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ANNEX III

of the Commission Implementing Decision on the Special measure in favour of the Hashemite Kingdom of Jordan for 2022

Action Document for Strengthening Access to Quality Primary Health Care Services for Syrian Refugees and Host Communities in Jordan

ANNUAL MEASURE

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and action plan/measure in the sense of Article 23(4) of NDICI-Global Europe Regulation.

1. SYNOPSIS

1.1. Action Summary Table

1. Title OPSYS Basic Act	Strengthening access to quality primary health care services for Syrian refugees and host communities in Jordan. Annual Measure in favour of the Hashemite Kingdom of Jordan for 2022 OPSYS business reference: NDICI-GEO-NEAR 2022 /ACT-60899 ABAC Commitment level 1 number: JAD 1020282 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	No
3. Zone benefiting from the action	The action shall be carried out in The Hashemite Kingdom of Jordan
4. Programming document	N/A
5. Link with relevant MIP(s) objectives/expected results	N/A
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Human development , 120 Health , 122 Basic Health : Primary Health Care services
7. Sustainable Development Goals (SDGs)	SDG 3: Good Health and Well-Being SDG 5: Gender equality and women's empowerment

	SDG 10: Reduce inequality within and among countries			
8 a) DAC code(s) ¹	12110 Health policy and administrative management 12220 Basic health care 12230 Basic health infrastructure			
8 b) Main Delivery Channel	World Health Organisation - 41307			
9. Targets	<input checked="" type="checkbox"/> Migration <input type="checkbox"/> Climate <input checked="" type="checkbox"/> Social inclusion and Human Development <input checked="" type="checkbox"/> Gender <input type="checkbox"/> Biodiversity <input checked="" type="checkbox"/> Human Rights, Democracy and Governance ²			
10. Markers (from DAC form)	General policy objective	Not targeted	Significant objective	Principal objective
	Participation development/good governance	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Aid to environment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gender equality and women's and girl's empowerment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Reproductive, maternal, new-born and child health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Disaster Risk Reduction	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Inclusion of persons with Disabilities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Nutrition	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	RIO Convention markers	Not targeted	Significant objective	Principal objective
	Biological diversity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Combat desertification	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climate change mitigation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climate change adaptation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11. Internal markers³ and Tags⁴	Policy objectives	Not targeted	Significant objective
Digitalisation		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Tags			
digital connectivity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
digital governance	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
digital entrepreneurship	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
digital skills/literacy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
digital services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<u>Connectivity</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tags			
digital connectivity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
energy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
transport	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
health	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
education and research	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Migration	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Reduction of Inequalities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COVID-19	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

BUDGET INFORMATION

12. Amounts concerned	Budget line(s) (article, item): 14.020110 Southern Neighbourhood Total estimated cost: EUR 15 300 000 Total amount of EU budget contribution EUR 15 000 000
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MANAGEMENT AND IMPLEMENTATION

13. Implementation modalities (type of financing and management mode)	Project Modality Indirect management with World Health Organization (WHO)
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1.2. Summary of the Action

This health action builds on the lessons learned from the ongoing EU Regional Trust Fund (EUTF) Jordan Health Programme for Syrian refugees and vulnerable Jordanians (TF Madad T04.202) implemented by WHO Country Office in Jordan. Under this programme, WHO conducted Primary Health Care (PHC) assessment to generate evidence on the availability, readiness, accessibility, and quality of primary care services in Jordan and suggested actionable recommendations to support the Ministry of Health for improving the structure and delivery of quality PHC services. The PHC assessment identified several gaps in governance and decision making, as well as resource management. The findings of the assessment report a lack of effective health systems governance, limited use of data for decision making and poor human resources management. Furthermore, sustained under-investment in PHC by government and development partners leads to progressive deterioration of quality of services and gate-keeping function with the population seeking care at secondary and tertiary levels for conditions that can be treated at the primary level.

The UNHCR Health Access and Utilization Survey 2021⁵ for Syrian refugees living in urban settings in Jordan identified certain gaps in access to the health care services by the registered Syrian refugees. 20% of pregnant women faced difficulties in accessing antenatal care, mainly due to unaffordability of user fees. Only 29% of the women tried to access contraceptives, largely through Ministry of Health (MOH) health centres. 19% of respondents reported having Non Communicable Diseases and 52% of them could not get their medicines for the past three months mainly due to unaffordability (which represents the double in comparison to 2018). 89% were able to obtain the health care services, 88% were impacted by the increase of health costs hence reducing the visits to health care facilities and reducing some medications. While reduced in comparison to 2018, the average spending on health still constitutes 44% of the monthly income. There was also a significant increase in inability of accessing other health services from 22% in 2018 to 48% in 2021.

Thus, the health action addresses two critical problems in Jordan: weak, poor quality primary health care system and poor access to and utilization of the primary health care services by refugees, in particular Syrian refugees, and their host communities. It will be addressing in particular gender equality and women empowerment through addressing the root causes of the inequality at the community level by identifying the young women who lack decision making power on the health and wellbeing of the children and strengthen community participation and support to them. Special efforts will be made to increase the proportion of female health care staff (doctors and nurses) that will result in improved acceptability and demand.

In this context, the Overall Objective of this action is to contribute to improving efficiency, equity, and responsiveness of the PHC system to address the needs of refugees, in particular Syrian refugees (with due attention paid to a one refugee approach) and their host communities in Jordan.

The Specific Objectives of this action are :

1. To support the Ministry of Health (MoH) in developing PHC-oriented policy frameworks benefitting refugees, in particular Syrian refugees and their host communities.
2. To pilot and evaluate a PHC-oriented comprehensive model of care at governorate level to increase the access to primary healthcare for refugees, in particular Syrian refugees, and their host communities.

The proposed action will pursue the implementation of a PHC-oriented model of care which will be responsive to the post COVID-19 health system needs (system recovery) with an aim of ensuring that all people receive the right care, at the right time, by the right team, and in the right place⁶. It will combine multi-sectoral policy and action; empowered people and communities; and primary health care and essential public health functions as the core of integrated health services available throughout the course of life.

This Action will synergise with an action implemented by the Spanish Cooperation AECID (Enhanced Support to the Public Health System in Jordan for Syrian Refugees and Jordanians: Prevention and Management of Non-Communicable Diseases through Primary Health Care) in the framework of the response to the Syrian crisis and in particular for the improvement in management and primary care in the field of Non Communicable Diseases (NCDs). At local level, this action will focus on the Irbid governorate, in addition to selective health facilities in locations with high density of refugees, in particular Syrian refugees and their host communities in South East Amman, Zarqa and Karak, based on well assessed priorities and needs, while AECID addresses the governorates of Mafraq, Ajloun and Tafleeh. As implementing partner of this action, WHO will ensure complementarity, synergy of interventions and coordination with donors, implementing partners like AECID and the World Bank in particular, national

⁵ <https://reliefweb.int/report/jordan/unhcr-health-access-and-utilization-survey-access-healthcare-services-among-syrian>

⁶ Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020. License: CC BY-NC-SA 3.0 IGO.

and international NGOs supporting the improvement of the primary health care system for Syrian refugees and their host communities.

