



**Exploring the viability and effectiveness
of alternative transitional financing systems
for the provision of essential health care services
among Syrian refugees in Jordan**

December 2022

Table of Contents

Preface	i
Abbreviations	iv
Executive Summary	v
1. Introduction	2
2. Background and context	3
3. Jordan's health system and health financing	4
3.1 Overview of Jordan's health system structure and functioning	4
3.2 Health financing in Jordan	5
3.3 Humanitarian-development coherence in the health sector.....	7
4. The refugee situation in Jordan	8
4.1 Health status of refugees	8
4.2 Jordanian policy on access to healthcare for refugees	10
4.3 External support for health services	12
4.4 Access to and affordability of healthcare for refugees.....	13
5. Cash for health (C4H) and community health	14
5.1 Agencies implementing C4H	14
5.2 Community health	15
6. Coordination and collaboration between development and humanitarian stakeholders.....	17
7. Potential health financing modalities	19
7.1 Review of potential health financing modalities	21
7.2 Proposed health financing modalities for Medair.....	24
7.3 Potential exit strategies.....	27
8. Advocacy recommendations.....	29
Annex 1: Key Informant Interviews undertaken for the study.....	32
References.....	33

Preface

Nearly 10 years ago, in response to the then emerging displacement of Syrians throughout the Levant region, Medair arrived in Jordan with the intent to address the basic and most urgent needs of those who sought safety in Jordan. Nearly a decade later we find ourselves in what is clearly a crisis that has been protracted by the continuing war in Syria, ever-present regional unrest, and precarious domestic economic and social realities in Jordan. While the Government of Jordan has generously provided sanctuary for nearly a million refugees, it has been relatively clear that the burden of meeting their basic needs must be shared with them by the international community. Within this context we as humanitarians have gone to work, with a commitment to meet the needs of the most vulnerable. Our collective efforts to address acute needs, particularly in the healthcare sector, has proven to be effective and has saved many lives.

For many years, Medair's Cash for Health approach has been seen as highly relevant and fit for the purpose. It provides essential healthcare services to families and individuals who simply do not have the means to afford it themselves. In early 2021 it seemed prudent for us to take a serious look at other potential strategies and approaches that could facilitate healthcare access in ways that are financially more efficient, as well as beneficial for the economic environment in Jordan.

When we commissioned this research project, we clearly stated that its purpose was to strengthen the evidence for potential transitional funding solutions for access to health care amongst refugees in Jordan. A practical and logical transitional approach within the framework of the humanitarian/development nexus was yet to be identified at the time. By examining and analyzing the feasibility of various transitional approaches that show potential in the Jordanian context, our aim was to make a unique "thought" contribution within this humanitarian context. We believe this report, as written and presented by our consultants, achieves this aim.

It is important to note that the report examines areas, and makes recommendations, that essentially go beyond Medair's humanitarian mandate. That is why it is essential that it be shared more broadly among the many key stakeholders in Jordan, including donors, NGO's, the Ministry of Health, UN agencies, and perhaps even the private healthcare and insurance sectors. While the report does not clearly identify a transitional health financing approach that could better accomplish greater humanitarian/development coherence in Jordan whilst it addresses the key needs of refugees, it still provides a solid basis for further analysis.

I want to say a special thanks to the authors of this report, Corinne Grainger and Anna Gorter. It is rare to find external consultants whose expertise and analytical capacities on global health issues actually translate into such a sound contextual analysis like this. The connections they made to have such quality key informants, as well as a crisp understanding of the healthcare landscape in Jordan, was made possible through Yassmin Moor of CashCap/WHO. This project would not have come into fruition without all three of these remarkable women.

Along with the consultants, I would also like to thank all the key informants for the valuable insights and information, and in particular Eng. Huda Ababneh, Director, Projects Management and International Cooperation in Jordan's Ministry of Health. The names of all key informants are set out in Annex 3, including those from the following organisations: Caritas Jordan, ECHO Jordan Office, International Medical Corps (IMC) Jordan, International Federation of Red Cross and Red Crescent Societies Jordan (IFRC), International Rescue Committee (IRC) Jordan, Johns Hopkins Bloomberg School of Public Health, the Jordan INGO Forum, Terre des Hommes Italy, UNHCR Jordan and Head Quarters, USAID Jordan, The World Bank Jordan Health and Social Protection teams, and the World Health Organisation (WHO) Jordan, EMRO and Head Office teams, for their time and insights. Particular thanks go to Dina Jardineh and Mohammad Fawad of UNHCR for their patient explanations and sharing of documentation.

Finally, I want to acknowledge the efforts and contributions of the Medair Jordan team, also to this report. Our dedicated staff and volunteer cohort is passionate about serving and supporting those in need. While we might not always fully understand the impact we make in people's lives, this report proves that our steady efforts over the years have been a model of quality and efficiency in the humanitarian sector. But even more importantly, what we collectively do on a daily basis saves lives. This is indeed what our work is all about, and something I am deeply proud to be a part of.

Nathan Harper
Country Director
Medair Jordan



Abbreviations

3RP	Regional Refugee and Resilience Platform
C4H	Cash for Health
CBO	Community-based organisation
CHV	Community health volunteer
CSO	Civil society organisation
EU	European Union
FP	Family planning
GDP	Gross domestic product
GOJ	Government of Jordan
HCC	Healthy Community Clinic
HIA	Health Insurance Agency
IMC	International Medical Corps
INGO	International non-government organisation
IRC	International Rescue Committee
JHF	Jordan Humanitarian Fund
JIF	Jordan INGO Forum
JHFR	Jordan Health Fund for Refugees (local name for the MDA)
JRP	Jordan Response Plan
LMIC	Low and middle-income country
MENA	Middle East and North Africa
MDA	Multi-donor account
MOF	Ministry of Finance
MOH	Ministry of Health
MOSD	Ministry of Social Development
NAF	National Aid Fund
NCD	Non-communicable disease
NGO	Non-government organisation
PHC	Primary health care
RHAS	Royal Health Awareness Society
RMS	Royal Medical Services
SGBV	Sexual and gender-based violence
SOPs	Standard operating procedures
SRH	Sexual and reproductive health
SSC	Social Security Corporation
UHC	Universal health coverage
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNWRA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
US	United States
USD	United States Dollar
VAF	Vulnerability assessment framework
WB	World Bank
WHO	World Health Organisation

Executive Summary

The Syrian crisis is now more than a decade old, and longer-term approaches are needed to continue to support access to health services for vulnerable refugees living in host countries such as Jordan. In this context, Medair, which has been active in Jordan since 2012, commissioned a study to further explore ways to transition towards more integrated and sustainable approaches to facilitating access to health care for refugees, while avoiding further fragmentation in the financing of health services in the country. While this study is based on Medair’s projects, other health focused humanitarian actors could make use of the recommendations and different financing modalities proposed in the Jordan context.

Recommendations included in this report are based on a review of documentation and interviews with 25 key informants (KIIs), comprising stakeholders engaged in the financing and implementation of health services in Jordan, including an interview with a senior Ministry of Health (MOH) representative. The full report describes the background and context for refugees residing in Jordan (section 2), and aspects of Jordan’s health system structure and financing that are most relevant to accessing healthcare for refugees and vulnerable Jordanians (sections 3 & 4).

In the health sector, Medair currently provides support through cash for health (C4H) and complementary community health services for refugees and vulnerable Jordanians (see section 5). C4H is provided to cover the costs of selected health services for refugees, and as ‘emergency cash’ for vulnerable Jordanians. Figure 1 provides a snapshot of Medair’s C4H transfer modalities.¹

Figure 1: Medair’s Cash Programming for Health

Transfer Modalities			
Reimbursement of priority health services	Unconditional cash	Emergency cash for Jordians	Conditional cash
Based on receipts provided by beneficiaries, used mostly for life saving and acute health care	Cash for pregnant women unable to pay OOP for their delivery, paid at a pre-defined rate, late in pregnancy	Humanitarian agencies required by GoJ to target 30% of support to vulnerable Jordanians. Provided once per year as emergency cash	Cash to pay for essential public health and preventive health services incl. NCD prevention and management

¹ Figure 1 is based on a presentation given by Amira Ameen of Medair in February 2022 (slide 8)

As of the time of this report, Medair is one of only a few organisations providing C4H to refugees in Jordan, alongside UNHCR and Terre des Hommes Italy (TdH). UNHCR considers C4H to be an important complementary activity to its strategy of integrating refugees into national health systems. Integration has been pursued (and to a large extent achieved) through the policy of the Government of Jordan (GOJ) to allow access for all refugees to public health services at the highly subsidised uninsured Jordanian rate (section 4.2), made possible through the provision of development partner funds via the multi-donor account (MDA). However, additional support is needed to cover the still high costs for the most vulnerable refugees in accessing health services, particularly for safe delivery, non-communicable disease (NCD) management and lifesaving and acute care. This additional support is provided in the form of cash transfers.

This study looks at Medair's work in the health sector in Jordan and at the appropriateness and feasibility of selected alternative health financing modalities (section 7.1).

The analysis concluded that the necessary enabling factors to support the development and implementation of most of these alternatives are not present in Jordan at the current time. The principal policy and health system characteristics which mitigate against adopting alternative health financing modalities are:

Health insurance:

- A large number of Jordanians remain without health insurance coverage, and the Jordanian Government is therefore prioritising these groups, with no plans to incorporate refugees into national schemes;
- The majority of refugees are not permitted to work and hence do not earn sufficient income to cover premiums in the longer term, which would make such an option more sustainable;
- The high level of fragmentation in the health insurance sector and lack of fiscal sustainability of existing national schemes makes this a complex option with multiple stakeholders;
- The evidence base indicates that refugees who are included in national health insurance schemes continue to be required to pay something towards the cost of their care, necessitating on-going support for the most vulnerable (mostly likely in the form of cash assistance).

Health Equity Funds, vouchers, and other reimbursement models:

- Existing policies require the institutions which pay on behalf of refugees to pay the higher 'foreigner' rate for public health services which, at the secondary and tertiary level, can be higher than the corresponding rates in the private sector;
- The highly centralised nature of Jordan's health sector means that reimbursements must be made at central level to the MOH, which charges administrative overhead fees that increase the cost of care, while highly bureaucratic processes and delays in invoicing are incompatible with Medair's funding cycles;
- Health facilities are unable to collect and use funds from reimbursements to improve quality of care and tackle issues on the ground (such as stock-outs), reducing their incentive to participate in such a scheme.

Performance-based contracting, as defined by the World Bank, is not currently being used by humanitarian partners in the health sector in Jordan. Instead, private health facilities are individually contracted and paid a fee-for-service for specific health services provided to refugees. This approach will continue to be used by Medair and other health sector stakeholders while Jordan's public health services continue to face capacity constraints. Furthermore, where the prices for secondary and tertiary health services in the private sector are lower than the corresponding public sector foreigner rates, reimbursing private sector providers clearly makes economic sense.

This is not recommended as a longer-term financing option for Medair, but can be seen as a gap-filling strategy which should ideally reduce over time.

Proposed health financing modalities for Medair – C4H

Given these contextual factors, and based on the analysis contained in the report, it is proposed that Medair continue with its existing strategies of C4H, accompanied by community health work, while considering a number of adaptations that could improve the efficiency, effectiveness, and sustainability of the C4H provided by all C4H partners. Adaptations to the C4H include (see section 7.2 for additional detail):

- **An increased focus on NCD management and treatment within the C4H component.** This should go hand-in-hand with Medair’s work at the community level on NCD prevention and management, with the aim of reducing reliance on more costly treatments that arise due to poor NCD control. Rationales for such a strategy include Jordan’s very high burden of disease from NCDs, weak and fragmented community health programmes, and the strong investment case for investing in NCD prevention and management to reduce pressure on Jordan’s health system and save money;
- **Introduction of operational efficiencies,** including more efficient systems for identifying and assessing the eligibility of beneficiaries, specifically for lifesaving and obstetric care. Medair could investigate the potential to:
 - Move away from the identification of refugees at household level, to take advantage of existing entry points for C4H such as through referral by other agencies (UNHCR, NGOs, community-based organisations, and MOH), and self-referral using Medair’s hotline or online registration systems;
 - Develop more harmonized targeting systems (i.e., under the ‘one refugee approach’), including the development of standardised medical criteria to determine medical vulnerability/eligibility, including clearly defined criteria for MOH health facilities to refer pregnant women and refugees to C4H agencies to cover the costs of life saving and obstetric care;
 - Establish a central referral hub for C4H, along the lines of UNHCR’s contract with IMC, to act as the interface between the payer (UNHCR, Medair, TdH) and the beneficiary, which would facilitate all administrative C4H processes, including assessing medical eligibility of refugees, locating and reviewing documentation, verification of invoices and costs, and monitoring. In the longer-term, this hub could potentially also serve as a focal point for improved coordination with the MOH at central and lower health system levels;
 - Instead of the current intensive post-distribution monitoring of all cash transfers, Medair could look at the potential for introducing sample-based monitoring and trend analysis to identify operational challenges on the ground as well as potential misuse of funds. This would involve follow-up of fewer beneficiaries, targeting those receiving higher transfer amounts. Medair might also look in the potential for a common monitoring process across C4H partners, as well as its localization by building the monitoring capacity of a local entity.
- **Support refugees to be eligible for UNHCR support.** For each case that is referred to Medair from UNHCR due to the lack of eligibility of the person of concern, Medair could systematically log and investigate the reasons for the lack of eligibility and develop advocacy and communication strategies to help these refugees gain the necessary status and documentation to be deemed eligible, as well as to ensure refugees understand the necessary processes (i.e., registration with UNHCR within 48 hours of admission, eligibility of medical cases). If successful, this could lead in the longer-term to a reduction in the number of referrals to Medair.

There are robust reasons for Medair to continue providing cash as the principal health financing modality for refugees in Jordan at the current time (set out in section 7.1). An overriding rationale for providing cash is that this modality is meeting a gap that a reimbursement model is unable to meet. However, Medair should continue to monitor the political and economic environment, and to engage in dialogue with government partners (MOH, Ministry of Social Development-MOSD and possibly also Social Security Corporation-SSC) and development partners to ensure that their health sector strategy continues to reflect the most appropriate options available.

