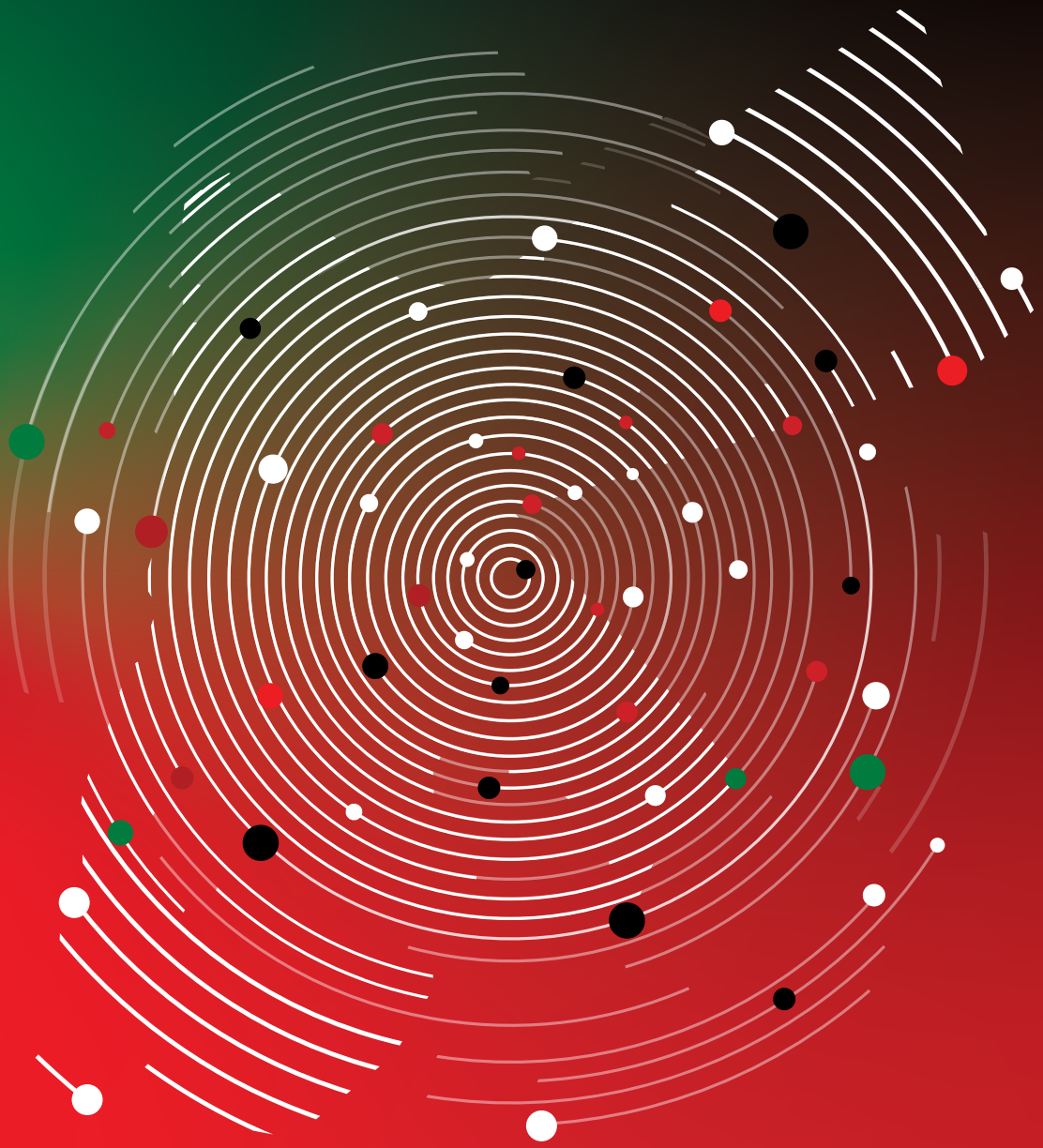
World Health Organization

وزارة الصحة

Refugee and migrant health system review

challenges and opportunities for long-term health system strengthening in Jordan



World Health Organization

Refugee and migrant health system review

challenges and opportunities for long-term health system strengthening in Jordan

Refugee and migrant health system review: challenges and opportunities for long-term health system strengthening in Jordan

ISBN 9789240094970 (electronic version)

ISBN 9789240094987 (print version)

Contents

Acknowledgements

Leadership and coordination

The joint mission to review health system capacity to identify opportunities and challenges in Jordan was conducted under the leadership of the WHO Department of Health and Migration, (WHO headquarters, Geneva), Department of Universal Health Coverage/Health Systems (WHO Regional Office for the Eastern Mediterranean, Cairo) and the WHO Country Office Jordan, in close collaboration with the Ministry of Health in Jordan.

This mission would not have been possible without leadership, collaboration and support from several WHO teams:

- **WHO Department of Health and Migration:** Dr Santino Severoni, Director; Ms Camila Polinori Castro, Technical Officer; Dr Mohammad Darwish, Technical Officer; Dr Sylvia Garry, Technical Officer; Dr Miriam Orcutt, Technical Officer; and Dr Apostolos Veizis, Consultant.
- **WHO Department of Universal Health Coverage/Health Systems:** Dr Awad Mataria, Director; Dr Ali Ardalan, Regional Advisor; Dr Tonia Rifaey, Technical Officer; and Dr Najibullah Safi, National Professional Officer.
- **WHO Country Office Jordan:** Dr Jamela Alraiby,WHO Country Office Representative; Dr Saverio Bellizzi, Emergency Team Lead; Khalid Kheirallah, Consultant; and Dr Christian Popescu, Technical Officer.

Review and documentation

The members of the Joint Review Team wish to express their sincere appreciation to the Ministry of Health of Jordan for its commitment to strengthening the national health system and its continuing efforts to protect the health of refugees and migrants in the country. The Joint Review Team is also particularly grateful for the support provided by the following entities and organizations during the planning and coordination of the different components of the joint review and field mission: Caritas Jordan, the International Labour Organization, the International Organization for Migration; the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR), the United Nations Population Fund, the United Nations Relief and Works Agency for Palestine Refugees in the Near East and the United States Agency for International Development.

Special thanks go to Engineer Huda Ababneh, Director of Project Management, Planning and International Cooperation, Ministry of Health, Jordan, for her overall technical and wider support throughout the joint review.

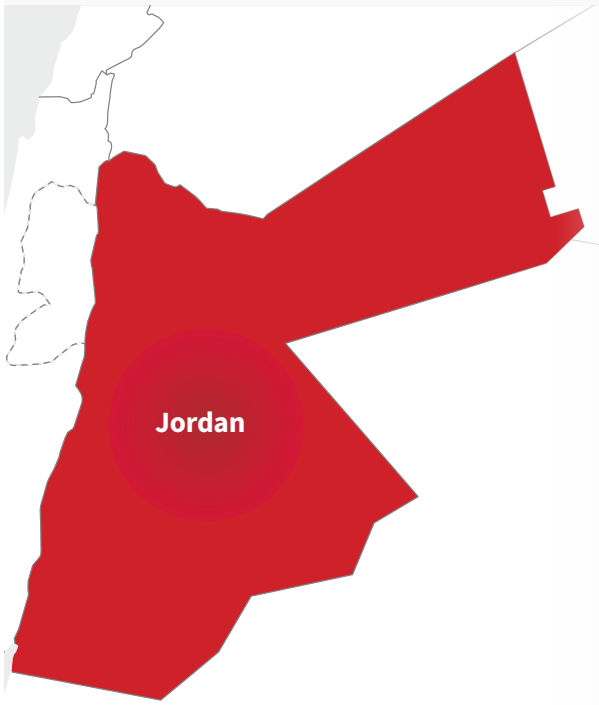
Joint Review Team members

- Hiba Abaza, International Organization for Migration Jordan
- Ibraheem Abu Siam, UNHCR Jordan
- Saverio Bellizzi, WHO Country Office Jordan
- Mohammad Darwish, WHO Health and Migration Department, WHO headquarters
- Sylvia Garry, WHO Health and Migration Department, WHO headquarters
- Layali Gharybeh, UNHCR Jordan
- Khalid Kheirallah, WHO Country Office Jordan
- Miriam Orcutt, WHO Health and Migration Department, WHO headquarters
- Christian Popescu, WHO Country Office Jordan
- Tonia Rifaey, WHO Department of Universal Health Coverage/Health Systems (WHO Regional Office for the Eastern Mediterranean)
- Najibullah Safi, WHO Department of Universal Health Coverage/Health Systems (WHO Regional Office for the Eastern Mediterranean)
- Iyad Shtayat, UNHCR Jordan
- Sitora Shokamolova, UNICEF Jordan
- Muna Sultan, UNICEF Jordan
- Apostolos Veizis, WHO Health and Migration Department, WHO headquarters

Abbreviations

CHC	comprehensive primary health care centre
ILO	International Labour Organization
IOM	International Organization for Migration
JOD	Jordanian dinar
NCD	noncommunicable disease
NGO	nongovernmental organization
PHC	primary health care
RCCE	risk communication and community engagement
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
UNWRA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development

Executive summary



JORDAN HAS MORE THAN 3 MILLION MIGRANTS
(one third of the country's total population)
and has witnessed three major waves of refugees in its modern history:

Palestinian refugees	Iraqi refugees	Syrian refugees
1948 and 1967	1990 and 2000	Since 2010

Under its commitment to achieving universal health coverage (UHC), Jordan has been continually supporting vulnerable populations such as refugees and migrants by offering subsidized access to essential health services, for example routine immunization. This commitment is further emphasized in the Ministry of Health Strategy 2023–2025.