2. RATIONALE

2.1. Context

Today, with the Syria crisis entering its second decade, Jordan hosts around 670,364 UNHCR-registered Syrian refugees, although the total of Syrians living in Jordan following the outbreak of the war was estimated at around 1.36 million. They make up about 12.3% of the total population in Jordan and an overwhelming majority of them (estimated 90%) is living out of the camps. In line with the EU-Jordan 2021-2027 Partnership Priorities⁷, the response to the Syria crisis continues to be politically and strategically framed by the Jordan Compact⁸. The EU and Jordan will continue working together to find durable and sustainable solutions to the Syrian crisis. The efforts will continue to provide access and services for both refugees and their host communities, through improved access and quality of essential health care services including mental health and psychosocial support.

Against a backdrop of continued extreme vulnerability of refugees and vulnerable host communities, further exacerbated by the COVID 19 pandemic, pursuing investments to improve their access to services, ensure respect of their human rights, working to enhance their potential for self-reliance, and creating opportunities for them to contribute to Jordan's economic development remain high on the agenda.

The Jordan Compact builds on the Jordan 2025 national vision and strategy, the national blueprint for a ten-year economic development path. It identifies three major priorities: (i) addressing currently high levels of unemployment, particularly for women and youth, (ii) reducing poverty, which is concentrated in disadvantaged regions and (iii) increasing investment. The effectiveness and efficiency of the Syria Response is therefore closely linked to developments in Jordan. Even more so as prospects of return remain uncertain and inclusion and sustainability issues move to the fore, as the rationale for humanitarian approaches weakens over time. An approach that ensures inclusiveness of all vulnerable groups, in particular Syrian refugees should be sought, ensuring more and more alignment between the EU's bilateral and Syria response programmes. This is also emphasised in the Multi-annual Indicative Programme (MIP)⁹ 2021-2027 for Jordan and in full adherence with the Jordan Compact and at European Union (EU) - hosted Brussels conferences 'Supporting the future of Syria and the Region'. The Compact and related health commitments focus on equitable, affordable access to, and quality of health care provision to improve health outcomes and strengthen services for all, including Syrian refugees. This also reflects the EU's priorities as formulated in the "Joint Communication on a Renewed Partnership with the Southern Neighbourhood – a New Agenda for the Mediterranean"¹⁰ and in the subsequent Council conclusions on a renewed Partnership with the Southern Neighbourhood of 16 April 2021¹¹. In addition, this action is based on in-country dialogue with EU Member States. It builds on the prominent role played by the EUTF for the Syria Crisis (Madad Fund) and existing regional programmes focusing on longer-term resilience and development support in health, for Syrian refugees and Jordanian host communities.

⁷ <https://data.consilium.europa.eu/doc/document/ST-3304-2022-ADD-1/en/pdf>

⁸ EU-Jordan Compact, adopted in December 2016, contains a comprehensive package which combines assistance in diverse policy areas such as trade, employment, mobility, countering violent extremism and education. In exchange, Jordan has adopted diverse measures to facilitate social and economic inclusion of Syrian refugees.

⁹ C(2022)3821

¹⁰ JOIN(2021) 2 final and SWD(2021)23 final.

¹¹ <https://data.consilium.europa.eu/doc/document/ST-7931-2021-INIT/en/pdf>.

Jordan has a recent history of rapid population growth due to regional crises and subsequent movements of people. The country has in fact welcomed people fleeing the Lebanese civil war, Iraqis seeking refuge after the Gulf War and Iraq War, and a large number of Palestinians coming from the West Bank and Gaza Strip. As of November 2021, 49% of Syrian refugees registered with United Nations High Commissioner for Refugees (UNHCR) were classified as vulnerable¹². Moreover, 37% of the population were identified as severely vulnerable with regards to access and availability of health services (an increase by 17% since 2017). Politically, sitting at the centre of a volatile region, Jordan continues to play a role as an anchor for regional stability committed to supporting refugees although not a signatory to the Convention relating to the Status of Refugees¹³. More generally, vulnerability of people increased due to a lack of workforce within the household, increased expenditure and debt levels as well as coping mechanisms adopted. However, the limited fiscal space as the result of COVID-19 pandemic leaves little opportunity for supporting even vulnerable Jordanians.

The country has been suffering from the debt that was 88 % of the GDP in 2020, a negative trade balance of close to USD 7,2 million, and a rise in unemployment rates from 18.4% to 25% for Q4 2020. Ability of the national economy to grow remains vulnerable to external shocks, particularly the forced migration from neighbouring countries. The growth rate is insufficient to solve the long-term economic, social and health development challenges. Therefore, the decisions of the government to invest in health and other areas will remain constrained to a certain extent, especially in the next few years.

In the area of health, Jordan faces major demographic challenges related to a rise in its natural population number, the increasing proportion of elderly people, large and unplanned population growth in the urban areas especially in the Amman Governorate and in major cities and the imbalance in population distribution between the governorates of the Kingdom. The large number of Syrian refugees and their host communities also became a challenge and a big burden for the health system of Jordan, especially in the Northern governorates, where the Syrian refugees are mostly concentrated. Demand for health services increased at an unprecedented rate that exceeds the capacity of the public health sector, putting high pressure on human resources, medical staff, hospitals infrastructure and health facilities, leading to a shortage of health human resources and medical supplies and burdening the available financial resources. Facilities in areas hosting large numbers of refugees are often overburdened, face shortages of medication and beds, overworked staff and short consultation times while demanding higher health care costs. This increased burden also fosters resentment amongst the Jordanian population.

¹² Vulnerability Assessment Framework (VAF). 2019 <https://data.unhcr.org/en/working-group/54>

¹³ <https://www.ohchr.org/Documents/ProfessionalInterest/refugees.pdf>

¹⁴ Jordan: Second Review Under the Extended Arrangement Under the Extended Fund Facility, Request for Augmentation of Access, and Modification of Performance Criteria-Press Release; Staff Report; Staff Statement; and Statement by the Executive Director for Jordan (imf.org)

Jordan provides health care services to its residents through four main ways: Primary Health Care (PHC) - the first contact for patients; Secondary Health Care - hospitals with major specialties and general surgery; Tertiary or highly specialised medical services; and Rehabilitation Care. PHC centres are managed by the Ministry of Health (MoH) and provide preventive and generalized services including reproductive, maternal and child health, dentistry, outpatient consultations and patient education. The network of MoH PHC facilities include 109 comprehensive health centres, 374 Primary Health Centres, 186 branch or village health centres. The PHC is continuously underfunded; the National Health Accounts (NHA) report for 2019 shows that the share of curative care expenditure as percentage of total public expenditure (TPE) was estimated as 73.7 % in 2017, while the share of primary healthcare expenditure was 19.6 % for the same year¹⁵. The government struggles to maintain the same quality of essential health services for Syrian refugees and their host communities. In addition, Jordan was hit hard by the COVID-19 pandemic with strict lockdown in 2020, which disrupted essential health services and stretched health system capacities. COVID-19 also affected the socioeconomic outcomes of migrant workers, particularly for irregular migrants and female migrant workers, who suffer from difficulties in accessing basic needs, information, and increased levels of gender-based violence¹⁶.