Proposed health financing modalities for Medair – community health

It is recommended that Medair continue to implement and consider expanding their community health programme. A number of recommendations are set out below:

- **Support greater coherence among community health partners and support MOH to develop and scale-up community health.** The MOH has signalled that it is prioritising preventive and primary health care and is consulting with development partners, including on the development of a community health curriculum and the creation of a new community health cadre. Medair can use its chairmanship of the Community Health Platform (and membership of other forums as appropriate) to embark on a consultation process designed to strengthen the quality of community health work, as recommended in Medair’s internal evaluation, and seek to strengthen coherence in the approaches taken by the different partners. Particular attention should be paid to ensuring community health partners together liaise with the MOH and that their work reflects national priorities.
- **Seek development funding (in addition to existing humanitarian funding) to expand community health interventions for all refugees.** NGOs such as Medair can continue to play a critical (interim) role in providing community health services, filling the (currently significant) gaps while the MOH develops and rolls out its own community health programme, which will likely take some years to achieve.ⁱⁱ **A strategy of localization should form a key component of this work** - building the capacity of local organisations to deliver preventive and basic community health services. Given the short-term and fragmented nature of humanitarian funding, Medair could usefully investigate how best to access development funding based on this more sustainable approach, drawing on the experience of Medair’s Social Protection team and, if necessary, bringing in technical assistance to develop proposals for funding.
- **Introduce an expanded package of community health services with a focus on NCD prevention and healthy lifestyles,** to accompany the C4H component. The package should also continue to cover reproductive and maternal and child health and should incorporate information on the importance and availability of FP services, given high levels of unmet need for contraception, particularly post-partum FP.
- **Strengthen referral pathways for refugees and vulnerable Jordanians to specialist services,** particularly for NCDs but also for mental health and psychosocial support, disability and SGBV services, working with other health sector partners as appropriate.

Alignment with national systems and processes

The continuation of Medair’s C4H work, supported by an expanded programme of community health and with a stronger focus on NCDs across all health activities, is well-aligned with national health priorities and strategies (KII MOH). The GOJ uses cash transfers as the preferred modality to provide support to the most vulnerable Jordanians through the NAF, and the MOH is currently working on a new national health strategy with preventive and primary healthcare at its centre (KII MOH). C4H is also the preferred modality of UNHCR for reimbursing lifesaving and acute care.

ⁱⁱ Medair could continue to dialogue with MOH to explore the potential timeline for the development and scaleup of a publicly funded and managed community health programme.

A stronger focus on NCDs is also endorsed by major development partners, including UNHCR, WHO (KII's UNHCR & WHO) and the European Union (EU), as demonstrated by the recently approved Euro 22 million grant from the EU Regional Trust Fund in Response to the Syrian Crisis to strengthen Jordan's primary health sector (with a focus on NCDs), and the work of Global Health Development/EMPHNET in support of the MOH to standardize treatment protocols and improve the quality of clinical care for hypertension and diabetes.

Additional health financing considerations:

- A number of additional proposals are set out below for consideration by Medair based on key informant interviews and correspondence with the Medair team:
- Consider investing in a study to compare the costs of C4H versus reimbursement models with the MOH, working with other health sector partners as appropriate (and sharing the cost).
- Given the target set by the MOH for humanitarian organisations to ensure 30% of total beneficiaries are vulnerable Jordanians, Medair and UNHCR could look at the potential to access the poverty identification systems of the Ministry of Social Development (MOSD) (as used by the NAF/Takaful programme) to identify beneficiaries in a more efficient way.
- In addition to building the capacities of selected local partners (CBOs, NGOs) to deliver community health services, Medair could work with these local organisations to provide them with the tools and expertise to seek donor funding, contributing to the sustainability of their work in the longer-term.
- In the longer-term, Medair could consider working with civil society organisations to support the establishment of a refugee-managed and led community-based organisation, should this be a feasible option in Jordan. Such an organisation would provide a focal point for liaising with MOH primary health care centres on issues related to refugee health status and care in the catchment areas.
- Should the MOH change its policy on charging institutions the full foreigner rate when reimbursing on behalf of refugees, Medair and health partners could explore the potential for and costs of contracting a third-party organisation (possibly a health insurance agency or health organisation such as IMC) to manage the processes involved in setting up and managing an MOU with the MOH. Such a third party could also possibly be considered for running a central C4H 'hub' (see above) if this were a more cost-effective option.

Thoughts on potential exit strategies

- **C4H:** There is no clear exit strategy for providing C4H for the most vulnerable refugees in Jordan, just as the GOJ and Royal Court recognize that the most vulnerable Jordanians will continue to require financial support to access health and other social services. The GOJ is supporting only a proportion of vulnerable Jordanians in need, and lacks the necessary resources to take on the additional costs of support to refugees. UNHCR is facing similar resource constraints.
However, Medair can work strengthen their C4H work through: a) introducing operational efficiencies so that the funds go further, as set out above; and b) working with partners to systematically investigate and address the reasons why refugees lack eligibility for UNHCR support, thus reducing the burden of referrals to Medair for C4H, while at the same time advocating with donors and other stakeholders to ensure sufficient funding for C4H for lifesaving and obstetric care at the current levels of provision;
- **Community health:** Medair can consider two strategies in community health which will build in sustainability and support an eventual exit strategy: firstly, Medair should seek opportunities to liaise with and provide support to the MOH in the development and roll-out of its community health programme, working with other health sector partners to ensure both a more coherent

approach to community health and alignment with national health priorities, as set out in the new Health Sector Strategy; secondly, Medair should seek to localize the community health work, which can be achieved by working with local NGOs, CBOs, refugee-led organisations or NCD patient organisations or groups (see also above). The exit strategy in this case would be one of moving to a supportive rather than a direct service provision role.

Advocacy Recommendations

Government partners: Medair could join health sector partners in **advocating for recognition of the special vulnerability of refugees regarding access to high-cost healthcare and for longer-term financing solutions**. A form of 'refugee window' under existing schemes such as the National Aid Fund (NAF) could be discussed, with pooled funding from development partners to cover the costs of access to lifesaving health services for the most vulnerable refugees. Eventually, such a fund together with the MDA, could be integrated with national health insurance schemes (such as those managed by MOH, MOSD or SSC) to finance premiums on behalf of refugees as has been done by UNHCR in Iran.

Development partners: Medair should consider how best to diversify its funding portfolio for health and seek longer-term funding from donors through development channels rather than humanitarian funding (see above). Articulating the strong rationale for providing a safety net for refugees in accessing high-cost lifesaving health care in the form of cash transfers, and building capacities and skills of local organisations in community health and NCD prevention and management, could form a good basis for accessing development funds.

NGOs and CBOs: Given the need to develop more sustainable approaches and to consider an eventual exit strategy, some health sector INGOs are working to build the capacity of local organisations to take on direct service provision, moving to a role of technical and management assistance. Medair could investigate how best to coordinate these localisation efforts, kickstarting a process of sharing experiences and identifying learning and good practices in this area.



© Medair/ Salsabeel Hanatleh



1. Introduction

The Syrian crisis is now more than a decade old. The protracted nature of this crisis, the overall decline in humanitarian funding, the bleak outlook for refugees to be able to return home,¹ and the global economic downturn, mean that longer-term ('transitional') approaches are needed to support access to health services for refugees living in host countries such as Jordan.

With the decline in humanitarian funding, the gap between overall funding requested by the Government of Jordan (GOJ) and total funding received is widening.² The Covid-19 pandemic, which has placed additional pressure on health systems everywhere, has served as a catalyst for the GOJ to put resilience back at the core of the Jordan Response Plan (JRP), and JRP partners are exploring and tracking the support provided in order to better coordinate and target interventions to strengthen public systems.³

In the light of these trends, in early 2022 Medair commissioned this report to systematically explore ways to transition towards more integrated and sustainable approaches to facilitating access to health care for refugees, while avoiding further fragmentation in the financing of health services in the country.

This report sets out the findings from a desk study exploring the feasibility of selected alternative financing modalities for the provision of essential health services to refugees and vulnerable host communities. It is based on a detailed analysis of Medair's operations in the health sector in Jordan, a review of the relevant literature and programme documentation, and key informant interviews (KIIs) with selected humanitarian and development partners.ⁱⁱⁱ While its findings are based on Medair's operations, it is still relevant for partners who are also thinking of health financing schemes in Jordan and in the region.

Essential health services are the most critical services to deliver in any given context. While there is no commonly agreed definition of essential health services, for the purpose of this study, they are defined as a set of primary and secondary health care services that are important for saving lives and improving health outcomes. These include child health, sexual and reproductive health (SRH), including maternal healthcare and family planning (FP), and noncommunicable diseases (NCDs), in addition to emergency and life-saving healthcare.

This report describes relevant information related to the background and context for health service delivery to refugees and vulnerable Jordanians (section 2), Jordan's health system and financing (section 3), and the refugee situation in the country (section 4). A more detailed investigation of Cash for Health (C4H) and community health is provided in section 5, while coordination and collaboration between health sector stakeholders are explored in section 6. The feasibility of selected health financing modalities is presented in section 7 and some potential advocacy recommendations are included in section 8.

ⁱⁱⁱ Analysis drawn from a key informant interview (KII) is referenced in brackets in the main body of the report. See also Annex 1 for a complete list of KIIs conducted during the course of this study.

2. Background and context

Jordan's population is estimated to be 10.3 million people (2021).⁴ The country's previously high population growth rate, which had been falling since the 1990s, rose again sharply with the mass migration caused by the Syria crisis in 2011.⁵ Childbearing among Syrian women living in Jordan starts earlier (19% of Syrian women age 15 to 19 have had a child compared to 2% of Jordanian women), contributing to larger family sizes among Syrians (an average of 4.7 children born to Syrian women compared with 2.6 children for Jordanian women).⁶ The average size of a Syrian household has remained stable between 2018 and 2021 at around 5.3 people, and for non-Syrian households this is 3.7 people (2021). The population is predominantly young, with around half of all people from Syria and a third of non-Syrians under the age of 18 years.⁷

Jordan is one of the world's largest refugee hosting countries relative to its population, with 89 refugees per 1,000 inhabitants (2020 data), with non-Jordanians representing about a third of the total population. The largest group are Palestinians, under the aegis of UNWRA and the large majority of refugees registered with UNHCR are Syrian, mostly concentrated in the four governorates of Amman, Zarqa, Irbid, and Mafraq. Refugees of other nationalities are from Egypt, Iraq, Pakistan, Sudan, Palestine, and Yemen, among others.

As of 2020, Jordan is classified as an upper-middle income country with GNI per capita of USD 4,310 (2020) and has moved in and out of lower and upper middle categories over the years.^{iv} For a middle-income country, poverty rates are relatively high, fuelled by the effects of the Syrian crisis, the Covid-19 pandemic, and global economic trends. The World Bank recently stated that "weak economic performance can be traced to the Syria crisis [...] which has had a negative effect on Jordan's growth, poverty reduction, and debt accumulation".⁸ Poverty rates are estimated to be 16% among Jordanians and 40% among non-Jordanians, and by late 2021, nearly three quarters of Jordanian households were reporting difficulties fulfilling their basic needs (rent, food, education, medicine, and heating).⁹

Many refugees remain dependent on humanitarian support, such as cash assistance, due to their inability to earn an income. While the GOJ is committed to expanding sustainable livelihood opportunities and broadening access to social security mechanisms, efforts have mostly been targeted at vulnerable Jordanians. Refugees and those without citizenship have highly restricted access to the labour market. Improvements are gradually being made and in 2021, Jordan issued a record 62,000 work permits to Syrian refugees, which was the highest annual figure since the permits were introduced in 2016.¹⁰

The Jordanian Government and Ministry of Health (MOH) are committed to the achievement of universal health coverage (UHC) and signed the UHC Global Compact in July 2018.¹¹ However, high population growth rates, the rising burden of NCDs, and the large number of refugees residing in Jordan relative to the population are exacerbating the existing limitations of the MOH's institutional capacity. The Government is well aware of the need to tackle the structural deficits of the health system (i.e. responding to the shortage of qualified medical professionals and strengthening primary health care services), and to develop more sustainable and longer-term health financing solutions for poor and vulnerable Jordanians as well as for refugees.¹²

^{iv} World Bank income classifications are up-dated each year based on GNI per capita in current USD (using the Atlas method exchange rates) for the previous year. [World Bank data](#) accessed on 15.03.22.

3. Jordan's health system and health financing

Below we briefly describe the aspects of the Jordanian health system structure (3.1) and health financing (3.2) that are most relevant to the analysis presented in this report, and set out the key mechanisms for greater coherence between humanitarian and development health sector partners (3.3).

3.1 Overview of Jordan's health system structure and functioning

Jordan has one of the most modern health systems in the region, along with a reputation for high quality healthcare.¹³ Prior to the pandemic, the country was attracting over USD 1 billion annually in medical tourism receipts, comprising a large part of overall tourism income which itself contributed around a fifth of the country's GDP.¹⁴ However, eleven years into the Syria crisis, Jordan's public health care system is facing increasing capacity constraints and economic recovery has been slower than predicted. The primary healthcare network in particular is overburdened, and secondary and tertiary health facilities are also underequipped and overcrowded, threatening the high quality of health services for which Jordan is known.¹⁵ The WHO refers to challenges related to equity, duplication of services, coordination among major providers, and limited quality improvement programmes as key challenges facing all healthcare providers in Jordan.¹⁶ Furthermore, there is no comprehensive health management information system to provide accurate data for decision making, with data scattered throughout the health system.

Echoing the pattern across government, the health system is highly centralised with decisions related to all key functions taken at the national level, including those related to human and financial resources for health, purchase and distribution of medicines, and infrastructure. Health facilities have no budgetary and little management autonomy, with user fees collected by health facilities and deposited in the Ministry of Finance (MOF) accounts. Although decentralisation has recently been voted on by the Government, this is the very start of the process. It will take many years for the necessary administrative decentralisation and capacity building of sub-national agencies before financial decentralisation is introduced (KII MOH).

The main health care provider in the country is the public sector, which provides the large majority of hospital beds and serves some 60% of the population. There are three principal public sector providers: the MOH; the Military Royal Medical Services (RMS); and two university-affiliated hospitals which are semi-autonomous. A large network of primary healthcare (PHC) clinics provides access to medical care and offers vaccination, maternity and childcare, and basic chronic disease management services. Comprehensive health centres offer some specialist care, including mental healthcare.

The Health Strategy 2018 - 2022 provides the following numbers of facilities in the public sector: 112 Comprehensive Health Centres; 375 Primary Health Centres and 190 Peripheral Health Centres distributed throughout the Kingdom, in addition to 505 Maternity Centres and 405 dentistry clinics. The MOH also runs 32 hospitals providing secondary and tertiary care.¹⁷ Home-based health care in Jordan is limited and is provided mainly through the private sector (KII IMC).^y There are an estimated nine health centres for every 100,000 Jordanians, which is very close to the recommended average of 10 per 100,000 people recommended by the World Health Organization (WHO). Around 90% of Jordanians live within a 4km radius of a health facility. There are around 26 physicians per 10,000 citizens, which is comparable to many richer countries. Public providers are interconnected through an unstructured referral system.¹⁸

^y However, the MOH has recently endorsed the country's first-ever national strategy for palliative and home healthcare, based on a USAID-funded pilot project with the King Hussein Cancer Centre in 2016-17.