With the objective of exploring opportunities to strengthen Jordan's Ministry of Health and the Jordanian health care system in providing services to refugees and migrants, as well as Jordanians, WHO conducted a joint review mission in collaboration with key stakeholders such as the International Organization for Migration (IOM), the United Nations Children's Fund (UNICEF), the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). The review consisted of a preparatory phase with the establishment of a national Steering Committee and the development of a desk review to inform priority areas for the field mission, which took place from 18 to 24 June 2023. The WHO Refugee and Migrant Health Country Assessment Tool, which includes standards questions around the health system, was tailored to the Jordan context and utilized to address challenges and opportunities at the levels of both primary health care (PHC; visits to six facilities) and governorate (interview with 15 health facilities' directors and frontline health care workers) in Amman, Irbid and Mafraq. The overall initiative supported the development of informed and evidence-based public health interventions, building upon existing public health system capacities, in essential

public health functions such as emergency preparedness and response, risk communication and community engagement (RCCE) and research, as well as the traditional pillars of the health system as a whole. Findings from the joint review confirmed the strain on the public health system by the long-standing presence of refugees and migrants, with the need to invest in competencies around cultural mediation, epidemiology and public health. The initiative revealed a unique opportunity for the Ministry of Health to start collaborating with other ministries in the refugee and migrant portfolio such as the Ministry of Labour, which oversees a number of health facilities in industrial areas that are not fully aligned with Ministry of Health plans and procedures. Cooperation with other Government institutions could facilitate more accurate estimation of the current numbers of refugees and migrants in Jordan, in addition to their health needs, in order to better plan and mobilize resources. From the policy perspective, there is a need to review the current tuberculosis (TB), HIV and *Haemophilus influenzae* type b screening for migrant workers, who are not allowed to work in Jordan if tested positive. PHC centres should have periodic evaluation for utilization, shortages and so on, in addition to feedback on their health information routine and emergency reporting. The health security agenda deserves particular attention, and a standard process for public health risk assessment at subnational level is required in order to develop and test emergency plans and ensure adequate human resources. However, the Jordanian Ministry of Health, in light of experiences with the COVID-19 pandemic, is showing great progress in the area of RCCE, which requires further fine-tuning to better meet the expectation of communities, including refugees and migrants. Health information in Jordan remains fragmented and it is critical to have an effective mainstreamed system operating, with standard disaggregation of crucial variables for refugees and migrants. This would also facilitate the research agenda, which is another unique opportunity for the Jordanian Ministry of Health to further foster evidence-informed decision-making.

1. Introduction

1.1 Background

JORDAN
is a lower-middle income country that is divided into 12 governorates.

The Department of Statistics estimated the population to be

11 057 000 people in 2019

(53% male) (47% female)

with **90.3%** living in urban areas.

Three quarters of the country population (74.8%) is concentrated in the three main cities of:

Amman	4.5 million	inhabitants, 22 areas
Irbid		2 million
Zarqa		1.5 million *(1)*

The population has expanded from 5.4 million in 2003, largely due to the influx of refugees and a relatively high birth rate.

The population growth rate (Jordanian) **in 2017–2018 was 2.3,** while the fertility rate was 2.8 children per woman *(2)*.

Jordan's maternal mortality continued to decline, from 50 per 100 000 births in 2013 to 32 in 2019, and almost all births (99.7%) take place in a health facility *(3)*. Under-5 and neonatal mortality rates, respectively, were estimated at 14.0 and 11.0 per 1000 live births in 2020 *(3)*.

Full vaccination coverage stood at 96% in 2020, which was down from the 99% coverage achieved in 2015. Immunization services further declined with the COVID-19 pandemic.

Communicable disease rates are among the lowest in the region *(3)* while the country is increasingly affected by a significant epidemiological transition towards noncommunicable diseases (NCDs), which accounted for 78% of deaths and represented the leading cause of mortality and morbidity among Jordanians in 2019 *(4)*; the main risk factors for NCDs are:

tobacco use, accounting for 41% of the overall population, and

unhealthy diet, with 60.8% of the population being overweight.

There is a growing burden of **mental health conditions**, which require dedicated multisectoral approaches. This situation is exacerbated by the presence of refugees, who experience a higher prevalence of mental health issues linked to the protracted crisis and not enough mental health services to support them.

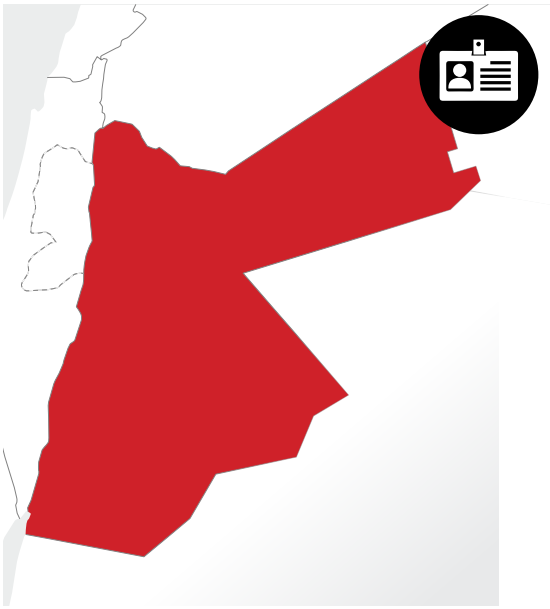
Jordan is committed to achieving UHC as part of its efforts to achieve the Sustainable Development Goals by 2030. The Jordan Vision 2025 sets a target of health insurance coverage at 95% *(5)*. Such commitment was reiterated by the Government in 2018, pledging to reach a health insurance coverage of 80% of Jordanians by the end of 2020 as a key milestone towards UHC. The Ministry of Health's National Health Sector Strategy 2016–2019 *(6)*, and the most recent Ministry of Health Strategy 2023–2025 *(7)* have clearly incorporated Health for All policies and UHC components. World Health Organization (WHO) has supported the Ministry of Health in these efforts, including a better understanding of the health system's (supply) requirements to better meet the needs of vulnerable groups including refugees, migrant workers and poor Jordanians.

1.2 Refugees and migrants in Jordan

In its modern history, Jordan has had three major waves of refugees: Palestinian refugees (1948 and 1967), Iraqi refugees (1990 and 2003) and Syrian refugees (since 2010). The United Nations estimated that the total number of migrants in Jordan was more than 3 million in 2023, about one third Jordan's total population and representing 52 nationalities *(8)*.

The Government of Jordan estimates that the total number of Syrian refugees (UNHCR registered or unregistered) living in Jordan is around 1.36 million. About 80% live among host communities, mainly in Amman and northern governorates, while nearly 20% have opted to live in camps *(9)*. Two major Syrian refugee camps are currently active: Za'atari (80 000 refugees) and Azraq (40 000 refugees). According to UNHCR Jordan, Jordan hosted 739 557 active registered refugees and asylum seekers (UNHCR records, 15 July 2023), mainly Syrians (88.5%) and Iraqis (8.8%). About half are children (46%), with 48% adults and 6% elderly people (UNHCR records, 15 July 2023). One fifth of UNHCR-registered refugees are either children under 5 years of age (12.5%) or adults over 60 years (5%), and 83% live in host communities *(8)*. Palestinian refugees in Jordan are estimated at 2.5 million, as serviced by UNRWA, with most having Jordanian nationality *(10)*.

Although precise numbers of migrant workers are not available, the Ministry of Labour estimated that there may be between 1.2 million *(3)* and 1.4 million *(11)* non-Jordanians working within the country.



Jordan has a total of
333 283 migrant workers with valid work permits issued by the Jordanian Ministry of Labour

54.1% from Egypt, mainly men

12.9% from Bangladesh

4.8% from India

3.7% from the Philippines

2.3% from Sri Lanka

Those from Bangladesh, India, Philippines and Sri Lanka work within industrial free zones in the exporting garment sector *(12)*. Around 48 622 migrant workers were employed in the exporting garment sector in 2021, the majority of them women (75%) *(13)*.

1.3 Legal frameworks and policies related to refugees and migrants

Jordan is not a State Party to the 1951 Convention relating to the Status of Refugees or its 1967 Protocol, and nor is it a Party to the 1954 Convention relating to the Status of Stateless Persons or the 1961 Convention on the Reduction of Statelessness. However, in 1998 a memorandum of understanding was signed that set the parameters for cooperation between the Government of Jordan and the UNHCR on the issue of refugees and asylum seekers. The memorandum of understanding outlined the major principles of international protection, including the definition of a refugee and the principle of non-refoulement. The memorandum was partially amended in 2014 *(14)*. The Ministry of Health is the main umbrella ministry providing health care services to refugees and usually regulates, along with the Ministry of Planning and International Collaboration, services provided through non-State actors by UNHCR and other global partners.

