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Building the Evidence on Forced Displacement

World Bank Consortium: The Big Questions in Forced Displacement and Health

Jordan Country Report June 2022



HEILBRUNN DEPARTMENT OF POPULATION & FAMILY HEALTH



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List of Acronyms

BCG	Bacille Calmette-Guérin
CBR	Crude birth rate
CIP	Civil Insurance Program
COVID-19	Coronavirus disease 2019
CPD	Continuing professional development
DHS	Demographic and Health Surveys
DoS	Department of Statistics
DPT	Diphtheria, Pertussis, and Tetanus
ECC	Exceptional Medical Care Committee
EmONC	Emergency obstetric and newborn care
EU	European Union
Fafo	Fafo Institute for Labour and Social Research
FFS	Fee for service
FGD	Focus group discussion
GCC	Gulf Cooperation Council
GCGF	Global Concessional Financing Facility
GDP	Gross domestic product
GoJ	Government of Jordan
HAKIM	A computerized system to capture the utilization of services by patient
HC	Healthcare
HFA	Health facility assessment
HHC	High Health Council
HIV	Human immunodeficiency virus
HP	Health provider
HR	Human resources
HRH	Human Resources for Health
HSSAG	Health Sector Strategic Advisory Group
IMC	International Medical Corps
IPC	Infection prevention and control
IPMC	Implementing Partners Management Committee
IRC	International Rescue Committee
JHAS	Jordan Health Aid Society
JHCAC	Jordan Health Care Accreditation Council
JLMPS	Jordan Labor Market Panel Survey
JPFH	Jordan Population and Family Health
JRP	Jordan Response Plan
KII	Key informant interview
MDA	Multi-Donor Account
MENA	Middle East and North Africa
MFT	Multifunction team
mhGAP	WHO Mental Health Gap Action Programme
MoF	Ministry of Finance
MoH	Ministry of Health
MOPIC	Ministry of Planning and International Cooperation
MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières/Doctors Without Borders
NCDs	Non-communicable Diseases
NGO	Non-governmental organization
PAPFAM	Pan Arab Project for Family Health

PHA	Private Hospitals Association
PHCC	Primary health care center
PTSD	Post-traumatic stress disorder
RRP6	Sixth Regional Response Plan
TB	Tuberculosis
TFR	Total fertility rate
UHC	Universal health coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
USD	United States Dollars
WHO	World Health Organization

Chapter 1: Background: Understanding the Displaced and Host Population, and the political context of Displacement.

1. INTRODUCTION

Since 1948, the Hashemite Kingdom of Jordan has accepted refugees from multiple neighboring countries in the Middle East and North Africa (MENA) region during conflict. In 2003, the war in Iraq resulted in a large influx of refugees in Jordan, whereby the United Nations High Commissioner for Refugees (UNHCR) along with local grassroots organizations were working towards meeting the needs of the refugees. Additionally, the ongoing civil war in Syria, which began in 2011, forced hundreds of thousands of Syrians to flee their country and seek international protection in neighboring countries. Today, Jordan hosts over 760,000 registered refugees from several countries including but not limited to Iraq and Syria rendering Jordan the country with the second highest refugee population per capita. The large influx of Syrian refugees to Jordan has placed enormous pressure on the country and its host communities.

Though Jordan has been mostly ‘untarnished’ by the violence that swept the region following the Arab Spring in 2010, the resultant regional unrest has impacted its economy [1]. Protests calling for economic reforms in 2018 erupted across Jordan calling for economic reforms that the government attempted to mask with delayed tax hikes, and extra Gulf aid [2]. While Jordan continues to accept refugees, the large influx from Syria placed substantial strain on national resources and infrastructure [2].

Despite seeking refuge in several countries in Europe and North America, most Syrian refugees have sought refuge in neighboring countries, such as Lebanon, Jordan, and Turkey [3]. Thus, several United Nations (UN) agencies work closely with the government of Jordan and several other national and international partners in providing protection and assistance to refugees and asylum seekers, as well as to Jordanian communities affected by the refugee influx.

2. DEMOGRAPHIC PROFILE

The Jordanian population consists of approximately 10,371,040 inhabitants as of 2022 [4]. Ninety-eight percent (98 percent) of Jordanians are Arabs, while the remaining 2 percent are other ethnic minorities. Around 2.9 million are non-citizens, a figure including refugees, and legal and irregular immigrants [5]. Jordan's annual population growth rate stood at 2.05 percent in 2017, with an average of three children per woman.

Over the years, Jordan has been historically known to have hosted several waves of refugees since 1948 which include Palestinian, Iraqi, and more recently Syrian refugees [6]. The Syrian population is more nuanced and complex due to the legal aspect of locating and registering Syrian refugees [7]. Jordan is home to 2,175,491 Palestinian refugees; the majority of which, but not all, were granted Jordanian citizenship [7]. Since 2011, over 1.4 million Syrian refugees have fled to Jordan to escape the violence in Syria, the largest population being in the Zaatari refugee camp [7]. The kingdom has continued to demonstrate hospitality, despite the substantial strain the flux

of Syrian refugees’ places on the country. The effects are largely affecting Jordanian communities, as the vast majority of Syrian refugees do not live in camps [7]. The refugee crisis effects include competition for job opportunities, water resources and other state-provided services, along with the strain on the national infrastructure. Most registered Syrian refugees reside in host communities in Jordan, particularly in urban areas (84 percent of refugees), with only a smaller subset of Syrian nationals residing in three camps (17.3 percent) [7, 8] (Figure 1). As of April 31, 2022, 674,458 Syrian refugees were officially registered with the UNHCR office in Jordan [9] (Table 1 and Figure 2).

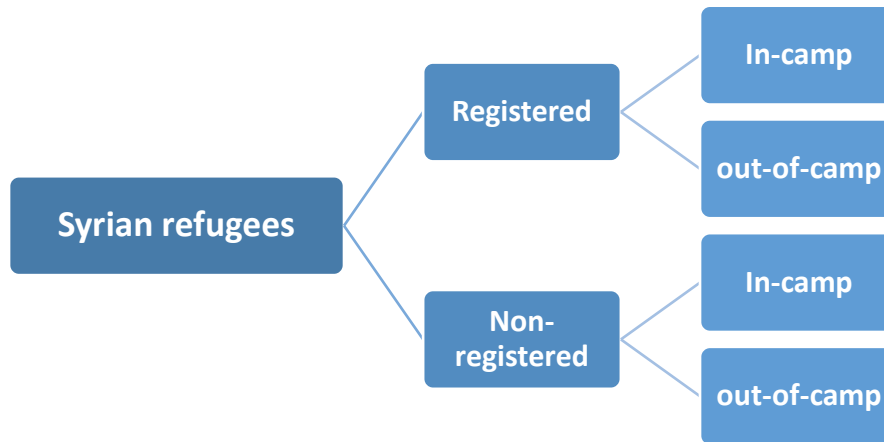


Figure 1. Categories of Syrian refugees in Jordan.

Table 1. Number of registered Syrian refugees by site of residence

Category	Number of Syrian refugees
Refugees from Syria (in-camp)	132,259
Refugees from Syria (out-of-camp)	542,199
Total	674,458

UNHCR 2022 (Last updated 30 Apr 2022)

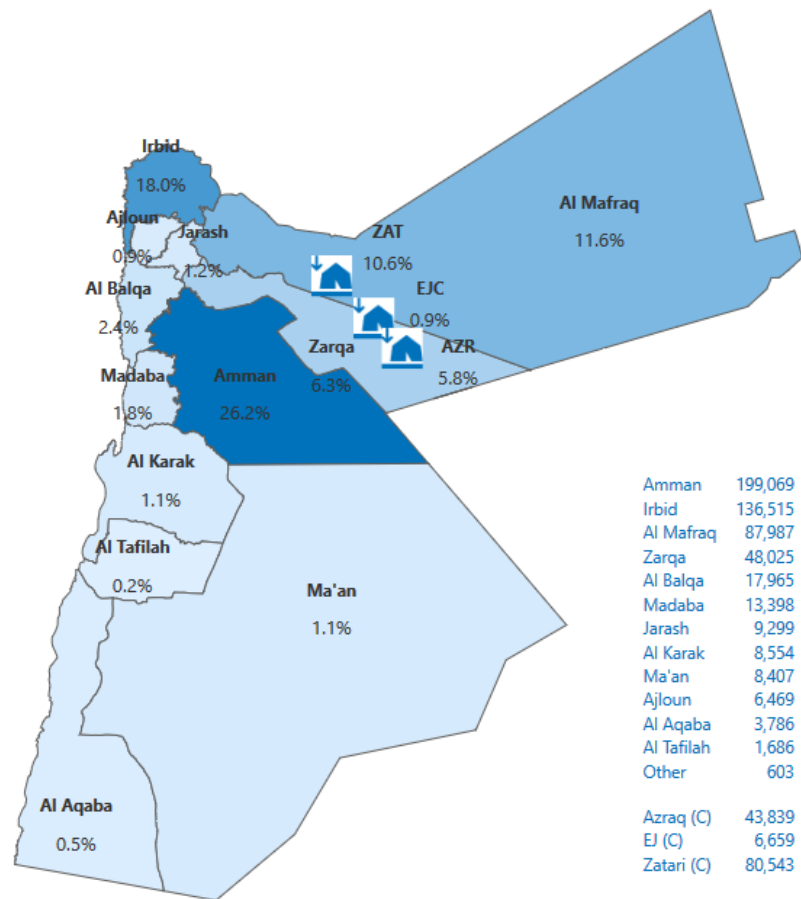


Figure 2. Syrian Refugees in Jordan, UNHCR (2021).

2.1 Host population

According to the 2017-2018 Jordan Population and Family Health Survey (JPFH survey) [10], approximately half (53 percent) of the population in Jordan is aged 24 years or below. The average household size in Jordan was 4.7 members [10]. Syrians in Jordan had a household size of 5.3 persons, which is higher than the overall Jordanian population. The Syrian mean household size remains unchanged compared with the latest Jordanian census carried out in 2015 [11]. Median household size is comparable within camps and out-of-camp, with in-camp slightly lower at 4.9 individuals per household. Jordanian children aged under 18 were more likely to be found living with both parents compared with Syrian counterparts (91.3 percent and 81.2 percent respectively) [12].

2.2 Displaced Population(s)

A separate survey conducted in 2017-2018 by the Department of Statistics (DoS) and Fafo studied the demographics of Syrian refugees in Jordan [11]. Ninety-seven percent (97 percent) of participants were Syrians registered with the UNHCR. Data was collected from 40,950 individuals and 7,653 households. In comparison with the Demographic and Health Surveys (DHS) survey, the Syrian population is much younger than the overall population in Jordan. Forty-eight percent

(48 percent) of Syrians are aged below 15 years of age. The Syrian population in Jordan is also younger than Syrians living in their local country prior to the war. Based on two separate surveys in Syria, 38 percent of the population was aged less than 15 years of age. It is noteworthy that 48 percent of Syrian refugees in Jordan originated from one rural area in Syria, Dara'a. In the Dara'a area, 44 percent of the population was under 15 years of age, based on the latest survey carried out in 2009 [11].

3. POLITICAL CONTEXT

3.1 Legal status of refugees in Jordan

According to a Memorandum of Understanding (MOU) signed in 1998 between the UNHCR and the Government of Jordan (GoJ), asylum seekers can remain in Jordan for six months after recognition, during which time the UNHCR has to find a resettlement country for them [13].

While Jordan is not a signatory to the UN 1951 Geneva Convention on Refugees, Article 21 of the Jordanian Constitution prohibits the extradition of "political refugees" [14]. Law No. 24 of 1973 on Residence and Foreigners' Affairs requires that those entering the country as political asylum seekers present themselves to a police station within forty-eight hours of their arrival. While Article 31 of this Law grants the Minister of the Interior the authority to determine on a case-by-case basis whether persons that entered illegally will be deported, it still fails to outline clear conditions under which individuals will be eligible for asylum [15]. It also does not impose any sanctions against asylum seekers who entered the country illegally [15].

Refugees in Jordan do not automatically acquire rights to residency, employment, public education, or health care. Foreigners cannot live in the country without acquiring a residency permit; such permits in most cases are valid for one year only and subject to renewal [16]. These permits are granted in very limited numbers to refugees. As per the UNHCR, only 30 percent of Iraqi refugees are granted residency permits, and a mere 300,000 Syrian refugees had working permits in Jordan by 2017 [16, 17].

The Jordanian Ministry of Labor additionally published a list of professions and industries in which only Jordanian citizens are allowed to work. These include medical, engineering, administrative, accounting, and clerical professions; telephone and warehouse employment; sales; education; hairdressing; decorating; fuel sales; electrical and mechanical occupations; guards; drivers; and construction workers.

3.2 International Political Will and Interests

Between 2014 and 2015, over one million people crossed into Europe to escape conflict from the MENA region [24]. The sudden influx of incoming refugees and asylum seekers sparked both a humanitarian and political crisis as Europe struggled and continues to struggle to respond. In an interest to keep refugees in host communities in the MENA region, a significant share of the continent's European Union (EU) Regional Trust Fund in Response to the Syrian Crisis has been given to these host communities. The Trust Fund reinforces an integrated EU aid response to the

crisis and primarily addresses longer-term resilience and needs to enhance self-reliance of Syrian refugees and, at the same time, contributes to ease the pressure on host communities and the administrations in neighboring countries such as Iraq, Jordan, Lebanon, and Turkey [25]. Since 2014, the Fund has underpinned the EU Compacts agreed with Jordan and Lebanon to better assist them in the protracted refugee crisis. The Fund mobilized over €400 million for Jordan in 2015 [25].

In 2019, the EU adopted a new €297 million assistance package to support refugees and host communities in Jordan and Lebanon via the EU Regional Trust Fund in Response to the Syrian Crisis [25]. The EU has also decided to extend the mandate of the Trust Fund to allow the Trust Fund's projects to run until the end of 2023 [25].

More recently, as part of the EU's global response to the coronavirus disease 2019 (COVID-19) pandemic, the EU Regional Trust Fund in Response to the Syrian Crisis has mobilized an additional €55 million for refugees from Syria and vulnerable persons in Jordan and Lebanon to fight the pandemic. It will provide critical and targeted support in key areas such as health, water, sanitation, and hygiene. The newly adopted package brings the total assistance mobilized through the EU Trust Fund to over €2.2 billion since 2015, doubling the target originally set [26].

Jordan received €20.1 million in total: (1) €11 million to contribute to the COVID-19 national response plan, in particular for procurement of medical equipment; (2) €4 million to support essential water and sanitation services and hygiene kits in refugee camps and for vulnerable host communities; (3) €3.6 million to strengthen ongoing health and social protection to Palestine Refugees from Syria and host communities; and (4) €1.5 million to support further equipping three emergency departments in hospitals to face the pandemic [26].

4. EPIDEMIOLOGIC PROFILE

4.1 Non-communicable Diseases (NCDs)

An increasing prevalence of Non-communicable Diseases (NCDs) is evident among Syrian refugees, however, data on NCDs among the Syrian population prior to conflict is scarce, making it difficult to assess the shift in prevalence. According to Rehr et al., old age and lower education were most strongly associated with the prevalence of NCDs. Approximately 21.8 percent of Syrian refugees residing in northern Jordan (post conflict) suffer from at least one NCD; hypertension (14 percent) and diabetes (9.2 percent) were the most prevalent NCDs[27]. In comparison, the Syrian population, prior to the conflict, estimates 20.3 percent and 10.1 percent hypertension and diabetes prevalence, respectively. Research studies point to a rise in NCDs amongst the Syrian refugee population in Jordan since 2011, particularly in urban areas [12]. The national-level data for other types of NCDs (such as chronic cardiovascular and respiratory conditions) are scarce.

Table 2. Prevalence of non-communicable diseases among non-camp Syrian refugees in northern Jordan [28].

	Hypertension	Diabetes (type I/II)	Cardiovascular conditions	Chronic respiratory conditions
Prevalence				
Gender				
Male	11.1%	7.7%	5.6%	2.8%
Female	16.4%	10.4%	5.7%	3.5%
Age				
18–39 years	2.2%	1.2%	1.1%	2.3%
40–59 years	24.0%	16.5%	7.9%	4.4%
≥60 years	61.8%	40.1%	28.3%	5.7%
Education				
None	43.5%	28.5%	17.5%	6.0%
Primary	15.8%	10.4%	6.2%	2.7%
Secondary & higher	7.6%	5.0%	3.2%	2.8%
Location of residence				
Rural	13.1%	8.6%	5.8%	3.5%
Urban	14.8%	9.7%	5.6%	3.0%

4.2 Fertility and Birth rate

According to the JPFH 2017-2018 survey, the crude birth rate (CBR) per 1,000 population was calculated based on data collected between 2014-2018 [28]. CBR was slightly higher in the rural population (23.7) when compared against the urban population (21.3), with a total CBR of 21.6 across various geographical areas [28]. There has been a decline in the Total Fertility Rate (TFR) among the Jordanian population in recent years. The TFR currently stands at 2.7 children per woman according to the JPFH 2017-2018 survey, with a fertility peak in the age group 25-29 years old [28]. A noticeable decline has followed a relatively stable TFR (3.5-3.8 children per woman) reported between 2002 and 2012. Syrian women in Jordan are generally younger than the pre-crisis population and have higher fertility rates. According to the United Nations Children's Fund (UNICEF), each month, an average of 2,000 Syrian refugee children are born in Jordan; and many new Syrian mothers and their infants in Jordan lack access to appropriate maternal and newborn health care. By 2017, over half of all under-five deaths in Jordan occur in the neonatal period [29]. Syrian women, on average, have a much higher number of children (4.7) when compared with Jordanian women (2.6) [29]. A decline in TFR nationally in Jordan, as well as a discrepancy in TFR between Syrian and Jordanian women, was also reported in the Jordan Labor Market Panel Surveys (JLMPS) [30].

Syrian refugees showed a higher TFR (4.4) compared with Jordanians (3.3) [30]. The national total TFR in 2016 was 3.4 births per woman [7]. However, it is noteworthy to mention that prior to the conflict in 2011, Syrian national TFR amongst was lower by an average of 1.4 persons (3.3) compared against a TFR of 4.7 persons reported in the JPFH survey [31]. It has been reported by

several sources such as the World Bank and the Pan Arab Project for Family Health (PAPFAM) that TFR was on the decline pre-conflict [32]. The high TFR among Syrian refugees compared with national data on Syrians pre-conflict and Jordanians can be explained by the fact that following the crisis in 2011, around half of the Syrian refugees living outside of camps and 85 percent of those living in Zaatari camp fled from Dar'aa, where the TFR is much higher than the national average [33]. When compared by wealth, TFR was highest in the poorest households and lowest in the wealthier households [34]. When considering education, women with no education (2.1 children per woman) or higher education (2.4 children per woman) have the lowest TFR while women with elementary education had the highest TFR (3.7 children) [34]. In terms of age at marriage, Syrian refugee women were twice as likely to get married before the age of 18 compared to Jordanian women. Ten percent (10 percent) of Jordanians were married before 18 years of age, compared with 20 percent of Syrian refugee women. Marrying before the age of 18 years old is associated with poorer economic and health outcomes due to poor financial circumstances and health issues caused by the crisis [35].

4.3 Child Mortality

Most child mortality metrics examined yielded a similar trend, with under-5 child mortality being higher among Syrian refugees (25 deaths/1,000) compared with Jordanian nationals (16 deaths/1,000) [36]. Infant mortality, defined by the JPFH survey as the probability of death between age 0 and 1 year old, was also higher among Syrian mothers (24 deaths/1,000) compared with Jordanian mothers (14 deaths/1,000) [36]. The perinatal mortality rate is calculated as the number of deaths per 1,000 pregnancies at seven or more months. Syrian women experienced higher perinatal mortality rates (20 deaths/1,000 births) compared with women of Jordanian nationality (13 deaths/1,000 births). Pre-conflict data for perinatal mortality was not available.

Prior to the Syrian crisis in 2011, the under-5 mortality rate in Syria (16.3 deaths/1,000 births) was closer to Jordanian mothers' mortality rates reported in 2018 (16.3) [37]. Antenatal care and skilled birth were both higher prior to the conflict [37]. Qualified maternal delivery was at 96 percent for Syrians pre-conflict [38]. In recent years, likely through humanitarian support, the JPFH survey reported somewhat high-qualified maternal delivery for Syrian refugees, at 94 percent [38]. Maternal mortality data was not available for Syrian refugees.

4.4 Vaccination

Humanitarian emergencies may lead to major and possibly continuous disruption of vaccination services provided through primary health care resulting in a drop in vaccination coverage [39]. Basic vaccination coverage is defined in the JPFH survey as 1 Bacille Calmette-Guérin (BCG) vaccine; 3 Diphtheria, Pertussis, and Tetanus (DPT) vaccines; 3 Polio vaccines; and 1 dose of Measles vaccine [12]. In Jordan, basic vaccination varies by governorate and nationality. Among children aged 12-23 months old, the rate of coverage ranged from 64 percent (Ma'an) to 91 percent (Ajloun) [12]. Compared to Jordanian children, Syrian refugee children had a 12 percent lower coverage rate. This coverage rate however could be higher given the fact that 27 percent of total participants were asked to recall vaccines undertaken without reviewing vaccine cards.