UNHCR, supported by the MoH, provides medical care to Syrian refugees inside camps; however, the healthcare needs of the larger population of refugees living outside the camps are not fully met. Until late 2014, the MoH provided free healthcare to all Syrian refugees registered with the UNHCR. This posed a large burden on the health care system, and free access to health care was replaced by 20% co-payment at the rate of uninsured Jordanians in 2014. These arrangements were in place until January 2017, when Syrians were requested to cover 80% of healthcare costs. This policy heavily affected access of the Syrian refugees to the health services, and the donor community established a Multi-Donor Account (MDA) that restored a 20% rate for Syrian refugees living outside camps. However, subsidised costs were not accessible for the unregistered refugees (around half of the total number). The public health access and health seeking behaviours assessment of Syrian refugees in Jordan conducted by International Rescue Committee (IRC) in 2019 showed that 46.6% of respondents reported financial cost as the main barrier to accessing services while 42.6% reported that the main barrier is the distance and time needed to reach the health facilities and the lack of transportation options.

Primary Health Care (PHC) assessment conducted by WHO Jordan in 2021 (unpublished) identified several gaps in governance and decision making, as well as resource management. Findings of the assessment report the lack of effective health systems governance, limited use of data for decision making and poor human resources management. Furthermore, sustained underinvestment in PHC by government and development partners leads to a progressive deterioration of the quality of services and gate-keeping function with population seeking care at secondary and tertiary levels for conditions that can be treated at PHC. Finally, PHC is also critical to make health systems more resilient and more proactive in detecting early signs of epidemics and more prepared to act early in response to surges in demand for services. Although the evidence is still evolving there is widespread recognition that PHC is the “Gatekeeper” of the health system and provides the foundation for the strengthening of the essential public health functions.

Accordingly, there is an urgent need to develop and adopt a participatory, problem-driven and refugee-centred approach to enhance and strengthen access to quality primary health care and sustain them in response to the evolving epidemiological and demographic context to enhance the utilisation of and access to health services. Considering the strong focus on support to the access to quality health care services for Syrian refugees and their host communities, the current action will be complementary to the ongoing

¹⁵ Reference: Jordan National Health Accounts for 2016 – 2017 Fiscal Years Technical Report No. 8. High Health Council. August 2019 (Jordan National Health Accounts for 2016 – 2017 Fiscal Years (jordankmportal.com)).

¹⁶ Assessment conducted by IOM in 2021 (unpublished)

EUTF Jordan Health Programme for Syrian refugees and their host communities (TF Madad T04.202) implemented by WHO, as well as to the project which is being implemented by AECID: The Public Health System in Jordan for Syrian Refugees and Jordanians: Prevention and Management of Non-Communicable Diseases through Primary Health Care (TF-MADAD/2020/T04.255). In addition, this action will be in complete synergy and complementarity with the World Bank's project initiating a conceptual work on family health team comprehensive package of services.

The EU will ensure strong coordination and cohesion between the three projects, fostering synergies and avoiding duplication of efforts, with the objective of longer-term planning perspectives based on needs and gaps responding. The EU will implement this action with refugee and migrant based approaches to support quality primary health care services for Syrian refugees and host community vulnerable patients embedded with gender equality. The objective is to move towards Universal Health Coverage (UHC) with the aim of improving health status and patient satisfaction through health system strengthening and piloting a PHC-oriented comprehensive model of care in governorates identified according to priorities and needs (Irbid, South East Amman, Zarqa and Karak).

2.2. Problem Analysis

Short problem analysis

Jordan is challenged by a fragmented health system, including complex interactions of different actors, both public and private. This kind of health system structure leads to inequity, duplication of services, inadequate participation of the private sector, limited quality improvement, and inefficient use of available resources, poor management of human resources, and a dysfunctional health information system.

The arrival of a high number of Syrian refugees has substantially impacted the health sector in Jordan in a multitude of ways, leading to the main challenges that are summarised as follow:

- Increasing demand for health services fuelled by the COVID-19 pandemic at an unprecedented rate that exceeds the capacity of the public health sector, especially in Northern governorates, leading to a poor quality primary health care system.
- Shortage and high pressure on human resources, medical staff, hospitals infrastructure, health facilities.
- Poor access to and utilisation of primary health care services by the Syrian refugees and their host communities, as well as a negative impact on the Jordanian patients in general who compete for limited health resources.
- Weak infection prevention and control practices at the PHC level, including waste management.
- Limited community engagement and health literacy among Syrian refugees and their host communities.

Jordan is committed to achieve the Universal Health Coverage (UHC) by 2030 as part of the SDG agenda. Reported essential health service coverage (UHC index, SDG 3.8.1) was 59.5% in 2019. Only 55% of Jordan's residents have access to health insurance, while only 68% of Jordanians are insured. The out-of-pocket payments were at 30.3% in 2019. Financial hardship among the poorest households is driven by spending on medicines (Household Expenditures and Income Survey 2017-2018)¹⁷.

Primary Health Care (PHC) is an important health system element and considered the 'programmatic engine' for UHC, the health-related SDGs and health security. The PHC facilities need to be strengthened

¹⁷ Tables of expenditure and household income – Department of Statistics (dos.gov.jo)

to accommodate current challenges and needs for prepared response for future health emergencies. In this context, a major gap related to Health Information System (HIS) was uncoordinated information gathering for specific programmes with limited interoperability that compromises the national capacities to generate sound evidence for decision making. Moreover, the existing referral system is not efficient being mainly paper based without a tracking system to monitor counter referral. Abundant factors related to utilisation of services were detected including users' perceived low trust in physicians, limited duration of consultation time, and lack of counselling, delays occurring due to overcrowding in some facilities, cost-per-visit which places a barrier for some vulnerable groups to access services. In addition, the COVID-19 pandemic impacted the accessibility of essential health care services at PHC. Furthermore, PHC has not been engaged in COVID-19 response (triage of patients and home care of COVID-19 cases), which led to hospitals being overwhelmed.