A 'gate keeping' system operates in the public sector whereby, in theory, PHC centres are the point of entry and referral to higher level care. However, many Jordanians prefer to bypass primary care in favour of ambulatory care at secondary and tertiary care facilities. If refugees go directly to a higher-level facility without a referral from a primary health centre, they are charged the non-subsidised 'foreigner' rate for services, as opposed to the subsidised uninsured Jordanian rate (see section 4).

The quality and availability of primary health care in Jordan is considered weak compared with the quality of higher-level care. Challenges relate to the lack of sufficient, well-trained human resources and the supply of commodities, resulting in long waiting times and stockouts of medicines and supplies. Some key informants stated public health staff have low motivation (KII WHO), and absenteeism is frequent among health providers due to dual practice in public and private health facilities, largely in response to relatively low salaries in the public sector (KII Modol).

There is a thriving private sector with over 60 private hospitals, diagnostic and therapeutic centres and large numbers of other private clinics and pharmacies. The private sector acts as an 'overflow' mechanism for the public sector, and patients are referred to private facilities through public health insurance schemes. The international and charitable sectors provide services through UNRWA-financed clinics for Palestinian refugees, and through multiple national and internationally financed clinics, including UNHCR-financed health centres for registered refugees.

Jordan's growing burden of NCDs requires a reorientation of the health system towards preventive and primary care to reduce the high levels of expensive NCD treatments at secondary and tertiary care levels, and to improve the health and quality of life of those with NCDs. Community-based healthcare is currently piecemeal and fragmented, and provided mainly through non-government organisations (NGOs) and community-based organisations (CBOs), which work with community health volunteers (CHVs). There is no established community health cadre in the public health system.

However, the MOH is well aware of these challenges and is currently focusing efforts on developing public preventive and community health care capacities. As part of this process, they are consulting with health sector stakeholders on the development of a more systematic approach to community health, and will draw on previous pilots, such as the Healthy Community Clinic (HCC) programme introduced in 2011 with support from the Royal Health Awareness Society (RHAS).^{vi}

3.2 Health financing in Jordan

In Jordan, the onset of the refugee crisis in 2011 acted as a catalyst, accelerating the flow of funds for healthcare from overseas aid partners. In 2018-19, the country ranked 6th in the list of top recipients of gross overseas development assistance globally.¹⁹ This steep increase in external funding has coincided with a corresponding decline in domestic health spending between 2008 and 2018, demonstrating an inverse relationship between external aid and domestic financing for health that has been witnessed in many other countries.²⁰

Overall, Jordan spends more per capita on its citizens' healthcare than its neighbours, spending around 7.5% of GDP in 2019, of which nearly half was provided by the Jordanian Government via the national budget and the remaining half by corporations, NGOs, and healthcare users. Out-of-pocket (OOP) payments account for around a third of total health spending, through insurance premiums and co-payments, and through user fees at the point of service delivery.²¹

^{vi} [RHAS](#) is a Jordanian NGO which initiates and supports community-based health and safety interventions in partnership with public, private and civil society institutions. HCCs are established within existing MOH primary care facilities and the programme provides medical practitioners with training and resources to improve preventive healthcare, particularly prevention and management of NCDs.

Public funds are collected primarily through general taxation while private funding is through private insurance contributions (from the insured and their employers) and user fees. While health financing (i.e., raising and collecting revenues for healthcare, pooling funds, and purchasing of services) is highly fragmented, financial decision making within the public sector is highly centralized and controlled, leaving little room for flexibility at the facility level.

All Jordanians have access to highly subsidised health services in the public sector, including those without health insurance who pay the 'uninsured' Jordanian rate. Those who are entitled to free services at public health facilities include all children under six years old regardless of their nationality, blood donors and families with a member who is an organ donor, citizens of areas classified as 'least fortunate' or remote, citizens who are over the age of 60, and those who are disabled or suffering from cancer.

According to the latest population census, about 70% of Jordanians and 55% of the Kingdom's overall population have some form of insurance, although there is considerable geographic variation in coverage levels.²² The sector is highly fragmented with multiple agencies providing health insurance including the Ministry of Social Development (MOSD) (for vulnerable Jordanians and informal sector workers), the Ministry of Health (through the Civic Insurance Programme - CIP), and private health insurance companies. The Social Security Corporation (SSC) is developing a new health insurance scheme for currently uninsured formal sector workers, which will provide access to private healthcare.^{vii}

The majority of insured Jordanians are insured by the public sector through the CIP, which is financed principally (77.5%) by the GOJ through the Ministries of Finance and Social Development, and sourced mostly from tax revenues.²³ The CIP covers civil servants and their dependents (and some wider family members) for care at MOH facilities, RMS facilities, university hospitals, and the private sector based on a grading system that depends on the level of seniority.²⁴ Paid membership in the CIP is also available for citizens who wish to be enrolled and are not otherwise covered, including pregnant women and those age 60 or younger.²⁵

Patients covered by health insurance pay very low, or no co-payments at the point of service delivery, while uninsured Jordanians have access to highly subsidised care, particular at the primary healthcare level. Reproductive health services are provided free of charge to everyone regardless of status in all health centres affiliated with the MOH, numbering around 520 centres. These services include antenatal and postnatal care, FP, immunisations for children and pregnant women, and health education. However, the more expensive delivery services, and management of maternal and neonatal complications have to be paid for.

Health insurance is not available to refugees unless they pay for private insurance. A Government official is reported to have said in an interview in November 2017, "There have been some attempts of international organizations to include Syrian refugees under the civil insurance umbrella, but this is very costly and the government cannot afford the insurance coverage. There is also no policy to stabilize Syrians forever in Jordan".²⁶ However, since July 2020, refugees of all nationalities can access all public health services at the 'uninsured' Jordanian rate (see 4.2 for more detail).

There is currently no comprehensive data on the costs of providing health services in Jordan, no defined essential health services package,^{viii} and consequently no strategic purchasing of services by

^{vii} See for example, [Jordan Times February 1, 2022](#).

^{viii} Efforts have been made by WHO and other stakeholders to bring in technical assistance to support the MOH in the development of an essential health services package. At the time of writing, this remained a distant goal.

the Jordanian Government. Health sector budgets are based largely on the previous financial year's budget and health facilities lack flexibility to use the allocated funds to address the needs on the ground as they arise.

3.3 Humanitarian-development coherence in the health sector

The humanitarian development nexus, sometimes referred to as the 'nexus approach',^{ix} is about seeking more coherent, longer-term solutions to the refugee situation in Jordan and the Middle East and North Africa (MENA) region. In the context of declining humanitarian funding and the protracted nature of the refugee crisis, the nexus approach seeks to strengthen "collaboration, coherence and complementarity of humanitarian and development actions to reduce overall vulnerability and the number of unmet needs".²⁷

In Jordan, coherence has largely been mainstreamed at the policy level through the Jordan Compact (2016 - 2021) and the JRP. Outcomes include: an increasing focus on a medium-term response that focuses on building resilience and increasing self-reliance; and, increasing efforts as well as policy developments which align the refugee response with broader national development strategies, most notably regarding economic growth and social services, including access to health services for both Syrian and non-Syrian refugees.²⁸

The health sector has made some progress in strengthening coherence between humanitarian and development approaches, in particular through the establishment of the multi-donor account (MDA) in 2018. The MDA was established in response to a successful advocacy campaign by humanitarian and development partners to persuade the government to roll back the 2018 policy of charging refugees the full price for health services, often referred to as the 'foreigner' rate or 'unified' rate (section 4.2). It channels donor funding as budget support to the GOJ to incentivise (and subsidise) the inclusion of refugees in the national health system.^x

While increased humanitarian-development coherence is on the agenda in Jordan, this effort does not permeate all sectors and all system levels. A recent report by the Durable Solutions Platform and Development Initiatives (2022) pointed to significant challenges, including the lack of a 'one refugee approach' which treats refugees of all nationalities in the same way in legislation and policies, and a lack of integration of refugees into Jordan's development plans, strategies, and vision. Furthermore, the short-term nature of the funding reaching displacement-affected communities inhibits the development of medium to long term programming and approaches.²⁹

There is currently no commitment to longer-term funding solutions for the healthcare costs of refugees, and the real risk remains that a reduction in external funding through the MDA may lead to the reversal of the policy which provides refugees access to public health services at the highly subsidised uninsured Jordanian rate (KII MOH). The UNHCR is focusing strongly on the twin strategies of a) integrating refugees into national health systems, through advocating with development partners on the replenishment of the MDA, and b) complementary activities to fill the gaps by providing C4H. UNHCR also continues to advocate with some success on the 'one-refugee approach' whereby all refugees regardless of their nationalities are treated equally (KII UNHCR 2).^{xi}

^{ix} Most development partners refer instead to humanitarian-development coherence (KII JIF).

^x The MDA is currently known as the Jordan Health Fund for Refugees (JHFR). There is also an MDA for education. In this report we use the term MDA since this is the term used by all key informants.

^{xi} UNHCR was recently granted approval by the Jordanian Government to work in an official capacity with non-Syrian refugees and continues to advocate strongly for their access to public services and support (KII UNHCR).

4. The refugee situation in Jordan

Jordan is the second largest per capita refugee hosting country in the world.³⁰ It is one of five countries in the Regional Refugee and Resilience Platform (3RP) for the Syrian Crisis, alongside Lebanon, Turkey, Iraq and Egypt, which has served since 2013 as the coordinating framework for all partner organizations and countries participating in the response and is co-chaired by UNDP and UNHCR. The 3RP provides the overarching framework for the country's operation plan, which is the JRP.

As of February 2022, there were 673,957 Syrian refugees in Jordan. Syrian refugees make up the large majority of refugees under the mandate of UNHCR in Jordan, and around 83% of Syrian refugees live in urban and peri-urban communities alongside host communities, while 17% are living in camps, such as Zaatari and Azraq camps. Overall, nearly 90% of the Syrian refugees live in the four Governorates of Amman (30%), Mafraq (25%), Irbid (20%) and Zarqa (15%).³¹

Although recent assessments suggest that the vast majority of refugees in Jordan are now registered with the UNHCR, which has made huge progress in addressing a backlog in registration documentation due to the Covid-19 pandemic, a recent report points to continued difficulties for refugees in accessing legal status, social protection, education, employment, and healthcare, with many facing increased vulnerabilities due to the Covid-19 pandemic.³² In June 2021, 80% of refugees in host communities were considered to be food insecure or at risk of food insecurity, with even higher levels among female-headed households and families with a person living with a disability.³³ Unemployment is high in Jordan at around a quarter of all working age people, and much higher among refugees;³⁴ fully 91% of refugees sampled in the 2021 CARE needs assessment reported being unemployed during the year, compared to 85.3% the previous year.³⁵ The JRP also points to increased incidence of sexual and gender-based violence (SGBV), and very high rates of indebtedness.³⁶

4.1 Health status of refugees

The high incidence of poverty and unemployment among refugees has contributed to worsening health status. The JRP highlights the fact that about half of Syrian households have severe or high health vulnerability based on the Vulnerability Assessment Framework (VAF), and refers to significant challenges posed by an increased prevalence of NCDs and other health problems.³⁷

Non-communicable diseases (NCDs) are one of the major health and development challenges of the 21st century.^{xii} The largest burden falls on LMICs where 85% of premature deaths due to NCDs occur in the 30 – 69 year age group, making NCDs an urgent development issue.³⁸ The heavy burden on LMICs reflects the close links between NCDs and poverty; treatment for NCDs is often lengthy and expensive and, when combined with loss of earnings, can quickly drain household resources due to the increased costs associated with health care.³⁹

Reflecting the global patterns, the principal NCDs in the MENA region are cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases, caused predominantly by tobacco use, harmful use of alcohol, physical inactivity, and unhealthy diet. Refugees are particularly at risk, with the trauma of displacement, experience of violence, and increased levels of socio-economic deprivation. A recent systematic review shows that vulnerable conflict-affected populations with the highest NCD burden include refugees from the MENA region fleeing the Syrian crisis to countries including Lebanon, Jordan, Iraq, and Turkey.⁴⁰

^{xii} Definitions of NCDs vary. Here we use the WHO definition of NCDs (also called chronic diseases) which includes hypertension, diabetes, cardiac diseases, cancers, asthma and COPD, mental health disorders and kidney disease ([WHO 2021](#)).

In Jordan, NCDs are the leading cause of morbidity and mortality, responsible for nearly 80% of the all deaths in 2019.⁴¹ The Jordan Vision 2025 recognises the heavy burden which NCDs are placing on the country’s economy and society in terms of the public health system, employment and productivity.⁴² Major challenges lie in the absence of a preventive health agenda, sub-optimal control of NCDs, the absence of comprehensive national NCD treatment guidelines, and inadequate management and follow-up by physicians.⁴³

However, some progress is currently being made. With support from Global Health Development/ EMPHNET, the Jordanian MOH is working to standardize treatment protocols and improve the quality of clinical care through staff training for hypertension and diabetes in the north of Jordan (Irbid, Mafraq, and Ramtha), adapting the WHO’s HEARTS technical package in primary healthcare settings.^{xiii} And the European Union (EU) recently approved a Euro 22 million grant to strengthen primary healthcare services, with a focus on NCD management.

Although data from different sources vary, approximately a fifth to one quarter of refugees are thought to suffer from NCDs, requiring costly and frequent long-term treatments.⁴⁴ The 2021 Household Access and Utilization Survey (HAUS) carried out with random samples of Syrian and non-Syrian refugees found that 26% of non-Syrian and 19% of Syrian refugees had at least one chronic disease.⁴⁵ Table 1 below provides a snapshot of the numbers and proportions of refugees suffering with an NCD.

Table 1: NCDs among refugees, vulnerability, and access to medicines

	Syrians	Non-Syrians	All POC
Number of registered refugees (UNHCR Feb 2022)	674,148	86,741	760,889
NCD prevalence (HAUS 2021)	19%	26%	760,889
People of Concern (POC) with an NCD	128,088	22,553	150,641
Number of POC overall who could not pay for medications	66,606	10,374	76,980
Proportion of refugees who could not pay for NCD medications and consultation fees (HAUS 2021)	52%	46%	
POC with NCD among highly vulnerable	22,003	2,507	24,510

A high proportion of refugees travelling from Syria as well as other fragile and conflict-affected countries, such as Ethiopia, Eritrea, and Yemen, are suffering from **emotional and mental health problems**. A 2018 review of health challenges and access to health care among Syrian refugees by Dator and colleagues found that nearly a third were suffering from one or more symptoms of mental distress and illness.

^{xiii} See this [WHO page](#) for more information on the Global HEARTS Initiative.