To address low vaccination coverage rates, UNICEF, the Ministry of Health (MoH) in Jordan, and UNHCR are currently rolling out an intervention to assess whether a smartphone app may increase coverage rates [41]. Results have yet to be shared. To date, no major infectious disease epidemics have occurred in Jordan, but outbreaks have appeared and risks are increasing [42].

4.5 Mental Health

According to the World Health Organization (WHO), only an estimated 305 individuals per 100,000 inhabitants are diagnosed with mental illness [43], which stipulates an existing diagnostic and treatment gap. As a consequence, rates of psychological distress (39 percent) and prevalence of mental disorders (26.3 percent) are considered high ranking in Jordan [44]. Estimates of the prevalence and burden of mental disorders in Jordan are limited. The majority of existing information focuses on adolescents, for whom symptoms of anxiety, depression, conduct problems, and hyperactivity are common [45]. A nationally representative survey of adolescents in schools reported that 41 percent of females and 26 percent of males reported moderate to severe depressive symptoms [46]. Most mental health care in Jordan is provided through hospital-based services. In 2010, the WHO trained primary care providers in mental health care, adapted intervention and training guidelines to the Jordanian context, and promoted implementation of community-based services for mental health as part of the Mental Health Gap Action Program (mhGAP) [47]. Despite these efforts, stigma remains high among health care providers as well as patients with mental disorders, limiting the provision and seeking of mental health services [47]. Jordanian adults in Amman who have received psychotherapy services report high rates of satisfaction despite high levels of self-stigma [48].

Refugees are especially vulnerable to mental illnesses being exposed to many distressing and potentially traumatic events such as war, sexual violence, dangers faced while fleeing their homeland, and risks associated with being confined in camps or detention centers. It comes as no surprise that refugees have been shown to experience elevated rates of mental health problems, including depression, anxiety, suicide risk, and post-traumatic stress disorder (PTSD) [49]. There is a sizeable variation in reported prevalence estimates of mental disorder and symptoms among conflict-affected Syrians (both in Syria and surrounding countries) [49]. Common symptoms of distress related to depression, prolonged grief, post-traumatic stress disorder, and anxiety [50]. However, psychiatric diagnostic terminology (e.g., depression, anxiety) may not be culturally relevant in Syrian culture and stigma may preclude individuals from identifying their symptoms as mental health problems. In clinical settings, distressed Syrians often use indirect expressions when asked about their current wellbeing. Dignity is a salient concept related to Syrian identity that affects emotional reactions, coping strategies, feelings of shame, and interpersonal relationships [51].

5. OBJECTIVES OF THE STUDY

The main objectives of the study are to understand how the health system responded to the immediate and longer-term needs of displaced populations and host communities and how the healthcare utilization, healthcare costs and healthcare spending vary between host and displaced

populations. In addition, the study aims to explore how the health financing system responded to the needs of displaced populations and what could be done to improve it.

Chapter 2: How the Health System has adapted over time to meet the needs of the displaced population, and how this compares to host population experiences of the health system.

1. BACKGROUND

1.1 National health system

1.1.1 Structure and components of the national health system

The Jordanian healthcare system consists of four major entities: public sector, private sector, international and charity sector, and councils and institutions.

Healthcare system structure in Jordan			
Private sector	Public sector	International and charity sector	Councils and Institutions
Includes private hospitals, diagnostic and therapeutic centers, and hundreds of private clinics	Includes ministry of Health, Royal Medical Services, university hospitals and the Center for diabetes endocrinology and genetics	Services provided through UNRWA clinics. This includes but is not limited to services for Palestinian refugees and Syrian refugees only of Palestinian origin	Responsible for development of health policies, mainly through the Higher Health Council.

Figure 3. Major contributors to the healthcare system Jordan [52].

1.2. National health coverage

The World Bank continues to support countries around the world, including Jordan, towards achieving universal health coverage (UHC) [53, 54]. According to the latest census carried out by the department of Statistics in 2015, only 68 percent of Jordanian nationals and 55 percent of the overall population are insured [55]. Insurance coverage also varies by region: 86.6 percent of the Jordanian population in rural areas is health insured compared to 66.3 percent of the Jordanian population in urban areas [56]. The government sector covers 71 percent of the health insurance burden, the private sector contributes 14 percent while the United Nations Relief and Works Agency (UNRWA) and other sectors contribute 4.2 percent and 10 percent respectively [56]. For Jordanian society, the ministry of Health Insurance is the most prevalent insurance (by about 42 percent), while for the non-Jordanian population 38 percent is health insured under special arrangements for Syrian refugees in terms of their health insurance under special

arrangements between the UNHCR and the Ministry of the Interior [56]. The population in Amman, the largest urban city in Jordan, was reported to have a relatively low insurance coverage rate (6 out of 10 covered) compared with other governorates such as Tafileh and Karak (9 out of 10 covered) [55].

Since the first influx of Syrian refugees to Jordan in 2011 Syrians who chose to live in host communities have been subject to changing health policies over the years. These policies directly relate to access and fees. The MoH took most of the burden with 132,432 primary level services provided to Syrians in public health centers in 2013. MoH data indicates that the number of outpatient visits to MoH primary health care centers (PHCCs) by Syrian refugees increased from 68 in January 2012 to 15,975 in March 2013. Similarly, and during the same period, Syrian refugees attending MoH hospitals increased from 300 to 10,330 to 20,804 patients. Altogether, the number of Syrians refugee served increased from 10,217 (February 2013) to 43,491 by February 2014 [57].

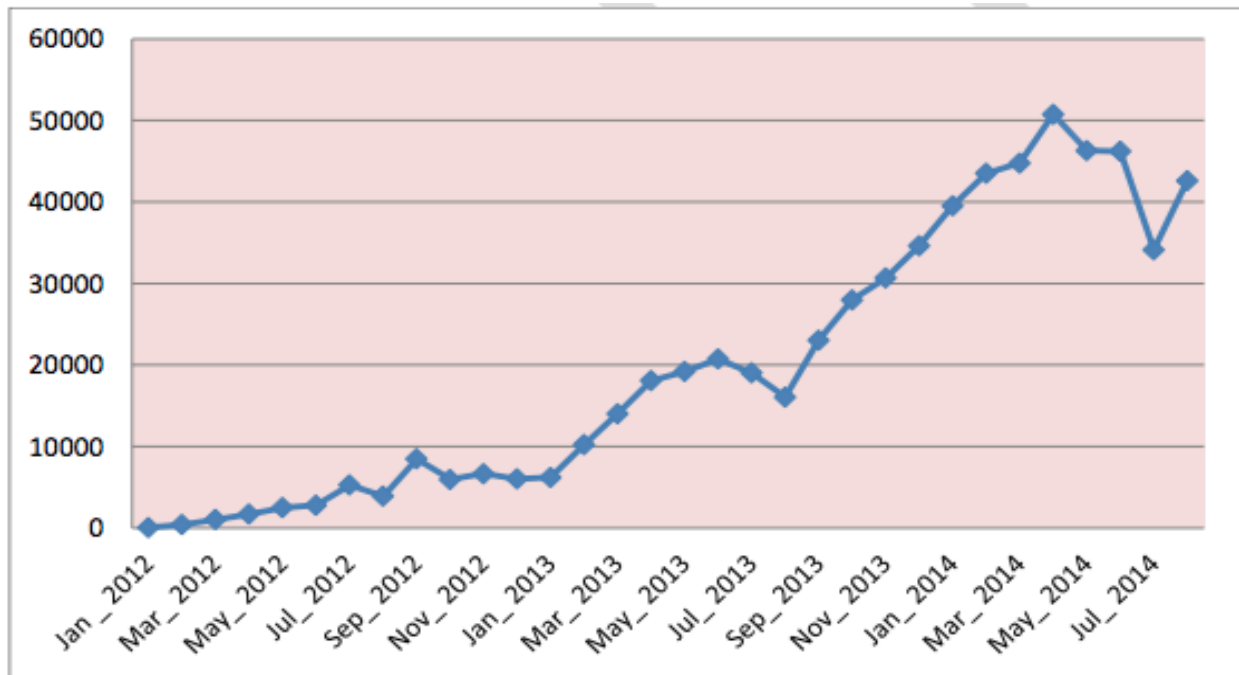


Figure 4. The evolution of the number of Syrian refugees who were served by MoH health centers during the period January 2012 and August 2013 (Extracted from HHC strategy 2015-2019) [52].

1.3. Healthcare services

Primary care centers in Jordan are managed by the MoH and aim to provide preventative and generalized services to the population [52]. These include services such as reproductive health, patient education, and mental health services [52].

The MoH's National Center also nationally leads mental health inpatient and outpatient services for mental health. Due to the social stigma associated with discussing mental health, services are

scarcer because of the low demand in addition to the low attractiveness of the job [58]. For these reasons, primary health care services are much more accessible than mental health care [59].

Secondary and tertiary care are services targeted for patients with specialized needs. These are less common and require higher expertise – the private and public sector provide these services. According to the 2015-2019 National Strategy for Health Sector in Jordan, the private sector has 3,998 hospital beds (33 percent of the beds in Jordan). Specialized care is financially more difficult to access for Syrian refugees in comparison to primary care [52].

Maternal, antenatal, and newborn care services are a priority in developing countries, as the quality of such services is associated with preventable deaths [60]. Maternal services are provided by the MoH, as well as through private clinics [61]. In Jordan, delivery and preventive maternal and child services are provided free of charge to all Syrian refugees and cover vaccination, , and antenatal and postnatal care [62]. Based on qualitative interviews, Syrian women expressed dissatisfaction with the quality of care in the public health sector [60]. Despite free access to maternal care in public health centers, Syrian women may still choose to seek care through private clinics. Women with higher education (84 percent) are much more likely to seek antenatal care, compared to women with lower education (55 percent) [60].

1.4. Home healthcare services

There is an emerging increase in demand for home care services in Jordan. Such services range from preventative measures such as nutrition to chronic disease management. The private and public sectors provide home care services [63]. Several home health care entities are currently licensed by the MoH across Jordan. Home visits by the MoH for chronic care were marked as a strength as part of WHO's health system assessment [64]. In a recent qualitative study focused on Syrian refugees, home services were particularly sought out by elders in the context of physical disabilities [65].

1.5. Health Policy timeline

Changes in health policies in Jordan are mostly relevant for Syrian refugees living outside of camps. Within the Azraq and Zaatari camps, UNHCR provides Syrian refugees with free services covering primary, secondary, and tertiary health care services [66]. Since 2012, three major health policy changes have affected refugees' access to health services in Jordan, particularly those living in host communities in urban areas:

1.5.1 First major health policy changes in 2014

During the early influx of Syrian refugees to Jordan in 2012, most Syrians were settled in the Zaatari camp and were registered with UNHCR [67]. In the year 2014, the MoH announced major policy changes relevant to refugees, and the regulations became more firm. For example, refugees were not allowed to leave their camps anymore to live in urban areas, except under unique circumstances [67]. Access to healthcare services was also affected. Prior to 2014, refugees registered with the UNHCR residing in host communities (outside of camps) could gain access to public health services similarly to insured Jordanians. After 2014, Syrian refugees in

host communities registered with UNHCR were faced with service fee rates equivalent to those of uninsured Jordanians [68].

1.5.2 Second major health policy change in 2018

In March 2018, the UNHCR announced the “regularization” or “amnesty” of Syrian refugees living in host communities without documentation between March and September 2018. This regularization targeted Syrian refugees who left the camp without legal authorization after the 2014 policy change, as well as those not registered with UNHCR [67]. This specific population is estimated to encompass 30,000 to 50,000 Syrian refugees. By the end of March 2018, 22,000 Syrians signed up as part of the “regularization” process [67]. As a result, these so-called “regularized” Syrian refugees were promised protection from arrest, as well as greater access to jobs and educational services. However, no benefits were offered for access to healthcare services [67]. As of February 2018, regulatory changes imposed that Syrian refugees revoke their access to non-insured Jordanian rates for healthcare services. Instead, they would pay 80 percent of the foreigner rates, thereby placing a financial burden on Syrian refugees living in urban areas [67, 69]. Exceptions to this policy included vaccinations, treatment for communicable diseases, prenatal and postnatal maternal care, and family planning [67].

1.5.3 Health policy amendments made in 2019

In April 2019, the government retracted the 2018 health policy changes [66]. Syrian refugees were provided access to MoH primary centers and public hospitals at uninsured Jordanian rates. Refugees were also exempted from fees associated with maternal and child services affiliated with the MoH [66]. However, this is only the case for refugees who present a valid UNHCR registration and Ministry of Interior service card with the same residence as the health facility approached [70]. Once registration expires, or if refugees are not registered at any point, they can continue to stay in Jordan, but they are required to pay the foreigner’s fee in governmental facilities, except for vaccination [70]. Drastic and swift shifts in policies towards the Syrian refugees in Jordan did generate mass confusion among the population in regards to their rights, access to healthcare services as well as livelihoods [71]. This has compromised UNHCR’s efforts to increase service utilization. According to the UNHCR 2015 report, only 64 percent of households knew that refugees have subsidized access to government PHCCs [71]. In contrast, 96 percent of households knew that refugees had access to free health care in 2014 [71].

2. RESEARCH QUESTION

How has the health system responded to the immediate and longer-term needs of displaced populations and host communities?

3. OBJECTIVES

The objective of this chapter is to assess how the health systems in Jordan responded and adapted to meet the needs of the displaced population. The chapter also aims to compare health

system experience between displaced population and host population, such as healthcare utilization, costs, service provision, and challenges to accessing healthcare.

4. METHODS

4.1 Key informant interviews (KIIs)

Semi-structured in-depth interviews were conducted at health facilities or online (via Zoom). To capture a range of perspectives, interviews were conducted with a) Government officials (including the MoH [planning department and health insurance entities] and the Ministry of Finance); b) Donors, including the World Bank; c) Multilateral and intergovernmental organizations, including UN agencies (WHO, UNHCR and UNICEF); d) International, national, and local non-governmental organization (NGOs); and e) Civil society organizations and community leaders.

The selection of individuals was based on a literature review and expert suggestions. Eighteen (18) key informants were interviewed focusing on the health needs and disease profiles of displaced and host populations, and how they have changed over time. It also included questions on epidemiological, economic, demographic, and monitoring data. In addition, the questions sought to understand the extent to which data are used to measure priorities in the health sector, public policy planning and implementation, and the organization and governance of the health system, with particular attention to human resources. They also sought nuanced information on vulnerable populations and those with unmet health needs, as well as the use of informal health care systems.

Interviews were conducted by an experienced interviewer and a note-taker. They were then transcribed and translated by a certified translator. Two members from the research team were involved in coding the data independently and any disagreements were discussed among them and with a third member to reach consensus. The thematic data analysis was conducted using software for qualitative data analysis (Dedoose).

4.2 Focus Group Discussions (FGDs)

Focus Group Discussions (FGDs) were conducted in health facilities and at designated places at camps in three regions (Amman, Irbid, and Mafraq). Twelve (12) FGDs were conducted with adults aged 18–65 years old, divided as follows: 1) Men from host communities; 2) women from host communities; 3) non-camp and camp Syrian refugee men; and 4) non-camp and camp Syrian refugee women. Each FGD included 8 refugees/members of the host communities. The FGDs were conducted by an experienced interviewer and a note-taker. They were then transcribed and translated by a certified translator. Two members from the research team were involved in coding the data independently and any disagreements were discussed among them and with a third member to reach consensus and thematic data analysis was conducted using software for qualitative data analysis (Dedoose). The main themes generated from the analysis of the FGDs are summarized in the table below:

Table 3. Main themes and subthemes identified from the FGDs thematic analysis.

Themes	Sub-themes
1. Financial barriers for seeking healthcare	<ul style="list-style-type: none"> - COVID-19 - Health services costs (provider fees, testing, and medications) - Legal work status - Transportation costs
2. Main challenges and barriers to accessing healthcare	<ul style="list-style-type: none"> - Financial: cost (direct and indirect) - Logistics - Long waiting time - Social: stigma, discrimination
3. Community perceptions about the services provided	<ul style="list-style-type: none"> - Healthcare workers attitude - Quality of care
4. Most important health needs and problems faced by the community	<ul style="list-style-type: none"> - Mental health problems - NCDs - Women
5. Difference in health services fees between Syrian refugees and Jordanian nationals	

4.3 Health Facility Assessment (HFA) tool

A health facility assessment was conducted in 22 health facilities in Amman, Irbid, and Mafraq to examine health systems readiness and service availability. The three aforementioned governorates were chosen since they host the highest refugee population living in host communities: Amman (26 percent), Irbid (18 percent), and Al Mafraq (12 percent) [72]. Data entry was performed by two team members to ensure accuracy, followed by data cleaning and data coding. The data was analyzed using the SPSS statistical software (descriptive and cross-tabulation).

The data were analyzed based on the WHO service availability and readiness assessment: a methodology for measuring health systems strengthening with the aim of generating a set of core indicators on key inputs and outputs of the health system, which can be used to measure progress in health system strengthening over time.

There are three focus areas of service availability and readiness assessment:

- I. **Service availability** refers to the physical presence of the delivery of services and encompasses health infrastructure, core health personnel, and aspects of service utilization.
- II. **General service readiness** refers to the overall capacity of health facilities to provide general health services. Readiness is defined as the availability of components

- required to provide services, such as basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines.
- III. **Service-specific readiness** refers to the ability of health facilities to offer a specific service, and the capacity to provide that service measured through consideration of tracer items that include trained staff, guidelines, equipment, diagnostic capacity, and medicines and commodities.

The HFA tool focused on the following services: psychosocial and mental health readiness, immunization service readiness, measles, diagnosis and treatment services readiness, tuberculosis service availability, emergency obstetric and newborn care (EmONC), and obstetric services and family planning services.

4.4. Health Provider (HP) tool

A health providers' questionnaire was conducted with 200 providers from the selected 22 facilities to provide data to assess the training and capacity of health providers and support the assessment of readiness and service quality indicators. Data entry was performed by two team members to ensure accuracy, followed by data cleaning and data coding. The data were analyzed using SPSS (descriptive and cross-tabulation).

5. RESULTS

5.1 Availability of services and capacity of the Health Facilities

The Health Facility Assessment tool was used to collect data from a total sample of 22 health facilities distributed across 3 different governorates (Mafraq, Amman, and Zarqa) in Jordan (Figure 5). This assessment determined the availability and quality of different health services at the selected facilities, such as NCD services, mental health services, Tuberculosis and Measles services, family planning services, and EmONC service in addition to assessing the availability of equipment and medications and the facility infrastructure. The assessment determined the availability, and quality of health services at supported facilities, with the purpose of understanding the health system response to the immediate and longer-term needs of displaced populations and host communities.

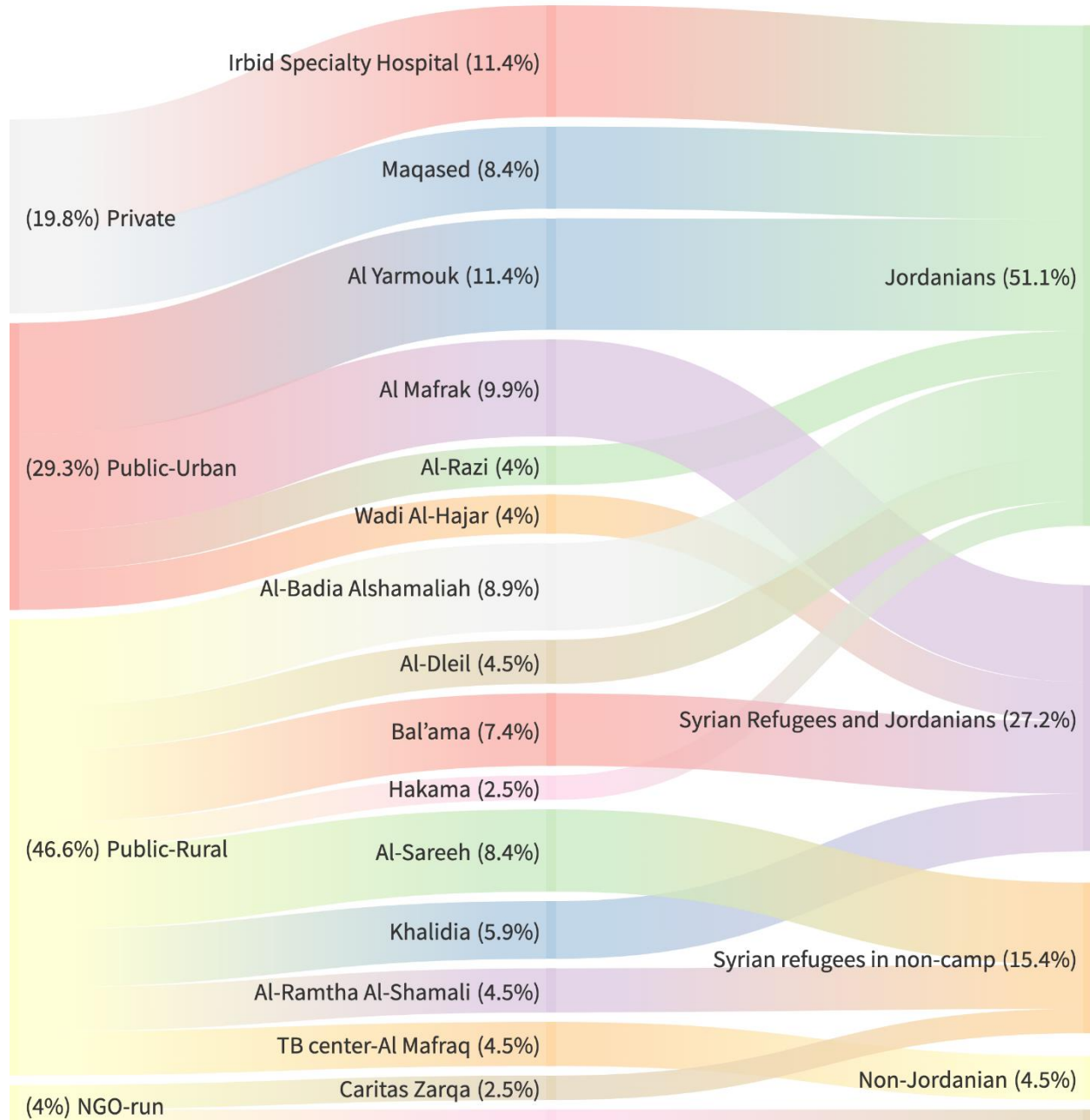


Figure 5. Selected health care facilities. n=22

The health facilities visited were comprehensive centers (36 percent), primary centers (27 percent), peripheral hospitals (9 percent), central hospitals (5 percent), and maternal and child health centers (5 percent) (Figure 6). Most of the health facilities were governmental (59 percent) or run by intentional NGOs (27 percent) (Figure 7). Half of the visited facilities served mainly Jordanian nationals and some Syrian refugees, 18 percent of the facilities served either all Syrian

refugees or about half Jordanian nationals half Syrian refugees and only 14 percent served mainly Syrian refugees with some Jordanian nationals (Figure 8).