Moreover, the UNHCR Health Access and Utilization Survey 2021 identified that more than half of the Syrian refugees were aware of subsidised access to government health facilities for all registered refugees while 65% of them were aware of access to UNHCR's supported health facilities. Most of women have visited health care centres during pregnancy, and 73% of them made more than four visits, while 20% of them faced difficulties mainly due to unaffordability of user fees. 95% had a vaccination card for their child, but 6% of refugees reported that their child did not receive measles, mumps, and rubella (MMR), and polio vaccines. 49% of the sample were informed about the family planning in the past year but only 29% tried to access contraceptives, largely through MoH health centres. 19% of respondents reported having chronic conditions and 52% of them could not get their medicines for the past three months mainly due to unaffordability (which represents the double in comparison to 2018). While 89% were able to obtain the health care services, 88% were impacted by the health costs increase, and this resulted in reducing the visits to health care facilities and reducing some medications. Even if reduced in comparison to 2018, the average spending on health still constitutes 44% of the monthly income. There was also a significant increase in inability of accessing other health services from 22% in 2018 to 48% in 2021. The STEPwise survey (2019) uncovered an alarming prevalence of non-communicable diseases and their risk factors among Syrian refugees and Jordanians alike¹⁸. 86% of those who sought the service paid for it with average payment of 37 Jordanian dinars (JOD) and maximum JOD 1,500¹⁹. Also community participation in health is not well established in the country. Only few of forty health facilities included into the PHC assessment had community health workers which had worked on the specific projects. The health literacy and awareness of the risk factors, danger signs on the diseases and entitlements to the free and subsidised PHC services are very limited among the Syrian refugees. Early marriages are quite common, and the young mothers have no decision-making power on the child's health and well-being; young mothers and Syrians had the highest rate of home deliveries, lower vaccination coverage and delays in vaccination²⁰.

On the top of the financial barriers, service providers reported legal challenges faced by Syrian beneficiaries. It was also perceived by many providers that well qualified staff, adherence to clinical protocols, and availability of medical equipment and devices, laboratories and x-rays would lead to timely, fair, and efficient health services utilisation.

Identification of main stakeholders and corresponding institutional and/or organisational issues (mandates, potential roles, and capacities) to be covered by the action.

The primary stakeholders of this proposed action are:

¹⁸ Surveillance of non-communicable diseases | Jordan (who.int)

¹⁹ <https://reliefweb.int/report/jordan/unhcr-health-access-and-utilization-survey-access-healthcare-services-among-syrian>

²⁰ JPFHS 2017-18; <https://dhsprogram.com/pubs/pdf/SR256/SR256.pdf>

- Ministry of Health (MoH): The MoH is considered the main stakeholder which has the greatest impact on initiating changes in the health care system. The MoH plays a central role in implementing, monitoring and decision-making, which are essential to address the needs of the refugees and communities, reduce health inequities and increase the accountability of the government.
- Ministry of Planning and International Cooperation (MOPIC): MOPIC holds overall responsibility for the coordination of the Syria response. It works as a liaison between donors and international financing institutions, and the ministries and government institutions.
- The private sector is a big employer of health cadres in Jordan after the public sector (especially medical doctors and nurses). The private sector attracts experienced professionals from the public sector due to the high financial returns in the private sector.
- The non-governmental national and international organisations and other UN agencies: they provide complementary support to the government and play prominent roles in enhancing the quality and access of primary health care services.
- Refugees and host communities. The final beneficiaries are also considered as a stakeholder and will be consulted to ensure this action is adapted to their needs. Providing quality health care services and access to both refugees and their host communities will have a positive impact on the overall health outcomes of the country.

There are two working groups coordinating the health response in relation to the Syria crisis in Jordan: the health Sector Working Group (HSWG) and the Jordan Health Development Partner Forum (JHDPF). The HSWG includes donors and national and international NGOs to support the continued provision of essential health services to Syrian refugees and vulnerable individuals. The WHO is the co-chair of the HSWG and coordinates with the different stakeholders to strengthen current policies that affect the health status of refugees, in particular Syrian refugees, and vulnerable people within the hosting communities in Jordan. The JHDPF coordinates among health partners working in the development sector including health, and is co-chaired by MoH, WHO and USAID.

Lessons Learned

EUTF Syria health projects and programmes are strategically aligned with the EUTF Syria's guiding principles and approaches and all the objectives are coherent with the current EUTF Syria Results Framework. Also, EUTF Syria health interventions are broadly in line with Syria Country Response Plans and, in general terms their designs reflect specific country needs and benefit from stronger local ownership.

Some lessons learned were drawn from the EUTF Jordan Health Programme²¹ in response to the Syrian crisis which are considered as key for future intervention:

- Community Engagement: there is no successful response without community engagement, which also includes ongoing feedback from the community.
- Incorporate Mental Health into the response: a culture of safety must be created with prioritising mental health especially with protracted crises within PHC facilities.
- Secondary effects from a global health crisis, such as from the COVID-19 pandemic should be acknowledged and addressed as part of primary response: seeking PHC services for non-COVID-19 related conditions should be incorporated into the preparedness plan and response, not addressed apart.
- Investment and Structuring of Human Resources: the biggest asset in any health crisis is human resources. There must be investment and strategic approach for human resources development.
- Investment in Health Systems and Public Health Strengthening are lacking.

²¹ EUTF Sector EVAL on Health https://ec.europa.eu/trustfund-syria-region/monitoring-evaluation_en

- **Improve Access to Primary Health Care Services:** improving access to health care services via community-based approaches, focus on primary care and investing in infrastructure at the national level.

Discussions also emphasised the need of including refugees with enhancing the equity and accessibility, as well as enhancing the health resilience plan to cope with health crises.

The lessons learnt will be translated at the sub-national level aiming to make an impact to improve the health status of Syrian refugees and vulnerable population, leading to Universal Health Coverage (UHC) agenda.

The WHO Results-Oriented Monitoring (ROM) mission (August 2021) has shown that the project is highly relevant to the health needs in Jordan and directly addresses the needs of the different target groups including key ministries of the Government of Jordan (GoJ), health providers and the final beneficiaries, i.e. refugees, in particular Syrian refugees, and Vulnerable Jordanians. The well-coordinated response between EU, WHO and MoH has transformed the COVID-19 crisis situation in an opportunity to offer an effective and highly needed response in a time where the Jordanian Health Care system was stretched to its limit and overburdened. At the strategic level, the project is aligned with National Strategies, EUTF priorities and SDG 3.