Since 2010 the Government of Jordan has signed multiple agreements with donors to incorporate Syrian refugees within the social structure of Jordan, including for health coverage and employment opportunities. The most prominent agreement was the establishment of the Multi-Donor Account to support Jordan's health sector to provide health care for vulnerable Jordanians and also Syrians *(15)*. Access to subsidized health care for Syrian refugees has been guaranteed through the Jordan Health Fund for Refugees (the Multi-Donor Account) *(16)*. In addition, the Ministry of Health has clear policies and regulations governing access to health care services for UNHCR-registered refugees at the PHC level, along with clear operational plans.

While the Ministry of Health and UNHCR continue efforts to maximize utilization of existing services, barriers to access for public health facilities at the subsidized rate have also been highlighted in the Health Access and Utilization Survey *(17)* and the Vulnerability Assessment Framework *(18)*. Main challenges to optimal access exist on both the supply and the demand side of the health system and are mainly attributed to the unaffordability of services for vulnerable refugees and lack of adequate awareness about the subsidy policy on both the supply and the demand sides. Two manuals were introduced by UNHCR, in collaboration with Ministry of Health, to address the latter issue.

Palestinian refugees living in Jordan (21.4% of the total population) are eligible to receive services if they are registered with UNRWA (2 334 789 registered Palestinian refugees; the majority of which have Jordanian nationality) and may be eligible for health care coverage elsewhere (private or public). About 18% of Palestinian refugees live in the 10 camps spread across Jordan *(19)*. Population subgroups serviced by UNRWA are categorized as:

- Palestinian refugees residing in Jordan (the majority with Jordanian nationality);
- ex-Gazans (refugees who came to Jordan from Gaza) and Palestinian refugees who came to Jordan after the war in Iraq; and
- Palestinian refugees residing in the Syrian Arab Republic who fled the war to Jordan.

UNRWA provides free PHC services to Palestinian refugees, including those who were residing in Iraq and the Syrian Arab Republic, as well as ex-Gazans. These services include maternal and child services, outpatient services, medications, laboratory testing, NCD management and immunization services. Referral to Ministry of Health hospitals is covered (partially) for admission only with approved referral from UNRWA clinics. Cardiology and gynaecology services are also provided through UNRWA in selected clinics. Among ex-Gazans living in UNRWA camps, access to affordable quality health services (outside UNRWA) was reported as "more difficult". Because of their non-citizen status, ex-Gazans are less likely to be covered by health insurance schemes and typically pay higher prices for public services and depend on more-expensive private services. This is particularly relevant for ex-Gazans in Jerash Camp as they are poorer and cannot afford such services *(20)*. According to UNRWA, ex-Gazans can access health care services as "capable Jordanians", with subsidized rates (see below).

The Ministry of Labour requires all migrant workers arriving in Jordan to have negative tests for TB, HIV/AIDS and hepatitis B and C. Once a work permit is issued, or when it is annually renewed, migrant workers have to complete a test for TB, HIV/AIDS and hepatitis B and C. Domestic household workers also have to take a pregnancy test. Migrant workers testing positive for any of the above will not be granted approval for their work permit by the Ministry of Labour (first time or renewal) and will be deported apart from migrants diagnosed with TB subsequent to receiving the first-time work permit. These migrants will be treated by the Ministry of Health unless they work in predefined occupations. Those with confirmed TB are provided with free treatment before being deported. Exemption from deportation is considered based on the type of occupation.

Some categories of migrant worker have no or limited access to essential medical services; while domestic (household) migrant workers should have access to health insurance, which is mandated by law and should be renewed yearly along with the work permit, their service coverage is for inpatient services only. The free clinics available for migrant workers within industrial zones are authorized under the Ministry of Labour and not the Ministry of Health and are not authorized to provide medications, even though a recent assessment found that essential medicines are provided. According to the International Labour Organization (ILO), the effectiveness of these clinics was not trusted and the services provided were limited, if any. If migrant workers need health care services from outside the clinic, the factories have to pay the costs incurred under the Collective Bargaining Agreement; this is particularly important for migrant workers as they do not always have access to health insurance during their stay at Jordanian factories *(21)*.

1.4 Scope and objectives of the review

The WHO Country Office Jordan, the WHO Regional Office for the Eastern Mediterranean Region and the WHO Department of Health and Migration in WHO headquarters, in close collaboration with the Jordanian Ministry of Health and key partners (Caritas, ILO, IOM, UNICEF, UNHCR, United Nations Population Fund (UNFPA), UNRWA, United States Agency for International Development (USAID) and World Bank), undertook a joint review mission to support the Ministry of Health on reviewing the health system needs of refugees, migrants and vulnerable host population in Jordan.

The aim of the review was to explore opportunities to strengthen the Ministry of Health's health care system in providing services for refugees and migrants, as well as for Jordanians. The review covered the health system building blocks as well as the essential public health functions, with particular focus on PHC.

The objectives of the review were to:

support the development of informed and evidence-based public health interventions that build upon existing public health system (Ministry of Health) capacities, with the focus on reduction of morbidity, mortality and health inequity among refugees and migrants.

enhance collaboration among partners involved in refugee and migrant health as well as intersectoral coordination and collaboration (including key governmental actors such as the Ministry of Interior and the Ministry of Labour).

1.5 Methodology

The country review in Jordan utilized qualitative methods. The selection of health care facilities and institutions was a collaborative effort between WHO and the Ministry of Health. These health care facilities were chosen based on data indicating their significant contribution to refugee and migrant services.

To ensure thorough participation, representatives from the Ministry of Health personally reached out to the administrations of the selected health facilities inviting them to actively engage in the review.

The interview guides were developed in English, and two team members who were native Arabic speakers translated them to Arabic during the interviews. The interviews were conducted in Arabic, and the team members proficient in Arabic translated the questions and answers for participants and other team members, providing translations in both Arabic and English. A third team member who speaks Arabic also participated in the validation of the translation.

This joint review utilized the Refugee and migrant health: country assessment tool, developed by the WHO Department of Health and Migration *(22)*.

Active preparation for this review began in December 2022 through meetings with Ministry of Health officials to establish the timeline, objectives and approach. A Steering Committee was formed with focal point members from organizations such as Caritas, ILO, IOM, UNFPA, UNHCR, UNICEF, UNRWA, USAID and the World Bank. Led by the Projects Management and International Cooperation Director at the Ministry of Health, the Committee convened in mid January to introduce the Refugee and migrant health: country assessment tool and outline the initiative's initial objectives. At the same time, a desk review of Jordan's health system, covering both the building blocks and essential public health functions, was initiated, with a specific focus on refugee and migrant health. Bilateral meetings were held within the organizations of the Steering Committee to gain further insight into their roles and engagement in Jordan's health system, as well as to collect relevant documents for the desk review. Additionally, meetings were conducted with Ministry of Health stakeholders and other ministries, including the Ministry of Labour and the Ministry of Interior. Table 1 provides an overview of the major stakeholders involved in the preparatory phase of the review.

Table 1. **Major stakeholders engaged in the desk review and initial stages of the review**

Stakeholder group	Specific stakeholders
Ministry of Health	Projects Management and International Cooperation Directorate, Primary HealthCare Administration, Epidemics Administration, Emergency Management Directorate, Health Awareness Directorate, Maternal and Child Health Directorate, Non-Communicable Disease Directorate, Communicable Disease Directorate, Mental Health Directorate, Respiratory Diseases, Migrant Health, and Occupational Health Directorate
Ministry of Interior	Syrian Refugee's Affairs Directorate
Ministry of Labour	Research and Surveys Directorate
United Nations agencies	ILO, IOM, UNFPA, UNHCR, UNRWA
Other agencies	Caritas, USAID, World Bank

A comprehensive draft document from the desk review was approved by the Ministry of Health and subsequently shared with the Steering Committee for feedback and approval. The review's concept note identified three priority areas for review: emergency preparedness and response at the subnational level, RCCE, and research within the Ministry of Health. Furthermore, the review considered key aspects across the six WHO building blocks of the health system. The concept note and desk review were shared with experts who agreed to participate in the field review mission (Table 1).

The members of the field review mission held regular meetings to discuss the desk review and refine the questions for evaluating the health care system's building blocks and essential public health functions. A final set of questions was determined and approved for the field mission.

The Ministry of Health identified the three main governorates with the highest numbers of refugees and/or migrants seeking care at PHC facilities: Amman (the capital), Irbid and Mafraq. These governorates were those most affected by the arrival of Syrian refugees and also host two major industrial zones in Jordan. Within each selected governorate, PHC centres with significant refugee and/or migrant catchment areas were identified and chosen for the field review visit.

The field visits were conducted between 18 and 24 June 2023 and were divided into two distinct sessions (Annex 1). The morning sessions consisted of semi-structured key informant interviews, took approximately 2 hours per visit and involved a comprehensive walkthrough of the different services provided in the centre. The semi-structured interviews utilized a specific interview guide tailored for individual interviews. The afternoon sessions involved a group interview with PHC centre directors, doctors and nurse managers using a unique interview guide designed to facilitate group dynamics, capture insights from multiple perspectives, foster discussion and allow for the exchange of ideas among participants.