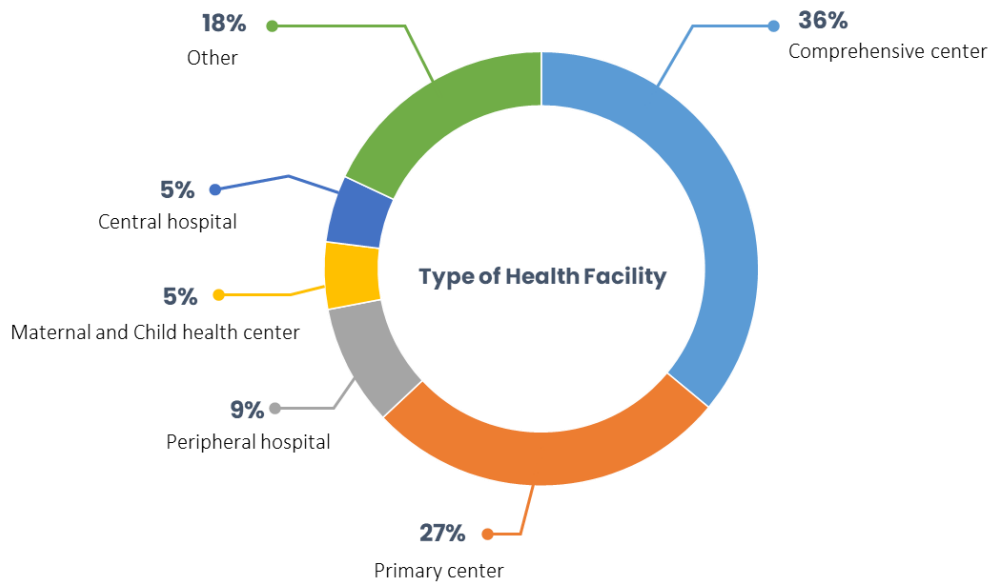


Figure 6. Type of health facility included as part of the Health Facility Assessment (HFA). n=22

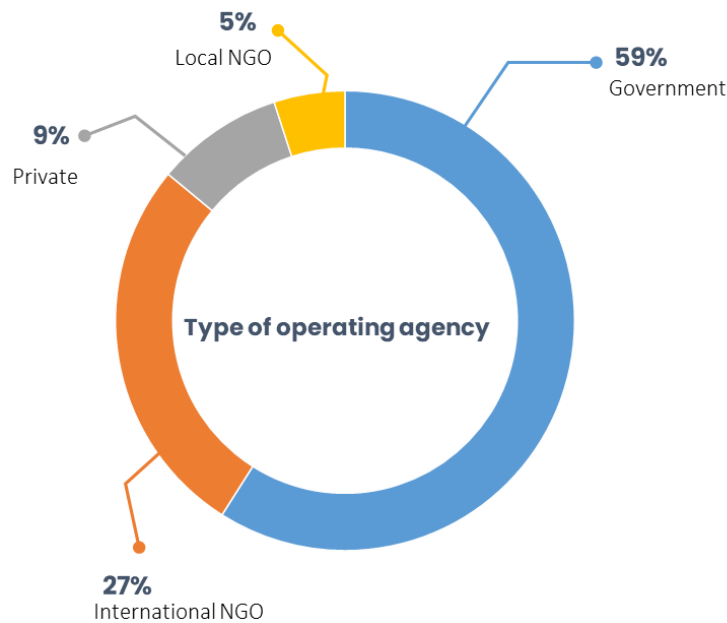


Figure 7. Type of operating agency included as part of the Health Facility Assessment (HFA). n=22

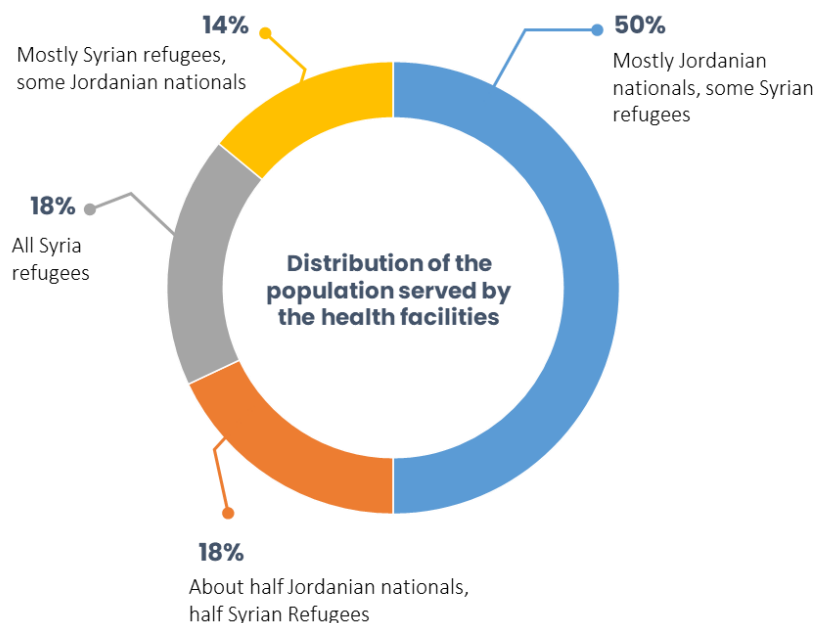


Figure 8. Distribution of the population served by the health facilities that participated in the Health Facility Assessment.

To assess the capacity of health facilities in providing health services, a General Readiness Index was computed, which is characterized by the following five domains of tracer indicators:

- Basic amenities
- Basic equipment
- Standard precautions for infection prevention
- Diagnostic capacity
- Essential medicines

The mean General Readiness Index among facilities was 39.5. Regarding readiness in terms of the basic amenities, we found that all health facilities scored above 60 percent in this domain. On basic equipment and supplies, most health facilities did not have the basic equipment to treat patients. The score of standard precautions for infection prevention sub-index among the 22 health facilities is above 36 percent, meaning that not all institutions have a protocol to manage infections. Concerning the diagnostic capacity, many facilities did not have the equipment to treat and diagnose malaria, measles, tuberculosis, and diabetes (Figure 9 and Table 4). The highest score obtained on the General Service domain score was 82 percent (in only 1 facility). Four (4) facilities scored 64 percent, 3 facilities scored 54 percent, 5 facilities scored 45 percent, and 9 facilities scored below 45 percent (Figure 10). The major types of services offered at the facilities were NCD services (hypertension 81 percent and diabetes 77 percent), followed by family planning (68 percent), immunization (50 percent), and Tuberculosis and psychosocial and mental health services (41 percent) (Figure 11).



Figure 9. General Readiness Index

Table 4: Descriptive statistics of the General Readiness Index and its 5 sub-domains

General readiness index sub-domains	Min	P25	Median	P75	Max
General service readiness	28	33.7	39.5	45.78	51
Basic amenities	60	60	80	80	100
Basic equipment and supplies	0	0	0	15.4	108
Standard precautions for infections	21	28.6	28.6	28.6	36
Diagnostic capacity	7	17.85	28.6	28.6	43
Essential medicines	0	48.65	60.55	76.33	100

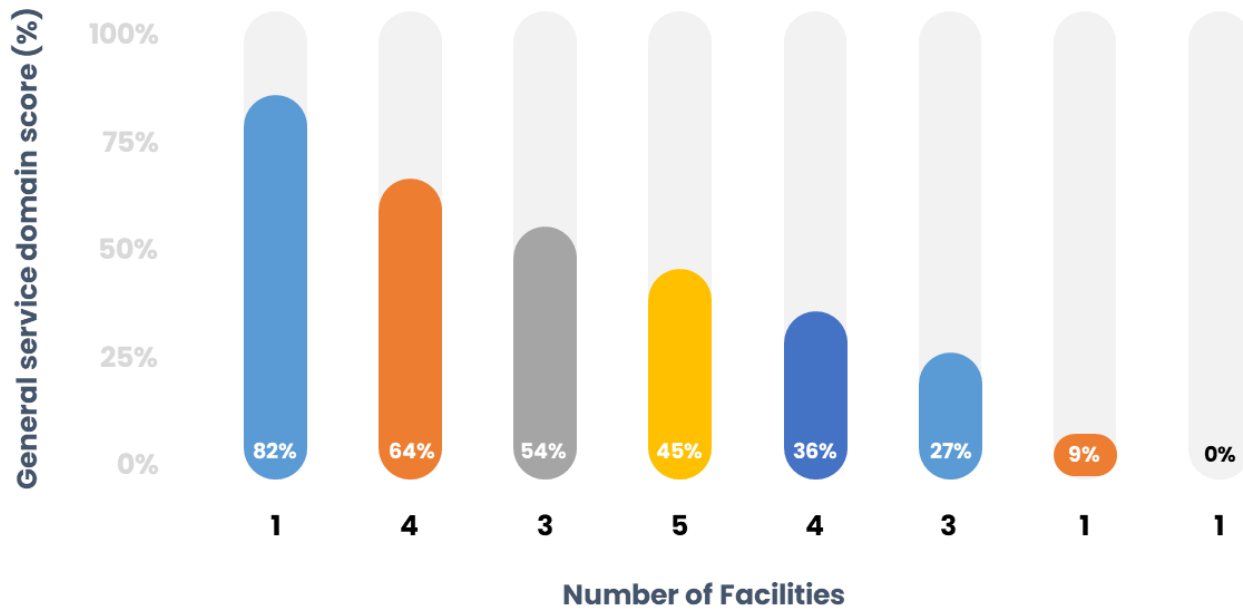


Figure 10. General Service domain score (%) obtained by the facilities.

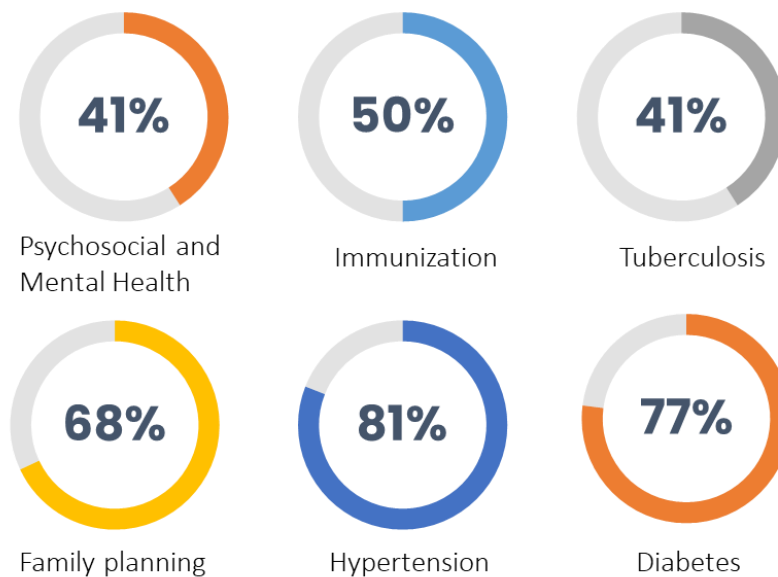


Figure 11. Type of services available at the health facilities.

The most often reported health problems faced by Syrian refugees and Jordanian nationals, revealed by the FGDs, are NCDs, mental health problems, sexual and reproductive health (SRH),

and children's illnesses. The most prevalent types of NCDs found in this study were hypertension and diabetes. Other less commonly reported NCDs included heart disease, arthritis, and asthma.

"I mean, in general, the health problems, whether it is for the Syrian brothers or for the Jordanian brothers, are hypertension and diabetes." Male Syrian refugee

Results from the KIIs showed that there is a strong correlation between health needs and socioeconomic status of Syrians and host communities. Syrian refugees of middle-to-high socioeconomic status are able to access all the care they need out of pocket and at private hospitals even if there are no funders/organizations helping them. In addition, patients who are not financially able to sustain themselves tend to delay seeking treatment which worsens their health outcomes.

"I mean, there are Syrians who come at their personal expense because there are no donors to cover them, so he prefers to come to the private sector, so he is not able to do everything, except, of course, for the Syrians, who have good financial situation." KII participant

Regarding the availability of mental health services, only 9 facilities reported providing psychosocial support and mental health services (Figure 12). For those that did provide these services, the data shows that the readiness to provide them was limited (Figure 12). Only 18 percent of the facilities scored 50 percent or higher on the availability of drugs to treat mental health problems, and 9 facilities reported that they did not have essential psychotropics available.

Mental health problems were identified as one of the major health needs, precisely among Syrian refugees in Jordan. The majority of the FGD participants reported high levels of stress, depression anxiety, nervousness, and insomnia. Syrian refugees reported facing mental health problems due to leaving their home behind and seeking refuge along with the stress that comes with being a refugee, such as financial burdens, dire living conditions, and health consequences. As for Jordanian nationals, a few reported facing mental health problems due to lack of jobs, financial burdens, and health problems.

"No, it is possible for the new generation to forget about this. As for us, those who were 15 years old when we came here to Jordan, he would not forget about this, nor what he saw...Those who had a brother, lost him, or he is not found. Most Syrians have dreams that they are still in the war and under bombardment. It happened to me." Male Syrian refugee

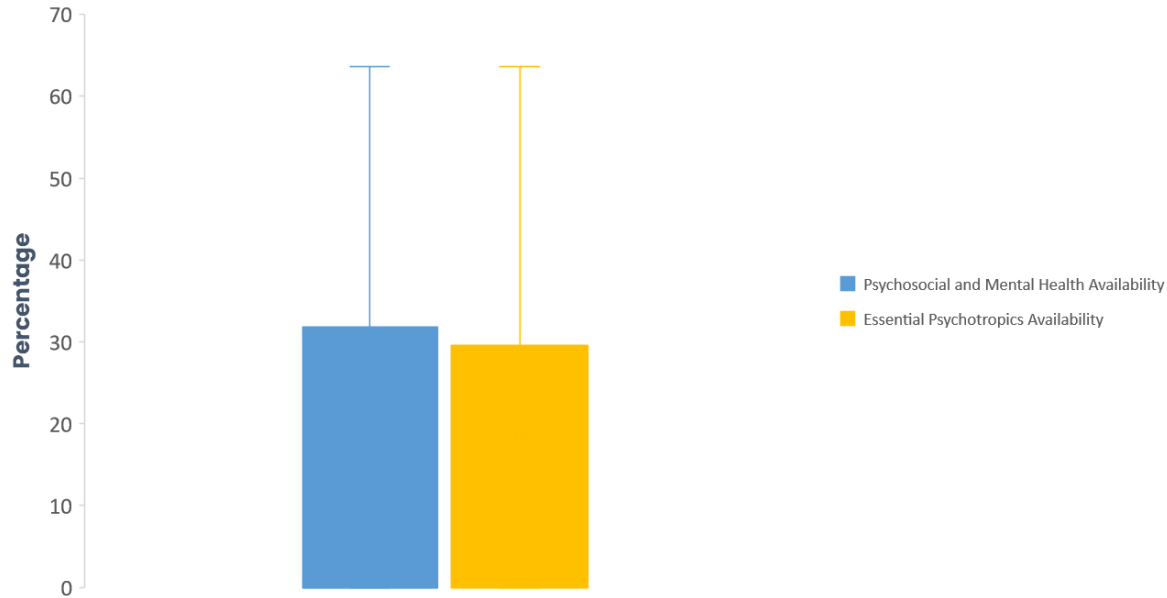


Figure 12. Psychosocial and mental health service availability indexes.

The availability of family planning services was relatively low. For instance, as shown in Figure 13, only half of the health facilities reported providing daily oral (13 facilities) contraceptive pills (12 facilities) and injectables and intra-uterine device (11 facilities), and none of the facilities provided vasectomy. As for Emergency Obstetric and newborn services, the major services reported to be provided by the facilities were antibiotics for neonatal sepsis and Corticosteroids in preterm labor (36 percent) and parental antibiotics and post-abortion care and safe abortion services (32 percent) (Figure 14).

Pregnancy-related issues were abundantly mentioned as major health problems faced by women in Jordan. Most women claimed a high prevalence of miscarriage and abortion as the physicians in charge would prescribe pills to induce abortion when a pregnancy seems weak instead of providing supplements. The study also identifies health-related issues among women postpartum including osteoporosis, vitamin deficiencies, anemia, postpartum hypertension, lack of contraceptive use, as well as childbirth complications, indicating the need for easily accessible and affordable gynecologist.

“As for gynecological issues, women go to specialists at the hospitals. Some physicians can't figure out if women are pregnant, some pregnancies are weak, and the only solution is abortion. Physicians can't save the fetus, so they dispense abortion pills for women in their first trimester.” Jordanian woman

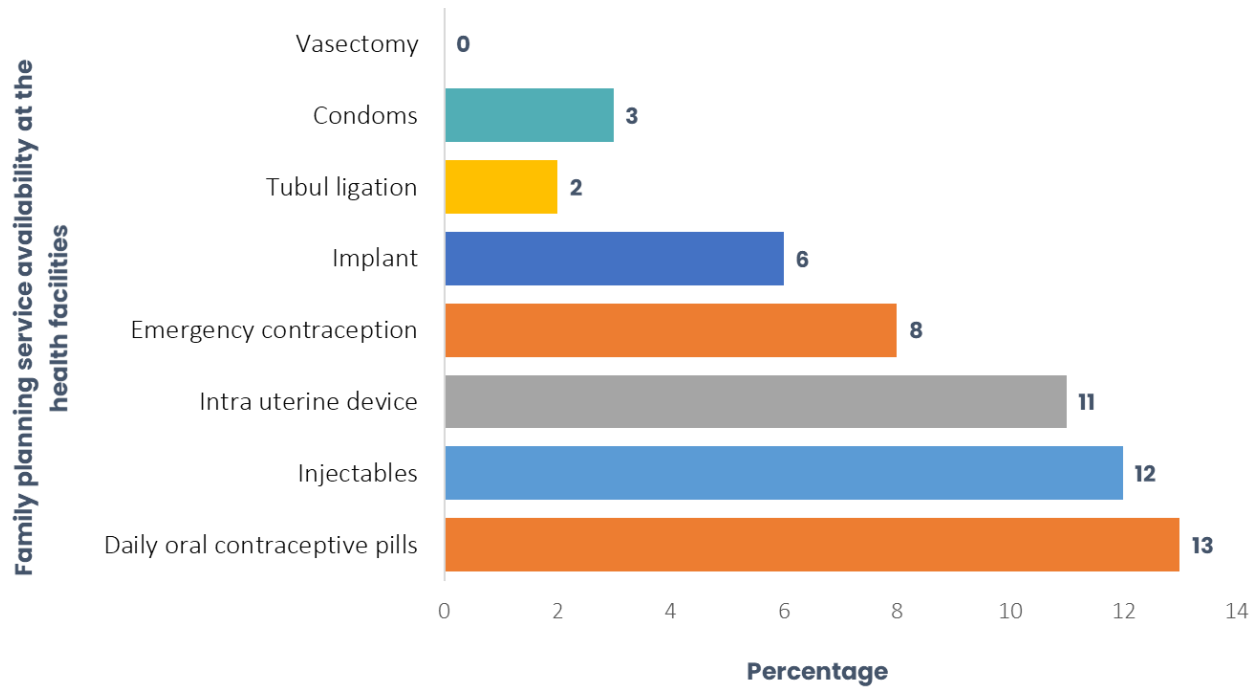


Figure 13. Availability of family planning services at the health facilities.