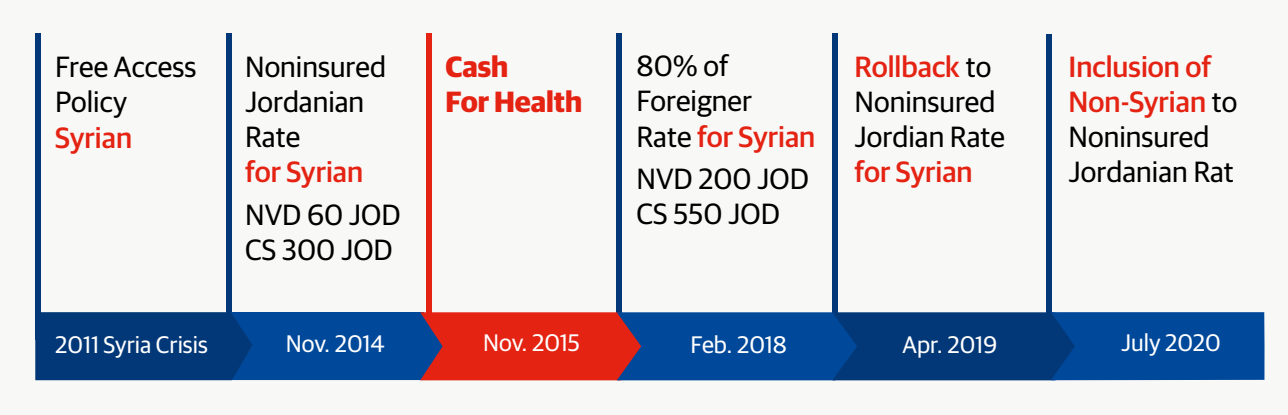
In above-cited 2021 HAUS survey, only 40% of Syrian refugees of reproductive age reported that they had heard that **family planning services** were available, and around half had received FP information in the year preceding the survey, mainly through health centre staff and community events. For non-Syrians taking part in the survey, only a fifth of women of reproductive age were aware of FP services, with 39% having received information relating to FP in the past year, indicating a clear unmet need for FP services among the refugee population.

The MOH is aware of many of the barriers faced by refugees in accessing care. At the launch of the National Reproductive and Sexual Health Strategy (2020 - 2030) in December 2021, the Secretary General of Administrative and Financial Affairs at the MOH, Dr Elham Khreisat referred to challenges in the provision of SRH services provided to Syrian refugees, and the existence of financial, social, cultural and awareness barriers that prevent refugees from reaching these services. She further stated that the MOH is working hard to improve the quality of health services provided, both preventive and curative, and to raise the level of reproductive health services.⁴⁶

4.2 Jordanian policy on access to healthcare for refugees

Jordanian policy on access to public health services for refugees has fluctuated over the years (figure 2). In the early years of the Syrian crisis, Syrian refugees living in Jordan could access services provided by the MOH at the same rate as Jordanians with health insurance (i.e., nearly free of charge). With the steeply growing numbers of Syrian refugees living outside the refugee camps, this policy was placing considerable strain on Jordan’s health system, and it was reversed in November 2014. Syrian refugees were then required to pay the same rate as uninsured Jordanians, which for primary health care is around 20% of the total cost leaving a relatively small payment to be made for medicines. For secondary and tertiary care, the prices are thought to be more like 35 to 60% of the full ‘foreigner’ rate, making them unaffordable even for some non-vulnerable households (KII UNHCR).

Figure 2: Health policy changes for refugees in Jordan



Source: Ahmad Alshibi (2021). Cash to access essential health services project, Public Helth Unit UNHCR

A new policy in early 2018 categorised all refugees, whether from Syria or elsewhere, as ‘foreigners’ rather than ‘residents’ with the steep rise in charges for health services. This policy was again rolled-back for Syrian refugees to the uninsured Jordanian rate in April 2019, while non-Syrian refugees continued to pay the ‘foreigner’ rate until July 2020.

Some services are provided free to all, regardless of their nationality or status. These include preventive maternal and child health care services (i.e. ANC and PNC, vaccination), FP, infant and child feeding programmes in addition to routine vaccination services which are available at MOH's Maternal and Child Health centres. This is free of charge for all refugees from all nationalities, with valid registration documents of Asylum Seeker or Refugee.⁴⁷ Furthermore, treatment of diseases of public health concern are also provided free of charge to the same groups. All refugee communities have been included in the national Covid-19 response.^{xiv}

Humanitarian partners provide health and other services to refugees living in the camps and, for secondary and tertiary care, UNHCR has established a referral system to public and private providers. When referring refugees residing in camps to public health services outside the camps, UNHCR pays on behalf of the refugees but must pay the 'foreigner' rate, which can be high, particularly for secondary care, and may be higher than the corresponding private sector prices.

The majority of refugees living outside camps, regardless of their nationality or country of origin, can access public health services at the same prices as non-insured Jordanians.^{xv} However, the system remains highly complex and certain groups fall outside the new policy and must still pay the full costs of their care at public health facilities when they lack registration, their registration document is no longer valid or is not the correct documentation to reside in an urban area.

When accessing the private sector, all refugees must pay the rates charged unless they have private health insurance. Despite the often-high prices in the private sector, many refugees continue to access health services in this sector, as demonstrated by the HAUS (2021).⁴⁸ Due to changing policies on the prices which refugees must pay to access healthcare, there is general confusion among both health providers and refugees on the prices to be charged to refugees at public health facilities (KII UNHCR 1, KII WHO).

To address this confusion, UNHCR has worked with the MOH and the Jordan Health Development Partners Forum (JHDPF) to develop a Policy Manual and Service Guide with the aim of improving communications around the current policies, systems and processes for refugee access to health services. In 2022 UNHCR and MOH conducted workshops for health staff and accountants in all governorates, along with awareness campaigns targeted at refugees. The aim of this exercise was to encourage greater use of public health services by refugees.

The GOJ policy of enabling refugees of all nationalities to access health services at the same rates as uninsured Jordanians has improved their access to public health services. However, it does not support refugees when facing catastrophic health care costs which can occur when secondary or tertiary care is needed. Prices for these services in the public sector are high; for example, a simple appendectomy costs between 150 and 350 JOD while a C-section costs between 240 and 320 JOD (KII UNHCR 1). Vulnerable refugees unable to bear the costs of lifesaving or obstetric care often have recourse to negative coping strategies, such as incurring debt or foregoing care, leading to increased morbidity and mortality.

^{xiv} As of February 2022, 90% of refugees in camps had been vaccinated and 50% in urban areas. [UNHCR Operational update](#), February 2022.

^{xv} Funds used by the Ministry of Health to subsidise care for refugees includes loans and grants from donors including the World Bank, USAID, Qatar, Canada and others.

4.3 External support for health services

There are multiple partners providing a wide range of humanitarian support in Jordan, including 10 UN agencies, 54 international NGOs and 86 local NGOs.⁴⁹ In the health sector, there are 8 UN agencies, 14 INGOs, and 16 local NGOs which participate in the Health Sector Working Group, and 12 local NGOs which do not participate in the Working Group.^{xvi} The vast majority of humanitarian aid as a whole comes into Jordan directly via UN agencies, while a third comes direct to international NGOs either from bilateral partners or via UN agencies.

Support for Jordan's health sector by humanitarian and development partners encompasses direct budget support to the MOF, MOSD and MOH; financial and technical assistance for health systems strengthening; capacity building support (e.g., of NGOs and civil society organisations - CSOs); strategic and management support by third party organisations - often working on behalf of donors such as USAID or UNHCR; direct provision of health services; and cash for health.

Budget support for health from multilateral and bilateral donors is partially channelled to the Jordanian Government through the MDA. As of October 2020, USD85 million had been provided by the US, Denmark, Qatar, Canada, the World Bank, Italy and Germany.⁵⁰ Alongside the World Bank, the EU is providing multilateral support to the health sector in both development and humanitarian spheres and recently approved a Euro 22 million grant to strengthen Jordan's primary health sector through the EU Regional Trust Fund in Response to the Syrian Crisis (known as the MADAD Fund).⁵¹

Various development partners are providing technical assistance. For example, USAID is working with the MOH to strengthen health systems, with a focus on quality of maternal, neonatal and child health care, infrastructure, and human resources for health. The World Health Organisation (WHO) is providing technical assistance to strengthen the vaccine supply-chain and laboratory services (with funding from the EU and others), and is also supporting the development of Jordan's National Health Accounts, among other activities. The multi-donor supported UHC Partnership is focusing on strengthening health sector governance and primary health care delivery.

The OCHA-managed Jordan Humanitarian Fund (JHF), which is a country-based pooled fund that functioned from 2014-2022, provided flexible funding to address the humanitarian needs of Syrian refugees and vulnerable host communities in Jordan, focusing on health and child protection. The JHF focused on maintaining long-term affordable access to essential lifesaving health services for most vulnerable refugees (women and girls during the reproductive period, children and patients with chronic life threatening illnesses), both for refugees in the camps and major northern urban centres. These focal areas, which are based on findings from the vulnerability assessment conducted by UNHCR, are the same across many other partners, including Medair (see section 5 below).

NGOs active in the health sector provide healthcare directly for refugees living in camps, and typically implement programmes to cover gaps in access to public health care and provide refugee-specific services for those living outside camps. Funding tends to be short-term and fragmented which mitigates against longer-term planning and vision. Despite this, NGOs play a critical role in enabling refugees and vulnerable Jordanians to access care. Alongside Medair, the principal implementing NGOs in the health sector include Caritas, International Medical Corps (IMC) and International Rescue Committee (IRC), alongside a wide range of national NGOs. Having worked in Jordan since 2013, MSF

^{xvi} Membership of the sectoral Working Groups is restricted to organisations working with Syrian refugees, and excludes organisations working exclusively with refugees of other nationalities or vulnerable Jordanians. This is because these Working Groups were established under the Syria Crisis Refugee Response Coordination Mechanism.

recently announced that it was withdrawing its work of supporting Syrian refugees in the north of Jordan but will continue to work in Amman where it runs a reconstructive surgical hospital.⁵²

There remain gaps in coverage for those services for which there is a higher demand among the refugee population in particular, and including for mental health services, SGBV-related support, and disability services. These are areas where humanitarian agencies can continue to play an important role in service provision, alongside working with local organisations to build their capacity.

4.4 Access to and affordability of healthcare for refugees

Funding levels in the health sector are less than half of what is needed to meet the health needs of refugees, with the result that many of the refugees living in urban and peri-urban areas do not receive the assistance they need.⁵³ Despite government policies which allow refugees to access public health services at the uninsured Jordanian rate, important barriers to accessing public health services remain, including indirect costs, such as transportation to/from a facility, paying for child-care, opportunity costs of time off work, and direct costs (co-payments). Additional barriers include low levels of awareness and understanding and ability among refugees to enforce their rights to access services at the subsidised rates. Non-Syrian refugees in particular experience difficulties in accessing health care and are often requested to provide financial deposits on admission to hospitals.⁵⁴

The unavailability of medicines and medical equipment, and long waiting times, are also important barriers, pushing refugees to seek care in the private sector, where they must pay out-of-pocket to cover the costs of services, consultations, and medications. For those refugees without the necessary documentation in place, making them even more vulnerable – they are required to pay the ‘foreigner’ rate for public health services which is often higher than the corresponding charges in the private sector.

The HAUS surveys reported a significant increase between 2018 and 2021 in the proportion of refugees unable to access medication for NCDs. Around half of the Syrian and non-Syrian refugees sampled with a chronic disease could not access their medication during the previous three months, mostly due to affordability, together with stock-outs of medication at the public health facilities. The same increase was reported for other health problems, specifically those which need treatment at a higher level. As one key informant said, “the higher the service level, the greater the barriers.” (KII IRC 1).

In summary, despite subsidized access to public health care for all refugees regardless of their country of origin, costs (direct as well as indirect costs) still pose an important barrier to accessing services for many refugees, particularly for secondary and tertiary care. Priorities for supporting refugees and vulnerable Jordanians remain the same; namely, lifesaving and emergency care, reproductive and sexual health including delivery care, and prevention and treatment of NCDs.

5. Cash for health (C4H) and community health

C4H responds to one of the four specific health sector objectives of the JRP 2020-2022 to increase access, uptake, and quality of secondary and tertiary healthcare. Other specific objectives concern uptake and quality of primary and community healthcare and strengthening the adaptive capacity of the national health system.

The UNHCR is currently pursuing twin strategies of a) integration of refugees into the public health system; and b) complementary activities to address the financial and other barriers for refugees in accessing care, while advocating strongly for a one-refugee approach (see Figure 3). The work on integration is focused on the replenishment of the MDA in order to continue supporting the Government to enable access to public health services for refugees at the subsidised rates, while C4H is an important part of the 'complementary' activities and is critical to address the financial barriers for vulnerable refugees to access health care for NCD management and treatment, obstetric care, and emergency and life-saving care at secondary and tertiary levels.

5.1 Agencies implementing C4H

There are currently two main agencies providing C4H; Medair and UNHCR. Both agencies started implementing this modality at the end of 2015 in response to GOJ policy which stipulated that while individual refugees could pay the subsidized rate for health services, institutions were requested to pay the 'foreigner' rate (see Figure 2). UNHCR provides C4H in all Governorates while Medair operates primarily in Amman, Irbid, Mafraq and Zarqa governorates, but accepts cases from other areas. Terre des Hommes Italy (TdH) started implementing a small C4H component at the beginning of 2020 in Mafraq and Zarqa specifically targeting populations living in remote and hard-to-reach areas. A fourth organisation, IRC, is in the process of transitioning away from direct provision of health services towards the C4H model, with a focus on refugees in need of NCD care.

Agencies implementing C4H provide broadly similar services. Medair provides cash transfers for delivery care (normal and complicated deliveries, including C-sections), lifesaving and emergency healthcare, and for management of NCDs, in addition to annual emergency cash transfers for vulnerable Jordanians (see Figure 1). UNHCR provides C4H for delivery and lifesaving care, but does not cover NCDs, while TdH provides predominantly cash for delivery care and lifesaving care for children. As part of the agreement with the MOH, partners also provide C4H to vulnerable host populations, and it is expected that 30% of all C4H beneficiaries will belong to this group.

All agencies implementing C4H work closely together using similar Standard Operating Procedures (SOPs), and regularly coordinate through the Health Sector Working Group (see also section 6). All partners access the Refugee Assistance Information System (RAIS), a portal managed by UNHCR, to prevent duplication of payments. When UNHCR is unable to support a vulnerable beneficiary due to its eligibility criteria - for example a case was not reported within 48 hours from admission to the health facility or the eligibility has expired - the case can be referred to another organization that has a less stringent eligibility criteria.