Table 2 provides an overview of the methodology for setting up and running the field visits. In total, the field visits covered three governorates and six PHC centres. Each field visit was coordinated with the respective health director, with the presence of additional staff members as required. Officers from IOM, UNFPA, UNHCR and UNICEF joined some of the sessions and the preparation for debriefing with the Ministry of Health (Table 2).

Table 2. Methodology for in-country review

Stage	Activities
Sampling/ selection of PHC centres	• WHO and Ministry of Health selected centres based on where there were the highest numbers of refugees/migrants in three governorates • Ministry of Health contacted directors of health facilities individually for participation in interviews
Translation of interview guides	• Interview guides originally developed in English • Two native Arabic speakers on the team translated guides to Arabic during interviews • Interviews conducted in Arabic with translations provided in both Arabic and English
Review	• Based on the Refugee and migrant health: country assessment tool *(22)*
Preparation phase	• Active preparation initiated in December 2022 • Meetings with Ministry of Health officials to establish timeline, objectives and approach • Formation of Steering Committee with focal points from various organizations • Desk review of Jordan's health care system and engagement with stakeholders
Field visits	• Conducted in three governorates: Amman, Irbid, and Mafraq • Morning sessions: semi-structured key informant interviews • Afternoon sessions: group interviews with PHC centre directors, doctors and nurse managers • Coordinated visits with health directors and presence of additional staff as necessary
Participants	• Six PHC centres • Group interviews completed with 42 participants (21 PHC centre directors and 21 nurse managers)
Additional participation	• UNHCR officers present in all field visits • UNICEF officers present in two field visits • IOM officer attended a portion of the sessions • UNFPA officer joined on the last day for preparations and debriefing with the Ministry of Health

2. Results

2.1 Health system governance and leadership

The health system in Jordan is a complex combination of three major sectors: public, private and charitable. The public sector consists of three major programmes that finance and provide care: the Ministry of Health, the Royal Medical Services and the university hospitals *(3)*. Health care services can be grouped in four main levels: PHC, secondary services, tertiary services and rehabilitation services *(23)*. The main components of the public health sector are scattered, fragmented and centred upon hospital care *(6)*.

The Ministry of Health provides a wide range of preventive and curative care through a network of 671 centres that are distributed across the Kingdom: 487 PHC centres that include 122 comprehensive multiclinic centres (CHCs), 184 branch/peripheral/village health centres, 502 maternal and child health centres, and 440 dentistry clinics. Branch/peripheral health centres have limited working hours, while CHCs have extended working hours and some CHCs provide 24/7 services. Diagnostics and laboratory services are not available within peripheral health centres. The Ministry of Health also runs 32 hospitals providing secondary and tertiary care *(24)*.

The Projects Management and International Cooperation Directorate is responsible for coordinating refugee and migrant health programmes with partners including Caritas, ILO, International Medical Corp, IOM, UNFPA, UNHCR, UNICEF, UNRWA and WHO. However, there is no dedicated technical unit at the national or governorate levels for refugee and migrant health.

Overall, the field review found that there was an established network of PHC facilities and a political commitment from the Ministry of Health for Health for All policies, including refugees and migrants. A well-defined policy for a payment system by typology of refugee or migrant was evident at the central level. The health workforce showed a great deal of dedication and commitment and took part in continuous professional development. In spite of this, a technical structure within the Ministry of Health that governs refugee and migrant health is lacking and should be established at all levels. Specifically, the establishment of a technical committee made up of representatives from the Ministry of Interior, the Ministry of Labour, the Royal Medical Services, United Nations agencies and other stakeholders would help to improve coordination and address the health care needs of refugees and migrants in alignment with that of the host population.

Collaboration within Ministry of Health directorates and between the Ministry of Health and other ministries, such as the Ministry of Interior and Ministry of Labour, should be strengthened. The cost of care seems to raise concerns over access to equitable health services by refugees and migrants. The health information system still seems to be fragmented and there is a lack of standardized disaggregation of data, with limited feedback mechanisms between central levels and PHC services. Regular professional development in different areas, including mental health, cultural mediation and gender-based violence, is needed at PHC facilities especially in rural areas. Monitoring and evaluation activities need enhancement and strengthening to ensure proper decision-making and planning activities.

2.2 Access to essential medical products

Jordan has a comprehensive national drug policy, an essential medicines list and standardized treatment protocols supported by a regulatory body, but the policy is not completely utilized at the PHC level *(3)*. Health insurance that covers access to essential medical products is only held by around 70% of Jordanians, 55% of the overall population. All children under 6 years of age, regardless of nationality, and citizens aged 60 years or older are eligible for insurance with the public health sector (Ministry of Health). Accordingly, irrespective of nationality and legal status, immunization is provided free of charge to all children *(25)*. UNHCR-registered refugees access medicines at 80% subsidized prices as do uninsured Jordanians. Depending on the catchment area population and the number of people registered with each health facility, the required medicines are supplied on a monthly basis.

Health insurance that covers access to essential medical products is only held by around 70% of Jordanians, **55% of the overall population.**

All **children under 6 years** of age and citizens aged **60 years or older** are eligible for insurance with the public health sector (Ministry of Health).

Palestinian refugees access health services and medicines through the health facilities managed by UNRWA. Within Syrian refugee camps, access to health care, including essential medicines, is granted "free at the point of delivery" for all refugees through UNHCR *(26)*. Family planning and laboratory diagnostic tests are provided free of charge in maternal and child health centres. Shortages of medicines for Syrian refugees, particularly for chronic diseases, are sometimes reported. In the absence of medicines for NCDs in PHC facilities, patients are referred to hospitals to obtain their medicines, which is associated with additional costs for transportation. Domestic (household) migrant workers should have access to health insurance, which is mandated by Ministry of Labour regulations and should be renewed yearly along with the work permit.

Medications are centrally purchased through tenders placed by the Ministry of Health (every 14 months), stored in Ministry of Health central stores and distributed to the health centres monthly. If a health centre runs out of medications before the end of the month, it can still order them without needing to wait till the following month *(27)*.

The UNHCR has collaborated with the Ministry of Health to produce an operational manual on procedures at Ministry of Health hospitals and health centres for refugees accessing the health services targeting health care providers and showing them their obligations under the current regulations *(28)*. A similar service guide has been produced to increase refugees' awareness of health care services provided at the Ministry of Health. Despite the Ministry of Health distributed more than 5000 manuals and service guides for health care workers in PHC, more awareness of their content seemed to be needed.

2.3 Service delivery

Jordan has shown political commitment to providing social protection for refugees, especially access to health services. A universal health package at the PHC level is currently being developed for all in Jordan *(3)*.

Refugees in Jordan are mostly from the Middle East and speak the same language as nationals. This is also the case for the majority of migrant workers although migrants working within the industrial zones mostly do not speak Arabic. The Better Work Jordan report *(21)* found that there were sufficient numbers of translators for non-Arabic-speaking migrant workers in factories who were receiving health services. However, the current joint review found some language barriers reported (using "Google translator" was mentioned few times as a mean to overcome this limitation).

Sexual and reproductive health services are provided under maternal and child health services at PHC settings. Antenatal care, postnatal care and family planning are provided for insured Jordanians and registered refugees. All these services, including all family planning services, are provided free of charge to insured Jordanians and registered refugees.

During the field visits of the six PHC clinics in three governorates, Amman, Irbid and Mafraq, the commitment to ensure access to essential services for all those living in Jordan was evident. However, a clear scheme regarding the availability and cost of services was sometimes lacking. Those using facilities were differentiated into those with insurance, not insured, registered with Ministry of Interior, registered with the UNHCR or holding a white card, which indicated the particular facility the person/family belonged to. Transportation to and from the facilities was seen as a barrier to service delivery.

All the facilities visited had maternal and child health services (including vaccines for children) and a pharmacy/dispensary; some had laboratory facilities (only the facilities in Mafraq did not) and one had mental health services managed by the International Medical Corp. The average number of patients seen each day was between 100 and 300 but catchment areas differed from 10 000 to 100 000. In Amman and Irbid, there were emergency rooms, with some of the CHCs allowing private access.

2.4 Health information system

Jordan does not have a consolidated health management information system for the different health sectors. Hakeem is an electronic health record solution allowing health care providers to electronically access medical records of patients within participating health facilities (205 sites since its launch in 2009) in the country *(29)*.

The UNHCR and UNWRA maintain their own health information systems, which are not integrated with Hakeem. In addition, the Royal Medical Services has its own Hakeem system within its facilities but this is not yet linked to that of the Ministry of Health. Accordingly, there is a lack of a unified medical record that links public and private facilities at a national level, in addition to the lack of inclusion of those without health insurance.

The Jordan Integrated Electronic Reporting System has been used by the Ministry of Health as an electronic platform for surveillance but is yet to be recognized as the official Ministry of Health system and yet to replace paper-based reporting *(29)*. Decision-making related to potential outbreaks and threats might be delayed because the Communicable Disease Directorate in the Ministry of Health still relies on a weekly aggregated reporting system. There is currently no mechanism through which health systems-related, disease-specific case-wise and group data are collected, collated and housed centrally on a regular/monthly basis, despite the fact that an annual statistics report is published by the Ministry of Health online and in print each year.

Routine surveillance data still rely on aggregate numbers and are not based on individual cases. The UNHCR gathers surveillance data from camps and has reports covering refugees. Surveillance data from the camps are also shared with the health directorate where the respective camp is located.