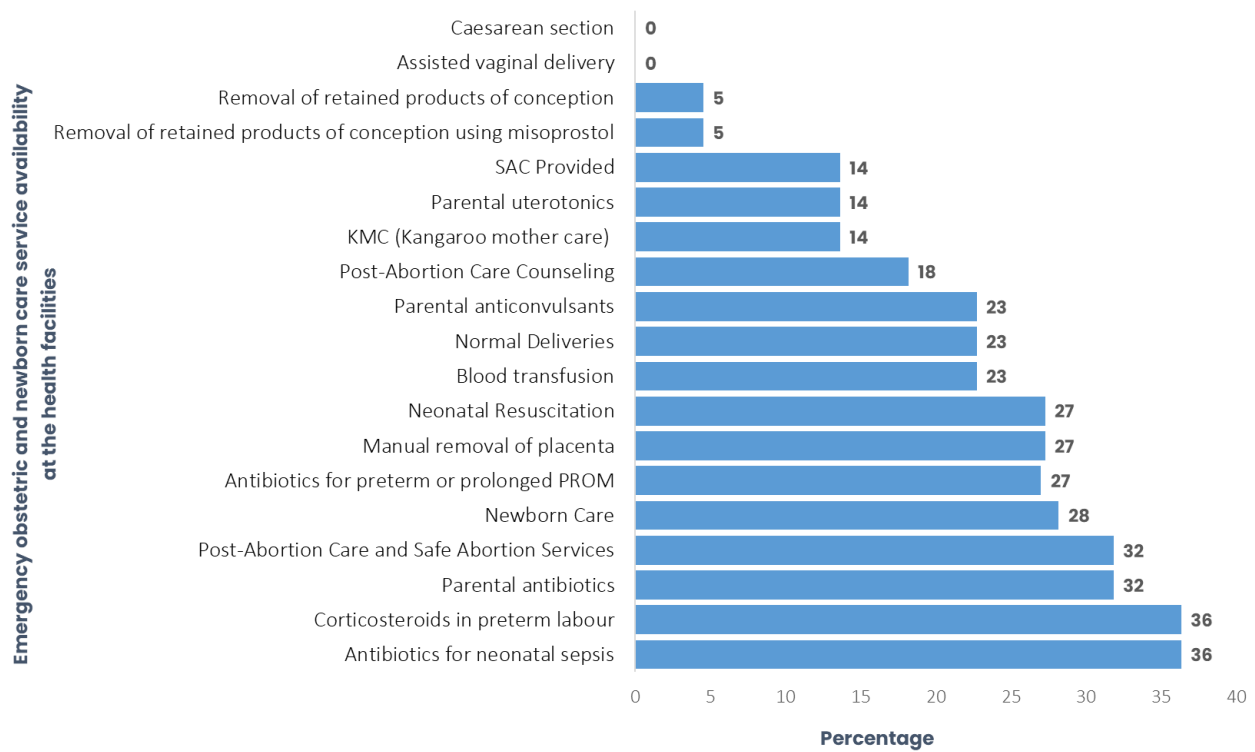


Figure 14. Emergency Obstetrics and newborn services availability at the health facilities.

5.2 Main challenges and barriers to accessing healthcare

5.2.1 Financial: cost (direct and indirect)

The main obstacle for accessing healthcare was reported to be the direct and indirect cost of health services that hinder Jordanians and Syrian refugees inside and outside the camp to receive healthcare.

A Syrian male said:

"I have a disc. I cannot work... If I find a simple job, I will do it. As for the heavy work, it tires me, so I can't do it... I did not do a disc operation because it costs a lot."

A Jordanian female added:

"Now I need tests that cost 100 dinars. I cannot afford it. I have a lump and the doctor told me I should monitor it for 6 months. But I cannot."

It seems that children suffer too from the high cost of health services and most of the time they do not receive proper service accordingly.

A Syrian mother shared her paralyzed son's experience:

"My son is paralyzed so they told me that needles cost around 1000 dinars...I'm still looking for someone who could help. And everyone is passing through a hard time no one will offer you 1000 dinars. Can you imagine that 1000 dinars are the cost of the needles only without the surgery nor the treatment?"

Syrian refugees also have an issue with the costly health services in public hospitals as compared with Jordanians.

A Syrian female refugee commented about the cost in one of the public hospitals:

"The expenses of the medications and the examination are doubled there because I am Syrian. For example, my neighbor and I wanted to do an X-ray, so I submitted both of our applications. She is Jordanian... So, the employee there told me that my neighbor should pay 2 liras, but I must pay 8 liras because I'm considered a foreigner."

These financial barriers have forced some Syrian patients to go back to Syria to receive treatment.

"Financial support is always cut off for dialysis. I mean, there are many people who return to Syria because of this problem to receive free dialysis. Despite the difficult conditions there, there are services... families return just for dialysis, because it is very expensive here." Syrian male

5.2.2 Long waiting time

All Jordanians and Syrian refugees complain about the long waiting time needed to receive healthcare services.

“Our problem is that we want a doctor in the governmental hospitals. I mean, for example, one needs an emergency operation within two days, they book him an appointment after 6-7 months. There was a patient who has been assigned an appointment in two months... He died after a week of seeking care... There are many other similar cases .” Jordanian male

A Syrian male confirmed this issue and compared the services in Jordan and those in Syria by saying about his dad:

“we’re not insured in any private hospital. It used to be through the UNHCR but not anymore... They refer him and give him an appointment after a year and a half. If we wait for a year and a half, he will die for sure...In Syria, entering the health center feels like entering a private hospital .”

The long waiting time leaves patients with no other choice but seek private care, which is costly. A Syrian male shared his friend’s experience:

“They give my friend appointments after a year and a half. So, he had to take a loan... about one thousand and two hundred dinars loan to do the operation in a private hospital .”

5.2.3 Logistics

Another subtheme that was emerged from the FGDs was the logistical barriers. Both Jordanians and Syrian refugees complain about the full NGOs that provide health services as well as people’s change in prioritizing health, which result in neglecting their health issues.

One Syrian male commented:

“Caritas cannot open a file for a new Syrian patient who has chronic diseases and need medication... so, where does he go to get it, and not all medicines are available in health centers .”

Another Syrian male refugee explained how people’s priorities shift:

“Chronic diseases are an issue that you can talk about. If NGOs or the United Nations did not help you, it is difficult for you... The problem is that changing the priorities of the Syrian refugee had led to neglecting the health status... He does not have the ability to buy the basics... The situation puts the person in a state of constant psychological pressure... The order of priorities has changed. If he wants to go and take medicine, then he wants to buy

it at the expense of his basic priorities...such as the expense of providing food for his family... this is a dangerous point .”

Transportation was also one of the main barriers to seeking healthcare reported in KIIs as well. Some Syrian refugees can't even afford the cost of transportation to and from the health facilities to get the care they need.

“Yes, the transportation also. There are people who do not have enough money to pay for the taxi to get their treatment from the center. Some live in remote areas and they will have to take any mean of transportation to reach here.” KII participant

5.2.4 Social stigma, discrimination

Another emerging subtheme, although not as prominent as other subthemes, was the social stigma and the discrimination against Syrian refugees by healthcare workers and some Jordanian people. The social stigma was evident against patients with sexual health problems.

“I mean, there are many people who suffer from sexual problems and are ashamed to go to a doctor. Instead, they seek close friends' advice .” Jordanian male

The discrimination was reflected in a delay in providing healthcare services for Syrian refugees in general.

“A while ago, an accident happened to me, my wife was bleeding... We took her to the hospital at night... The doctor heard that we were Syrians... The doctor said if you are Syrians, there is no treatment for you. He had the treatment though. We asked him for the medication, and he said not even a medication...I took this issue as personal...I mean this person hates Syrians... another doctor likes Syrians, I mean the doctor who likes Syrians serves us for free and the ones who don't like us because of some political background refuse to treat us.” Syrian male

The issue of nepotism in receiving healthcare also emerged from the FGDs.

“God has given us nepotism, Dr. XX who was able to give us an appointment for a catheterization within 3 weeks...I mean, had it not been for the nepotism, my husband would not have been able to do the catheterization.” Jordanian female

“We went to the governmental hospital because of an emergency... They gave us an appointment four months later... People who have nepotism only benefit from these public hospitals.” Syrian refugee

In contradiction to what was reported by Syrian refugees in the FGDs, key informants reported no discrimination in treatment between Syrian refugees and Jordanian nationals. There is no difference in health needs between Syrian and Jordanians, especially Jordanians who are less

advantaged and with lowest socioeconomic status. There is no difference in the way of communication and quality of service between Syrian refugees and Jordanians, even though most NGOs provide services for Syrian refugees more than host communities

“Frankly, we used to treat the Syrian refugee like any patient, and we did not distinguish between a refugee or a non-refugee, or any Jordanian patient visiting the center.” KII participant

5.3 Impact of COVID-19 on health services delivery

COVID-19 has led to a decrease in the provided services at all surveyed health facilities. The number of patients visiting primary healthcare centers or hospitals decreased especially in the beginning of the pandemic

“30-40 people used to come into the center but during the pandemic, this number has decreased.” KII participant

In addition, there has been prioritization of services to include the more critical cases.

“We preferred to provide service only to the cases that were really in need, and we wanted to keep the best doctors and best staff to be working. We set priorities for examples, we avoided awareness sessions.” KII participant

COVID-19 affected primary health services in terms of absenteeism of health workers and sickness and lockdown, especially with the already existing shortage in staff. This was exacerbated when a member of the staff is exposed to COVID-19 and need to quarantine, thus increasing the workload on the rest of the staff.

“This led to the decrease in the number of cadres because there were absentees. For example, if one of the employees is infected, he will have to go home for 10-14 days, and another employee will take the workload.” KII participant

Most NGOs ensured the delivery of medications for chronic patients to their homes.

“For chronic diseases, yes, they were delivered to the homes of the center’s patients. I mean, each center has a specific patient machine. We delivered to all of our patients. The medicines were delivered to homes, whether Syrian or Jordanian.” KII participant

The pandemic affected both host population and Syrian refugees psychologically. The loss of a loved one or losing a job due to the pandemic, negatively impacted the mental health status of individuals, calling for an increase in mental health services and support.

“I see that the psychological aspect was affected a lot after COVID-19, I mean, frankly, it became necessary for some people who lost loved ones due to the disease, who lost people who cherished them, was affected, so I expect it should happen, I mean, the psychological aspect we have to focus on it more, explicitly rehabilitating.” KII participant

6. POLICY IMPLICATIONS AND RECOMMENDATIONS

The above results suggest that the health needs of displaced populations and Jordanian nationals are not met with Jordan's current healthcare system. Additionally, it was evident that very few health facilities target the health needs of Syrian refugees residing in Jordan. The Jordanian healthcare facilities need to acquire basic supplies and equipment to treat patients, manage infections, and early diagnosis of communicable and NCD as the study showed a low grade for health facility readiness. Particularly, policies should be formed to include family planning and maternal services among health facilities in Jordan as these issues were abundantly mentioned as major health problems with a concurrent lack of available service.

Furthermore, the study identified mental health issues as a major health need among Syrian refugees and, to a lesser extent, among Jordanian nationals. With that being said, the study interestingly revealed that very few facilities provide psychosocial support, mental health services, and essential psychotropic drugs. Thus, the study suggests implementing policies to incorporate mental health services and psychosocial support in most facilities to target the needs of the population.

Lastly, the study findings suggest increasing the involvement of international NGOs and the government in supplying funds to the health facilities as the main obstacle reported for accessing healthcare was due to direct and indirect cost of the health services provided.

Thus, policies pertaining to the provision of health services to Syrian refugees and Jordanian nationals should be reinforced and tailored to the specific needs of the population.

Chapter 3: Human resources for health response

1. BACKGROUND

1.1 Key health actors and role

1.1.1 Government

Public health services in Jordan are provided by the MoH, two university hospitals, the Royal Medical Services and the Center for Diabetes and Endocrinology, and Genetics. The MoH is by far the largest entity and the most relevant for Syrian refugees. It is single handedly the largest financier and healthcare provider in Jordan [73]. Most of its annual budget is provided by the Jordanian Ministry of Finance. The Civil Insurance program, the largest program in the country, also provides funds [74].

1.1.2 Health Workforce

A Jordanian National Human Resources for Health (HRH) strategy was co-developed with the WHO in 2018 for the period 2018-2022. In this report, the total number of healthcare professionals in Jordan was deemed below international standards and recommendations [75]. There are also vast differences in patient-to-physician ratios across governorates, as recorded in 2016 – the latest year with available staff ratio data (Figure 15, 16). The health workforce of all categories is concentrated in the Central Region with a geographic disparity in the distribution of health workers between the governorates of the Kingdom, especially doctors [80]. There are additionally imbalances in the distribution of health personnel between different health sectors and between primary and secondary health care levels and between different governorates [80].

Jordan [76]	Oman [77]	Qatar [78]	Canada [79]	United Kingdom [79]
14.4	15.41	19.40	24	28

Figure 15. Ratio of Physicians to 10,000 population, country comparison, 2016.

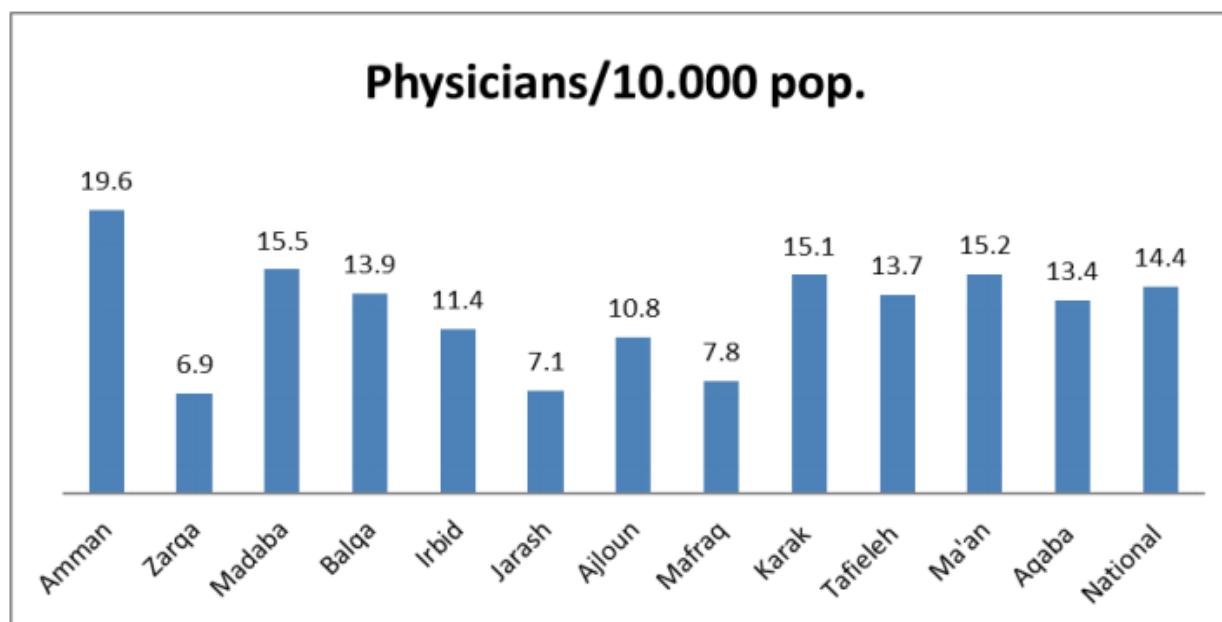


Figure 16. Ratio of Physicians to 10,000 population, Jordan governorates, 2016.

1.1.3 Staff ratio trends

In a separate governmental report co-developed in 2017 with the National Human Resources of Health observatory, an overall trend for health staff ratios was mapped based on the annual statistical book for the MoH [81]. Since 2014, the physician-to-patient ratio has decreased. A similar downward trend is observed in 2015 across staff ratios, with minor improvements in 2016 for pharmacists and nurses, and no improvement for dentists (Figure 17). One cause for the sharp decrease in the staff-to-patient ratio could be the Syrian refugee influx.

10.000/ YEAR	2010	2011	2012	2013	2014	2015	2016
Physicians	26.5	25.5	27.1	28.6	29.4	22.2	14.1*
Dentists	9.3	9.8	10	10.4	10.3	7.1	7.1
Pharmacists	15	12.6	16.3	17.8	18.3	12.7	15.5
Registered nurses	44	43.7	46.6	44.8	45.3	24.8	26.4

Source: Annual Statistical book, MOH, 2017

Figure 17. Human Resource Ratio Development (2010-2016).

The main workforce challenges faced by the High Health Council (HHC) can be grouped into four high-level themes: (1) Governance gaps, (2) Human Resources for Health (HRH) mismanagement, (3) HRH education, production, and development gaps and finally (4) poor HRH planning (Figure 18).

Governance, policy, and partnership	HRH management
<ul style="list-style-type: none"> - Absence of a national HRH strategy - Inadequate generation of evidence-based HRH decisions - Deficient endorsed national job descriptions - Absence of a national board to license/relicense healthcare fields (Larocco,2015) - Lack of collaboration with other healthcare fields (Jordan Nursing Council, 2016) - Adoption of the Civil service Bureau performance appraisal system represents a change from current practices - Pressure, particularly in the governorates, to hire more staff at the MoH because of the high unemployment rate in remote/underserved areas 	<ul style="list-style-type: none"> - Lack of awareness and skills on the part of top management team and other managerial levels of the critical linkages between MoH strategic/operational planning and human resources planning - Difficulty in attracting and retaining qualified health performance - Overemphasis on tenure and credentials over performance - Weak performance management (unclear criteria, lack of transparency) system to inform career path and succession planning - Weak linkages between the current performance appraisal system and incentives - Risk that employees will focus on behaviours that are rewarded and neglect other work-related behaviours - High stress and low job satisfaction (Hamaideh & Ammouri,2011; Mrayyan 2007; Nawafleh, 2014) in remote/underserved areas (Nawafleh,2014) - Workplace violence
HRH education, production, and development	HRH planning
<ul style="list-style-type: none"> - Interdependence of CPD with other HR policies (e.g, employee selection, career path planning, succession planning, and job analysis and description) - Lack of requisite skills on the technical aspects of training and development for those who work at training and development directorate - Lack of national CPD system linked with re-licensing - Lack of funding for human resources department - Weak capacity building and continuing education initiatives (Jordan nursing Council,2016) - Lack of internship opportunities - Limited provision of holistic care 	<ul style="list-style-type: none"> - Limited supply of specialties in the labour market as they take considerable time to develop - Skill-mix, gender, and facility maldistribution of human resources across the country - Weak linkages between the human resources planning system on one hand and the performance management, reward, incentive, training, and development systems - Shortages of midwives - High turnover - Weak effective HRH information system especially that of the private sector

Figure 18. Challenges in the workforce according to HRH [82].

A report co-developed between the High Health Council (HHC) and the WHO highlighted the pressure placed by Syrian refugees on the healthcare workforce [52]. Due to insufficient funds and brain drain, the government reported a high ratio of the patient-to-staff as a cause for concern. A survey assessing the public perception of healthcare also supported this view: 60 percent of Jordanians considered an overcrowded healthcare system as a cause for tension, compared with 39 percent Syrians [83].

Brain drain remains a challenge in Jordan, as talent is attracted to countries such as Gulf Cooperation Council (GCC), Europe, and North America after becoming qualified and experienced

[73]. The turnover rate is particularly high for nurses. One study conducted in Jordan found a turnover rate as high as 36.6 percent [84, 85]. Geographical location, financial remuneration and relationship attachments were three factors associated with the retention rate in Jordan. In addition, workforce skill sets are not optimally allocated within the healthcare system [86]. Particularly in the context of mental health, there is a workforce gap further exacerbated by the needs of Syrian refugees. It is part of the government's strategic direction to embed mental health services more strongly as part of the primary health care services [87]. As of 2018, 45 percent of the MoH national budget is allocated to staff salaries and benefits [88]. Salaries at the MoH and Royal Medical Services are provided in line with national military and civil financial schemes [52]. While in theory, the incentive scheme is systematic, the government acknowledges unfair incentive schemes as one of the causes for high turnover rates.

1.1.4 Private Sector

The non-governmental sector (private and civil organization sector) is the main employer of health cadres in Jordan – especially medical doctors, dentists, and pharmacists (Figure 19). The private sector attracts experienced professionals from the public sector due to the high financial returns [52]. Although it is prohibited for public sector doctors and other health personnel to work in the private sector, the MoH has contracted some private doctors in certain medical subspecialties to cover the shortage in these disciplines in the public sector [52].