2.4.2. Public Policy

In line with its commitment to the Sustainable Development Goals, Jordan identified health sector priorities and acknowledged the important role of PHC in achieving the SDG3 and leaving no one behind to ensure Universal Health Coverage (UHC). This is evident in several national health policies. Jordan has signed the declaration of Salah reaffirming its commitment to UHC as both a desirable and an attainable policy goal. The Ministry of Health made numerous statements on the importance of primary health care in health services delivery and need for PHC strengthening. Thus, the MoH requested WHO support in the development of MoH Strategic plan 2023-2027, where PHC will be a key priority.

One of the main activities undertaken by the Ministry is to provide primary healthcare services through a network of health centres distributed across all governorates, in addition to providing secondary and tertiary healthcare through its hospitals or the private sector hospitals. In order to achieve this objective, the Ministry adopted a number of initiatives to provide and improve primary healthcare services, the most important of which are: providing family doctors in health centres, building staff capacities through various training programmes (continuous education, scholarships and residency programmes), restructuring health centres and reinforcing larger and centrally located centres, merging some centres based on the health map, providing pharmaceutical, dental and major lab services, promoting community engagement through health committees, continuing the enforcement of accreditation and quality enhancement standards, acquiring accreditation for health centres - the number of accredited centres increased from (97) in 2017 to (147) in 2022, and computerizing health centres - the number of computerized health centres increased from (142) in 2017 to (478) in 2022.¹⁹

According to the Prime Minister decree in 2019, the refugees are entitled to the treatment in all Ministry of Health facilities (primary healthcare centres and hospitals) according to the rate of non-insured Jordanians, referral to the nearest hospital if the services are not available at the health centre and access to emergency services in all Ministry of Health hospitals and health centre according to the rate of non-insured Jordanians. This applies to primary and secondary health care services, hospital admissions and mental health services. The decree stipulates the services that are provided for free, including antenatal care, family planning, postpartum and neonatal services, screening for genetic diseases and monitoring of growth and development, vaccines according to the National Immunization Programme, treatment of communicable diseases, food poisoning, epidemics, mass accidents and natural disasters.

The Jordan Health Fund for Refugees (JHFR) was established in December 2018, with the initial timeframe until 2021, which was later extended to 2024. The main objective of establishing the JHFR was to offset the cost of care of the refugees and enable the Jordanian government to reduce health service fees for UNHCR-registered Syrian refugees in 2019 and for all UNHCR-registered refugees in 2020 through the Joint Financing Arrangement. As a result, the UNHCR registered refugees of 56 nationalities in Jordan have access to the MoH's Facilities at the uninsured Jordanians rate. Contributors to this fund include USAID, Denmark, Canada, Qatar Fund, World Bank and Germany. In addition to supporting the needs of the vulnerable and the refugees by granting access to the public health facilities, this fund contributes to strengthening the health system in Jordan by allowing the increase in the quality of care through the enhancement of the infrastructure of health facilities.

While the establishment of JHFR and Multi-Donor Account improved accessibility and affordability to the health care services for the registered refugees, the current arrangements leave around half of the unregistered refugees, predominantly Syrians without support and exposed to impoverishing health expenditures. In addition to that, many registered refugees appear to have limited awareness on the services available and entitlements for the free services but also opt in for the private PHC services due to the poor quality of services in the public sector, e.g., PHC assessment identified that antenatal care services are mostly sought in the private health facilities with reasons being longer consultation time, higher quality of services, better interpersonal and communication skills of healthcare providers, better treatment, more advanced equipment, and devices, availability of female obstetricians, and more flexible appointment times. The sustained response to the health needs of refugees is critical to ensure that such needs are met by maintaining long-term affordable access to comprehensive essential health services.

3. DESCRIPTION OF THE ACTION

3.1. Objectives and Expected Outputs

The proposed action will pursue the implementation of PHC-oriented model of care which will be responsive to the post COVID-19 health system needs (system recovery) with an aim of ensuring that all people receive quality care including refugees, in particular Syrian refugees, and the hosting communities. It will adapt a whole-of-government and whole-of-society approach through engagement of all sectors and society groups to health that combines: multi-sectoral policy and action; empowered people and communities; and primary care and essential public health functions.

The Overall Objective (Impact) of this action is **to contribute to improving efficiency, equity, and responsiveness of the PHC system to address the needs of refugees, in particular Syrian refugees (with due attention paid to a one refugee approach), and their host communities in Jordan.**

The Specific(s) Objective(s) (Outcomes) of this action are:

1. To support the MoH in developing PHC-oriented policy frameworks benefitting refugees, in particular Syrian refugees, and their host communities.
2. To pilot and evaluate a PHC-oriented comprehensive model of care at governorate level to increase the access to primary healthcare for refugees, in particular Syrian refugees, and their host communities.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives (Outcomes) are:

1.1 PHC-centred policies developed at national level to increase the access to primary healthcare for refugees, in particular Syrian refugees, and their host communities.

- 2.1 Infrastructures, essential equipment and supplies upgraded at primary care facilities in the targeted governorates.
- 2.2 Digital approaches to improve patient interactions, flow of patients, referrals and data availability in targeted PHC facilities introduced.
- 2.3 Health workforce capacities strengthened at primary care facilities in the targeted governorates.
- 2.4 Community engagement mechanisms to improve health seeking behaviour of refugees, in particular Syrians, and host communities adopted at primary care facilities in the targeted governorates.
- 2.5 The MoH is better equipped to provide effective and efficient emergency health care services to refugees, in particular Syrians, and host communities requiring emergency treatment and referral services in the targeted governorates within PHC facilities.

3.2. Indicative Activities

Activities related to Output 1.1:

- Review and update the evidence-based national policies and standards for PHC facilities (infrastructure, staffing, equipment and supplies, IT).
- Develop a National Healthcare Quality and Patient Safety policy, through participatory approaches.
- Strengthen institutional capacities of the MoH on PHC multisector actions.

Activities related to Output 2.1:

- Conduct needs assessment at the PHC facilities on the availability of the appropriate infrastructure, equipment, and essential health services.
- Improve infrastructure and availability of the equipment, communication means at the selected PHC facilities, based on the outcome of needs assessment.

Activities related to Output 2.2:

- Assess the flow of patients, referral system and data availability and expand the electronic system in targeted governorates.
- Use of mobile-health to empower health workers and communities on innovative and interactive mobile platform.

Activities related to Output 2.3:

- Expand enrolment of general physicians (GPs) into family doctors (FDs) training programmes.
- Improve human resource management fostering task-shifting and skill mixing.
- Build capacities on Infection, Prevention, and Control (IPC) practices at primary care level.
- Support the implementation of the updated national management protocol and guidelines at PHC level.
- Activate/develop quality assurance teams to ensure monitoring a pre-defined set of quality indicators at the health facility level.
- Building capacities to strengthen facility management capability and leadership and supportive supervision.