The PHC facilities visited did demonstrate that they used Hakeem and one of the centres had introduced the Jordan Integrated Electronic Reporting System. Surveillance, however, was based on telephone calls/WhatsApp messages to the health directorate if the disease was highly contagious or involved a number of people. Regular reporting occurred as weekly and monthly reports. It should be noted that the reporting line flowed from the bottom up with no information cascading downwards, leaving many at the PHC facilities unable to fully comprehend the scope of any outbreak. In addition, while communication from facilities flowed vertically upwards, there was little or no communication across the PHC facilities in each governorate.

Overall, the review found that the public health surveillance and health information system is in place and that refugee/migrant accommodations came under the jurisdiction of the health directorates in governorates. Health information on displaced populations is captured in these systems if they interact with a health care provider, for example through a visit to a general practitioner or hospital; this includes timely reporting of public health surveillance data from health care providers to the health directorate in their governorate and onwards to national level. In addition, a list of immediately notifiable conditions is available and processes are in place for notification from PHC centres to health directorates in governorates and then to the national authority. The health directorates in governorates submit weekly reports to the Ministry of Health that include non-health status indicators for forcibly displaced populations. Immunization records are documented at regional level and shared to national level.

Challenges in the health information system were also noticed. For example, it was not possible to disaggregate epidemiological data on refugee and migrant health indicators at national level. This limits the ability to monitor trends in morbidity, mortality and key health indicators in this vulnerable population. Further, cases of epidemic-prone diseases may go undetected if refugees or migrants do not seek health care.

2.5 Health workforce

Workforce governance and management in Jordan are centralized, which limits decision-making based on local needs. The strain on public health services is primarily in the northern governorates due to the influx of Syrian refugees, affecting the health workforce and financial resources. There has been a decline in the ratio of health care professionals per 10 000 people since the Syrian crisis began *(30)*. Disparities in the distribution of health workers among governorates and gender imbalances in medical specialties are major issues in particular situations. Furthermore, there is a shortage of family physicians and specialists, particularly in CHCs, leading to higher workloads. The Ministry of Health faces challenges in staffing health centres in certain areas and with specialized doctors, who prefer working in other sectors or abroad *(23)*.

The National Human Resources for Health Strategy for Jordan aims to improve health services and outcomes by enhancing human resources for health *(31)*. However, the governance of the health workforce is currently scattered across different institutions, and gaps in information about supply and demand hinder the delivery of quality services. Human resources management practices are inadequate, and continuous professional development opportunities are limited. Facilities in Jordan are mostly managed by general practitioners who have no management training, and there is a lack of guidance on staff roles and responsibilities for managing NCDs, sexual and reproductive health and mental health *(31)*.

The USAID is collaborating with the Ministry of Health to develop a continuing professional development programme that addresses the needs and gaps among health care providers. However, there is a need to build competencies within refugee and migrant health and incorporate them into undergraduate education. Humanitarian preparedness and response training for health care workers is insufficient, and there is a need for a national human resources plan for certain fields such as mental health and psychosocial staff *(32)*.

Mobile teams for outreach services are active through non-State actors but are not governed by the Ministry of Health. There are specific professional standards, licensing and accreditation systems, but Syrian refugee health workers are not utilized in health service delivery.

2.6 Health financing

In Jordan, according to the latest national health account, **health expenditure ranged from 6.98% to 7.07% of gross domestic product** between 2016 and 2019.

Budget allocation for health has decreased, while out-of-pocket expenditure and private sector financing have increased. PHC has been underfunded, leading to lower quality services *(33)*.

Geographical disparities and high out-of-pocket costs create inequity and financial hardship. Unit-cost variations were noticed between some health centres, and treatment for NCDs is underfunded. The Ministry of Finance is the main source of funds, and uninsured individuals seek care in private facilities at higher costs *(34,35)*. The complex fund flows, lack of comprehensive data and inflexible budgeting hinder the health sector.

Efforts are underway to establish an essential health package for PHC services, with the aim of achieving UHC and improving health financing strategies. Uninsured individuals often seek care in private facilities, where they face higher costs and limited access to free treatment. A significant proportion of families, particularly ex-Gazans, experience catastrophic health expenditure *(36)*.

Fund flows within the health sector are complex, leading to fragmented risk pooling and increased administration costs. High out-of-pocket expenditure on medicines and related products creates financial strain and reduces equity and financial protection. Additionally, there is a lack of comprehensive data on the costs of providing health services, no defined essential health services package and limited flexibility in utilizing allocated funds. The COVID-19 pandemic has further increased the financial burden on the Jordanian Government, although the increased donor share of health care financing did contribute to decreasing this. Collaboration between the Ministry of Health and the UNHCR has led to the preparation and distribution of operational manuals and service guides on the costs of health services to enhance awareness of health care services among refugees and health care providers *(28,34)*.

The Ministry of Health has a three-tier payment plan that is applied to those seeking health care at PHC centres: non-capable Jordanians, capable Jordanians and non-Jordanians (pricing given in Jordanian dinars (JOD)). Non-capable Jordanians have health insurance from other social protection programmes and pay JOD 0.5 for a specialty visit and JOD 0.25 for each medication dispensed (no payment when seen by a general practitioner). The capable Jordanian tier, which covers registered refugees and ex-Gazans, includes fees for a general practitioner visit (JOD 0.4), specialty visit (JOD 1.65) and medications (5% of the purchase price to be JOD 0.25–10.00 per medication). The last cost is set at 196% at the CHCs. A white card is issued for the non-capable and capable tiers to ensure that health care services are sought as assigned by geographical location. If there is a discrepancy between the address on the white card and the centre, the treatment cost would increase and could be doubled.

Non-Jordanians (excluding registered refugees and ex-Gazans) pay JOD 2.1 for a general practitioner visit, JOD 4.9 for an emergency room visit, JOD 9.8 for a non-emergency visit, and 182% of the medication cost at PHC centres. A referral to a specialist requires a JOD 0.25 fee regardless of tier.

While these payment policies were clear at the central level, there seemed a need to expand this clarity among staff at PHC centres.

2.7 Preparedness and response to outbreaks, natural disasters and other emergencies

Many aspects of Jordan's emergency care system are well developed. For example, all public prehospital emergency care is provided by the General Directorate of Jordan Civil Defence, which is able to dispatch ambulances staffed with trained paramedics across all regions in the country. The National Centre for Security and Crisis Management oversees emergency preparedness and response in general in the country, with the Ministry of Health mandated to manage health emergencies. It should be noted that public health emergency preparedness and response is also one of the strategic priorities of the Jordan Centre for Disease Control.

While emergency response plans have been developed by the National Centre for Security and Crisis Management for different threats, such as terrorism, violence or environmental threats, the Ministry of Health's national plan (all hazard) for emergency preparedness and response, updated in 2017, was never endorsed. A national emergency response plan exists at the National Centre for Security and Crisis Management and includes a strategy for human resource surge capacity, additional supplies and clinical space, alternative communication strategies and transportation mechanisms for personnel during mass casualty events. All emergency plans are inclusive of refugees and migrants.

There is a national Public Health Emergency Operations Centre located in the Ministry of Health that is activated on an ad hoc basis. Activation triggers are not well defined. There is also a national Emergency Operations Centre in the National Centre for Security and Crisis Management, which monitors all events concerning Jordan, not only events related to health.

There is currently no established incident management system structure with standard operating procedures that oversees the health sector response to health emergencies, including coordination and leadership, surveillance (including deployment of rapid response teams), health information, case management (including deployment of emergency medical teams), RCCE, planning and so on. Routine surveillance activities for notifiable diseases and syndromic illnesses are well established within the Ministry of Health and PHC facilities but not properly documented in terms of standard operating procedures. Active disease investigation and active surveillance are still based on the central (national) levels, with limited roles for the district levels and especially for the PHC level. While surveillance data are collected on refugees and migrants, reliance on aggregate numbers limits presentation by refugee-related variables or refugee/migrant status.

Governorates are mostly responsible for preparedness planning and response to disasters/outbreaks in their areas of responsibility and each governorate has a multisectoral council/committee responsible for local emergency preparedness and rapid response teams for response. They have well established indicator-based surveillance. However, emergency preparedness and the inclusion of the migrant populations are much better developed at central levels than at PHC levels.

Ministry of Health staff within PHC centres are trained mainly in first aid/clinical work and not on applied epidemiology or emergency responses. There are sufficient protective measures and equipment in PHC facilities for both health and non-health personnel.

The field mission identified a lack of a standardized approach in public health risk assessment to inform emergency preparedness and response plans at peripheral levels.

Standardized case investigation methodology and tools are available, but requests for support to strengthen operational use of these by responders was requested.

2.8 RCCE

Over recent years, there has been noticeable progress in RCCE efforts within the Ministry of Health in Jordan. RCCE has been acknowledged as a crucial component in responding to health emergencies and has been incorporated as one subplan (pillar) of the National Preparedness and Response Plan, which was developed for the COVID-19 pandemic, yet implementation faces challenges because of the lack of dedicated and trained RCCE personnel. Efforts have been made to engage communities in health-related initiatives, and to include refugees and migrants, leading to some success in raising awareness and promoting health-seeking behaviours, with partnerships and collaborations with UNICEF, the Royal Health Awareness Society and other organizations.