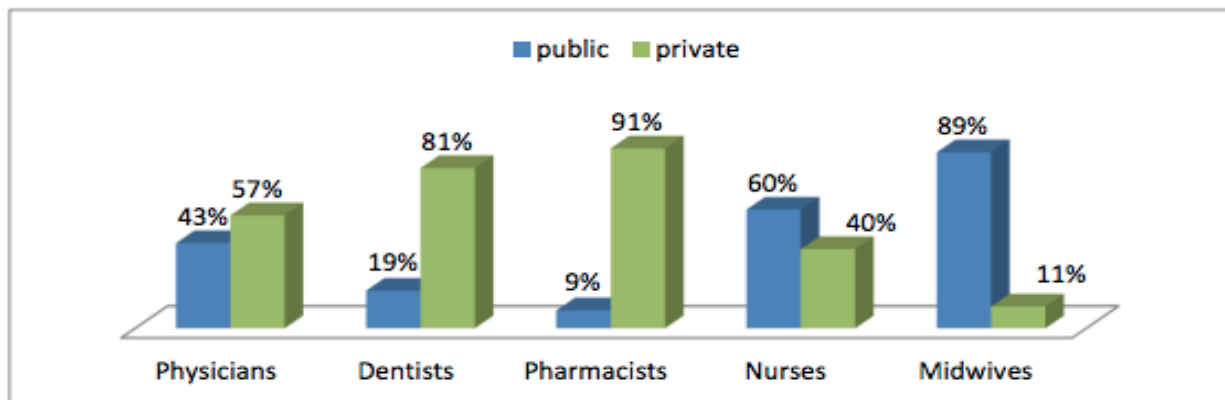


Figure 19. Health Professionals in Jordan, Private vs Public Sector, 2013. (Source: Report of the National Observatory for Human Resources for Health in Jordan, 2013- Higher Health Council).

The private sector is more challenging to study quantitatively as this sector consists of independent clinics, largely delivering secondary and tertiary services [52]. It is therefore a decentralized system, providing relative freedom of diversifying practices as long as they are accredited. The Private Hospitals Association (PHA) represents this group of disparate, independent service providers. PHA is a private entity aimed at representing the interests of private hospitals in Jordan [73]. One of the major functions of the PHA is to provide local accreditation to ensure that hospitals and care providers adhere to international standards. Equipping hospitals with technology is yet another important function.

In a 2016 survey conducted with 1,550 Syrian refugees living outside of camps, approximately half (51.5 percent) of Syrian refugees sought the public sector, 38.7 percent sought private care and a much smaller proportion (9.8 percent) sought care from NGOs [83]. It is also possible for UNHCR to refer patients from within camps to either public or private services, making it a significant sector serving Syrian refugees' health needs. Patients could seek private care free of charge only if approved by UNHCR, and if the patient is not able to receive the same service at a non-insured Jordanian rate from the public sector [89].

1.1.5 Non-Governmental Organizations (NGOs)

NGOs, coordinated by the UNHCR, play a crucial role in providing foreign-funded services to refugees, mostly through refugee camps. As mentioned in the previous section, only 1 in 10 Syrian refugees living in host communities chose to seek care through NGOs. In yet another study, 16.6 percent of Syrian refugees with chronic care conditions in host communities sought care through NGOs or charities [83]. Among those who do seek care through NGOs, 70 percent do so due to affordable costs, compared with 40 percent and 30 percent in the public and private sectors, respectively [65].

NGOs have a stronger presence within camps, and they are managed and coordinated by UN agencies, which are funded from sources outside of Jordan. The UNHCR regularly monitors Syrian refugees' health access and utilization behaviors in host communities through yearly surveys and data collection on health issues of priority such as vaccination and antenatal care [90]. However, information on the management of services within camps is scarce.

A general understanding of how services are operated by the UNHCR can be found in the Zaatari camp [91]. All services are provided free of charge for in-camp refugees. Primary care is provided outside of the camp in coordination with the MoH (through the Saudi Government, Médecins Sans Frontières [MSF], and others) [92]. Secondary care is provided in camp through military field hospitals (Moroccan, Jordanian, and Italian) [91]. Tertiary care is provided through referrals outside the hospital and fees are covered by the UNHCR if approved [91].

Outside of camps, Syrian refugees presenting their UNHCR card are eligible for public health services at uninsured Jordanian rates as per the latest policy change in 2019 [91]. These include primary, secondary, tertiary services, including emergency, mental health, and pregnancy, and delivery services. Nutrition services are also provided. If unregistered, UNHCR may support vulnerable refugees based on a vulnerability assessment. Service cost coverage for registered refugees and vulnerability assessments for unregistered refugees are both provided through the Jordan Health Aid Society (JHAS) and Caritas [93].

1.1.6 Informal Sector

The informal health sector is more relevant to examine outside of camps. It is defined as any service that does not include private, public, or NGO health services. The informal sector is, by nature, a gray area, which makes it difficult to study quantitatively.

Qualitative research points to the informal sector as being most relevant when it comes to primary care needs or basic check-ups [94]. Based on 68 in-depth interviews with Syrian refugees

living in host communities, basic and initial care needs are largely met through NGOs or pharmacies [64]. If needs are not met, refugees then re-orient themselves towards government services or private care [64]. Policy shifts in Jordan since 2014 have made it costly for refugees to access care. A needs assessment conducted in 2019 highlights that Syrian refugees seek care through pharmacies due to high formal healthcare service costs [64]. Another reason refugees seek care through pharmacies is the inability to receive timely medication through the formal health sectors (NGOs, public, and private). Several reports have consistently raised the issue of supply chain disruption when it comes to medication in the NGO and public sectors [65].

2. RESEARCH QUESTION

How is the distribution of human resources among facilities and how is this serving the needs of displaced populations?

3. OBJECTIVES

This chapter aims to assess the training and capacity of health providers among health care facilities in Jordan. The chapter also examines the readiness and service quality indicators of the health facilities.

4. RESULTS

The Health Provider (HP) questionnaire was filled out by healthcare workers from 22 facilities across Jordan, to assess the training and capacity of health providers and support the assessment of readiness and service quality indicators. Most participants were nurses (42.3 percent) and medical doctors (21.9 percent). The percent of clinical officers and midwives was equal (15.9 percent) and the least participating profession was family medicine (0.5 percent) (Figure 20).

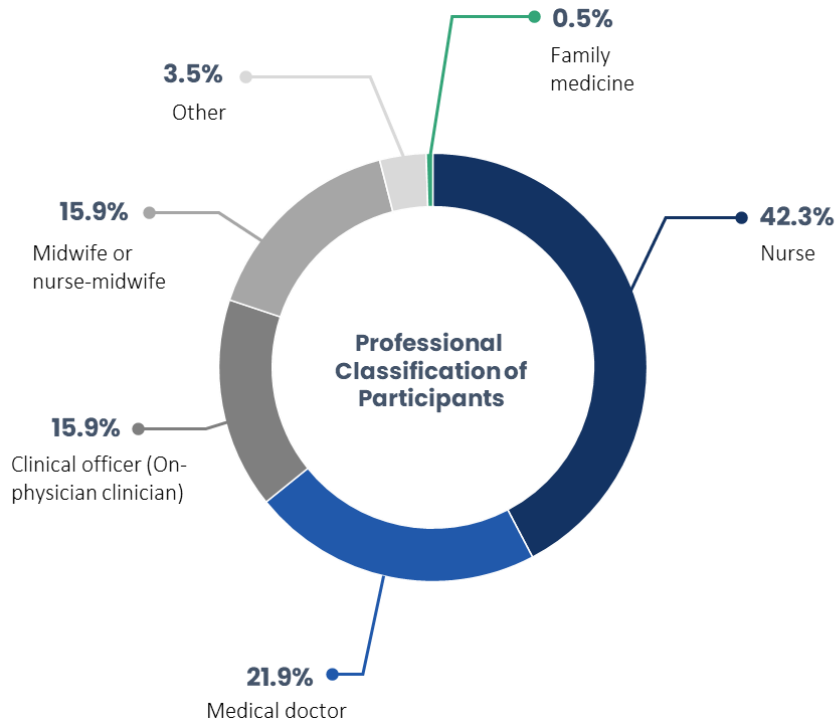


Figure 20: Professional classification of Participants. The professional classification of healthcare providers who participated in the ‘Health provider questionnaire’ from 22 health facilities across Jordan serving both Syrian refugees and Jordanian nationals.

The infection prevention and control (IPC) (51 percent) was the most received on-the-job training as reported by healthcare professionals, followed by diagnosis and management of diabetes (38 percent), and newborn resuscitation (29 percent). The training least reported to be received include treatment of multi-drug resistant TB (9 percent); corticosteroids administration to a mother with preterm labor (9 percent); hepatitis A diagnosis and treatment (8 percent); and management of human immunodeficiency virus (HIV) and tuberculosis (TB) co-infection (7 percent) (Figure 21).

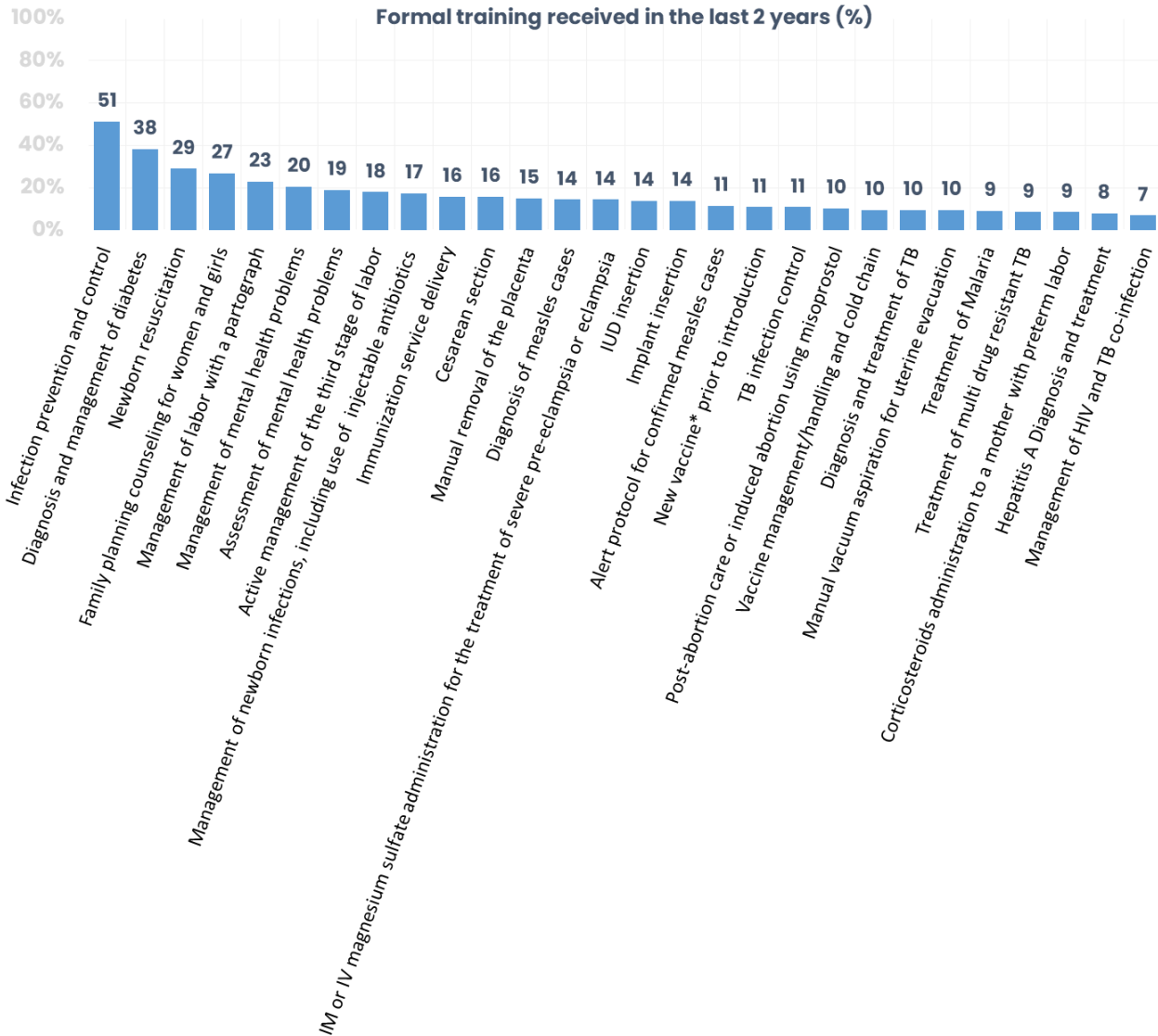


Figure 21. The type of on-the-job training reported to be received by healthcare providers from 22 health facilities across Jordan.

Findings from FGDs suggested un-satisfaction with the services provided at health facilities. In most public hospitals and clinics, both Syrian refugees and Jordan nationals mentioned misdiagnosis, negligence, insufficient types of services, and lack of specialized doctors as major reasons for not choosing a certain facility. Participants mentioned that radiology, along with other diagnostic tests are often misread and a wrong diagnosis is given when compared to other well-established clinics or hospitals. Nevertheless, participants mentioned a limited availability of specialized doctors (such as dentists and therapists), treatments, advanced supplies, or services provided. Moreover, many participants reported neglect from the healthcare workers, as they do not attend to emergencies as quickly as they should, and they do not provide the patient with the appropriate attention. Additionally, some participants mentioned long waiting

hours and hardship trying to schedule an appointment, even in urgent cases. Participants also reported that the healthcare workers do not examine the patients at all, and some prescribe medication without proper examination. Lastly, most of the participants agreed that there is a shortage of medication and no organization in certain public hospitals/clinics, hence, choosing a different health facility.

“A while ago, I went to do some laboratory tests since I was feeling really tired. The doctor did not do the laboratory tests for me and mentioned that I am fine however I didn't feel well. I asked him to dispense me painkillers and so he did.” Jordanian female.

On the other hand, a few participants believed that the doctors were strong and professional, however, it is the system that was weak. Others also stated that physicians provided them with the appropriate care, treatment, diagnosis, and medication. A few mentioned the chosen health facility has ready and available services and specialists.

“But to be honest the doctors there are good ... but the system is not.” Jordanian female.

5. POLICY IMPLICATIONS AND RECOMMENDATIONS

The above results highlight the need to implement training policies to human resources in health facilities in Jordan. Training should be done to ensure that 1- patients do not feel neglected by the health workers, 2- appropriate time and attention is provided for each case, and 3- emergency cases are attended to as a priority.

Additionally, there is a need to recruit specialized personnel to provide specialized services such as dentistry and therapists, that are not available in most health facilities. Facilities should also invest in additional types of services, treatments, and supplies to cover all types of needs in the population.

Most importantly, results highlight the need for specialized personnel for appropriate diagnosis, which will help reduce misdiagnosis in different diagnostic tests, such as radiology. Efforts should be made to ensure diagnostic tests are being analyzed by qualified and trained health personnel.

Chapter 4: Health Information and Reporting Systems: Health and demographic data collection, monitoring, and reporting systems

1. BACKGROUND

1.1 Humanitarian health system: organization and coordination

Coordinating care for Syrian refugees is essential to ensure timely and appropriate care. By striving for optimal coordination, duplication of effort is avoided, and Syrian refugees are directed where they need to go to access the appropriate care. At a national level, there are currently two large programs aimed at supporting Syrian refugees in Jordan:

The Jordanian Response Plan: led by the Government with UN support. This program is aimed at granting access to Syrian refugees to the public health sector and developing policies for the integration of refugees [95].

The Sixth Regional Response Plan (RRP6): a broad, multifaceted program that encompasses an essential role in coordinating Syrian refugees' health response [96]. The RRP6 is led by the UNHCR but involves other key members in the health sector. In 2013, an Inter-sector working group was created to coordinate and facilitate information sharing and management of Syrian refugees' health [97]. Working groups consist of members from UN bodies, donors, and NGOs (Figure 22) [98]:

- The **Health Sector Strategic Advisory Group (HSSAG)** is chaired by the UNHCR and WHO. It is a platform for all relevant stakeholders in Jordan to coordinate the management of Syrian refugees' health services [99].
- The **Non-communicable diseases (NCDs) Task Force** is chaired by the UNHCR and WHO. It is aimed at guiding the national response to NCDs by supporting the MoH. Initiatives include the provision of hospitals with medication and laboratory equipment, the guidance of physicians with a software program, and disease surveillance [96].
- The **Community Health Platform** is aimed at Syrian refugees and Jordanians alike. Its function is to disseminate information to encourage the population to access healthcare services. It is largely based on volunteer efforts.
- The **Nutrition Sub-Working Group** is chaired by UNICEF and Save the Children. This group focuses on inter-agency and cross-sector outreach to treat micronutrient deficiencies, particularly anemia, as well as improving nutritional surveillance through research [99].
- The **Reproductive Health Sub-Working Group** was originally created in the context of Iraqi refugees in Jordan [100]. It is led by the United Nations Population Fund (UNFPA) and aimed at encouraging and ensuring access to maternity and family planning services.
- The **Mental Health and Psychosocial Support Sub-Working Group** is also not restricted to serving Syrian refugees but also Jordanians. It is the focus area of Save the Children [101]. This group works collaboratively with the Government of Jordan to embed psychosocial support as part of the public health system. As mentioned earlier in this report, the efficiency and effectiveness of mental health care in Jordan require improvement. According to in-depth qualitative studies, Syrian refugees consistently reported that the cause of their physical illnesses starts with poor psychological health [94]. This highlights the need for a working group to carry out mental health surveillance and support.

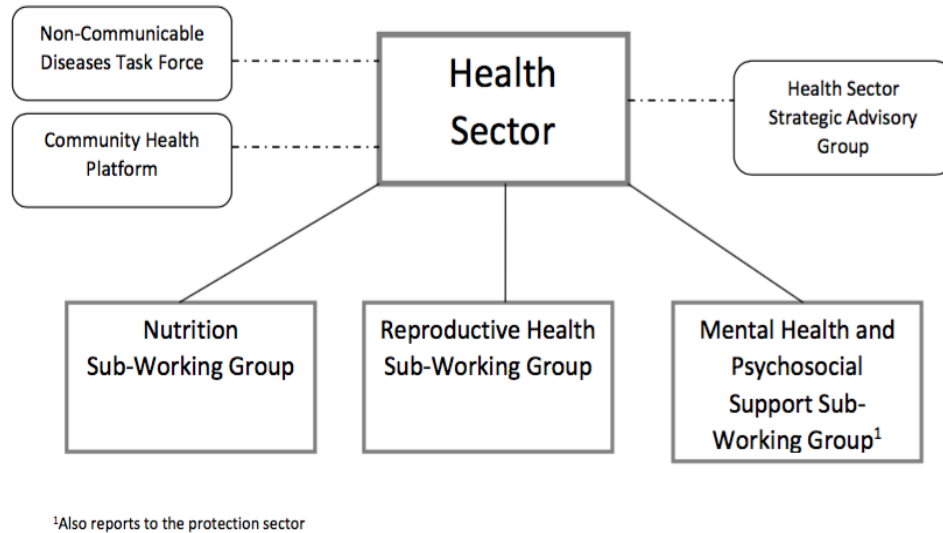


Figure 22. Health sector coordination working groups in Jordan.

Whilst the UNHCR aims to work closely with all health sectors in Jordan, it becomes more challenging to coordinate Syrian refugees’ care outside of the camp. The Syrian refugee population is spread out geographically, providing them with more options to seek care and making it easier to get “lost in the system.” Under such circumstances, refugees’ decision-making process is less predictable. Transportation costs, service fees, and alternative methods of care become essential factors to consider [102].

Therefore, despite efforts to coordinate care, Syrian refugees’ experience suggests many opportunities for improvement. Challenges raised by participants were not directly attributed to the UNHCR, but rather an experience shared when navigating the healthcare system. This experience includes all sectors involved, which makes it an individual as well as collective effort on the part of NGOs (led by UNHCR), public and private sectors to improve service cohesiveness.

Furthermore, Syrian refugees living in urban areas have raised concerns around the difficulty in navigating healthcare services. Services are disjointed, with refugees having to direct themselves to different locations on different dates to diagnose and treat their health issues [94]. Part of the cause for such a disjointed patient experience could be miscommunication. It is reported that communication between UNHCR and Syrian refugees could be improved, as many are unaware of the services, which they are eligible for [96].

1.2 Key health challenges

1.2.1 An overburdened healthcare system

Research studies consistently report an overburdened Jordanian healthcare system since the first influx of Syrian refugees in 2011-2012 [59]. For instance, 12 out of 16 neo-natal incubators in the

Mafrq hospital were occupied by Syrian refugees [103]. Moreover, a rise in surgical operations for Syrian refugees at the MoH facilities is also reported, jumping from 105 operations per month to 622 in the span of 3-months [103].