Activities related to Output 2.4:

- Establish/activate Community Health Committees to foster community engagement with a focus on health literacy for the most vulnerable and underserved population.
- Introduce integrated outreach activities targeting village health facilities, hard to reach population, and people with disabilities.

Activities related to Output 2.5:

- Provide and/or improve infrastructure and equipment in emergency rooms opened in the PHCs and increase referral services in the targeted governorates based on the outcomes of needs assessment.

3.3. Mainstreaming

Environmental Protection, Climate Change and Biodiversity

Outcomes of the Strategic Environmental Assessment (SEA) screening (relevant for budget support and strategic-level interventions): The SEA screening concluded that no further action was required.

Outcomes of the Environmental Impact Assessment (EIA) screening (relevant for projects and/or specific interventions within a project).

The EIA screening classified the action as Category C (no need for further assessment).

Outcome of the Climate Risk Assessment (CRA) screening (relevant for projects and/or specific interventions within a project).

The CRA screening concluded that this action is no or low risk (no need for further assessment).

Gender equality and empowerment of women and girls

As per OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. This implies that gender equality and women's and girl's empowerment is a significant objective of the action. Increasing women's empowerment is foreseen in different components of the action, including policy development, strategies and action plans, human resources development and women leadership, as well as in foreseeing equal and fair access to service delivery. A focus on gender equality examines how differences in power relations result in differential risks, exposures, vulnerabilities, and outcomes in health for men and women. Gender integrated approaches treat women and men's relative social, political, economic, educational, and health status as interrelated, intersectional, and inter-dependent but also changeable. Consequently, to be successful, gender-focused health programmes often have to be multi-sectoral and engage a wide variety of female and male stakeholders, regardless of whether the focus of the programme is on women's, children's, or men's health²².

Gender equality and intersectionality will be addressed throughout the project phases planning, implementation and impact:

- Empower marginalised voices, including women and youth, by giving them a meaningful place and a meaningful role in participatory activities.
- Ensure the enrolment of women in training programmes.
- Improve appropriate participation of women in decision-making of their health care seeking behaviour through community engagement.
- Promote female enrolment as health and community workers.
- Ensure gender equitable service provision at PHCs.
- Increased equal capacities for women at service provision- health centres.

²² Gender analysis tool kits for health systems. Maternal and child health survival programme, USAID and John Hopkins University,

- Empower women and girls to engage in gate keeping functions between PHCs and their community.
- Ensure to develop equitable policies, standards and intervention to reduce discrimination and expand opportunities for women, men, girls, and boys.
- Ensure to design, implementation, monitoring, and evaluation of programmes, to address gender and intersectionality, including to examine how power relations facilitate or restrict opportunities for women and men.

Human Rights

The protection of human rights is a cross-cutting theme embedded in all of the action’s activities. This action will adhere to the EU’s core principle and ensure the respect of human rights also in the field of health, addressing core components such as i) availability - ensuring that a sufficient quantity of functioning health care facilities is available with improved services; ii) Accessibility - ensuring that services at targeted facilities in this action are accessible for vulnerable population in terms of physical, economical and informational; iii) Quality - ensuring to improve the quality of care which is the key component of UHC for all underserved target population.

Disability

As per OECD Disability DAC codes identified in section 1.1, this action is labelled as D1. This implies that the inclusion of persons with Disabilities is a significant objective of the action. The action ensures all rights of vulnerable groups and safeguards their inclusive access to its benefits.

The 2030 SDG agenda emphasises that Universal Health Coverage (UHC) is the core driver of the SDG-3. The current action will be planned to increase the UHC coverage of Jordan through addressing the specific needs of refugees, in particular Syrian refugees, and vulnerable population in hosting communities with respect to their access to essential health services at PHC level. Human rights will be achieved through ensuring a safe, effective, people-centred, timely, equitable, integrated, efficient health care for targeted population. This action shall aim for the improvement of services for vulnerable populations, specifically youth with developmental disorders and intellectual disabilities. Thus, the inclusion of beneficiaries of vulnerabilities is of central priority in the implementation of all activities. Disability will be inclusive in all the stages of projects.

Conflict sensitivity, peace and resilience

The action will strengthen the capacity of the MoH institutions and facilities to be more resilient, to assist them in improving efficiency, equity, and responsiveness of the PHC system to address the needs of refugees, in particular Syrian refugees and their host communities.

3.4. Risks and Assumptions

Category	Risks	Likelihood (High/Medium/Low)	Impact (High/Medium/Low)	Mitigating measures
Planning, processes and systems	Accessibility : Given the need for the partner to access public	Medium	High	- Decentralised approach depends on locality based PHCs, local communities. - Involve government counterpart at every stage of project planning.

	primary health level facilities, any change in the provision of access due to MoH change of policy or security measure could hinder the implementation of the project.			
People and the organisation	Culture and tradition, and language : Cultural sensitivity and use of terminologies in documents/community awareness materials might risk to access the target population	Medium	Medium	<ul style="list-style-type: none"> - Socio-cultural factors – Knowledge, Attitudes and Practices (KAP) studies. - Terminology sensitivity in all documents, capacity building materials will be addressed through local community advisors/experts.
Communication and information	Infrastructure-communication, transportation and mobile network, IT: Risk of delay in programme implementation in targeted governorate due to lack of digitalization at PHCs.	High	High	<ul style="list-style-type: none"> - Field visits to PHCs in targeted venues selected for project implementation. - Focus on low- hanging fruits such as supporting procurement of IT equipment and infrastructure. - Local transportation and IT support for logistics.
People and the organisation	Lack or poor coordination between national and governorate stakeholders, including development partners and the community may delay the project activities.	Low	Medium	<ul style="list-style-type: none"> - Coordination with local and international partners, including development partners, different government sectors. - Establish project steering committee for better coordination. - Regular updating meetings with MoH and community focal points. - Make use of the Risk Communication and Community Engagement (RCCE) strategy developed from previous EUTF project for community engagements. - Community Health Committees for the targeted governorate and as gatekeeper between governorate and national level.
Planning, processes and systems	Availability of staff: Shortage of health public personnel.	High	High	<ul style="list-style-type: none"> - Enrollment of general physicians to family doctors training programmes will increase the availability of capacities and enhance the

				performance of the family practice teams.
Planning, processes and systems	Approvals/registrations: Substantial delays in the registration of the programme in Joriss.	Low	Medium	- Close coordination and involvement of MoH and MOPIC.
External environment	Impact of COVID-19 : - Shortage of staff - Capacity building and other participatory events duration and venue	Medium	Medium	- Outcome of PHC assessment concluded will be adapted to identify workforce capacities at governorate level and local level. - Engage community health workers for community outreach and monitoring - Use digital platforms for online training. - Integrate community engagement in COVID-19 response activities.
Planning, processes and systems	Sustainability of the action: Lack of ownership by MoH and limited absorption capacity, reduces the effectiveness of the action.	Medium	High	Action is designed in a demand driven basis.
Choice of the implementing partner	The implementer does not have the sufficient capacity to implement the programme.	Low	High	The selection of the implementer will ensure that the implementer has sufficient capacities and experience to implement the action.