During the field visits, it was evident that RCCE within the Ministry of Health needs several improvements; coordination of RCCE at the local level is smooth, with PHC centres serving as the central point. However, at the directorate level, RCCE is underdeveloped, requiring greater capacity and specific guidance to achieve the desired outcomes. Capacity-building efforts face challenges, as directorates lack designated RCCE focal points to support local centres, resulting in varying RCCE capacities and efforts, particularly in community health committees. Community health committees include volunteers from different sectors, with some Syrian refugees as members while other nationalities were supported by the committee's activities. Implementation of health awareness by the community health committees involves planned sessions and community outreach. However, issues arise with one-time interventions lacking sustained impact, announcements not taking into account any lack of ability to access social media by vulnerable groups (including refugees and migrants) and structural barriers impeding attendance at health facilities such as transportation costs. Community engagement planning varied among centres, some having proper plans based on priorities while others lacked systematic approaches. The feedback mechanisms did not differentiate based on nationality, which made it difficult to track effectiveness for refugees and other groups. Although there has been a shift to managing reports on a digital platform, this process still requires more support to improve its effectiveness. School–community programmes were effective for both Jordanian and Syrian refugee students, covering vaccines, follow-ups and dentistry.

Specific needs identified during the visits included for communicable diseases such as hepatitis, chickenpox and scabies among refugees; mental health issues were more prevalent among Syrian refugees and migrants, but there was limited awareness and services available.

The preferred communication channels for refugees and migrants were WhatsApp, Facebook and personal networking, with traditional communication channels such as television, radio and flyers playing a supporting role. Language and cultural barriers were not reported during visits as Syrian refugees spoke Arabic, and migrants had adapted to the country.

Despite the inclusive nature of most PHC centres, some were considered as not inclusive as they were located on an upper floor, which presents challenges of access for individuals with physical disabilities. This indicates the necessity for additional efforts in facilitating inclusivity and accessibility.

2.9 Research at the Ministry of Health

Research within the scope of Ministry of Health is fragmented between different units and mainly focuses on donor needs in collaboration with the Ministry of Health. Further, one of the most predominant challenges faced by the Ministry of Health includes the capacity to gather, analyse and use health workforce information. Digitalization of the system is critical to ensure the more timely and accurate data flows that will enable policy-makers to make informed decisions *(31)*.

National approach to research

The review found that, overall, there is a willingness and interest from all levels of the health system and workforce to incorporate and improve health service provision and health system response using a data-driven, evidence-informed approach. Specific areas requiring additional evidence and knowledge to support decision-making and resource allocation included:

effective monitoring and evaluation framework and practices within the Ministry of Health to collect and analyse information aimed at understanding the health-related knowledge and behaviours of communities, particularly child-focused ones, including refugees and migrants;

effective models of delivery of care in a needs-based approach (such as mental health and screening);

sustainable long-term financing mechanisms and models for achieving migrant- and refugee-inclusive UHC; and

assessment and awareness of the barriers to accessing health care (including out-of-pocket expenses).

There were several identified examples of using evidence-guided practice, including experiences from managing the COVID-19 pandemic, inclusion of WHO Best Buys in NCD policy and building the Jordan Roadmap to achieving UHC.

However, across all levels, and especially for health care delivery, there was variable understanding of what is research and research-driven policy, with many interpreting this as limited to service data analysis, needs assessments or surveillance.

Conducting research

There are several routine surveys to understand the population, which may include the general, refugee and migrant populations. Surveys of samples of the population include health indicators in the Demographic and Health Surveys *(37)*, stepwise surveys for NCDs *(4)* and nutrition in the Micronutrient and Nutrition Survey *(38)*. The UNHCR's focus on refugee populations includes surveys of vulnerability such as the Vulnerability Assessment Framework *(18)* and access to health care such as the Health Access and Utilization Survey *(17)*.

Some specific examples of research were shared during the field visit: presenting studies of cases or patient cohorts at conferences by health centres; working with community groups to understand uptake of vaccinations in the community (Irbid); and identifying issues around health service utilization in the community (suspected low uptake of antenatal services in Irbid, which was referred back to the directorate for support and advice). There were also examples of medical schools and universities sending students to do dissertations and research projects at PHC centres, which was agreed through the Ministry of Health.

Communication and collaboration

Communication and information sharing between the different levels of health care provision, research institutes and the health information system are not fully integrated. There is not currently a systematic approach to research on the health of refugees and migrants across Ministry of Health facilities. PHC centres cannot effectively communicate their concerns or unanswered questions on research needs, nor can they get feedback on these.

Health research on refugees and migrants in Jordan is fragmented between different academic institutions, research centres and nongovernmental organizations (NGOs). There is a lack of evidence/research sharing between different stakeholders collecting evidence and data, for example between operational actors such as NGOs, United Nations agencies and academia. These entities lack an established research agenda for health care for refugees and migrants and do not communicate/coordinate with others for the conduct of research.

One PHC centre (Irbid) was directed by the Ministry of Health to collaborate with local NGOs to improve evidence collation on the health of refugees, which included Care, GIZ (the main German development agency), the International Rescue Committee and Islamic Relief, with areas for research that would be directed by the NGO. UNHCR collaborates with Johns Hopkins University (United States of America) to focus on some particular research questions.

For migrants, data collection and research are funded mainly by the ILO and IOM, with little attention paid to health status. The IOM reported minimal research activities around health in Jordan currently. Academic institutions have actively participated in conducting such research, occasionally in partnership with the Ministry of Health; however, these collaborations with the Ministry of Health are not carried out in a consistent and systematic manner. Examples of these research efforts include:

- Johns Hopkins University is undertaking research collaborations in Jordan, particularly focusing on the impact of the COVID 19 pandemic on access to health services and strategies for improvements;
- the Centre for Strategic Studies at the University of Jordan is an academic unit primarily concerned with regional conflicts, international relations and security, but with minimal focus on health; and
- the Refugees, Displaced Persons and Forced Migration Studies Centre at Yarmouk University in Irbid focuses on refugees within the social structure, but again with limited research on health.

Setting the national research agenda

Decisions for research involvement, collaboration and prioritization locally and regionally were reported to be centralized within the Ministry of Health, with lack of empowerment on prioritization of research themes at the directorate level. There was a lack of systematic integration of refugee and migrant health research within the current research plans of the Ministry of Health. Research is fragmented between different units currently, with a lack of coordination on national research priorities. Research on refugee and migrant health has generally been driven by NGOs and donors to identify needs and gaps in provided services within camp and host community settings, and as such takes place in an ad hoc reactive manner with no centralized coordination and oversight mechanism. This is an area that offers a further opportunity for the Ministry of Health to provide coordination and leadership in setting a national research agenda or research prioritization on the health of refugees and migrants, to identify the priority topics nationally and convene stakeholders around these.

Overall, the Ministry of Health showed willingness and interest to have an evidence-informed decision-making approach, with efforts to establish a research platform within Ministry of Health. The experiences of the COVID-19 pandemic have provided a good example that can attest to the role of research in guiding health policies and decision-making in Jordan. There is also evidence of an established research collaboration between Ministry of Health directorates and NGOs on research activities related to refugees. However, further collaboration on research activities is required at all levels; a needs-based prioritization of research agenda is not evident, and the translation of health information and research into implementation actions/policies is not the norm at the Ministry of Health.

3. Main recommendations for consideration

3.1 Health system governance and leadership

- **Establish a technical platform at the Ministry of Health on refugee and migrant health.** This platform should be integrated into all levels of care to ensure effective and timely interventions that can address the complex health needs of refugees and migrants in Jordan.
- **Enhance collaboration between ministries by:**
  - strengthening collaboration between Ministry of Health directorates and between the Ministry of Health and other ministries involved in refugee and migrant support;
  - using a collaborative approach to gain a comprehensive understanding of the health needs of refugees and migrants and provide better support; and
  - addressing the issue of payment for emergency case/ambulance for migrants/non-registered refugees.
- **Create feedback mechanisms to enhance the quality of health services.** Robust feedback mechanisms can facilitate communications between central and district levels and PHC services. These should include feedback on referred cases, surveillance data and other performance indicators.
- **Support capacity-building for priority areas.** A comprehensive capacity-building plan should focus on building competencies among health care providers in addressing the specific health needs of refugees and migrants, with emphasis on priority areas such as mental health and inclusive community engagement.

3.2 Access to essential medical products

- **Assess the numbers and health needs of non-registered Syrian and migrant populations.** Collaboration among relevant ministries, such as the Ministry of Interior and the Ministry of Labour, will provide the data needed to facilitate better public health planning, resource mobilization and priority setting for health care activities.

3.3 Service delivery

- **Establish a system of cultural mediators to enable tailored health messages.** Cultural mediators can help to ensure effective communication and understanding of health-related information among refugees and migrants.
- **Align medical facilities under the Ministry of Labour with Ministry of Health standards.** Proactive measures are needed to align medical facilities under the two ministries to ensure consistent and high-quality health care access for all, including migrants.
- **Implement measures to ensure basic health care is accessible at PHC level for all individuals, regardless of their status.** Such measures should include refugees and migrants plus other vulnerable groups.