The preferred hospitals for all agencies providing C4H are public sector hospitals, although in specific approved cases, Medair will refer beneficiaries to the private sector. For example, when a particular service is not available in the public sector or if there is a long waiting list.^{xvii}

^{xvii} During the period in which the MOH policy did not subsidize the costs of accessing public health services for refugees, the costs of care in the private sector were regularly lower than in the public sector, and in such cases Medair and other organisations such as IMC would refer patients to private hospitals.

The C4H modalities differ according to the health service; pregnant beneficiaries receive the cash in advance and, while agencies advise beneficiaries to access delivery care in MOH hospitals, some beneficiaries are willing bear the additional costs in order to use a private hospital. In the Governorates of Aqaba and Tafelah, where there are no MOH hospitals, beneficiaries can access the RMS hospitals.

The total annual number of C4H beneficiaries of all three agencies has been increasing, from around 7,700 beneficiaries in 2017 to around 9,200 in 2021.^{xviii} On average, UNHCR provides C4H to around 3,850 beneficiaries each year, with Medair supporting 3,900 beneficiaries with cash and TdH supporting 100 beneficiaries. The average costs for health services per beneficiary has to date been approximately 200 JOD, rising and falling somewhat according to the GOJ policies regarding refugee subsidies.

In 2021, a total of around 1.9 million JOD was transferred to beneficiaries of C4H. However, UNHCR stated that funding for C4H has not been sufficient to cover elective cold cases, such as cardiac and cancer patients, and elective surgeries which are lifesaving but not acute. As a consequence, waiting lists for these services have been growing. Less than 2% of the overall C4H funding was directed to such cases during the last two years.^{xix}

When refugees are in need of certain specialist services available through other partners, they are referred, for example to Humanity & Inclusion for disability and rehabilitation services, La Chaîne de l'Espoir for early screening of congenital abnormalities and paediatric cardiac and orthopaedic surgeries, and to Islamic Relief and TdH for elective surgeries. Hearing and visual aids, ophthalmology services, and ear surgeries refugees are referred to International Orthodox Christian Charities.

5.2 Community health

As stated above, community health care is provided mainly through a large number of NGO and CBOs in Jordan, with the result that it is fragmented. Efforts appear to be underway within the MOH to develop a more systematic approach to community health, as evidenced by consultations with health sector stakeholders around a community health curriculum and role of CHVs.

One of the key national stakeholders for community health is RHAS, which works with the MOH as well as with IRC and others to strengthen health awareness, preventive and community healthcare, working in both the education and health sectors. The HCC model, which RHAS began piloting in 2011 in collaboration with the MOH, aims to build the capacity of participating public health centres to empower patients to manage their diseases and reduce future complications. Vulnerable and underserved groups in the communities surrounding the health centres are invited for periodic medical examinations and to take part in health awareness sessions. The project is currently being evaluated by EMPHNET.^{xx,55}

A number of international NGOs work in the community health sphere including Medair and IRC. IRC recently moved from a model of direct service delivery, where it employed 180 CHVs managed by its three clinics in the north of Jordan, to one of working through local partners (RHAS and the Jordanian Institute for Family Health - IFH). They contract out care on behalf of refugees to the private sector through a reimbursement model. IRC is building the capacity of RHAS and IFH to incorporate a greater focus on NCD prevention and management into their community work, and channel funds to

^{xviii} Data are from the internal data base of Medair, plus Medair's C4H case study produced by CALP, from the annual reports produced by UNHCR, and data obtained during the KII with TdH

^{xix} UNHCR fact sheets on CAEHS (Cash Assistance for Essential Health Services).

^{xx} We have not been able to ascertain the reach of the HCC approach at the current time in Jordan

pay the CHVs employed by both organisations. IFH is also working with IOCC to build the capacity of 18 community-based rehabilitation workers to screen, assess, and refer cases of disability. There are many other examples of this kind of work.

Medair’s community health programme is focusing on reproductive health, including maternal and new-born care, infant and young child feeding, nutrition and psychological first aid. Across the four governorates, Medair works with 89 CHVs who conduct community health awareness sessions and identify vulnerable people of concern for referral to the C4H programme as well as linking them to public health services. Medair reaches between 30,000 and 50,000 households each year through their community health awareness work, including both vulnerable Jordanians and refugee households.^{xxi} Medair also chairs the Community Health Platform (sub-sector Working Group) which is the main coordinating body for community health (see section 6).



© Medair/ Abdallah Aoudah

^{xxi} Data from the post-distribution monitoring provide different data to other internal Medair documents and household visits were affected in 2021 by the Covid-19 pandemic. We therefore provide a broad estimate here.

6. Coordination and collaboration between development and humanitarian stakeholders

In addition to the document and literature search, all Key Informants were asked about the extent of coordination and collaboration both within the humanitarian sector and between humanitarian and development partners.

Within the humanitarian sphere, coordination is mainly ensured through the **Health Sector Working Group (HSWG)**, currently chaired by the UNHCR and WHO, and a large number of sub-sector Working Groups (sometimes referred as Task Teams) on C4H, reproductive health, NCDs, mental health, nutrition, rehabilitation, and community health. However, challenges for improved coordination remain. The meetings mostly concern coordination of activities rather than joint planning, or discussions around efficiency and effectiveness. Interaction between the Working Groups and the MOH was flagged in many of the KIIs as an area that requires strengthening to keep MOH officials actively participating and engaging in Working Group meetings. It is also worth noting that membership of sectoral Working Groups in Jordan is limited by definition to agencies working with Syrian refugees, as they were established under the Syria Crisis Refugee Response Coordination Mechanism.

A recently published article by Parmar and colleagues (2021) refers to unhelpful competition for funding between NGO members which mitigates against collaboration, particularly in the current context of declining humanitarian funding. The authors quote an NGO health programme administrator as saying, "When I started, we were attending the NCD Working Group health sector meetings. I noted that these are not run as efficiently as they should be. It was a parade of bragging. No one is collaborating and actually sorting out what they should be doing, NGOs fight to maximize funding. There seems to be no entity regulating/coordinating which organization should focus on what specific issues".⁵⁶

Medair plays an active role in these groups, chairing the Community Health Platform and the Amman Referral Coordination Meeting, and is well known for its collaborative and coordinated approach. Furthermore, Medair staff participate in several working groups set up by Jordan INGO Forum (JIF), including the Human Resources and Government Liaison Working Groups and is actively involved in coordination between other humanitarian actors through a variety of forums (KII Medair). On a day-to-day basis, Medair coordinates closely with other implementing partners, including UNHCR and TdH on the C4H programme, and Caritas and IMC as facilitating organisations working with UNHCR.

The overarching framework for the HSWG is the JRP, which is updated annually.^{xxii} To some extent, the JRP responds to the need for a longer-term approach to the refugee situation through the dual pillars of direct support to refugees and building resilience in the Jordan health sector. However, a recently published report by the JIF (2020) points to a lack direction for how stakeholders should prioritise among what is a very long list of activities in the JRP.⁵⁷

The principal platform for coordination and collaboration between development and humanitarian partners is the **Jordan Health Development Partners Forum**, which is chaired by USAID and WHO with key members from MOH and the Ministry of Planning and International Cooperation (MOPIC), UN agencies and MDA donors. This forum was active in pushing for refugees to be included in the national Covid-19 response and is supporting efforts to roll-out the new Policy Manual on treating refugees at public facilities, among other activities.

^{xxii} Activities are streamlined bi-annually, in line with available budgets (KII WHO).

While the JHDPF is the primary health sector platform through which development partners interact with their government counterparts, NGOs do not participate directly but are represented in this forum by the UN agencies. This would appear to miss an opportunity to feed key lessons from direct work with refugee groups on the ground into longer-term development discussions and planning.

While highlighting progress in the health and education sectors, where a degree of joint assessment and planning is leading to approaches that are more aligned with national plans and strategies, the JIF report (2020) also referred to the “very small level of coordination between those doing humanitarian work and those doing development work”.⁵⁸ Echoing these findings, key informant interviews with NGO implementing organisations pointed to the lack of coordination with development partners. UNHCR, on the other hand, pointed to recent efforts to strengthen this forum and felt it was a useful platform and conduit for advocating for change with the GOJ (KII UNHCR 2).

Outside the health sector, two groups were set up with the aim of strengthening coherence between the humanitarian and development spheres: the Humanitarian Development Partners Group; and the Humanitarian Development Nexus Task Team, established in July 2019. Key informants consulted during this study were not well-informed about these groups and could not provide further details on their functioning or linkages with the health sector.

In addition to platforms and other groups with a specific mandate for improved coherence, there are some specific financing instruments designed to support pathways to medium to longer term solutions, such as European Union (EU) Regional Trust Fund in Response to the Syrian Crisis (known as the ‘Madad’ Fund’), France’s Minka Fund and the Global Concessional Financing Facility (GCFF). However, in general, the short-term nature of the humanitarian funding for NGOs, which are the primary stakeholders working directly with displacement affected communities, inhibits the development of medium to long term programming and approaches.⁵⁹



7. Potential health financing modalities

This section summarises findings on the feasibility of selected health financing mechanisms for Medair in Jordan (7.1)^{xxiii}, makes proposals for Medair's health sector work going forward (7.2), and provides initial thoughts around potential exit strategies for Medair's support to the health sector (7.3). These summaries and evidence are specific for Medair's CFH work, however it is relevant to other actors with similar interventions as they explore health financing mechanism and exit strategies while ensuring refugees are able to cover their health costs.

7.1 Review of potential health financing modalities

The consultants explored the feasibility and applicability of the following financing modalities for Medair's work in the health sector in Jordan, within the current context:

- National health insurance schemes
- Health Equity Funds
- Value vouchers and service vouchers
- Performance-based contracting
- Continuation or adaptation of cash for health (C4H) approach

Below we set out a brief summary of the evidence for each of these modalities, the important contextual factors which either enable or inhibit the approach in Jordan, and where relevant, the feasibility of the approach for Medair.

National health insurance schemes

While the integration of refugees into existing national health insurance schemes is sometimes considered to be a more sustainable option for financing their access to healthcare, there is only a handful of countries where refugees have gained access to these schemes. Examples include Rwanda, where UNHCR has financed participation in the national community-based health insurance (CBHI) scheme for urban refugees and students whose parents reside in camps,^{xxiv} and Iran where UNHCR is financing the insurance premiums for the Universal Public Health Insurance Scheme on behalf of the most vulnerable refugees.^{xxv}

A number of enabling factors need to be in place for refugees to gain access to national health insurance schemes. These include high insurance coverage of the host country population, including for vulnerable people, a political decision by the host country government to integrate refugees into the national scheme, and available funds - or fiscal space to raise the funds - to subsidise coverage for vulnerable refugees. It is politically very difficult for a government to grant benefits to refugees while they are not providing the same benefits to its own vulnerable citizens, as seen in Jordan when the Government reversed its initial policy in 2014 to grant Syrian refugees access to public services at the insured Jordanian rate.

^{xxiii} Selected health financing mechanisms were agreed with the Medair teams (Jordan and regional office) as part of the finalisation of the Inception Report.

^{xxiv} In Rwanda, UNHCR financially supported the project 'Community-based health insurance for urban refugees and refugee students in Rwanda' after the Rwandan government committed to a) ensuring 100% of refugees have proper documentation; and b) allowing registered refugees to participate in the national CBHI scheme. UNHCR saw this option as a more cost-effective and sustainable approach to meeting health needs of urban refugees and by March 2021, 85% of urban refugees and students were enrolled, subsidised by the government. See [here](#) for more information.

^{xxv} In Iran, where refugees are allowed to work, UNHCR covered the costs of insurance premiums for 100,000 of the most vulnerable refugees in 2020 with an additional 20,000 supported in 2021 due to the Covid-19 pandemic. See [here](#) for more information.

Furthermore, this option becomes more feasible in countries, such as Iran, where refugees are permitted to work, with some refugees earning sufficient income to cover the costs of premiums, leaving only the most vulnerable to be covered by humanitarian or development funding.

In Jordan, these factors are largely not present. A large number of Jordanians remain without health insurance coverage and the majority of refugees are not permitted to work in the formal sector. The high level of fragmentation in the health insurance sector also makes this option more complex. Refugees are also not permitted to join either the schemes run by the Ministry of Social Development through the NAF, which is targeted at vulnerable Jordanians,^{xxvi} or the Ministry of Health's CIP.

Furthermore, lessons from past assessments of the feasibility of including refugees in national or community health insurance schemes indicate that refugees are still often required to pay something towards the cost of their care, demonstrating the importance of the strategic use of cash assistance alongside other integrative approaches.⁶⁰

Health Equity Funds

The health equity fund (HEF) approach was developed in Cambodia to improve financial protection for the poor when accessing public health services, specifically for user fees charged in secondary and tertiary care. It has been implemented since 2000 and is now fully integrated into Cambodia's policies and strategies (i.e. the National Poverty Reduction Strategy and Health Strategic Plans) with guidelines published by the Cambodian MOH. It is a flexible approach that can cover both the direct and indirect costs of accessing care and is co-financed by the Cambodian Government and external development partners. Pooled at the national level, funds are reimbursed to health facilities based on the level of service utilisation by the designated groups (i.e., the very poor) for investment at the local level. Literature assessing this approach broadly concludes that utilisation of primary and secondary care services by the poor has increased, and out-of-pocket spending on healthcare has decreased, while beneficiaries are also encouraged to use the public rather than private health services.⁶¹

The enabling factors which support the development and implementation of HEF schemes include: the existence of a national system to identify those who are vulnerable, such as a unified benefit registry; public financial management systems whereby health facilities can receive and use income from the HEF scheme to improve the quality of care and address needs at the local level; the existence of a standardised essential health package; and, the possibility of reimbursement on behalf of those covered by the scheme together with verification systems to prevent fraud.

Certain aspects of the UNHCR approach to C4H operate in a similar way to a HEF. At the hospital level, the Cambodian HEF provides a 'meet and greet' service using a HEF-Promoter designated as a 'patient concierge' whose role is to ensure that the beneficiary can navigate the system and receive the services s/he needs. The UNHCR contracts IMC and Caritas to facilitate the implementation of the C4H scheme, including a series of IMC focal points at the larger public hospitals and telephone numbers operated by Caritas where refugees can access information and start the referral process. Jordan is also making progress towards a unified benefit registry, with support from the World Bank through the social protection pathway, and UNHCR's RAIS system lists all registered refugees, providing a potential basis from which to identify beneficiaries for such a financing modality. Presently there is not a unified list or registry for unregistered refugees. Instead, Humanitarian actors regularly share lists between themselves in order to reduce likelihood of duplication of assistance.

^{xxvi} Ex-Gazans who arrived in the country many decades ago are an exception and are covered by the NAF/Takaful scheme.

