanian culture has a high level of social support, which in turn, could play a major role in meeting these needs of older adults and preventing the physical or mental health consequences. Social relations contribute significantly to high life satisfaction and loneliness relieving (McAuley, et al., 2000), and this is linked to exercises performing, leading genuinely to subjective well-being enhancement among older adults (McAuley, et al., 2000) as depicted in adopted model of CSDH (Figure 2).

Quality of Life (QOL) using WHOQOL-BREF:

World Health Organization has defined this concept as individuals' perceptions of their position in the life in terms of the culture and values that they live with and how that associated are with goals, expectations, standards and concerns (1996). The instrument, that could be used to operationalize the QOL among the older adults, is WHOQOL-BREF. This instrument has been translated and culturally validated into several Arabic versions (Al Sayah, Ishaque, Lau, & Johnson, 2013). However, the dialect of each Arab country should be taken into account while selecting a particular version. The negative health perception also play a major role in the well-being among Jordanian people aged 60 years and older as reported in a study conduct in one of the Jordanian governorates, Al-Karak (Youssef, 2005); 44.0% of the participants had a negative health perception associated with arousal of depressive symptoms. Thus, the change of negative perception about the health behaviors among older adults is associated with less psychological consequences, leading to mitigate their health issues and high quality of life.

Conclusion

Several issues have emerged pertaining to health cost, access, and quality of Jordanian older adults. Some of those could be potential causes of health disparities between older adults and other age groups. CSDH, as a conceptual framework, might be the best framework utilized to guide and drive the proposed intervention aiming to eradicate the latent health disparities and enhance the quality of life among older adults in Jordan. Healthcare preventive, social care, and physical activity partaking denote a backbone of the effective interventions in achieving the aforementioned goal of. Eventually, the ultimate outcome of the mentioned interventions is well-being promotion of older adults. Because of close-knit family structures, Jordanian culture has a high level of social support, which in turn, contributes genuinely to assist in setting up successful interventions relied on the social context in Jordan.

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