3.4 Health information system

- **Accelerate adoption of a national digital health information system.** An integrated digital health information system will enable data disaggregation, including for crucial variables for refugees and migrants. This will aid in monitoring health trends and shaping effective policies and public health actions.
- **Provide clear guidance on health record usage and confidentiality.** Such guidance is essential to prevent data abuse and discrimination against migrants and displaced populations.
- **Conduct a thorough evaluation of the early warning alert and response system.** The system should ensure rapid detection of health threats for all populations, including refugees and migrants, and that all can access response measures.

3.5 Health workforce

- **Implement the *Refugee and Migrant Health: Global Competency Standards (39)*.** This will support health care workers in providing culturally sensitive and effective care that recognizes the impact of refugee status on physical and mental health and ensure that health care providers are equipped to address the unique needs of these populations.

3.6 Health financing

- **Ensure a transparent payment system** by:
  - implementing a clear and easily accessible system that displays payment details at PHC centres for all segments of the population, including Jordanians, refugees and migrants; and
  - increasing awareness regarding the published operational manual and service guides developed in partnership with UNHCR, which should be readily available for both health care providers and seekers.

3.7 Preparedness and response to emergencies

- **Strengthen the Ministry of Health's capacity in responding to public health emergencies.** The Ministry should have both authority and capacity to include displaced populations in national emergency preparedness and response plans.
- **Improve surveillance and feedback mechanisms.** Coordination among key government stakeholders is essential. A functional surveillance system should have established feedback mechanisms to enhance early detection of health threats.
- **Involve refugees and migrants in emergency preparedness planning and response efforts.** Utilize community networks and tailored communication to reach these populations effectively

3.8 RCCE

- **Institutionalize RCCE and coordination among all relevant entities.** RCCE is centred within the Ministry of Health in the Health Communications and Awareness Directorate. Coordination with other departments and national RCCE entities should be strengthened and a dedicated unit/person at the directorate level created for enhanced coordination.
- **Provide training for capacity-building at multiple levels.** RCCE planning, reporting, monitoring and evaluation should be enhanced by training within both the Health Communications and Awareness Directorate and PHC centres, and a human-centred approach used to address community needs effectively.
- **Promote accessibility for people with disabilities.** Both staff training and structural factors should be addressed to support individuals with disabilities to access health centres. Representatives of people with disabilities within health centres/committees would help to improve accessibility and communication.

- **Identify and utilize effective networking channels.** Communication and outreach to refugee and migrant communities can be improved by utilizing their preferred network channels. Communication materials should be customized to address specific community needs.
- **Enhance feedback mechanisms and evidence generation.** Provision of updated reporting templates for comprehensive data capture would enhance data collection throughout health centres, and automation would allow for real-time data analysis. The Ministry of Health helpline could provide easy access during emergencies and the Ministry could also support social listening for feedback.
- **Engage with schools and the private sector.** Schools can provide effective platforms for outreach programmes and awareness initiatives. Partnerships with the private sector can support effective public awareness campaigns, particularly during critical times such as disease outbreaks.

3.9 Research at the Ministry of Health

Several areas were repeatedly raised as concerns requiring further research and knowledge production for the Government of Jordan to effectively support the health needs of refugees and migrants. These included (i) developing sustainable models of funding for refugee- and migrant-inclusive UHC and PHC nationally; (ii) strengthening service quality and coverage by identifying inequalities in health service access and unmet health needs; and (iii) improving effective and appropriate service utilization by refugees and migrants through better understanding of health-seeking behaviours, service utilization and health system barriers. In addition, there is a need to streamline the translation of research results into policy. A number of recommendations for consideration to support these functions are given.

- **Map stakeholders and increase networking among entities.** A number of stakeholders and agencies are involved nationally and internationally in the development and production of research and putting the results into practice as policy. Coordination could include engagement to understand research pathways and implementation; data collection, storage, analysis and sharing; and networking regarding existing and planned collaborations. This could include upcoming collaborations proposed with USAID.
- **Build research and expert capacity across the system.** Effective prioritization of resources for conducting research and utilizing the knowledge to guide policies requires expertise not only in research methodology but also in liaising across systems to identify key areas of focus and support implementation of research into practice. This could be achieved by incorporating public health, health economy, research and epidemiological expertise across the Ministry of Health and directorate levels.

- **Agree a national research agenda.** The effective allocation of time, resources and funding to guide policy-making and support the country's needs and priorities can be encompassed in a national research agenda. This will require clear engagement from relevant national stakeholders and can be supported by the WHO toolkit on research agenda setting *(40)*. One specific outcome from this would be an action plan based on these priorities.

- **Consolidate coordination and leadership.** A central unit established within the Ministry of Health could oversee the following within a national research agenda: strengthening systematic liaison and coordination with NGOs, academic institutions and civil society who conduct operational research; establishing system-level mechanisms for knowledge and data sharing from Ministry of Health to directorate level and from directorate to local level, including identification of regional and local research priorities; facilitating knowledge translation into policy and practice; and building research capacity across the system.

References

1. Jordan in figures 2019. Amman: Department of Statistics; 2019 (https://dosweb.dos.gov.jo/product/jordan-in-figure2019/, accessed 1 March 2024).
2. Jordan demographic and health survey 2017–2018 [website]. In: GHDx. Seattle (WA): Institute for Health Metrics and Evaluation; 2023 (https://ghdx.healthdata.org/record/jordan-demographic-and-health-survey-2017-2018, accessed 1 March 2024).
3. Country cooperation strategy for WHO and Jordan 2021–2025. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (https://iris.who.int/handle/10665/356889, accessed 1 March 2024).
4. Jordan national stepwise survey (STEPs) for noncommunicable diseases risk factors 2019. Amman: Ministry of Health; 2019 (https://www.moh.gov.jo/ebv4.0/root_storage/en/eb_list_page/stepwise_survey_(steps)_2020_technical_report-english.pdf, accessed 1 March 2024).
5. Jordan 2025: a national vision and strategy. Amman: Government of Jordan; 2015 (https://gbd.gov.jo/Uploads/Files/jordan-2025/2025-en.pdf, accessed 1 March 2024).
6. The national strategy for the health sector in Jordan 2015–2019. Amman: High Health Council; 2015 (http://www.hhc.gov.jo/uploadedimages/The%20National%20Strategy%20for%20Health%20Sector%20in%20Jordan%202015-2019.pdf, accessed 1 March 2024).
7. The strategic plan of the Jordanian Ministry of Health 2023–2025. Amman: Ministry of Health; 2023 (https://moh.gov.jo/ebv4.0/root_storage/ar/eb_list_page/%D8%A7%D9%84%D8%AE%D8%B7%D8%A9_%D8%A7%D9%84%D8%A5%D8%B3%D8%AA%D8%B1%D8%A7%D8%AA%D9%8A%D8%AC%D9%8A%D8%A9_%D9%84%D9%88%D8%B2%D8%A7%D8%B1%D8%A9_%D8%A7%D9%84%D8%B5%D8%AD%D8%A9_%D9%84%D9%84%D8%A3%D8%B9%D9%88%D8%A7%D9%85_2023___2025__%D8%A7%D9%84%D9%86%D8%B3%D8%AE%D8%A9_%D8%A7%D9%84%D9%86%D9%87%D8%A7%D8%A6%D9%8A%D8%A9_12_03_2023_(1).pdf, accessed 9 March 2024) (in Arabic).
8. Jordan profile [website]. In: UNHCR global website. Geneva: United Nations High Commissioner for Refugees; 2024 (https://www.unhcr.org/countries/jordan, accessed 1 March 2024).
9. Syria regional refugee response: Jordan [online database]. Geneva: United Nations High Commissioner for Refugees; 2024 (https://data.unhcr.org/en/situations/syria/location/36, accessed 1 March 2024).
10. UNRWA registered population dashboard 2022 [online database]. Amman: United Nations Relief and Works Agency for Palestine Refugees in the Near East; 2024 (https://www.unrwa.org/what-we-do/relief-and-social-services/unrwa-registered-population-dashboard#block-menu-block-10, accessed 1 March 2024).

11. A challenging market becomes more challenging: Jordanian workers, migrant workers and refugees in the Jordanian labour market. Beirut: International Labour Organization; 2017 (https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_556931.pdf, accessed 1 March 2024).

12. Annual report 2021. Amman: Jordan Ministry of Labour; 2021 (https://mol.gov.jo/ebv4.0/root_storage/ar/eb_list_page/التقرير_السنوي_لعام_2021.pdf, accessed 1 March 2024) (in Arabic).

13. Better Work Jordan annual report 2022: an industry and compliance review. Amman: Better Work Jordan; 2022 (https://betterwork.org/reports-and-publications/better-work-jordan-annual-report-2022-an-industry-and-compliance-review/, accessed 9 March 2024).

14. Submission by the United Nations High Commissioner for Refugees for the Office of the High Commissioner for Human Rights' compilation report – universal periodic review: Jordan. Geneva: United Nations High Commissioner for Refugees; 2013 (https://www.refworld.org/policy/upr/unhcr/2013/en/90547, accessed 1 March 2024).

15. Jordan response plan for the Syrian crisis 2020–2022. Amman: Jordan Ministry of Planning and International Cooperation; 2016 (http://www.jrp.gov.jo/Files/JRP%202020-2022%20web.pdf, accessed 1 March 2024).