However, there are also important differences. A key constraint for the adoption of HEFs in Jordan is the fact that institutions that make payments for health services on behalf of refugees must pay the 'foreigner' rate for health services which, for many secondary and tertiary health services, is considerably higher than the corresponding charges in the private sector. Based on a series of interviews with key informants,^{xxvii} as well as on information provided to the consultants in April 2022, the likelihood of the Jordanian Government reversing this policy in the near future would appear to be very small, although this should remain a key advocacy objective of all health sector stakeholders (see section 8).

In addition, the Jordanian health system is highly centralised with no financial autonomy at the local level to collect and use the funds, and there is no standardised minimum or essential package of health services. This high degree of centralisation in Jordan's health financing systems mean that reimbursements would have to be made at the national rather than the health facility level, often with extended delays. Medair would also be required by the MOH to provide a blanket statement of commitment undertaking to cover not only the costs as calculated by the Health Insurance Agency (HIA) of the MOH, which are at risk of being significantly inflated from the published price list, but also an administrative overhead.^{xxviii} These constitute considerable barriers to the introduction of a HEF in Jordan.

Value vouchers and service vouchers

A voucher can be a paper or an electronic voucher (i.e., like an e-wallet but with restricted use) and can either be exchanged for selected health services, such as a package of safe delivery services, or can be used by beneficiaries to pay directly for health services at selected and contracted health facilities up to a financial limit. Health vouchers therefore act like restricted cash in that they can only be used to access health services by a specific group of beneficiaries, and/or to cover the indirect costs of accessing health services (i.e., transport). Both types of vouchers strengthen the supply of services by channelling reimbursements directly to health facilities, and enable demand for services through door-to-door or community-based distribution, which is also an entry point for delivering information about the health services (the what, where, why). There is robust evidence to show that vouchers can increase up-take of underutilised health services among a defined target population, and can have a positive impact on the equity of service utilisation.⁶²

One small study was found of a voucher to enable access to breast cancer screening in a refugee camp in Jordan in 2011. In this project, education about breast cancer and breast health was provided to some 2,400 refugee women by trained community outreach workers, accompanied by the distribution of vouchers for mammography screening to eligible women aged 40 or older. Receiving a free mammography voucher increased the likelihood of women attending the mammography unit for screening.⁶³

As part of its transition away from direct service provision, IRC is planning to offer three health financing modalities for refugees, comprising: cash transfers in advance of treatment; a value voucher which can be exchanged for health services of the beneficiary's choice up to a financial ceiling at selected affiliated health facilities; and direct reimbursement at private sector facilities. The choice of modality will depend on the vulnerability assessment and the extent to which the beneficiary is deemed to be 'health literate', with those beneficiaries who are highly health literate, medically controlled and able to prioritise expenditure within their household budget receiving cash.

^{xxvii} See Annex 1 for a list of KIIs conducted as part of this study.

^{xxviii} The consultants understand that Medair has previously explored with the MOH the possibility of reimbursing health facilities directly on several occasions, most recently in 2021, and that the obstacles would appear to be insurmountable at the current time.

In the MENA region, UNFPA has used vouchers to enable access to maternal health services in Syria, and a long-running reproductive voucher programme is operating in Yemen, financed by the German Development Bank KfW and implemented by MSI Reproductive Choices.⁶⁴ Elsewhere, there are several innovative voucher interventions operating in fragile and conflict-affected settings, such as in Burkina Faso and Chad, and in Ukraine (prior to the current conflict) a voucher scheme enabled access to medicines and consumables for maternal child health care and emergency surgery at private pharmacies that were not available at public health facilities.⁶⁵ Vouchers are a financing modality approved by ECHO for humanitarian situations and routinely used by humanitarian partners (UNICEF, FAO, WFP and others) to deliver a range of non-health assistance to beneficiaries such as food and winter clothing.

In Jordan, the technology is in place to use electronic vouchers; the e-wallet and u-wallet systems are well established as modalities to transfer cash to refugees and vulnerable Jordanians. This technology could be used to develop an electronic health service voucher or health value voucher.^{xxix} The most important constraints for establishing a voucher programme in Jordan are the same as for the HEF and include the inability to reimburse health facilities for the services provided to refugees at the subsidised uninsured Jordanian rate, as well as the lack of health facility autonomy to collect and use the funds to improve service delivery quality. It is not clear at the current time what advantages vouchers would have over the current C4H programme, as implemented by Medair and UNHCR.

Performance-based contracting

The World Bank defines Performance-based contracting (PBC) as “a type of contracting with a clear set of objectives and indicators, systematic efforts to collect data on the selected indicators to judge contractor performance, and consequences for the contractor, either rewards or sanctions, based on performance”.⁶⁶ Using this strict definition, to our knowledge PBC is not being implemented by non-state actors in the health sector in Jordan to enable access to services by refugees. The majority of peer reviewed literature on PBC in LMIC is related to the contracting out of health service provision in a defined geographical area to management organisations, such as in Cambodia and Afghanistan, and does not evaluate the contracting of individual private sector health facilities to provide services on behalf of a specific group.

However, contracting of private healthcare providers or health care agencies (private-for-profit and not-for-profit), with payments based on a simple result (i.e., a fee for a service provided) is a form of contracting that is widely practiced in Jordan. This form of contracting is used to deliver subsidies to refugees and vulnerable Jordanians in the form of reduced user charges for services at affiliated private sector providers, when public services are not available at the right time or in the right place, such as for delivery services, emergency and life-saving services and treatment for NCDs.

For example, through its referral project, IMC uses such agreements to enable access to specific private health services for camp refugees who cannot access these services in the public sector due to their high costs (foreigner rate). As part of its transition away from direct clinic-based service delivery, IRC is also contracting private health facilities in the north of Jordan to provide essential services to refugees. A key benefit cited by IRC is that private providers will visit beneficiaries in their homes (particularly important for people with mobility problems) and even provide transport to the facility.

^{xxix} There are three main operators offering a mobile wallet or e-wallet in Jordan: Orange, Zain and Umniah (which provides the u-wallet). This enables beneficiaries or customers to send and receive funds (business to business, business to customer, customer to third party, and so on). A MOI card with national ID number is required to set up an e-wallet.

However, IRC plans to move away from the contracting of private providers to a C4H model in the next few years, viewing this as a more complementary and aligned strategy, whereby refugees make use of the strengthened public sector NCD services.

The principal reason for not recommending this approach is the current efforts underway by UNHCR and partners including Medair to shift health service utilisation from private to public sector providers. While some access to private services may be needed to fill the gaps in public provision, this should remain a gap-filling option for Medair and other health sector organisations and where possible a last resort (see section 7.2).

Continuation or adaptation of cash for health (C4H) approach

The use of cash transfers is now widely recognised as one of the most efficient and effective ways of getting humanitarian assistance to people affected by conflicts or disasters. However, the evidence of how to provide ongoing financial support to vulnerable people of concern in protracted crises, such as that caused by the conflicts in Syria and Yemen, is less clear.

For Jordan in particular, there are a number of important reasons why cash remains the most appropriate option to provide support to refugees and vulnerable Jordanians in the health sector. The rationale for using C4H to support ongoing access to essential health services for refugees and vulnerable host communities can be summarised as follows:

- Cash acts as a safety net, addressing the still-high financial barriers to health services for the many vulnerable refugees and Jordanians, particularly for accessing secondary and more specialised, complex care;
- Cash transfers are an accepted approach used by the Government of Jordan to support the most vulnerable Jordanians (including financing their access to health insurance through the Takaful programme);
- Cash is a more cost-effective modality due to the GOJ policy that institutions paying on behalf of refugees must pay the higher 'foreigner' or 'unified' rate when reimbursing public health facilities. Reimbursements must be made to the MOH at the national level, with reimbursement amounts determined by the HIA, with no negotiating power on behalf of organisations such as Medair to verify that these amounts reflect the actual services provided or their given prices. Not only does this represent poor value for money, the unpredictable (and often inflated) reimbursement level and delayed invoicing constitute a barrier to effective planning and budgeting;
- Cash is a flexible modality that can be adapted to the wide range of costs incurred in the health sector at different levels and for different services. It can be provided as restricted conditional cash or as restricted unconditional cash, and can be targeted to the most vulnerable refugees using existing targeting approaches;
- Cash can be used to address different types of financial barriers, including indirect costs such as transportation and childcare, and opportunity costs of work foregone, which are important barriers to accessing care for the most vulnerable;
- Finally, cash is relatively straightforward to implement within the humanitarian context where partners have established comprehensive systems to distribute cash efficiently to refugees for other purposes, as well as systems to monitor distribution.

There appears to be very little prospect of a change in GOJ policies which a) prevent institutions from reimbursing health facilities on behalf of refugees at the subsidised uninsured Jordanian rates; b) which prevent refugees from accessing public health insurance. Lead humanitarian agency UNHCR was clear that C4H is a complementary approach to integrating refugees into national systems (i.e.,

through subsidised access to public health services), and that now is not the time to move away from cash as a key health financing modality in Jordan.

Consequently, in the current context in Jordan, there appear to be no other health financing modalities which could match the ability of cash to address barriers to healthcare for refugees and vulnerable host communities.

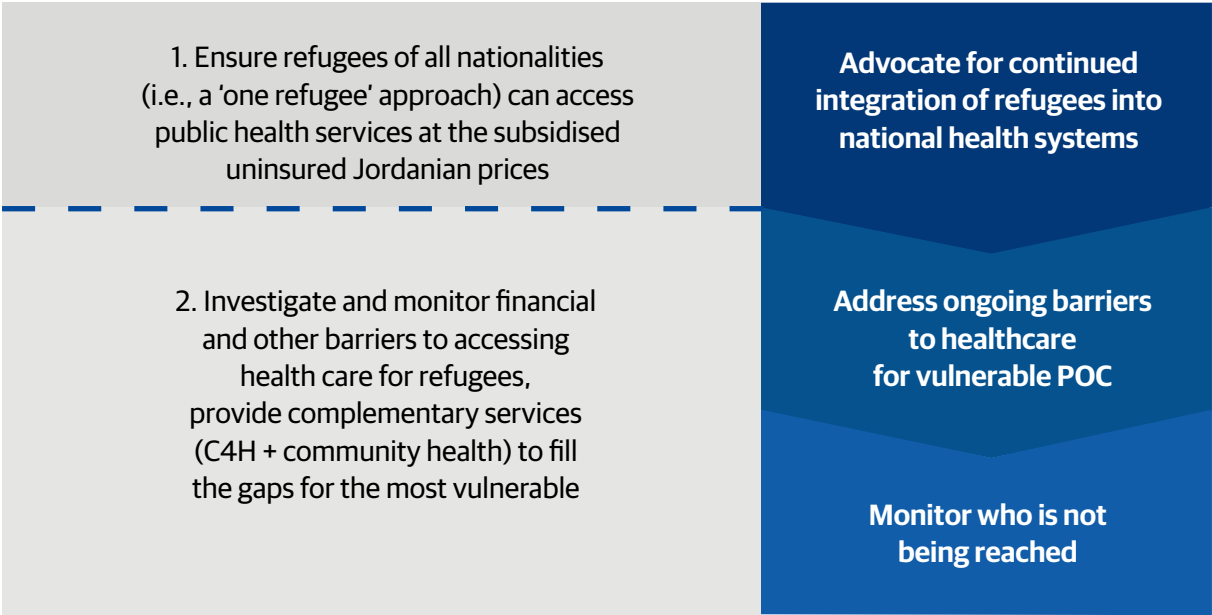
7.2 Proposed health financing modalities for Medair

Drawing on the above analysis, we set out below the proposed modalities for Medair’s consideration. In line with recommendations from UNHCR and other humanitarian and development partners, these proposals revolve around Medair’s existing twin strategies of providing C4H and community health.

Adaptation to the C4H component

Providing cash for health is aligned with UNHCR’s twin strategies of integrating refugees into national health systems, and providing complementary services to fill the gaps in access to health services for refugees, as set out in figure 3 below (see also section 6). This provides a framework within which humanitarian and development partners can work.

Figure 2: Health financing strategies to improve access to health services for refugees and vulnerable Jordanians in a protracted crisis



Based on the above analysis, it is proposed that Medair continue its C4H work as an essential element of the complementary services, alongside the current longer-term strategy to integrate refugees into national health systems (i.e., through subsidised access to public health services at the uninsured Jordanian rates). There are a number of actions which could improve the efficiency and effectiveness of the C4H as provided by all humanitarian partners, including Medair, UNHCR and TdH, and in future IRC and others using this modality.

Increase focus on NCDs over the next five years: Based on the burden of morbidity and mortality from NCDs in Jordan, it is recommended that Medair increases its focus within the C4H component on cash for NCD management and treatment in the short-term in order to support a greater number of

people with NCDs. The levels of cash provided to NCD beneficiaries could be critically reviewed with a view to varying the amount according to the costs incurred for the type of disease as some conditions are much more costly than others and as some people do suffer from more than one NCD. It would be useful to discuss this with IRC as well as they have done quite a lot of thinking in this regard.

Why focus on NCDs? The proportion of refugees and vulnerable Jordanians suffering from NCDs is high (see 4.1), and the links between poverty and NCDs are well-established.⁶⁷ The health systems in place to prevent and to manage NCDs for refugees (i.e., primary and community healthcare systems) are weak and/or fragmented, and coverage of effective NCD management in Jordan remains low. UNHCR recommends a strong focus on NCDs for these reasons (KII UNHCR 2). Interestingly, a quasi-experimental study by Emily Lyles and colleagues (2021) comparing the effects of multi-purpose cash, CHV-led education, and CHV plus a conditional cash transfer (CCT) on health measures among Syrian refugees with type II diabetes in Jordan during 2018 - 2022, found that CHV-led education combined with CCTs was the only modality which led to significant increases in both regular and specialist care visits. The authors conclude that, while health education may have increased demand for services in the CHV group, cost remained a barrier to care-seeking. Removing this barrier through the provision of cash empowered refugees to seek care.⁶⁸

The returns on investing in NCDs are high. In the Lancet Series on NCDs (2018), the authors calculate the net present values of both the costs of addressing NCDs and the benefits which these investments would bring for a range of countries. Using the OneHealth Tool of the UN, the authors found a strong benefit to cost ratio for investing in NCD prevention and treatment in upper-middle income countries such as Jordan. Benefits were 4.2 times higher than costs when looking at purely economic returns such as labour force participation and productivity, and 7.1 times higher when adding the associated social benefits of better health.⁶⁹

Increased focus on NCDs within the C4H component should go hand-in-hand with investing in community health to strengthen the focus on NCD prevention and improved NCD management, with the aim of reducing reliance on more costly treatments which arise due to poor NCD control (see 7.2 below).