A summary of healthcare challenges for Syrian refugees seeking access to public care setting based on a qualitative and quantitative study (column 1: concerns of healthcare providers, column 2: concerns of Syrian refugees in camps, column 3: concerns of Syrian refugees in urban areas) [64]:

Strengths and weaknesses of the Jordanian health care system	Strengths:	Strengths:	Strengths:
	<ul style="list-style-type: none"> • Providing free/subsidized care to Syrian refugees • Hospitality towards Syrian refugees • Dedication to providing quality health care to Syrian refugees and Jordanian citizens <p>Weaknesses:</p> <ul style="list-style-type: none"> • Lack of electronic health information systems, especially in primary care • Limited mental health care services • Insufficient health education programmes targeting chronic disease prevention, smoking, domestic violence and mental health stigma • Provider burn-out due to long work hours and staffing shortages • Lack of community health outreach programmes 	<ul style="list-style-type: none"> • Availability of primary health care facilities and small hospitals inside the camp • Recreational activities for children, such as after-school sports and art programmes • Mental health clinics run by International Medical Corps and other international organizations; vaccination awareness campaigns • Home visits by field officers for chronic diseases <p>Weaknesses:</p> <ul style="list-style-type: none"> • Periodic lack of essential medicines for chronic diseases, such as high blood pressure and diabetes • Long waiting times due to limited staffing in camp clinics • Discrimination and inhumane attitude of health care providers 	<ul style="list-style-type: none"> • Iris scan technology is a convenient way to access cash assistance <p>Weaknesses</p> <ul style="list-style-type: none"> • Cost is the primary barrier to health care access • High health care costs drive refugees to seek care in pharmacies instead of clinics • Discrimination in the health care setting and inhumane treatment from health care providers • Physicians perform insufficient physical examinations and do not spend enough time with patients • Legal status makes access to health services a challenge • Lack of birth certificates and changing UNHCR policies complicate health care access • Lack of access to dental care • Lack of female antenatal care providers • Hospitals that provide 24/7 emergency care are located far away • Current policies do not allow donation of blood among Syrians; thalassemia patients cannot access blood transfusions • Current policies do not allow Syrian health care providers to work while in Jordan

Figure 23. Healthcare challenges for Syrian refugees seeking access to public care setting.

1.2.2 Communication and coordination challenges between key factors

UNHCR has been working closely with the Jordanian government to support the MoH. In 2019, UN agencies supported the MoH with assistance in more than primary health care centers [96]. However, government officials have expressed concerns vis-a-vis underfunding from international humanitarian bodies. It also seems that the UNHCR and government initiatives are not fully aligned in their strategic priorities and initiatives. According to his Majesty King Abdullah II, UNHCR efforts do not support Jordan’s economic and humane issues. Since these issues have been raised, coordination is continuously being improved. More recently, UN agencies and the Government of Jordan co-developed a JRP for 2020-2022 [104]. It is a national plan detailing international funding and a national plan to further integrate and strengthen services for both Syrian refugees and vulnerable Jordanians.

In the context of the wider health system, collaboration issues were raised between the GoJ and UNHCR. In the specific context of displacement response, poor communication has also been raised between NGOs [105]. It is worth noting that the UNHCR has been praised for being well-coordinated internally. For instance, UNHCR was able to quickly identify challenges in implementing its educational initiatives, whereby children did not attend educational programs due to parental fears around safety. In response to this challenge, UNHCR began to successfully track the program and adapt it to ensure children's attendance. Such challenges highlight the importance of taskforce and working group platforms to continuously coordinate care [96].

As a result of suboptimal communication and coordination between key actors, many Syrian refugees are unaware of their rights and their abilities to access services. For example, only 35 percent of Syrians understood the latest policy changes as of 2019 [106]. Lack of awareness of the different services offered decreases the likelihood that refugees will seek care, a point directly raised in qualitative interviews [96].

1.3 Opportunities/Innovations

1.3.1 Prioritize Mental Health Services

Epidemiological data strongly suggests the need to prioritize mental health challenges. In the last few years, mental health services are becoming more embedded within primary care in Jordan [107]. However, many barriers from both refugees and the healthcare system persist. From the refugees' perspective, barriers include the cost of service, transportation cost, social stigma, and feelings of helplessness. The health sector also makes it challenging for refugees to access care. Of all staff shortages, the government considers mental health workers to be the biggest gap due to the widely known social stigma attached with working in the mental health field [52]. The ratio of psychiatrist to citizen in Jordan is 1 for every 50,000 [107]. Syrian refugees themselves consider mental health to be a predecessor to their non-communicable diseases [94]. Preventing physical diseases would therefore necessitate a strong focus on effective biopsychosocial support [108]. Thus, non-communicable diseases, both physical and psychological, need to be prioritized and successfully addressed.

1.3.2 Prioritize Prevention of NCDs to Address Funding Gaps

To address the gaps in funding, developing cost-effective solutions is paramount. Empowering Syrian refugees to address risk factors and social determinants associated with physical and psychological disorders could be one of the most effective solutions to prevent diseases [109]. The WHO publishes detailed costing and quantitative analyses in favor of preventative interventions [110, 111]. Such interventions may be tailored for Syrian refugees to alleviate both financial strains and preventable suffering [111].

1.3.3 Improved Communication Between Key Health Actors

Due to the hierarchical nature and size of the programs taking place in Jordan, it is not surprising that bureaucracies and miscommunications are being reported. Whilst improvements are continuously being made, it is also evident that further efforts are required to provide consistent

information to all parties involved. This includes all health actors (private, public, and NGOs), as well as Syrian refugees.

In addition to better communication, improving Syrian refugees' journey in the healthcare system could improve access to care. The journey starts at prevention, followed by diagnosis, treatment, and finally follow-up care. Based on qualitative interviews, this journey is confusing for Syrian refugees. It is therefore recommended to strengthen collaboration between the UNHCR and other health sectors to address challenges raised by refugees along their healthcare journey. Based on available data, some solutions could include creating a 'one-stop' location to provide diagnosis and treatment, efficient referrals between health actors, and other solutions aimed specifically at reducing inefficiencies and delays.

1.3.4 Invest in Local Skills and Staff Retention

Whilst international support is a beneficial response to the Syrian refugee crisis, empowering local communities to support and become healthcare practitioners could address some of the challenges found in the literature. Most notably, understaffing and high turnover in the health sector were raised as a challenge by the government of Jordan [95]. Providing interested Jordanian and Syrian candidates with training and scholarship opportunities could increase system capacity.

To address insufficient data, as well as to better understand staffing needs, the USAID HRH 2030 is rolling out (as of 2018) a program in collaboration with the WHO and the MoH [88]. The WHO is introducing a tool, "Workload Indicators of Staffing Needs", which will be used to make data-driven decisions pertaining to human resources management. This includes task allocation, workload management, and capacity planning.

Chapter 5: Healthcare Access, Utilization, and Cost of healthcare Services for Refugees

1. BACKGROUND

Since 2011, Jordan has welcomed a massive influx of refugees due to the conflict in Syria. According to UNHCR, Jordan hosts the second-largest share of refugees per capita [112]. While Syrian refugees account for 1.3 million persons or 13 percent of the de-facto population, as of January 31, 2022, only 673,188 Syrian were officially registered with the UNHCR office in Jordan [9]. UNHCR provides primary, secondary, and tertiary health care services free of charge for both refugees inside camps and refugees in urban areas [113]. Between 2011 and October 2014, registered refugees, both in camp and non-camp settings, with the UNHCR could access free care at MoH facilities. Between November 2014 and 2018, the MoH required refugees to pay a 20 percent co-pay at MoH clinics. In 2018 that decision was reversed, and refugees were required to pay 80 percent co-pays. The policy again changed in 2019, requiring refugees to pay a 20 percent co-pay for services received at MoH facilities. These changes led the UNHCR to adopt the "Cash to Access" approach, reimbursing patients for care received at the MoH facilities.

2. RESEARCH QUESTION

What is the nature of the healthcare access, utilization, and cost to refugees in an urban setting in Jordan?

3. OBJECTIVES

This chapter investigates healthcare access, utilization, and cost to refugees in an urban setting in Jordan.

4. METHODS

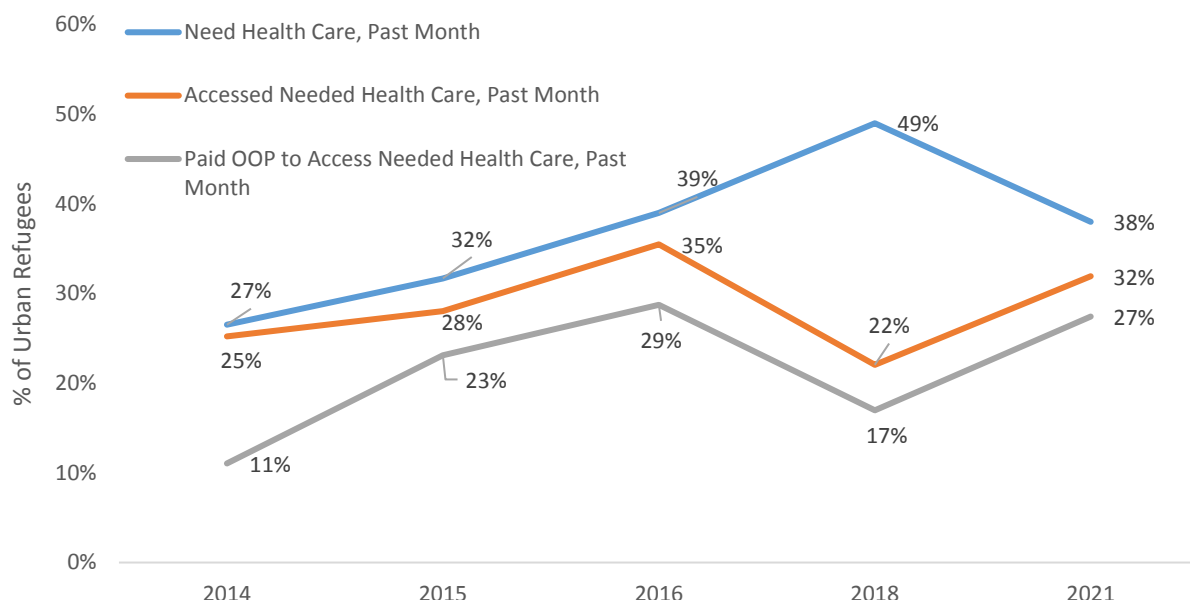
To estimate the need for health care, access to health care, utilization of health care services, and out-of-pocket spending on health services, we used two primary sources. The first source was a national survey of refugees in Jordan conducted by Johns Hopkins University in 2014. The survey allowed us to estimate (1) the need for health care services among the refugee population, (2) access to ambulatory services, (3) utilization of ambulatory care, (4) the proportion of households who had at least one member admitted to the hospital at least once in the last six months, (5) the average number of admissions, and (6) length of hospital stay. This data allowed us to estimate the average number of ambulatory visits and hospital bed days utilized by an average refugee per year. The second source was the UNHCR Health Access and Utilization Surveys reports and data, which allowed us to track changes in (1) the need for health care services, (2) access to health care services, and (3) spending on health care between 2014 and 2021 [114]. In addition, we used this source to (4) identify the type of providers refugees used when they utilized health care services (public vs. private vs. NGOs) and (5) estimate the out-of-pocket spending by provider type.

In this study, we also estimated the annual overall cost of providing health services for Syrian refugees in urban settings. We used the following sources of data: (1) the Jordanian National Health Accounts from 2014 to 2018, (2) the MoH annual statistical reports from 2014-2020, (3) the MoH budget from 2019 through 2021, and (4) the number of refugees treated at MoH facilities between 2018 and 2020, which allowed us to estimate the cost of an ambulatory visit and the cost per bed day at a MoH facility using the macro-costing methodology. From the UNHCR Health Access and Utilization Surveys report of 2021, we learned that 63 percent of refugees were aware of the subsidized health services available to them, leaving the remaining 37 percent vulnerable to paying out of pocket for health care. We used the reported data from the UNHCR survey to estimate the average cost of care at a private and an NGO facility. For the cost of services provided at the private facilities, we used a pricing ratio of 2.44 based on the differences in payment made at a public compared to a private facility, as reported by refugees who paid for care. For the cost of care at an NGO, we used the payment reported by refugees who paid out-of-pocket for health care services, as reported in the Health Access and Utilization Survey 2021.

5. RESULTS

5.1 Access to Health Care Services

As illustrated in Figure 24, the percentage of urban refugees who stated they needed health care in the last month increased over time, with a peak increase in 2018 by 85 percent (from 27 percent in 2014 to 49 percent in 2018), followed by a decrease to 38 percent in 2021. As presented in Table 3, nearly 90 percent of those who needed health care sought health care services in 2012, 2015, 2016, and 2021. The percentage of refugees who reported seeking needed health care services dropped sharply to 45 percent in 2018. This drop was concurrent with the change in MoH policy regarding healthcare provision to refugees at MoH facilities and the increase of copayment to 80 percent. However, prevalence reversed back to 84 percent of refugees seeking healthcare when needed in 2021 with a simultaneous change in MoH policy after the establishment of the multi-donor account, in turn supporting the MoH to provide health care to refugees and vulnerable Jordanians in host communities. The percentage of refugees who stated paying out-of-pocket for healthcare services doubled from the base year (2014) following the installation of 20 percent co-pay requirement by the MoH. In 2018, the high co-pay requirement resulted in a reduced utilization and spending on health care, whereby only 22 percent sought care when needed.



Source: UNHCR Healthcare Access and Utilization Surveys, 2014-2021

Figure 24. The trend of need for health care services, access to health needs, and out-of-pocket spending on health care, 2014-2021.

Table 5. Utilization and spending on health care services by refugees, 2014-2021

	2014	2015	2016	2018	2021
Needed health care, last month	27%	32%	39%	49%	38%
Sought health services for needed care last month	95%	88%	91%	45%	84%
Paid for healthcare last month	44%	82%	81%	77%	86%
Percentage of refugees who utilization needs health care services, last month	25%	28%	35%	22%	32%

Source: UNHCR Healthcare Access and Utilization Surveys, 2014-2021

In 2021, 22 percent of the refugees reported a chronic condition (23 percent of females and 21 percent of males), and 9 percent reported having an impairment (7 percent of females and 11 percent of males). Only 3 percent reported having a chronic condition and an impairment (3 percent females and 3 percent males). As shown in Table 6, 68 percent of those who sought health services first sought private facilities (hospital, clinic, or pharmacy), 24 percent sought care at a public facility, 7 percent sought care at an NGO facility, and 2 percent utilized other providers. On average, 32 percent of the refugee households reported having at least one female member pregnant in the last two years, 41 percent of which had at least one antenatal care service. As for delivery, 39 percent reported giving birth at a public health facility, 54 percent at a private facility,

and 8 percent delivered at home or other types of facilities. Approximately 33 percent reported having no cost for delivery, 12 percent spent less than US\$141, and only 3 percent paid more than US\$1,056 (Table 7). Finally, 94 percent of children under the age of 4 in refugees' households were vaccinated. This service is covered for free by the GoJ at the MoH facilities for all children under 6.

Table 6. Percentage of refugees who sought care by provider type and aggregate out-of-pocket spending in USD, 2021

Provider Type	% Sought care	Aggregate cost, US\$
Private sector (clinic/hospital)	35%	4,975,389
Private Pharmacy	33%	967,285
Public sector (Clinic/Hospital)	24%	1,396,025
NGO clinic	7%	101,907
Others	2%	230,241

Source: UNHCR health access and utilization survey, 2021

Table 7. Percentage of refugee women who gave birth in the last two years by type of health care provider and the amount of out-of-pocket spending in US\$, 2021

Provider Type	Deliveries by provider type	Paid Nothing	<\$141	\$141-\$353	\$354-\$1,056	>\$1,056	Don't know
Government Hospital	39%	31%	29%	22%	15%	1%	1%
Home delivery without a skilled birth attendant	1%	100%					
Home delivery with a skilled birth attendant	1%	50%		50%			
other	6%	64%	9%				27%
Private Clinic / Hospital	54%	30%	1%	22%	39%	5%	2%

Source: UNHCR health access and utilization survey, 2021

5.2 Utilization of Health Care Services

From the Refugees Health Care Access and Utilization Survey administrated by the University of Johns Hopkins in 2014, we estimated a baseline for the average annual number of ambulatory services and the number of hospital bed days utilized by an average Syrian refugee in urban

setting. We then adjusted these statistics using an adjustment factor based on the change in utilization rate in 2014 and 2021, as reported in Table 5. As presented in Table 8, a typical refugee will use 2.94 ambulatory visits and 0.62 hospital bed days. Most of the ambulatory visits occurred in the private sector (68 percent), followed by the public sector (23 percent), while a small proportion utilized NGO clinics. Most inpatient care occurred in the public sector (69 percent), followed by the private sector (24 percent), and a minority were hospitalized in NGO hospitals (7 percent). These assumptions are supported by survey data and communication with KIIs (Personal communication with MoH and World Bank officials).

Table 8. Annual utilization of ambulatory services and hospital bed days for a typical refugee by provider type, 2021

	% of ambulatory visits by facility type	% of inpatient bed days by facility type	Ambulatory visits	Inpatient bed days
Observed annual care per Syrian refugee in 2014			2.32	0.49
Utilization adjustment factor			1.26	1.26
Estimated annual healthcare visits per Syrian refugee, 2021			2.94	0.62
Observed annual care at public facilities per Syrian refugee, 2021	23%	69%	0.68	0.43
Observed annual care at private facilities per Syrian refugee, 2021	68%	24%	1.98	0.15
Observed annual care at NGOs facilities per Syrian refugee, 2021	9%	7%	0.28	0.04

Sources: Johns Hopkins 2014 Syrian refugees health access and utilization survey; UNHCR access and utilization surveys 2014, 2021

5.3 Cost of Care at Ministry of Health Facilities

Providing health services for refugees demands resources. To understand the financial burden for both donors and the government of Jordan to provide health services for refugees, we used a macro-costing methodology to estimate the cost of services provided at the MoH facilities. This method, combined with utilization data, would allow us to have an overall estimate of the cost of care for an average refugee, and the resources needed to cover these needs for future planning. Utilizing the national health accounts for the years 2014, 2015, and 2018 (latest available National Health Accounts reports), we estimated the cost of providing care at the MoH

health centers (after excluding spending on public health services) and expenditures from all sources on MoH hospitals, excluding Prince Hamza Hospital, a semiautonomous hospital with a unique financial arrangement with the Civil Insurance Program (CIP). We adjusted the cost for inflation using the GDP inflator. We addressed potential fluctuation in cost by taking the average cost per setting (i.e., ambulatory vs. bed day) for 2014, 2015, and 2018. Table 9 illustrates the steps taken to estimate the cost of health care services provided at the MoH. As presented in Table 10, the average cost for a hospital admission at a MoH hospital was US\$469.26, a bed-day US\$149.68, and an ambulatory visit (outpatient or emergency) at a hospital setting was US\$47.90. The cost of a visit at a health care center was US\$14.90, and the weighted average of an ambulatory visit in either setting (i.e., hospital or health center) was US\$24.42.

Table 9. Macro-costing analysis to estimate the cost of services at MoH facilities, 2014-2018

	2014	2015	2018	Average (2014-2018)
Primary health care				
Expenditure on personal health care services at MoH centers + vaccinations (all HC levels), 2020 USD	\$244,747,511	\$204,002,471	\$205,103,950	\$217,951,311
Number of visits at MoH facilities	15,199,795	14,042,612	12,481,268	13,907,892
Number of immunizations	3,794,924	3,854,237	3,135,075	3,594,745
Conversion factor (immunization/visit)	0.205	0.205	0.205	
Campaign immunization service equivalent to health center visit	778,491	790,658	643,129	737,426
Adjusted number of primary health care services (actual visits+ fraction of the immunization campaign services)	15,978,286	14,833,270	13,124,397	14,645,318
Cost per service, 2020 USD	\$15.32	\$13.75	\$15.63	\$14.90
Secondary (hospital) care				
Expenditure on personal health care services at MoH hospitals, 2020 USD	\$448,960,356	\$455,704,145	\$440,822,889	\$448,495,797
Number of registered beds	4,200	4,431	4,712	4,448
Occupancy rate	65.6%	65.5%	69.5%	66.9%
Average number per patients per day	2,755	2,903	3,275	2,978
Annual bed days	1,005,585	1,059,571	1,195,407	1,086,854
Total hospital ambulatory visits	5,829,705	5,653,464	6,559,679	6,014,283
Rel. factor: outpatient visit/inpatient day	0.32	0.32	0.32	0.32

Hosp. ambulatory bed-day equivalents	1,865,506	1,809,108	2,099,097	1,924,570
Total bed-day equivalents	2,871,090	2,868,679	3,294,504	3,011,425
Cost per bed day equivalent, 2020 USD	\$156.37	\$158.86	\$133.81	\$149.68
Cost per ambulatory visit, 2020 USD	\$50.04	\$50.83	\$42.82	\$47.90
A weighted average of ambulatory services provided at MoH facilities	\$24.60	\$23.99	\$24.69	24.42
Average length of stay	3.07	3.09	3.26	3.14
Cost of admission, in 2020 USD	\$480.68	\$490.88	\$436.23	\$469.26
Per capita GDP, 2020 in USD	\$3,466.47	\$3,466.47	\$3,466.47	\$3,466.47
MoH hospital bed day as % of Jordan GDP per capita	4.5%	4.6%	3.9%	4.3%

Table 10. Cost of services provided at the MoH facilities in 2020 USD

	2014	2015	2018	Average
Cost of hospital admission	\$480.68	\$490.88	\$436.23	\$469.26
Cost of an ambulatory visit in a hospital setting	\$50.04	\$50.83	\$42.82	\$47.90
Cost per bed day	\$156.37	\$158.86	\$133.81	\$149.68
Health center visit	\$15.32	\$13.75	\$15.63	\$14.90
Cost of ambulatory services provided at MoH facilities*	\$24.60	\$23.99	\$24.69	\$24.42

* This is the weighted average of the cost of ambulatory services received at health centers and hospital settings (outpatient and emergency departments)

5.4 Cost of Health Care Services for Refugees in Urban Setting

As presented in Table 11, the cost of health care per refugee was USD 309.64, 52 percent was for ambulatory care, and 48 percent for hospitalization. The aggregate cost per refugee was US\$208,372,158, of which 30 percent occurred at a public facility, 65 percent at a private facility, and 5.3 percent at an NGO facility.