External Assumptions

- Security situation does not deteriorate.
- King Abdullah II and his Government continue to push for health reform.

3.5. Intervention Logic

Health challenges are multifaceted, interconnected, and enormously complex, and the need for more sustainable projects in the health sector has never been greater. The underlying intervention logic for this action is that the Ministry of Health (MoH) has satisfactory capacities at institutional and individual levels to ensure the sustainability of the essential benefits gained through EU supported projects. Such capacities still need to be strengthened and upgraded regularly to improve the quality of health services that are provided by MoH facilities. The EUTF projects in Jordan have been designed with a focus of being effectively embedded in local structures. The commitment and ownership of the MoH makes it reasonable to assume that whatever elements are under their effective control will be maintained. Sustainability can be achieved through continued commitment of MoH to the programme's goals and mission, increasing capacity in local systems, changing knowledge and attitudes, ongoing collaboration, improving services

models, and implementing new policies that support programme impact. These will help the MoH to save resources and become more efficient to make progress in the areas of sustainability and resilience.

Based on proportionality, this action will focus on the Irbid governorate which hosts one of the highest density of Syrian refugees in Jordan. It will also focus on selective health facilities in South East Amman and Zarqa, based on well-assessed priorities and needs of refugees, in particular Syrian refugees, and their host communities. Finally, this action will also consider selective health facilities in the Karak governorate where UNHCR has recently stopped delivering health services, due to budgetary cuts (e.g. mobile clinics run by Caritas on behalf of UNHCR had to stop and refugees' vulnerability in this Governorate has increased). The selection of the primary health care facilities in the various locations addressed will be proportional to the number of refugees, in particular Syrian refugees and host communities. The criteria to be used for the selection of facilities to be targeted by the intervention include: local epidemiologic and demographic data (to be cross-checked with UNHCR data), vulnerability assessments, the catchment area of these PHC facilities, whether they are owned or rented, and the quality of primary health care services. This list is not exhaustive and will be progressively fine-tuned.

In short, the EU health strategy revolves around optimal access of refugees, in particular Syrian refugees, and their host communities to primary health services and prevention of critical gaps in the delivery of these services. As such, this project model will continue to ensure sustainable access of the most vulnerable refugees to essential services who are excluded from support from the public health system or any alternative sources of access. This model will support the public health system to be strengthened to the desired level to absorb all the case load from Syrian refugee population in need of essential services. A solid capacity strengthening element is included in the project strategy in order to continue to invest in country capacity which will support the exit strategy after the course of over ten years of response to the Syria crisis in Jordan.

If the Ministry of Health (MoH) is supported to strengthen its capacities to lead and steer the public health system at PHC level through the revision and updating of the existing policies setting PHC standards, whilst adopting initiatives to improve healthcare quality and patient safety, then the National capacities to govern the health system at PHC level will be improved with beneficial effects on the health service delivery, health workforce, and health information system functions.

Also:

If a PHC-oriented comprehensive model of care is successfully piloted in the targeted governorates to the benefit of both the health services users and providers;

AND

If the National capacities to govern the health system at PHC level are improved with beneficial effects on the health service delivery, health workforce, and health information system functions;

Then:

The Action will contribute to improving the equity, responsiveness, and efficiency of PHC system at the targeted governorates, whilst creating an enabling environment for enhanced governance at National level.

If the primary care facilities in the targeted governorates are supported to:

- Addressing the shortage of family doctors by enrolling more general practitioners in the family medicine diploma to enrich the family practice teams;
- Improve their capacities to engage communities in taking parts to decisions related to their own health, whilst supporting the capacities of the primary care facilities to bring the services closer to the communities;
- Adopt digital approaches to improve patient flows at primary care facilities to the benefit of both health service users and providers, whilst enhancing the existing referral system;

- Improve the existing infrastructure and expand the availability of essential equipment and supplies in primary care facilities, whilst standardising the delivery of essential health services across the piloted centres;
Then:
- A PHC-oriented comprehensive model of care will be successfully piloted in the targeted governorates to meet the needs of the health services users regardless of their nationality.

Assumptions

1. The Ministry of Health is committed to pilot a PHC-oriented model of care in the targeted governorates.
2. The Ministry of Health is committed to adopt policies and strategies to create an enabling and conducive environment for a PHC-driven health system reform.
3. The Health Directorates in the targeted governorates are engaged and involved in the piloting of the PHC-oriented model of care.
4. The epidemiological situation related to the COVID-19 pandemic does not deteriorate leading to the adoption of fresh restrictions and to a shifting of national priorities.
5. Health partners with whom the EU engages remain committed to creating synergies across different programmes and avoid duplications.

3.6. Indicative Logical Framework Matrix

Results	Results chain: Main expected results [maximum 10]	Indicators [it least one indicator per expected result]	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To contribute to the efficiency, equity, and responsiveness of the Primary Health Care system regarding the needs of refugees, in particular Syrian refugees, and their host communities.	1. UHC service index 2. Immunization coverage 3. Out of Pocket expenditure	1.59.5% 2. <80% at subnational level 3. 30.3%	1. 70% 2. >80% 3. <20%	1 WHO UHC index 2019 2 MoH Annual report/Immunization coverage reports 3.DOS	<i>Not applicable</i>
Outcome 1	PHC-oriented policy framework by MoH is adopted	1.1 Number of PHCs accredited for improved quality of care. 1.2 Access to health care by Syrian refugees and their host communities (disaggregated by age, sex and community of origin)	1.1 10% (11/110) 1.2 (to be defined during baseline assessment)	1.1 50% 1.2 30% more of Syrian refugees and their host communities	MoH reports, statistical reports, HCAC	Increased commitment of MoH capacities at towards PHC accreditation. Improved leadership of MoH at governorate level health. Increased number of referrals from PHC to secondary care. Improved quality of service provision at PHCs