16. Jordan: how the Global Compact on Refugees is turning into action in Jordan. Geneva: United Nations High Commissioner for Refugees; 2024 (https://globalcompactrefugees.org/gcr-action/countries/jordan, accessed 1 March 2024).

17. Access to healthcare services among Syrian refugees living in urban setting in Jordan. Geneva: United Nations High Commissioner for Refugees; 2021 (https://data.unhcr.org/en/documents/download/90316, accessed 9 March 2024).

18. 2022 VAF population report for refugees in host communities Geneva: United Nations High Commissioner for Refugees; 2022 (https://data.unhcr.org/en/documents/details/93754, accessed 1 March 2024).

19. Where we work [website]. Beirut: United Nations Relief and Works Agency for Palestine Refugees in the Near East; 2024 (https://www.unrwa.org/where-we-work/jordan, accessed 1 March 2024).

20. Kvittingen A, Tiltnes ÅA, Salman R, Asfour H, Baslan D. "Just getting by." Ex-Gazans in Jerash and other refugee camps in Jordan. Oslo: Fafo; 2019 (https://www.fafo.no/zoo-publikasjoner/fafo-rapporter/just-getting-by, accessed 1 March 2024).

21. Better Work Jordan: assessment of health care services provided to workers in the garment sector in Jordan. Amman: Better Work Jordan; 2022 (https://betterwork.org/reports-and-publications/better-work-jordan-assessment-of-health-care-services-provided-to-workers-in-the-garment-sector-in-jordan/, accessed 1 March 2024).

22. Tool 13: refugee and migrant health: country assessment tool. In: Refugee and migrant health toolkit/Module 4: country assessment, health monitoring and health information systems [website]. Geneva: World Health Organization; 2023 (https://www.who.int/tools/refugee-and-migrant-health-toolkit/module-4/tool-13, accessed 22 April 2024).

23. WHO, Saadeh R. Jordan: a primary health care case study in the context of the COVID-19 pandemic. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/372727, accessed 8 March 2024).

24. Twenty-five years of royal interest in achieving integrated health care. Jordan News Agency (PETRA). 10 February 2024 (https://www.petra.gov.jo/Include/InnerPage.jsp?ID=270915&lang=ar&name=archived_news&cat=news, accessed 17 March 2024) (in Arabic).

25. Nazer LH, Tuffaha H. Health care and pharmacy practice in Jordan. Can J Hosp Pharm. 2017;70:150. doi:10.4212/CJHP.V70I2.1649.

26. Mindset, UNHCR Jordan 2022 Vulnerability assessment framework population survey for refugees living in camps. Amman: UNHCR Jordan; 2022 (https://microdata.unhcr.org/index.php/catalog/739, accessed 10 March 2024).

27. Primary healthcare report: assessment of supply and demand drivers. Amman: USAID Health Finance and Governance Activity; 2018 (https://pdf.usaid.gov/pdf_docs/PA00TG9G.pdf, accessed 1 March 2024).

28. Guide to healthcare services for refugees in Ministry of Health facilities. Amman: UNHCR Jordan; 2023 (https://help.unhcr.org/jordan/wp-content/uploads/sites/46/2023/04/%D8%AF%D9%84%D9%8A%D9%84-%D8%AE%D8%AF%D9%85%D8%A7%D8%AA-%D8%A7%D9%84%D8%B1%D8%B9%D8%A7%D9%8A%D8%A9-%D8%A7%D9%84%D8%B5%D8%AD%D9%8A%D8%A9.pdf, accessed 14 March 2024) (in Arabic).

29. Health information system strategic plan 2019–2023. Amman: Ministry of Health; 2019 (https://moh.gov.jo/ebv4.0/root_storage/ar/eb_list_page/%D8%A7%D9%84%D8%AE%D8%B7%D8%A9_%D8%A7%D9%84%D8%A7%D8%B3%D8%AA%D8%B1%D8%A7%D8%AA%D9%8A%D8%AC%D9%8A%D8%A9_%D9%84%D9%82%D8%B3%D9%85_%D8%A7%D9%84%D8%AF%D8%B1%D8%A7%D8%B3%D8%A7%D8%AA_%D9%88%D8%A7%D9%84%D9%85%D8%B9%D9%84%D9%88%D9%85%D8%A7%D8%AA_(2019_-_2023).pdf, accessed 10 March 2024).

30. Annual human resources for health report 2016. Amman: National Human Resources for Health Observatory; 2017 (http://www.hhc.gov.jo/uploadedimages/c4ee4ba5-7ade-41a8-b5e6-fcfdbdba13aa.pdf, accessed 1 March 2024).

31. National human resources for health strategy for Jordan (2018–2022). Amman: High Health Council; 2018 (https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/jordan/national_human_resources_for_health_strategy_2018-2022_en.pdf, accessed 1 March 2024).

32. National mental health and substance use action plan 2022–2026. Amman: Ministry of Health; 2021 (https://www.moh.gov.jo/ebv4.0/root_storage/en/eb_list_page/national_mhsu_action_plan_2022-2026_(english)_(2)-0.pdf, accessed 10 March 2024).

33. Tareq SM, Jin H, Kitsios E, Khemani P. Jordan. Public expenditure review and rationalization : issues and reform options. Washington (DC): International Monetary Fund; 2018 (https://mof.gov.jo/ebv4.0/root_storage/en/eb_list_page/public_expenditure_review_and_rationalization_-_issues_and_reform_options.pdf, accessed 1 March 2024).

34. Jordan national health accounts for 2016–2017 fiscal years. Technical Report No. 8. Amman: High Health Council; 2019 (https://jordankmportal.com/resources/jordan-national-health-accounts-for-2016-2017-fiscal-years, accessed 10 March 2024).

35. Hammad EA, Alabbadi I, Taissir F, Hajjwi M, Obeidat NM, Alefan Q et al. Hospital unit costs in Jordan: insights from a country facing competing health demands and striving for universal health coverage. Health Econ Rev. 2022;12:11. doi:10.1186/s13561-022-00356-0.

36. Abdo N, Abu Naqera K, Batieha A, Abu Zayed I. Catastrophic health expenditure among ex-Gazan families in Jerash camp, Jordan. Public Health. 2020;186: 101–6. doi:10.1016/j.puhe.2020.07.014.

37. Department of Statistics, ICF. Jordan population and family and health survey 2017–18. Amman: Department of Statistics; 2018 (http://dosweb.dos.gov.jo/products/dhs2017-2018/, accessed 1 March 2024).

38. Jordan national micronitrient and nutritional survey 2019. Amman: Ministry of Health; 2021 (https://www.moh.gov.jo/ebv4.0/root_storage/ar/eb_list_page/jnmns19_report_220207_printable.pdf, accessed 1 March 2024).

39. Refugee and migrant health: global competency standards for health workers. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/350533, accessed 1 March 2024).

40. Global research agenda on health, migration and displacement: strengthening research and translating research priorities into policy and practice. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/373659, accessed 1 March 2024).

Annex.
Agenda for the joint review mission

The mission ran from 18 to 24 June 2023.

Day	Date	Activity	Time
	Sunday 18 March	Arrival	
1	Monday 19 March	Meeting with Ministry of Health senior authorities; briefing on the review process/activities and gathering necessary information	9:30 am–12:00 pm
2	Tuesday 20 March	Field visit: Amman	
		Sweileh Medical Centre (مركز صويلح الشامل)	8:30 am–10:30 am
		Al Bayader Comprehensive Health Centre (مركز صحي البيادر الشامل)	11:00 am–1:00 pm
		Meeting with representatives (directors) of 5 to 7 health care centres	1:30 pm–4:30 pm
3	Wednesday 21 March	Field visit: Irbid	
		Ibn Sina Healthcare Centre (مركز صحي ابن سينا الشامل)	9:00 am–11:00 am
		Dahiyyat Al Hussain Healthcare Centre (مركز صحي ضاحية الحسين الشامل)	11:30 am–1:30 pm
		Meeting with representatives (directors) of 5 to 7 health care centres	2:00 pm–5:00 pm
4	Thursday 22 March	Field visit: Mafraq	
		Al-Mafraq Primary Healthcare Centre (مركز صحي المفرق الاول)	9:00 am–11:00 am
		Hay Al Hussein Primary Health Centre (مركز صحي حي الحسين الشامل)	11:30 am–1:30 pm
		Meeting with representatives (directors) of 5 to 7 primary health care centres	2:00 pm–5:00 pm
5	Friday 23 March	Team meeting: WHO Country Office	TBD
6	Saturday 24 March	Final presentation at Ministry of Health	9:00 am–11:00 am

WHO Country Office, Jordan
Ministry of Interior Circle, Mohammad Jamjoum Street,
PO Box 811547, Amman 11181, Jordan

Universal Health Coverage/Health Systems (UHS)
WHO Regional Office for the Eastern Mediterranean
Monazamet El Seha El Alamia Street, Extension of Abdel
Razak El Sanhouri Street, P.O. Box 7608, Nasr City,
Cairo 11371, Egypt

WHO Department of Health and Migration
World Health Organization | 20, avenue Appia,
1211 Geneva 27, Switzerland

www.who.int

9789240094970