C4H operational efficiencies can also be gained. Medair could investigate sharing certain operational tasks with other C4H partners with a view to increasing efficiency and reducing administrative and other overhead costs. The UNHCR-chaired Cash for Health Platform would be one of the key forums for some of the discussions set out below.:

- **Identification of beneficiaries:** investigate potential efficiencies by moving away from identification of refugees at household level, to take advantage of existing entry points for C4H such as through referral by other agencies (UNHCR, INGOs, and local NGOs and CBOs) and self-referral using Medair's hotline or online registration. Referrals from MOH health facilities of pregnant women and refugees for life saving care using clearly defined criteria could also be investigated. In the longer-term, given the target set by the MOH for humanitarian organisations to ensure 30% of total beneficiaries are vulnerable Jordanians, Medair and UNHCR could look at the potential to access the poverty identification systems of the MOSD and National Aid Fund (NAF), which have recently been updated with support from the World Bank. Jordan is moving towards having a National Unified Registry covering all social protection programmes based on a unique identity number,^{xxx}

^{xxx} We understand that some initial discussions on interoperability between the two systems of the MOSD and UNHCR have already taken place and that UNHCR has concerns related to data security and privacy (KII World Bank Social Protection team). However, there may be means to address these concerns using firewalls and other technologies.

- **Defining eligibility:** If not already involved, Medair could actively participate in the UNHCR and World Bank-supported efforts to harmonize the targeting systems for cash assistance for refugees, and advocate for further harmonization of these approaches under the 'one refugee' approach. Inclusion of standardised (or more harmonized) medical criteria to determine medical vulnerability/eligibility could be useful and could avoid, in a number of cases, the need to implement the VAF at the household level each time C4H support is provided for delivery and lifesaving care;
- **Referral hub:** all C4H partners could investigate the potential to harmonize their referral systems and processes, and in particular to look at the feasibility of designating a single main referral hub which could act as the interface between the payer (UNHCR, Medair, TdH, IRC) and the beneficiary as IMC currently does on behalf of UNHCR. This referral hub would provide invoice management services for all C4H partners, ensuring medical decision making, refugee eligibility, and possibly standardisation of prices. In the longer-term, this hub could potentially also serve as a focal point for improved coordination with the MOH at central and lower health system levels. For example, there could be an option for Medair to gain access to the Continuity of Clinical Records System (CCR) system which is owned and managed by IMC and which is used by them to support the referral process;
- **Monitoring:** instead of the current intensive post-distribution monitoring of all cash transfers, Medair could look at the potential for introducing sample-based monitoring and trend analysis to identify operational challenges on the ground as well as potential misuse of funds. This would involve follow-up of fewer beneficiaries, targeting those receiving higher transfer amounts. Medair might also look in the potential for a common monitoring process across C4H partners, as well as its localization by building the monitoring capacity of a local entity.

C4H for lifesaving and obstetric care. It is proposed that C4H to support access to delivery and lifesaving care should continue, given the risks to the lives of refugees who cannot access this level of care and Medair's policy of 'do no harm'. Refugees in Jordan do not have the same recourse to safety net programmes as vulnerable Jordanians, who can benefit from social safety net programmes such as Takaful/NAF, and who also have recourse to the Royal Court Fund to pay for healthcare costs. Consequently, refugees have on-going needs for financial support from humanitarian and development partners. C4H cannot be the sole responsibility of UNHCR given the constraints on UNHCR in supporting refugees without the proper documentation or registration status or who do not fulfil other eligibility criteria. However, as part of its exit strategy for the health sector, Medair could look at how best to support on-going advocacy efforts of UNHCR to champion the 'one refugee approach' and to reduce the number of refugees not deemed eligible to receive C4H support via UNHCR (see 7.3).

At the same time, given the downward trend in humanitarian funding for Jordan, and the preference of development actors to finance longer-term approaches which build the capacity of host country health systems, expanding Medair's C4H into new areas, such as SGBV or disability, would not seem like an appropriate option. Instead, these areas could be incorporated into an expanded programme of community health and better referral pathways for refugees to access specialist care provided both by the public sector and other agencies.

Creation of a C4H Common Fund

Assuming little change in GOJ policy over the next 5 years in terms of reimbursements to MOH on behalf of refugees for their health service costs, it may be useful to consider the creation of a common fund (i.e., a C4H Fund or a C4H Equity Fund) which development and humanitarian partners can contribute to and which would be responsible for longer-term financing of activities to address the financial barriers to accessing healthcare for the most vulnerable refugees. Such a fund would act as a safety net to finance costs associated with accessing secondary and tertiary health services in particular and avoiding catastrophic healthcare costs for refugees.

Community health work

Focus on community work for all refugees and participate in ongoing efforts to review the community health curriculum. Medair's community health work should continue and should ideally constitute the main focus of the organisation's work with all refugees, with a renewed focus on NCD prevention and healthy lifestyles. The package should continue to cover reproductive and maternal and child health and should incorporate information on the importance and availability of FP services given high levels of unmet need for contraception, particularly post-partum FP. It should also include referral pathways for refugees and vulnerable Jordanians to specialist services such as mental health and psychosocial support and SGBV services. The WHO's Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (2018) may serve as a useful resource, and Medair can work through platforms such as the Community Health Platform and sub-sector Working Groups to engage with like-minded stakeholders with the aim of developing an approach to community health that is both aligned with current MOH thinking as well as informed by global best practice.

Improved coherence between organisations supporting community health work. In the absence of a national community health strategy, Medair could use the Community Health Platform (CHPF) (which it currently chairs) and other forums as appropriate, to embark on a consultation process designed to strengthen the quality of community health work, as recommended in Medair's internal evaluation, and improved coherence in the approaches taken by the different partners as well as the MOH. Such a process would include identifying what works for different beneficiary groups and sharing good practices. The MOH (preferably departments tasked with NCDs, community work and HCC) and key community health partners such as the RHAS and IFH should participate in this consultation. As above, Medair could use the Community Health Platform as an entry point for these consultations and may consider setting up a technical consultation group.

Localization of community work. In line with the goals of humanitarian work, Medair could investigate a localization strategy for health, working through and building capacity of local NGOs and CSOs, including refugee led organisations. This approach has already been introduced and will be scaled up within Medair's social protection work and we understand that localisation is also now being piloted in Medair's psychosocial support work. Lessons could be drawn from this experience, as well as tools such as the capacity needs assessment, to inform the design of localization strategies for health. Other humanitarian partners such as IRC are already following this approach.

In the longer-term, Medair could consider working with civil society organisations to support the establishment of a refugee managed CSO or CBO, if this is a feasible option in Jordan.

7.3 Potential exit strategies

The consultants considered the potential to develop an exit strategy for Medair's health sector work. The considerations set out below are divided between Medair's C4H work and the community health work, following the recommendations in 7.2 above.

Cash for health

There are no clear exit strategies for providing C4H to the most vulnerable refugees in Jordan, just as the GOJ and Royal Court recognize that the most vulnerable Jordanians will continue to require safety nets in order to access health and other social services in the future. The GOJ is supporting only a proportion of vulnerable Jordanians in need, and lacks the necessary resources to take on the additional costs of support to refugees. UNHCR is facing similar resource constraints and does not have the financial capacity to cater to the health needs of all vulnerable refugees residing in Jordan. In the longer-term, a more sustainable option would be to create a single pooled fund (possibly linked to existing funds and schemes such as those managed by the MOSD and SSC) to address the financial

barriers for the most vulnerable refugees. This would be aligned with existing national social safety net systems and leaves the door open for integration at some future point.

However, Medair can strengthen their C4H work through: a) introducing operational efficiencies so that the funds go further and are used in a more cost-effective way, as set out above; b) working with partners to systematically investigate and address the reasons why refugees lack eligibility for UNHCR support, thus reducing the burden of referrals to Medair for C4H; and c) advocating strongly with donors and other stakeholders to ensure sufficient funding for C4H for lifesaving and obstetric care at the current levels of provision.

Community health

Medair should consider its community health work as a medium term strategy (i.e. 3 - 5 years), with two key strategies: firstly, Medair should seek opportunities to liaise with and provide support to the MOH in the development and roll-out of its community health programme, working with other health sector partners as appropriate to ensure a more coherent approach to community health, and ensuring alignment with national health priorities, as set out in the new Health Sector Strategy (forthcoming); secondly, Medair should seek to localize the community health work, which can be achieved by working with local NGOs, CBOs, refugee-led organisations or NCD patient organisations or groups (see also above). The exit strategy in this case would be one of moving to a supportive rather than a direct service provision role.



© Medair/ Jennifer Hooker

8. Advocacy recommendations

Below we set out a number of advocacy recommendations, set out by key target audiences as agreed with Medair. However, it should be noted that the consultants do not have a detailed understanding of the reach and influence of Medair within the health sector in Jordan and therefore these recommendations are presented as a first step for further discussion and refinement.

Government and Ministry of Health

Advocacy recommendation at this level should be aligned with those of lead agencies such as UNHCR. As above, UNHCR is advocating strongly for the one-refugee approach; the continuation of subsidised access for all refugees to public health services financed through the MDA, and complementary support (i.e., C4H plus community healthcare) to fill the gaps and strengthen financial protection for refugees, as set out in figure 3 above. The continuation (and replenishment) of the MDA was also highlighted by the MOH as being critical for the continuation of subsidised access to public health services for refugees (KII MOH). Many of the key informants mentioned the increasing openness of the MOH to collaborate with external partners, and the growing number of opportunities for advocacy and collaboration.

The UNHCR and MOH, with support from the JHDPF, have rolled out a Policy Manual and Service Guide in the governorates to inform health service providers and communities about government policies on refugee access to public health services. Medair could **advocate for this activity to be followed up by the establishment of more systematic communication channels between those implementing community health interventions and primary health care facility staff**. This would ideally involve an exchange of information between facility staff and community groups and could cover many important topics such as healthy lifestyles, NCD management, and so on. This would also help to develop clear referral pathways for NCD patients requiring medical care. At the current time, an important gap in Jordan's health system that was mentioned by many key informants, is the lack of any mechanism through which patients can express their views on the quality and content of the health services they use.

Given that refugees have no recourse to the support structures for accessing healthcare available to very vulnerable Jordanians (i.e., the Royal Court Fund and the Takaful programme of the NAF), Medair could join UNHCR and other partners in **advocating for recognition of the special vulnerability of refugees regarding access to high-cost healthcare** (i.e., care which can lead to catastrophic health care costs) **and for longer-term solutions to financing this access**. In the longer-term, some form of 'refugee window' under existing funds such as the NAF could be discussed, with pooled funding from development partners to cover the costs of access to health services for the most vulnerable refugees. Eventually, this could also cover the costs (i.e., premiums) of integrating refugees into public insurance schemes (either those managed by MOH or MOSD). The SSC will also be an important stakeholder given that on-going discussions in Jordan indicate that SSC is being lined up to be the lead agency for health insurance in Jordan (KII MOH). Medair can investigate the most appropriate pathways to bring this type of idea to the table, potentially through institutions such as UNHCR and Jordan's major health sector development partners (i.e., World Bank, WHO, USAID).

Donors and UN Agencies

Medair could consider how best to diversify its funding portfolio for health and **seek longer-term funding from donors through development channels rather than humanitarian funding**. For example, it could do this by seeking funding to scale up its community health work and capacity building of local organisations; activities that are in line with national health priorities and aligned with the work of other health sector partners. We understand that similar activities are under way in Medair's social

protection team through negotiations with for example Swiss Development Cooperation (SDC). Medair could usefully invest resources in the packaging and articulation of its longer-term health approach to facilitate this activity (e.g., for inclusion in funding proposals, and to provide consistent messaging).

International NGOs (INGOs)

Various INGOs are currently engaged in (or planning to engage in) capacity building of local health partner organisations (a strategy of 'localisation') as part of efforts to strengthen the sustainability of their work in the context of declining humanitarian funding in Jordan. **Medair could investigate how best these localisation efforts of INGOs could be coordinated and kick-start a process of sharing experiences and learning in this area.** It would appear that there are currently no health sector platforms which address humanitarian development coherence (the so-called 'nexus') which include NGOs, and this is a gap in the dialogue around transitional health financing modalities.

Such a platform or committee could also address the finding in the report by Burlin and colleagues (2022) on the mapping of humanitarian development coherence in Jordan that "more could be done within the international community to develop a comprehensive strategy among international actors to reduce the existence of parallel services and focus on moving towards system strengthening and capacity building as part of a long-term exit strategy" (p. 94).⁷⁰

National NGOs and CBOs

National organisations have been somewhat left out of discussions on how to increase coherence between humanitarian and development partners, even though they are clearly part of the solution. The above-mentioned study by Burlin and colleagues (2022) finds that Jordanian organisations rarely attend UN Working Groups and that national and local actors largely do not participate in the Humanitarian Development Partners Group or Health Partners Forum. In any case, coherence between humanitarian and development partners is rarely on the agenda at Health Working Group meetings. Medair could use its close working relationship with UNHCR and with other INGOs to **seek ways to actively involve local health sector organisations in key forums and to ensure that humanitarian development coherence is tabled on the agenda at UN Working Group meetings,** starting with the Community Health Platform which it currently chairs.