Table 11. Cost of health care per refugee by type of services and type of provider, 2020 USD

	Overall	Public facilities	Private facilities	NGOs
Projected utilization in 2021				
Ambulatory	2.94	0.68	1.98	0.28
Inpatient bed days	0.62	0.43	0.15	0.04
Cost per service, USD 2021				
Ambulatory		\$28.14	\$68.76	\$19.05
Inpatient bed days		\$172.42	\$421.37	\$258.63
Total cost per person, USD 2021	\$309.64	\$92.71	\$200.60	\$16.33
Ambulatory	\$160.71	\$19.06	\$136.40	\$5.25
Inpatient bed days	\$148.93	\$73.66	\$64.20	\$11.07
Aggregate cost for Refugees in Urban Setting	\$208,372,158	\$62,391,138	\$134,993,811	\$10,987,208
	8	9	1	8

Source: Authors computation

5.5 Difference in health services fees between Syrian refugees and Jordanian nationals

Sixty-two (62 percent) of health facilities reported that health services fees, including provider fees medications and lab tests, were higher for Syrian refugees compared to Jordanian nationals

(Figure 25). This finding was especially pronounced in centers serving mainly Jordanian nationals (Table 12).



Figure 25. Difference in health provider fees, medication, and testing costs between Jordanian nationals and Syrian refugees as reported by health facilities.

Difference in fees	Mostly Jordanian nationals, some Syrian refugees	About half Jordanian nationals, half Syrian refugees	Mostly Jordanian nationals, some Syrian refugees	All Syrian refugees
Higher for Syrian refugee	69.20%	23.10%	7.70%	0.00%
Same for both populations	25.00%	12.50%	25.00%	37.50%
Total	50.00%	18.20%	13.60%	18.20%

Table 12. Difference in health provider fees, medication and testing costs between Jordanian nationals and Syrian refugees stratified by the type of population mainly served by centers.

The direct and indirect cost of health services were identified as major barriers that hinder Jordanians and Syrian refugees inside and outside the camp to receive healthcare.

“I have a disc. I cannot work... If I find a simple job, I will do it. As for the heavy work, it tires me, so I can’t do it... I did not do a disc operation Because it costs a lot .” Syrian male
“Now I need tests that cost 100 dinars. I cannot afford it. I have a lump and the doctor told me I should monitor it for 6 months. But I cannot.” Jordanian female

It seems that children also suffer from the high cost of health services and most of the time they do not receive proper care accordingly.

A Syrian mother shared her paralyzed son’s experience:

“My son is paralyzed so they told me that needles cost around 1000 dinars...I’m still looking for someone who could help. And everyone is passing through a hard time no one will offer you 1000 dinars. Can you imagine that 1000 dinars is the cost of the needles only without the surgery nor the treatment?”

Syrian refugees face barriers related to the costly health services in public hospitals as compared with Jordanians.

A Syrian female refugee commented about the cost in one of the public hospitals:

“The expenses of the medications and the examination are doubled there because I am Syrian. for example, my neighbor and I wanted to do an X-ray, so I submitted both of our applications. She is Jordanian... So, the employee there told me that my neighbor should pay 2 liras, but I have to pay 8 liras because I’m considered a foreigner.”

These financial barriers have forced some Syrian patients to go back to Syria to receive treatment.

“Financial support is always cut off for Dialysis. I mean, there are many people who return to Syria because of this problem to receive free dialysis. Despite the difficult conditions there, there are services... families return just for dialysis, because it is very expensive here.” Syrian male

Similar results were obtained from the key Informant interviews. All key informants agreed that there is no stability in the fund provided for Syrian refugees’ health services. Interviewees reported that the focus of fund lately was on capacity building of Syrian refugees and skill acquirement and private funders ceased the fund without previous notice leaving hundreds of Syrian refugees without service. Also, several clinics and services were either closed or downsized.

One interviewee reported:

“At first there was no problem dealing with funders, but with time some difficulties happened like saying we do not have funds now and coverage for all refugees became hard.”

Interviewees also reported that the mode of fund is project-based which leads to a challenge for service providers. At the beginning of the Syrian crisis the money was provided directly from NGOs, but now all fund is provided to the MoH and Ministry of Planning and International Corporation and then distributed to health facilities.

5.6 Financial barriers to seeking healthcare services

A major theme that emerged from the FGDs is financial barriers faced by Jordanians and Syrian refugees for seeking healthcare. This theme has four subthemes:

5.6.1 Impact of COVID-19

The first subtheme elicited was the impact of COVID-19 Pandemic along with resulting curfews and lockdown on people, which hindered them from seeking healthcare when needed.

“Everyone has been affected by COVID, even doctors and engineers .” Jordanian male
“Here we are all the same, Jordanians and Syrians were affected similarly by CORONA...no difference...some people lost their jobs.” Syrian male

All participants agreed that day-to-day laborers and workers who are paid wages not monthly salaries are the most affected by the pandemic.

5.6.2 Health services costs (provider fees, testing, and medications)

The second subtheme of the financial barriers to seeking healthcare is the cost of the health services including provider fees, testing, and medications.

A Syrian male told us his story of not being able to afford performing surgery for him. He said:

“I couldn’t afford to pay 1500 JD for my eye surgery. I applied to Caritas two years ago and until today I did not receive any response...I tired other NGOs such as Care organization but no luck.”

A Jordanian female added:

“One decides to go to the hospital once he is very tired.”

Most importantly, people do not receive help when they need it most.

“He broke his arm and after we removed the splint, he needed physiotherapy, but we could not do it...I mean, even physiotherapy is expensive, meaning the cheapest session costs 15 dinars, and in the end, the splint needs to be removed and put it again.” Syrian female

Jordanians were perceived like Syrian refugees in level of affording money for health services.

“I say that we as Jordanians, suffer from the same financial problems as Syrians, and we cannot afford it anymore.” Jordanian male

Lack of medical insurance is a big issue for Syrians as well as some Jordanians.

“It is a burden for all Jordanians or Syrians who do not have health insurance... I took this boy to the hospital and pay 20 dinars, out of nowhere.” Jordanian male

Patients with chronic diseases suffer the most because they need to secure medications on a regular basis.

“Some doctors used to treat Syrians for free, but they could not give them treatments for free... if you have a chronic disease, then the treatment may not end tomorrow, it may take a long time.” Syrian male

The high cost of medications -even for some insured patients- force people to buy medications from overseas.

“My friends tell me they will get me three boxes of my medication. Why? Because in Egypt, the same medicine is sold for four dinars only; a Jordanian-made medication, made in Jordan, sold for four dinars in Egypt and 27 dinars here in Jordan.” Jordanian male

The high cost of medication and some healthcare services have resulted in some mental and psychological problems.

“Lack of resources leads to mental illness. It’s all linked... and you are not psychologically prepared.” Syrian female

Another issue with the cost of healthcare services is the lack of 100 percent coverage from NGOs or the lack of several health services that these NGOs do not cover.

“If it’s a large amount, NGOs will only cover half and the patient should cover the rest.” Syrian refugee

Most females in the FGDs were disappointed by the decision of several NGOs that only cover natural births but not cesarean section. Regardless, Syrian refugees are covered in health centers and pay similar to an uninsured Jordanian adult, and this small amount still perceived high to some Syrian refugees.

5.6.3 Legal status and UNHCR, Work permit

Another subtheme that emerged was the work permit issue for Syrian refugees and the legal status of Syrian refugees according to UNHCR inspection. Most Syrian refugees complained about the process of the UNHCR inspection undertaken to assess the degree of financial and medical assistance that need to be provided for Syrian families.

“Even the UNHCR is unfair in this matter...there is no justice in the home visits they do to assess us. There are people we know dearly, whose situation is good, but they still benefit a lot from UNHCR...while other poor people do not have such support.” Syrian male

“Also, we do not have an eye print or eye signature that the UNHCR grants for some Syrians...wherever we go here, they ask us for it but we don’t have it” [...] “The eye print is for the Syrians, but how can you get one and why do some people have it and others don’t?...I don’t know, no one knows. Even the employee who comes to take data tells you I do not know. I will collect the information from you and send it to the UNHCR. Ok but what is the standard? What is the standard and how much do they evaluate? no one knows.” Syrian female

A similar issue that Syrian refugees complain about is the legal/security status (ID).

“Sometimes they don’t provide us with the treatment and if they do, we will have to pay half the value ourselves... They did not allow my kids to get treatment for 5 months until I got them a legal ID.” Syrian female

As for Syrian refugees who are willing to work in Jordan, a work permit needs to be issued to become legal employees. A Syrian male doctor commented:

“I cannot work legally here in Jordan, but I can practice my job illegally. I worked here from 2012 till 2019.”

5.6.4 Transportation costs

Transportation cost, which is related to the financial barriers to seeking healthcare services theme, is a subtheme that emerged during the FGDs of both Syrian refugees and Jordanians. The transportation costs were related to both traveling to NGOs to seek approvals for treatment or simply to seek healthcare services in healthcare facilities.

Jordanian male highlighted this issue by sharing his experience:

“I had to walk for 40-50 minutes to arrive to Caritas and then I came back home from there walking because I don’t have money to pay for transportation... and I did not benefit at all... Unfortunately, I’m Jordanian.”

Poor public transportation is another barrier in Jordan, as shared by the majority of FGDs participants. This barrier forces individuals to take private taxis to and from healthcare facilities and NGOs.

A Jordanian male said:

“You will need a taxi to come and go, that is 3 liras and 3 liras; a total of 6 JDs, and currently there are no buses in this time... The buses are broken.”

6. POLICY IMPLICATIONS AND RECOMMENDATIONS

We found that there is a great need for health services among refugees. In 2021, 38 percent of refugees needed health care in the last month, of which 84 percent could access health care services to address their needs. However, we found that access to care was affected substantially by the change to user fee policy at the MoH facilities. The utilization of health care among refugees dropped significantly in 2018 when refugees were asked to pay the same rate as foreigners for health care services at MoH facilities.

Regarding the service providers, most ambulatory services were provided in the private sector, while most hospitalization occurred in the public sector. In 2021, an average refugee who needs health care and had access to care used 2.94 ambulatory services and 0.62 inpatient bed-days. It seems that NGOs provide ambulatory health services at a lower unit cost while public facilities provide inpatient care at a lower cost. We understand that the services provided by NGOs for refugees focused on primary health care services, while the ambulatory services at private and

public facilities include secondary services. Overall, it is important to continue engage NGOs in delivery needed services for refugees. The future refugee health system should explore leveraging the strengths of the three sectors (NGOs, private, and public sectors) to improve health services for refugees.

This study estimated the average annual cost of care for a Syrian refugee at US\$309.64 per refugee in 2020 or US\$208 million for Syrian refugees registered with UNHCR. According to a paper published in 2020, the health expenditure per capita for vulnerable Jordanians was US\$244 in 2020 USD [115]. Providing health services for refugees is costly. The estimated health expenditure per refugees is higher than that per vulnerable Jordanian. The higher cost could be due to the higher demand for health services among refugees, differences in lifestyle and therefore health care needs, and health related social needs.

While most refugees were able to access health care when needed, still 6 percent were not able to access needed care. The reasons are complex and include lack of knowledge of subsidized services offered at public and UNHCR supported health facilities and confusion regarding the MoH policies toward refugees regarding user fees (i.e., cost). While progress is made to address the need of this vulnerable population, it is crucial to find a sustainable mechanism to support their access to needed health care.

Chapter 6: Health financing system response for the displaced population

1. BACKGROUND

Jordan hosts the second-largest share of refugees per capita [112]. There are 2.2 million Palestinian refugees registered with UNRWA and 755,050 refugees from 57 countries registered with UNHCR; the majority (88 percent) are Syrian refugees. UNRWA has 25 primary health facilities serving the Palestinian refugees, including those who fled from Syria since 2011. For non-Palestinian refugees, UNHCR provides comprehensive primary, secondary, and tertiary health care services free of charge in its camps and for registered refugees in urban settings through UNHCR supported clinics and subsidized care at MoH facilities. For the purpose of this research, we will focus only on Syrian refugees who are registered with UNHCR and living in urban settings. Still, readers should be aware that some refugees were not registered with UNHCR, and their vulnerability and health needs should be addressed in future research.

In response to the Syrian crisis in 2011, the GoJ offered free health care services at all MoH facilities for Syrian refugees who reside outside refugee camps if they met any of the three requirements: (1) registered with the UNHCR, (2) have a UNHCR-issued asylum seeker certificate, and (3) have a Ministry of Interior Service security card issued by the GoJ. However, the persisting conflict in Syria, the increased number of refugees, and the mounting financial burden which caused a fiscal crisis forced the GoJ to introduce steps to control utilization and cost. In November 2014, Syrian refugees seeking care at MoH facilities were treated as uninsured Jordanians. They were asked to pay a minimal co-payment for many services received at the MoH facilities (estimated at 20 percent of the cost of care). Services provided at maternal and child clinics, vaccinations, and thalassemia treatments, remained free. By 2015, more than 1.4 million vaccines were administered to Syrian refugees, and more than 251 thousand Syrians utilized services at the MoH facilities [116]. The highly subsidized health care at the MoH facilities had an enormous burden on the country's resources and health system; between 2011 and 2016, the GoJ reported spending US\$2.1 billion on health care for Syrian refugees [117, 118]. To address the refugees' needs, including health care services, the GoJ coordinated donors' response to the Syrian crisis through the Jordan Response Plan (JRP) and asked for itemized funding to meet the refugee's needs, including health care needs [119]. However, the gap between the amount requested and the amount funded was substantial. Between 2018 and 2020, the GoJ estimated the direct cost of providing health care services for the refugee population at over US\$115 million annually, and for the 2017-2019 Jordan response plan, the GoJ requested US\$224 million to cover the health needs of Syrian refugees and host communities, but only 51 percent of this amount was funded [120, 121]. The financial burden of providing health care for refugees forced the GoJ to again change its policies toward refugees seeking care at MoH facilities. In February 2018, refugees were required to pay the foreigners' rate to receive care at the MoH facilities (estimated at 80 percent of the actual cost). This change was associated with a massive drop in refugees' access to needed health care in 2018, see Figure 22 and Table 2, and led in 2019 to the establishment of the multi-donor fund to assist the MoH with covering the cost of providing health care for refugees, with US\$22.5 million contributed by the US, Denmark, and Canada as of June 2019 [112]. In April 2019, the MoH rolled back its 2018 co-payment policy to the pre-2018

level, requiring Syrian refugees to pay the noninsured Jordanians rate. In July 2020, the GoJ expanded this benefit to refugees from other nationalities registered with UNHCR [122].

2. RESEARCH QUESTION

How has the health financing system responded to the needs of displaced populations and how could it improve?

3. OBJECTIVES

This chapter presents the source of financing health care services for registered Syrian refugees, share lessons learned from financing the health care needs of the Syrian refugees since 2011, and discuss the innovative approaches the MoH, UNHCR, and local NGOs used to address the needs of urban as well as in-camps refugees. It also recommends actions to maintain and improve access to health care services and ensure stable financing for refugees' health care.

4. METHODS

We built on the costing analysis conducted in Chapter 5 to estimate the source of financing refugees' health care, conducted a desk review to understand how registered refugees' health care services is being financed, and conducted key informant interviews (KII) with 13 officials from the MoH, MOPIC, UN agencies, World Bank, and local NGOs working with refugees in-camps and in urban settings. The interviews helped fill the gap in the literature and provided a better understanding of how addressing the refugees' health care needs is coordinated between different stakeholders (see Table 13 for a breakdown of KIIs). Data were rigorously analyzed to identify themes relevant to the research questions, including lessons learned, challenges, and opportunities.

Table 13. The distribution of the Key Informant Interviews by stakeholders

Stakeholder Type	No. KIIs
United Nations High Commissioner for Refugees (UNHCR) local office in Amman	1
World Health Organization (WHO) local office in Amman	1
World Bank (WB) local office in Amman	1
Ministry of Health (MoH)	4
Ministry of Planning and International Cooperation (MOPIC)	1
Local NGOs	5

Source: Authors document

5. RESULTS

5.1 Expenditure on Health Care Services by Source

As presented in Table 14, the estimated average annual expenditure on health care services utilized by UNHCR registered Syrian refugees was US\$208 million, of which 19.7 percent was funded by the GoJ, 26.7 percent by refugees out-of-pocket, and 53.5 percent by donors. We categorized providers into three categories, public facilities, private facilities, and NGO facilities. On average, 5.3 percent of refugees' health care expenditures were for services provided at NGO facilities, 29.9 percent at public facilities, and 64.8 percent at private facilities. These results are consistent with the UNHCR's 2021 Access and Utilization Survey, which showed a declining number of refugees being aware of the free services provided at UNHCR supported clinics and subsidized services provided at MoH facilities (65 percent in 2021 compared to 81 percent in 2018) [123].

Table 14. Financing source of refugee health care services and expenditures by type of the health care facility.

	Donors	Refugees Households	GoJ	Expenditures by facility type	% of exp. by facility type
Aggregate cost of health care for Syrian urban refugees, 2020 USD	\$111,560,968	\$55,726,686	\$41,084,504	\$208,372,158	100.0%
Private facilities	\$98,891,302	\$36,102,509		\$134,993,811	64.8%
Public facilities	\$4,620,857	\$16,685,777	\$41,084,504	\$62,391,139	29.9%
NGOs facilities	\$8,048,809	\$2,938,400		\$10,987,208	5.3%
Funding distribution by source	53.5%	26.7%	19.7%		

Source: Authors computation

As presented in the next section, under the Jordan response platform for the Syrian Crisis, the average annual estimated budget for refugees' health care was US\$180 million. The GoJ spent US\$41 million for UNHCR registered Syrian refugees. In addition, the MoH's highly subsidized care covers refugees not currently enrolled with the UNHCR (estimated at around 600,000 refugees) under an arrangement where they pay a fee for service similar to uninsured Jordanians. A policy change in 2020 to include the refugees from other nationalities, would improve access to health care services at MoH facilities but further increase the financial burden on the MoH. Moreover, as efforts are made to integrate refugees within the formal healthcare sector, we expect access and utilization to increase, leading to the higher aggregate cost of care.

5.2 Key Initiatives and Action Taken by GoJ to Address the Syrian Refugees' Need for Health Care Services

5.2.1 Jordan Response Platform for the Syrian Crisis

In response to the Syrian crisis and influx of more than 1.26 million Syrian refugees into Jordan, the Jordan Response Platform for the Syrian Crisis, a partnership between the GoJ, donors, UN

agencies, and NGOs, was established in September 2013 [124, 125]. After a sequence of comprehensive need assessments that started in 2013, the GoJ drafted the three **Jordan Response Plan (JRP)** in 2017-2019, 2018-2020, and 2020-2022 highlighting priority resilience projects by sector and the required budget, including an annual average of US\$180 million for health over the 2017-2022 period [116, 126]. The health priorities focused on the following areas: (1) capacity building, (2) provision of health care services at MoH hospitals and health centers, (3) strengthening of MoH non-communicable disease control, and (4) provision of quality youth-friendly, and gender-based violence control services. Funding is generated in two mechanisms. The first is through a bilateral agreement with the Ministry of Planning and International Cooperation (MOPIC); under this mechanism, the MOPIC plays the role of financing agent and allocates resources to the needed entities. The second mechanism is direct funding for implementing agencies. This mechanism applies mainly to the United Nations Agencies and International NGOs.

Opportunities: The JRP aimed to coordinate donors' contributions to finance sustainable, cost-effective programs supporting refugees and the host communities based on a predetermined list of national priorities. The GoJ aimed to share this priority list (with clear goals, objectives, and budget) with donors who would support these priorities. This innovative approach allowed the GoJ to provide an annual list of needs based on evidence from need assessment studies and share with the international community the priority and burden of providing care and improving the livelihood of refugees in Jordan. The JRP managed to channel needed funding to programs that met the needs of refugees and the host communities by working with other governmental institutions, such as the MoH. In addition, the JRP kept donors up to date with the needs of the Syrian refugees, both in and outside the camps.

Challenges: Several challenges impede the optimal implementation of the JRP. Three main concerns raised from the interview. First, many donor-funded projects are soft activities that do not address the capital and infrastructure needs but focus on awareness campaigns and training (with no follow-up with trainees) that are not sustainable. Second, there seems to be a conflict between the GoJ and donors' priorities. Some donors prioritize their programs to the GoJ national priorities. When officials at MOPIC review and provide their input, the donors would politely acknowledge the feedback but maintain their priorities and programs in the final proposal causing more concern than solving problems. The third is the sustainability of funding and budget deficit. Over the last few years, donors' contributions dwindled, and the funding received to meet the needs of refugees was nearly half of the requested budget. Of the US\$178 million requested by the MOPIC in 2019 for refugees' health 51 percent (i.e., US\$91 million) was funded (Personal communication with MOPIC [127]).

Lessons learned: GoJ through MOPIC developed and shared the JRP with donors and key stakeholders to address the needs of Syrian refugees and the host communities with streamline to ministries responsible for implementing these programs. The JRP identified priorities, goals, and objectives, and estimated the budget needed for implementation. The JRP aimed to avoid duplication of services, expand services to all geographic areas instead of easy-to-reach localities,

and reduce operational costs by adopting one delivery mechanism. However, inadequate funding, different and sometimes conflicting priorities, and what seems like a lack of commitment to address the root cause of the challenges through investment in infrastructure and capital projects led to wastage in implementing unsustainable programs. There is an urgent need for the international communities and donors to (1) localize their priorities to align with those identified by the GoJ, (2) allow pooling of their resources with resources from other donors, (3) meet their financial commitments, and (4) be mindful of the feedback received from the host country.

5.2.2 Multi-Donor Account

In December 2018, the MoH established the Multi-Donor Account (MDA) Directorate as a continuum of the Jordan Response Platform for the Syrian Crisis to streamline funding from donors to projects and programs needed by the MoH to meet the health care needs of refugees and the host communities. Through the MDA, the MoH took ownership of the refugees' agenda and proactively set the ministry's priorities based on needs identified in the field. The MoH through the MDA reached out to donors for support and follow-up with implementation plans and achievements. The MDA supported infrastructure projects, the purchase of medical equipment, and invested in human resources by focusing on capacity-building programs. The MDA is a separate account from the MoH budget and is part of the "outside-of-the-budget" account that includes funding from MOPIC. It is supported by the USAID (biggest contributor), the World Bank (through loans), countries like Canada and Denmark, the EU, and Gulf states (through funds such as the Qatar Fund, the Kuwait Fund, and the Saudi Fund). For example, the Jordan Emergency Health Project with a total budget of US\$250 million allocated part of the funding, US\$30 million, to cover healthcare costs for registered Syrian refugees. Based on the agreement between the World Bank and the GoJ, the Ministry of Finance (MoF) was required to transfer US\$7.5 million per year for four years to the MDA to support the MoH effort.

Opportunities: The MDA allows the MoH to identify priority areas, develop targeted proposals for submission to donors who, after negotiation with MoH officials, would fund these projects. There is a rigorous process to ensure appropriate implementation. The MDA has a steering committee that meets twice a year to discuss project implementation and challenges and review new project proposals. Field visits and financial reports detail progress, and ad hoc meetings are used to address needs and challenges in real-time. To ensure accountability, the audit bureau is involved in reviewing the financial reports for accuracy and consistency. During the COVID-19 pandemic, MDA provided flexible funds used by the MoH, in addition to other mechanisms such as national fundraising campaigns, to respond to the devastating impact of COVID-19 on the health care system.

Challenges: The MDA operates within the framework of expanding health coverage to achieve universal health coverage. Funding remains a concern as donors' attention shifts to other conflicts, the sustainability of this fund might be jeopardized.

Lessons learned: MDA was an opportunity for the MoH to take ownership of identifying operational gaps and proactively coordinate with donors to address needs. The system

developed through the MDA could be a model to adopt as GoJ moves toward an inclusive universal health care system. GoJ and donors should work on a mechanism to ensure sufficient funds are available to the MoH as needed to fill the gaps.

5.2.3 Ministry of Health

Since the beginning of the Syrian crisis in 2011, the MoH has been providing care to the Syrian refugees in its facilities, contracting with private providers for the provision of care or referring patients to other providers including university hospitals. Funding of the Syrian refugees at MoH facilities has two mechanisms. The first is through the MoH budget which accounts for 6-7 percent of the total GoJ budget. The budget was determined using a historical approach and based on the previous year's budget. In 2018, the GoJ decentralized the budgetary process and asked the governorates to provide a detailed budget set by goals to cover their needs for the coming year. The MoH consolidated all governorates' budgets and submitted it to the MoF. This was a new and challenging process for the governorates and required training which was provided in subsequent years through the MDA. The second mechanism is the "out-of-the-budget" where funds are channeled from MOPIC through a bilateral agreement with donors and the MDA.

With the assistance of the USAID, the MoH has been introducing HAKIM, a computerized system to capture the utilization of services by patient, nationality, and insurance status, into its health care centers and hospitals. HAKIM allows the MoH to track the number of patients and type of services provided at its facilities and would allow the MoH to estimate the cost of care. Currently, HAKIM operates in 14 percent of the MoH centers. However, HAKIM implementation has been unevenly distributed across governorates with most HAKIM-enabled health centers located in central governorates, due to the high volume of patients in these localities. HAKIM is a crucial functionality. It allows the MoH to determine the resources needed (i.e., staffing, capital, and recurrent resources), the type of services utilized to develop containment plans if needed (e.g., incentives to reduce the prevalence of non-communicable diseases), and plan for future investments.

Opportunities: With thousands of refugees utilizing services at the MoH facilities, the quality of health care services deteriorated prompting the MoH to consider different scenarios to improve the quality of care [116]. Different options are available but need commitment and financial resources to implement. The first is requiring public health centers to become accredited by the Jordan Health Care Accreditation Council (JHCAC). Synchronizing utilization information by patient type and disease as well as the cost of care from HAKIM would allow the MoH to predict the resources needed to provide care at the center level. In partnership with donors, the MoH could develop benchmarks for key health indicators to hold providers accountable for both quality and cost of care. Another scenario mentioned during the interviews with KII is to allow all Civil Insurance Program (CIP) beneficiaries to seek care in the private sector, where they would pay a 20 percent co-insurance. Supporters of this option argue this approach would reduce utilization at MoH facilities and allow providers there to provide high-quality care to vulnerable Jordanians and refugees.

Challenges: The influx of refugees seeking care at the MoH have direct and indirect cost to the MoH; a direct cost of providing care, and an indirect cost of providing a lower quality of care. The MoH is working through different channels to address the direct cost and is currently working to address the quality of care. In the opportunity section, we covered three directions the MoH might consider improving the quality of care at the MoH facilities, based on the KIIs. (1) Requiring that all health centers at MoH facilities obtain health accreditation from the JHCAC. This would require substantial financial and human resources to meet the JHCAC rigorous accreditation standards, but it could be obtained gradually; (2) Build on the MoH experience in decentralization, accreditation, and digitalization to shift to value-based care. The key challenge with this option is ensuring accurate up-to-date data on utilization, and commitment to provide the needed resources, so sustainable funding in the short term might be an issue; and (3) Opening the door for CIP beneficiaries to utilize services in the private sector. While MoH through the CIP has experience purchasing services from the private sector, the current system is based on volume rather than on quality of care. Hospitals are required to be accredited but more needs to be done to convert the current system from FFS to value-based purchase. This is an area where health system strengthening activities could contribute to assisting MoH and CIP effort in shifting health care systems from volume-based to value-based financing. The other challenge with this approach is the possibility of developing a two-tier healthcare system where the refugees and vulnerable Jordanians use the MoH facilities and the well-off, including those covered by CIP, utilize the private sector. Without an appropriate mechanism to control utilization, this scenario might have an adverse impact on MoH, especially if MoH resources are moved to CIP to pay for care at private facilities.

Health needs of Syrian refugees were tremendous at the beginning of the influx. They have been through war, those with chronic diseases were left untreated for a certain period of time which affected their health outcomes; however, these needs began to diminish over time after refugees began to settle down and adopt a healthier lifestyle. Mental health was the most prominent issue among Syrian refugees.

“Then, when they merged into society and lived in the area and so on, their needs became like any disease, influenza, etc., like any of these diseases. Diseases like the Jordanian citizen. As for the beginning, frankly, because they came from a war we noticed, for example, that they needed more special care, I mean, especially from a psychological point of view, I mean, there were people among them visiting you I noticed that they were Broken they need psychological care, more psychological care than ordinary curative care.” KII participant

5.3 Role of UN agencies in providing care for refugees

While the MoH provides care for all Syrian refugees regardless of their status, the UNHCR provides care only for those registered with the agency regardless of their residence (i.e., in-camps or in urban settings). UNHCR operates two camps (Za’atari and Azraq camps) and provides

health care for refugees through its implementation partners. The implementation partners include local NGOs, International Medical Corps (IMC), Arabian Medical Relief (AMR), Saudi clinic, Qatari health facilities, and Syrian American Medical Society. Most of the care provided in camps are primary health care services, through the implementing partners' clinics, and a hospital run by IMC. Most of the services focus on primary health care, while secondary and tertiary care go through the UNHCR referral system, operated by the Jordan Health Aid Society (JHAS) then by IMC, for care outside the camps. Due to the budget constraints, the conditions for referrals were limited to emergency lifesaving conditions with approval from UNHCR. The referral process includes a case review by the Exceptional Medical Care Committee (ECC), which consists of 2 external medical professionals (1 oncologist and 1 internist), and a representative from UNHCR, to determine the prognosis and cost of each case. On average, the committee reviews 200 to 300 cases each month for referral pathways. However, UNHCR faced a challenge that under the existing referral system by UNHCR partner implementing secondary health care services, UNHCR's implementing partner is charged the unified rate (known as the foreigner's rate) which is several times the uninsured Jordanian rate. Of the in-camp cases referred for tertiary care, nearly 70 percent went to private hospitals. The referral to the private sector was seen as cost-effective by the implementing partners due to the current agreement between IMC and the MoH whereby IMC is charged a foreigner rate at public facilities and would need an agreement of understanding to get the subsidized rate, and the perception that there might be a long waiting time to get care at MoH hospitals (Personal communication with UNHCR official). Of these referrals, 90 percent are lifesaving and end-of-life referrals.

UNHCR solicits implementing partners through an expression of interest advertisement. Interest agencies submit proposals and UNHCR review these proposals through a multifunction team (MFT). The MFT makes a recommendation to the Implementing Partners Management Committee (IPMC). When the IPMC endorses a new partner and approval is received from Geneva, UNHCR signs a Project Partner Agreement (PPA) with the selected implementing partners. The implementing partners are reimbursed quarterly for services they provided during the previous quarter. To monitor the quality of services, the UNHCR conducts performance visits. The quarterly payment is determined based on information provided from different sources, including the monthly utilization reports submitted by the implementation partners, the health information system, clinical data management, and CCR software.

Opportunities: UNHCR implemented **Cash-for-Access**, a program that reimburses Syrian refugees for essential health care expenditure. In January 2021, this program was extended to include non-Syrian refugees as well. The provision of CASH assistance means refugees can pay for services themselves and will be charged the non-insured Jordanian rates. Thus, it is more cost effective to support the refugee to pay for themselves when they access Ministry of Health services. UNHCR has the expertise to contract and monitor health care providers. It can use this data to estimate the utilization and cost of care in the camps and contract with implementing partners based on the number of refugees who could be enrolled to seek care at the partner's facility. This information could reduce the administrative cost and shift the focus to the population served. While this arrangement might shift the financial risk to providers and the

implementation partners, with accurate data and fair compensation this arrangement would allow the implementing partners to be creative in providing health care services for their member. It might allow them to address health-related social needs as well, such as providing nutrition advice and planned medical food plans to refugees with chronic conditions.

Challenges: Funding is a critical challenge. The UNHCR budget has been reduced annually with an 8 percent reduction in 2022, from US\$25 million in 2021 (Personal communication with UNHCR official) due to donor fatigue and emerging crises elsewhere. In addition, some of the operational partners, including MSF, Moroccan field hospital and IRC withdrew their services from camps due to lack of funding, reducing the services available at the camps and increasing the pressure faced by the local NGOs who continued to operate in the camps amid the COVID-19 pandemic.

5.4 The Future of Refugees Health Care Financing: Donors Perspective

The World Bank (WB) has two active operations related to refugees' health. The first operation is the **emergency health response** required by the GoJ in 2017, whereby the World Bank funded refugees' services at MoH health centers and focused on reimbursing two line-items including medication provided at the primary and secondary health care levels. To estimate the amount spent on refugees, the GoJ hired a third party to verify the medical record at a sample of health centers, reviewed a sample of hospitalized cases from the electronic record at the central ministry or hospitals, and requested the financial audit bureau to conduct the financial audit of the line-item budget. As a result, the World Bank approved a US\$30 million four-year emergency health response project. The World Bank disburses US\$7.5 million annually to the MoF, which allocates the money to the MoH. While the World Bank is not a signatory to the MDA and doesn't directly fund this account, the MoH can decide if it desires to include this World Bank annual contribution to the MDA funds. To address the sustainability challenge, the World Bank collected and created a data set on the utilization of health care services. The World Bank is currently in the process of analyzing this data to assist in the World Bank's and MoH's effort to strengthen the health care system through a comprehensive health insurance reform with a focus on refugee health.

The second World Bank-funded operation is the **COVID-19 response** using Global Concessional Financing Facility (GCFF) concessional financing to procure and deliver vaccines allowing Jordan to offer COVID-19 vaccine to all residents, including refugees regardless of their nationality. This operation was built on cooperation with the MoH as a technical partner and in collaboration with the WHO, USAID, and other partners.

Opportunities: the World Bank has the technical expertise needed to help the GoJ build the capacity needed to arrive at a consensus regarding the comprehensive health care benefit packages, contract with providers, monitor the care, and reduce the program's waste and fraud. However, this would require access to data currently unavailable to the MoH. In the long run, another opportunity is for donors to consider financing health insurance premiums instead of financing services. Although the MoH is currently not willing to include refugees into existing

health insurance schemes or create a new health insurance scheme unless donors guarantee their continuous commitment to cover the refugees' health service. It is critical for donors to continue engaging the MoH in the discussion of developing health insurance schemes for refugees, which would help the future integration of refugee health into Jordan's national system.

Challenges: Financial sustainability for refugees' health is a critical challenge as donors' funding has been dwindling in the last two years, thus increasing the burden of financing health care services on MoH and refugees. The World Bank emergency response operation targets and collects data only on UNHCR registered refugees. Many Syrian refugees are not currently enrolled with UNHCR for various reasons, including the restrictions on certain occupations work permit registered refugees have, compared to the employment opportunities they might have in the informal sector. Excluding this population from the data collected by World Bank on access, utilization, and cost of care for refugees leaves the unregistered Syrian refugees at a disadvantage and might misinform the effort to develop **an inclusive health care system**.

Participants also reported that funding has massively decreased in the past two years when compared to the beginning of the Syrian crisis. At the beginning of influx there were little monitoring for huge fund but recently there is less fund with higher monitoring and restrictions:

"Loans and grants also decreased by about fifty percent from what they were in the beginning, and this is evidence that the funding will decrease more and more, and the priorities of countries differed, and the priorities of citizens of countries also differed. Therefore, I think that, as a country of Jordan, which has limited resources, it will not be able to continue to provide good quality health services in light of the Corona pandemic."
KII participant

There has been a sudden ceasing of funds by private funders without previous notice leaving hundreds of Syrian refugees left without service. Also, several clinics and services were either closed or downsized. At the beginning of the Syrian crisis, the money was provided directly from NGOs but now all fund is provided to the MoH and Ministry of Planning and International Corporation. This instability in funding puts pressure both on service providers (staff) and refugees.

"The service was discontinued, for example, in 2014, before we took over it, it was in the Red Cross. There were challenges with the fund, so the hospital was closed for a month, and then it returned to work when we took over it. It was a bad experience for the refugees."
KII participant

5.5 The Enhanced Role of Local NGOs in Provision of Health Care for Syrian Refugees

Since the beginning of the conflict, local NGOs stepped up to meet the demand of refugees by providing frontline medical units, health care, shelter, camp management, coordinated volunteers' effort, as well as 24/7 paramedic services. Local NGOs are categorized into three groups: those who operate in camps only, those who operate outside camps and focus on urban

refugees, and those who operate both in camps and in urban settings. Most of the NGOs operating in the refugee camps are funded by donors, and their services focus on primary health care and on operating a maternal hospital. The funding arrangement is based on an annual contract, with the possibility of renewal, executed after a lengthy process of writing and submitting a proposal, negotiating with funders, and signing a funding agreement/contract. The local NGOs are reimbursed after submitting a request for payment, usually on a quarterly basis. Initially, NGOs working with UN agencies have procured the medical equipment and necessities from the local market. However, the funding UN agencies have changed their procedures and are conducting global procurement and disseminating medical necessities to their implementing partners based on a list of needs submitted by the implementing partner on a monthly basis. Some local NGOs have a sophisticated Clinical Data Management System software with medical services and profiles that allows a single pharmacist to monitor medication stock in clinics and send a request for the needed medication to the UN agencies.

Opportunities: The conflict in Syria and the influx of refugees led to a dramatic demographic shift in Jordan that overwhelmed the GoJ. However, it was an opportunity for the local NGOs to flourish and contribute to the GoJ response to the Syrian crisis. During the past decade, local NGOs enhanced their capacity in writing proposals and winning donors' funding to support their operations. These new skills could be used to target specific services that might ease the burden of providing primary health care at MoH facilities or complement some of the services provided by the MoH. The MDA created a venue where stakeholders from all sectors meet to discuss the refugees' needs and discuss opportunities to address these needs. This could be an opportunity for the MoH to delegate some of the services to the local NGOs, especially since some of them are adopting an inclusive approach to address refugees' needs including social and health needs. During the COVID-19 pandemic, local NGOs were the only entities providing care in refugee camps, proving their commitment to improving refugees' health. In addition, some local NGOs are engaged in fund-generated activities, like training, to sustain their services.

Challenges: Again, funding and delay in payment from non-UN donors is a major challenge facing local NGOs in Jordan, as they might find themselves in financial limbo, and might be forced to close operation for some time till funding mechanisms are reestablished.

All participants in the KIIs agreed that there is no stability in the fund provided for Syrian refugees' health services. The mode of funding is project-based which leads to a challenge for service providers. It is extremely important to allocate a sustainable funding and not a temporary solution for financing healthcare services for refugees.

"In my personal opinion, we cannot remain dependent on loans, we cannot remain dependent on grants, too. The countries of the world are suffering, so one day they will tell us about grants, for example, we will not be able to give you grants that are enough, loans also." KII participant

6. POLICY IMPLICATIONS AND RECOMMENDATIONS

There is a consensus that an inclusive universal health care system that integrates the refugee population is the goal of the GoJ, but data needed to develop this inclusive system is lacking, and funding, especially for refugees, is not guaranteed. The GoJ and donors should explore the feasibility of a range of options, including expanding the government’s own health insurance system and attempting to gradually include all refugees rather than creating a separate refugee insurance system. The question here remains who will fund such initiatives especially given the fact that registered Syrian refugees have limited employment opportunities, where they can only work in certain occupations open to foreigners; and many sectors with good pay such as health, engineering and technical professions are not available to them.

Strengthening the health care system requires a restructuring of the current health care system which focuses on the volume of services instead of the quality of care. While limited health care accreditation is available in Jordan, the full potential of this tool has not been utilized. The GoJ and donors should focus their health care strengthening efforts to create a system that focuses on value instead of volume. This would require investment in digital systems and health information technologies. The MoH has already started this process with the help of the USAID through the HAKIM program. Donors and the MoH should enhance the functionality of this program to provide them with the data for better planning and monitoring. In addition, this data could help in estimating the annual cost per beneficiary which can be used in the future to restructure the health system toward value-based finance. The analysis presented in Chapter 5 is one example of how this data could be used.

Finally, improving the health care of refugees and vulnerable Jordanians requires a multisectoral response, to address health-related social needs including employment for both Jordanians and refugees.

Conclusions And Lessons Learned

Our findings indicate a humble capacity of health facilities to provide health services as indicated by the mean *General Readiness Index* (39.5). The health facilities offer a wide range of services, however insufficiency in providing other specific services still exists. Both Jordanian nationals and Syrian refugees still face many obstacles in accessing healthcare such as health services costs, long waiting time, and social discrimination, and the majority are not satisfied with the quality of services provided, especially at public hospitals and clinics. The refugees' health needs are relatively high. The future refugee health system should explore leveraging the strengths of the three sectors (NGOs, private, and public sectors) to improve health services for refugees. Financial sustainability for refugees' health is a critical challenge as donors' funding has been dwindling in the last two years, thus increasing the burden of financing health care services on MoH and refugees. Funding and delay in payment from non-UN donors is a major challenge facing local NGOs in Jordan, as they might find themselves in financial limbo, and might be forced to close operation for some time till funding mechanisms are reestablished. Finally, improving the health care of refugees and vulnerable Jordanians requires a multisectoral response, to address health-related social needs including employment for both Jordanians and refugees.

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