© Medair/ Salsabeel Hanatleh



Annex 1: Key Informant Interviews undertaken for the study

Key Informant	Title/ role	Organisation
Adam Musa Khalifa	Senior Public Health Officer	UNHCR Jordan
Alonso Garbayo	Coordinator Health Systems & Non-communicable Diseases	WHO Jordan
Andre Griekspoor	Senior humanitarian policy advisor	WHO HQ
Ann Burton	Chief of Public Health Section	UNHCR HQ
Professor Arfa Chokri	Health Economist, coordinating health financing activities on behalf of WHO Jordan	WHO Jordan
Awad Mataria	Director, UHC and Health Systems	WHO EMRO
Baptiste Hanquart	Coordinator Jordan INGO Forum	Jordan INGO Forum - JIF
Diana Haddadin	Senior C4H manager	International Medical Corps - IMC
Dina Jardeneh	Public Health Officer (C4H)	UNHCR Jordan
Ehab Tyban	Medical Referral Manager	International Medical Corps - IMC
Eng. Huda Ababneh	Director, Projects Management and International Cooperation	Ministry of Health, Hashemite Kingdom of Jordan
Jean-Paul Jemmy-Ghoms	Health Expert	ECHO Jordan
John McKay	Deputy Director, health	USAID Jordan
Jonathan Brass	Operations Manager: Emergency Social Safety Net (ESSN)	International Federation of Red Cross and Red Crescent Societies - IFRC
Laith Qusos	Liaison officer	Terre des Hommes - TdH
Luay Abu Sammour	Programme Coordinator	International Rescue Committee - IRC
Maysa Al-Khateeb	Management Specialist, Population and Family Health	USAID Jordan
Muhammad Fawad	Public Health Officer - Co-coordinator Health Sector Working Group	UNHCR Jordan
Paul Spiegel	Director of Center for Humanitarian Health (former Deputy Director UNCHR's Division of Programme Management & Support Services)	Johns Hopkins Bloomberg School of Public Health
Rada Nawwaf Nafe Naji	Social Protection Specialist	World Bank Jordan
Saverio Bellizzi	Emergency Team Lead (Co-lead Health Sector Working Group)	WHO Jordan
Takahiro Hasumi	Health Specialist, Middle East and North Africa Region	World Bank
Uday Raj Naidu Canchi Bhoopal	Medical Coordinator - Referral system	International Medical Corps - IMC
Xavier Modol	Independent health financing specialist	na
Yara Sunaa	Medical Coordinator	Caritas Jordan - CJ

References

- ¹ [Human Rights Watch](#) (Oct 2021), Syria: Returning Refugees Face Grave Abuse
- ² Ministry of Planning and International Cooperation (2021). [Foreign assistance committed to Jordan report.](#)
- ³ The Hashemite Kingdom of Jordan, Ministry of Planning and International Cooperation (MOPIC). [Jordan response plan for the Syria crisis 2020 – 2022.](#)
- ⁴ [World Population Review](#), accessed on 21.03.22.
- ⁵ [World Bank data](#), accessed on 15.03.22.
- ⁶ The Hashemite Kingdom of Jordan, MOPIC (2020). [Jordan response plan for the Syria crisis 2020 – 2022.](#)
- ⁷ UNHCR and Headway Jordan (2021a). [Health access and utilization survey \(HAUS\): Access to Healthcare Services Among Syrian Refugees living in urban setting in Jordan](#), follow-up report, November 2021. And UNHCR and Headway Jordan (2021b). Health access and utilization survey (HAUS): Access to Healthcare Services Among non-Syrian Refugees living in urban setting in Jordan, November 2021.
- ⁸ [The World Bank in Jordan: overview](#), accessed on 11.03.22.
- ⁹ Regional Refugee and Resilience Plan (3RP) (2022). [Regional strategic overview 2022](#). p. 11.
- ¹⁰ [UN: Jordan issued record number of work permits to Syria refugees.](#) Middle East Monitor (Momo) 26 January 2022.
- ¹¹ [UHC 2030 \(2018\)](#). UHC2030 warmly welcomes Jordan as a member and signatory to the Global Compact for progress towards UHC.
- ¹² [Lupieri & Doetter \(2020\)](#). Transnational interdependency and healthcare system change: The role of humanitarian and development aid in shaping health policy in Jordan.
- ¹³ Nazer L., and Tuffaha H., (2017). [Health Care and Pharmacy Practice in Jordan](#). Canadian Journal of Hospital Pharmacy [online]; 70(2): 150–155.
- ¹⁴ Jordan Investment Commission (2017). [Sector profile: tourism](#).
- ¹⁵ USAID (2020). [Improving healthcare quality. Jordan](#). Fact sheet
- ¹⁶ WHO (2020). [WHO Jordan: joint collaboration programme 2016–2017 – achievement report](#). Cairo: WHO Regional Office for the Eastern Mediterranean; 2020. Licence: CC BYNC-SA 3.0 IGO.
- ¹⁷ These data are cited in Jordan Strategy Forum (2020). [Enhancing the competitiveness of the health sector in Jordan](#), and are taken from the Ministry of Health Strategy 2018–2022, p.20.
- ¹⁸ Hammad E, Alabbadi I, Taissir F, Hajjwi M, et al. (2022). [Hospital unit costs in Jordan: insights from a country facing competing health demands and striving for universal health coverage](#). Health Economics Review 12:11.
- ¹⁹ [Aid at a glance](#), online, accessed 22.03.22.
- ²⁰ Lupieri S., and Doetter L., (2020). [Transnational interdependency and healthcare system change: the role of humanitarian and development aid in shaping health policy in Jordan](#). Global Social Policy; 20(2) 192–214.
- ²¹ [World Bank data](#) accessed on 15.13.22.
- ²² Nazer & Tuffaha (2017). [Health Care and Pharmacy Practice in Jordan](#). Canadian Journal of Hospital Pharmacy [online]; 70(2): 150–155.
- ²³ Hammad E, Alabbadi I, Taissir F, Hajjwi M, et al. (2022). [Hospital unit costs in Jordan: insights from a country facing competing health demands and striving for universal health coverage](#). Health Economics Review 12:11.
- ²⁴ Shepard DS, Halasa-Rappel YA, Al-Halaseh I, Fardous T, et al. (2017). Health Care Cost Study at Ministry of Health and the Cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees. UNICEF, Jordan.

- ²⁵ Bietsch K, Rosenberg R, Stover J, Winfrey W, (2020). [Determinants of Health Insurance Coverage and Out-of-pocket Payments for Health Care in Jordan: Secondary Analysis of the 2017-18 JPFHS](#). DHS Further Analysis Reports No. 138. Rockville, Maryland, USA: ICF.
- ²⁶ Cited by Lupieri & Doetter (2020). Lupieri S., and Doetter L., (2020). Transnational interdependency and healthcare system change: the role of humanitarian and development aid in shaping health policy in Jordan. *Global Social Policy*; 20(2) 192-214. p.205.
- ²⁷ Burlin A, Jordan Z, Al-Khatib B, Ghreiz E (2020). Mapping humanitarian-development coherence in Jordan: reflections from INGOs and other key stakeholders. Final report, page. 3.
- ²⁸ Burlin A, Jordan Z, Al-Khatib B, Ghreiz E (2020). Mapping humanitarian-development coherence in Jordan: reflections from INGOs and other key stakeholders. Final report
- ²⁹ Durable Solutions Platform and Development Initiatives (2022). [Financing for Protracted Displacement in the Syrian Refugee Context in Jordan](#).
- ³⁰ Regional Refugee and Resilience Plan (3RP) (2020). [3RP Regional Strategic Overview 2021-2022](#)
- ³¹ [UNHCR Operations Portal](#), accessed on 11.03.22.
- ³² Durable Solutions Platform and Migration Policy Institute (2021). [A Bridge To Firmer Ground: Learning from International Experiences to Support Pathways to Solutions in the Syrian Refugee Context](#). Research report.
- ³³ World Food Programme (WFP) (2021). [Mobile vulnerability analysis and mapping \(mVAM\): refugees in Jordan](#).
- ³⁴ 3RP (2022). [Regional strategic overview 2022](#).
- ³⁵ CARE Jordan (2022). [11 years of crisis: against all odds](#). A Summary of the 2021 Annual Needs Assessment, p.8
- ³⁶ CARE Jordan (2022). [11 years of crisis: against all odds](#). A Summary of the 2021 Annual Needs Assessment.
- ³⁷ The Hashemite Kingdom of Jordan, MOPIC (2020). [Jordan response plan for the Syria crisis 2020 – 2022](#).
- ³⁸ The NCD Alliance (2017). [The Global Epidemic](#).
- ³⁹ WHO (2021). [Non-communicable diseases](#).
- ⁴⁰ Shah S, Munyuzangabo M, Gaffey M, Kamali M, et al. (2020). [Delivering non-communicable disease interventions to women and children in conflict settings: a systematic review](#). *BMJ Global Health*; 5:e002047.
- ⁴¹ Ministry of Health (2020). Jordan National STEPwise Survey (STEPS) of noncommunicable diseases and their risk factors 2019.
- ⁴² Jordan 2025: a national vision and strategy.
- ⁴³ Global Health Development (GHD) and Emphnet (2020). [Jordan Addresses Increasing NCD Burden Among Vulnerable Communities](#)
- ⁴⁴ For example, please see: Rehr M, Shoaib M, Ellithy S, Okour S, et al. (2018). Prevalence of non-communicable diseases and access to care among non-camp Syrian refugees in northern Jordan. *Conflict and Health*; 12:33; Doocy S, Lyles E, Akhu-Zaheya L, Burton L, Burnham G (2016). Health service access and utilization among Syrian refugees in Jordan. *International Journal for Equity in Health*; 15: 108; UNHCR and Headway Jordan (2021a). Health access and utilization survey (HAUS): Access to [Healthcare Services Among Syrian Refugees living in urban setting in Jordan](#), follow-up report, November 2021; and UNHCR and Headway Jordan (2021b). Health access and utilization survey (HAUS): Access to Healthcare Services Among non-Syrian Refugees living in urban setting in Jordan, November 2021.
- ⁴⁵ UNHCR and Headway Jordan (2021a). [Health access and utilization survey \(HAUS\): Access to Healthcare](#)

[Services Among Syrian Refugees living in urban setting in Jordan](#), follow-up report, November 2021. And UNHCR and Headway Jordan (2021b). Health access and utilization survey (HAUS): Access to Healthcare Services Among non-Syrian Refugees living in urban setting in Jordan, November 2021.

⁴⁶ UNFPA (2021). [Launching the national reproductive and sexual health strategy for the years 2020 - 2030](#). Online, accessed on 30.03.22.

⁴⁷ UNHCR website (2022). [Health](#), accessed on 21.03.22.

⁴⁸ UNHCR and Headway Jordan (2021a). [Health access and utilization survey \(HAUS\): Access to Healthcare Services Among Syrian Refugees living in urban setting in Jordan](#), follow-up report, November 2021. And UNHCR and Headway Jordan (2021b). Health access and utilization survey (HAUS): Access to Healthcare Services Among non-Syrian Refugees living in urban setting in Jordan, November 2021.

⁴⁹ OCHA (2022). [Jordan: Humanitarian Partnerships and Capacity Exchange Analysis 2021](#). Infographic.

⁵⁰ Durable Solutions Platform and Development Initiatives (2022). [Financing for Protracted Displacement in the Syrian Refugee Context in Jordan](#).

⁵¹ Jordan Times (online). [EU approves 22-million-euro grant to strengthen Jordan's public health system](#). Published on 13 September 2021, accessed on 21.03.22.

⁵² MSF (2022). [Jordan brings down the curtain on one of its largest interventions in the country](#). Online, accessed on 19.03.22.

⁵³ OCHA (2021). [Allocation Strategy Paper Jordan Humanitarian Fund](#), May 2021 - 1st Standard Allocation. Online. May 2021.

⁵⁴ UNHCR (2021). CAEHS-Jordan. Factsheet.

⁵⁵ Emphnet (2021). [Implementation Research Services for the Integrated Non-Communicable Diseases \(NCDs\)- Humanitarian Response Project](#). Online, accessed on 15.03.22.

⁵⁶ Parmar PK, Rawashdah F, Al-Ali N, Abu Al Rub R, Fawad M, et al. (2021). [Integrating community health volunteers into non-communicable disease management among Syrian refugees in Jordan: a causal loop analysis](#). *BMJ Open*;11:e045455. p. 5.

⁵⁷ Burlin A, Jordan Z, Al-Khatib B, Ghreiz E (2020). Mapping humanitarian-development coherence in Jordan: reflections from INGOs and other key stakeholders. Final report, p. 113.

⁵⁸ Burlin A, Jordan Z, Al-Khatib B, Ghreiz E (2020). Mapping humanitarian-development coherence in Jordan: reflections from INGOs and other key stakeholders. Final report, p. 95.

⁵⁹ OCHA (2022). [Jordan Humanitarian Partnerships and Capacity Exchange Analysis 2021](#).online, accessed 28.03.22.

⁶⁰ UNHCR (2021). Global public health strategy 2021-2025.

⁶¹ For example, please see Jithitikulchai T, Feldhaus I, Bauhoff S, Nagpal S (2021). Health equity funds as the pathway to universal coverage in Cambodia: care seeking and financial risk protection. *Health Policy and Planning*; 36 (1): 26-34; Annear P (2010). A comprehensive review of the literature on health equity funds in Cambodia 2001-2010 and annotated bibliography. Health policy and health finance knowledge hub working paper No.9 2010. Nossal Institute for Global Health, The University of Melbourne; and Annear PL, Tayu Lee J, Khim K, et al. Protecting the poor? Impact of the national health equity fund on utilization of government health services in Cambodia, 2006-2013. *BMJ Global Health*;4:e001679.

⁶² For example, please see Neelsen S, de Walque D, Friedman J, Wagstaff A. (2021). Financial incentives to increase utilization of reproductive, maternal, and child health services in low- and middle-income countries a systematic review and meta-analysis. Policy Research Working Paper 9793, Development Economics Development Research Group, World Bank Group; Bellows B, Bulaya C, Inambwae S, Lissner C, et al. (2016). Family planning vouchers in low and middle income countries: A systematic review. *Studies in Family Planning*, 47(4), 357-370.

⁶³ Taha H, Nyström L, Al-Qutob R, et al. (2014). Home visits to improve breast health knowledge and screening practices in a less privileged area in Jordan. *BMC Public Health*;14:428;

⁶⁴ See for example, Grainger C, Gorter A, Al-Kobati E, Boddam-Whetham L (2015). [Providing safe motherhood services to underserved and neglected populations in Yemen: the case for vouchers](#). *Journal of International Humanitarian Action* (2017) 2:6; and Boddam-Whetham L, Gul X, Al-Kobati E, Gorter A. (2016). [Vouchers in Fragile States: Reducing Barriers to Long-Acting Reversible Contraception in Yemen and Pakistan](#). *Global Health*:

Science and Practice, 4(Supplement 2):S94-S108.

⁶⁵ Gorter A, Grainger C (2021). [A 'Stocktake' of CVA for health outcomes in the MENA Region: moving from evidence to practice](#). Cash and Action Learning Programme (CaLP) and AA.

⁶⁶ World Bank (2008). Performance-Based Contracting for Health Services in Developing Countries: a toolkit. Health nutrition and population series. The World Bank Group.

⁶⁷ Niessen L, Mohan D, Akuoku J, Mirelman A, et al. (2018). [Tackling socioeconomic inequalities and non-communicable diseases in low-income and middle-income countries under the Sustainable Development agenda](#). *The Lancet Taskforce on NCDs and Economics 2*; 391: 2036–46

⁶⁸ Lyles E, Chua S, Barham Y, Pfeiffer-Mundt K, et al. (2021) Improving diabetes control for Syrian refugees in Jordan: a longitudinal cohort study comparing the effects of cash transfers and health education interventions. *Conflict and Health* 15:41

⁶⁹ Bertram M, Sweeny K, Lauer J, Chisholm D., et al. (2018). [Investing in non-communicable diseases: an estimation of the return on investment for prevention and treatment services](#). *The Lancet Series on NCDs and Economics 5*; 391: 2071–78.

⁷⁰ Burlin A, Jordan Z, Al-Khatib B, Ghreiz E (2020). Mapping humanitarian-development coherence in Jordan: reflections from INGOs and other key stakeholders. Final report.