Outcome 2	PHC-oriented comprehensive model of care at governorate level piloted and outcome evaluated	<p>2.1 Percentage of PHCs that has adapted model of care</p> <p>2.2 Number of PHC consultations for Syrian refugees</p>	<p>2.1 0</p> <p>2.2 (to be defined during baseline assessment)</p>	<p>2.1 100%</p> <p>2.2 increase by 50% from the baseline</p>	<p>2.1 implementation reports, field monitoring records</p> <p>2.2 patient referral sheets</p>	<p>Quality of PHC increased with increased number of referrals and reduced number of visits to hospitals for primary care.</p>
Output 1 related Outcome 1	<p>to</p> <p>1.1 Governance of primary care strengthened at national level</p>	<p>1.1.1 status of the National Policy on Primary Health care</p> <p>1.1.2 status of the National quality and patients' safety health care policy</p> <p>1.1.3. Number of MoH staff trained on primary care governance, disaggregated by sex and community of origin (Through EU)</p> <p>1.1.4. Percentage of PHCs with improved infrastructure (supported by EU)</p>	<p>1.1.1 not available</p> <p>1.1.2 not available</p> <p>1.1.3. 0</p> <p>1.1.4. 0</p>	<p>1.1.1 available</p> <p>1.1.2 available</p> <p>1.1.3. 200</p> <p>1.1.4. 100%</p>	<p>1.1.1 National documents, inception reports</p> <p>1.1.2. National documents and inception reports</p> <p>1.1.3. Training report, participants registration list</p>	<p>Existing criteria to establish PHCs updated. PHCs were made more comprehensive and responsive to the needs of the targeted population</p>
Output 1 related Outcome 2	<p>to</p> <p>2.1 Infrastructure, essential equipment and supplies, access to persons living with disabilities upgraded at primary care facilities in targeted governorates.</p>	<p>2.1.1 Essential list of equipment developed</p> <p>2.1.2 Number of PHCs upgraded in standards or equipped</p>	<p>2.1.1 no</p> <p>2.1.2 0</p>	<p>2.1.1 yes</p> <p>2.1.2.55 (50%)</p>	<p>2.1.1 Assessment reports,</p> <p>2.1.2 Procurement logs, quarterly reports</p>	<p>Quality of care improved at PHCs supported with essential equipment. Number of visits to PHCs increased with an increase in referrals. Delivery of essential</p>

						health services across the different primary care facilities standardised
Output 2 related to Outcome 2	2.2 Patient flow and referral system improved and electronic system expanded in the targeted governorates	2.2.1 Number of PHCs with functional digital appointment/referral system (EU supported) 2.2.2 Number of registrations in mobile application (disaggregated by geographical location and sex)	2.2.1 0 2.2.2 0	2.2.1 70 2.2.2 779,839	2.2.1. Project reports, field monitoring reports, mobile application data	Proportion of health care providers vs patients improved. Number of visits to PHC and referrals increased with decreased number of hospital visits for primary care
Output 3 related to Outcome 2	Family practice approach enhanced at primary care facilities in the targeted governorates	2.3.1. Number of general physicians trained (disaggregated by sex, age and community of origin and subject of training) 2.3.2. Number of General Physicians at PHCs benefitting from Family Medicine Diploma (disaggregated by geographical location, community of origin and sex) 2.3.3. Number of PHC health care providers trained on IPC measures (disaggregated by sex, age and community of origin) 2.3.4. Number of staff at PHCs trained on WHO technical	2.3.1. 0	2.3.1 900	2.3.1. Enrolment logs , training reports	Quality of care at PHCs improved with patients centred approach. Facility management improved with improved supportive supervision. Service provision at PHC for NCDs, Mental

		<p>packages (disaggregated by types of packages- NCDs, MH)</p> <p>2.3.5. Number of national (MoH) health staff trained on the monitoring of quality of PHC using defined indicators (disaggregated by sex, age, community of origin)</p> <p>2.3.6. Number of national health staff trained on facility management and supportive supervision (disaggregated by sex, age, community of origin)</p> <p>2.3.7 Number of trainers trained in PHC measures.</p>				Health improved.
Output 4 related to Outcome 2	Community health seeking behaviour at primary care facilities in the targeted governorates improved	<p>2.4.1. Number of community health committees activated to foster community engagement mechanisms (disaggregated by type of community and geographical area covered)</p> <p>2.4.2. Number of refugees, in particular Syrian refugees and their host communities benefitted through outreach activities (disaggregated by locality/community of origin)</p>	<p>2.4.1.0</p> <p>2.4.2. 0</p>	<p>2.4.1.</p> <p>2.4.2. 240,456</p>	<p>2.4.2. Progress monitoring report, Government records</p> <p>2.4.2. Activity log, progress reports.</p>	Knowledge and practice on health care among the vulnerable population increased with an increase on the health accessibility and family care.
Output 5 related to Outcome 2	Availability and access to the emergency health services at the PHC level is improved.	2.5.1 Number of emergency rooms opened in the PHCs in the targeted governorates	2.5.1 0	2.5.1 11 (5 in Irbid and 2 each in Karak, Zarqa and East Amman)	2.5.1. Progress monitoring report, Government records	Access to and availability of the emergency services is limited in the

					2.5.1. Activity log, progress reports	targeted governorates
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4. IMPLEMENTATION ARRANGEMENTS

4.1. Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with the Hashemite Kingdom of Jordan.

4.2. Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 48 months from the date of adoption by the Commission of this financing Decision.

Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this financing Decision and the relevant contracts and agreements

4.3. Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures²³.

4.3.1. Indirect Management with a pillar-assessed entity

This action may be implemented in indirect management with the World Health Organisation (WHO). This implementation entails supporting MoH in the development of the Primary Health Care-oriented policy frameworks (specific objective 1) and to pilot and evaluate PHC-oriented comprehensive model of care at governorate level (specific objective 2).

The envisaged entity has been selected using the following criteria:

- Strong and longstanding partnership of trust and mutual accountability with the Government of Jordan and national stakeholders can be considered as an added value to facilitate the effective management and implementation of the project.
- leadership in supporting Jordan in the normative adoption of international health standards, legal frameworks, and policies related to health;
- Reliable resource mobilisation capacity, both for the national development priorities of the Government and in the context of humanitarian response to the Syrian refugee crisis.
- Strong technical assistance and experience in capacity development, as well as strategic coordination at different levels of the implementation process, based on the different expertise within the WHO systems.
- Central role in health sector coordination and the facilitation of sector dialogue between Government and its partners, across humanitarian assistance and health development.
- WHO has appropriate monitoring and reporting mechanisms to assess implementation progress. WHO has the capacity in terms of human resources and organisational set-up to collect data, analyse it and report on results.

The WHO is responsible for the design, programmatic management, effective implementation, monitoring and reporting of the project, in cooperation with the Ministry of Health (MoH).

²³ www.sanctionsmap.eu Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

4.3.2. Changes from indirect to direct management (and vice versa) mode due to exceptional circumstances

If negotiations with the entrusted entities identified are unsuccessful in section 4.3.1 due to circumstances outside of the Commission's control, the action may be implemented in direct management through procurement.

4.4. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.5. Indicative Budget

Indicative Budget components	EU contribution (amount in EUR)	Third-party contribution, in currency identified
Implementation modalities – cf. section 4.4		
SO1 Composed of Indirect management with a pillar-assessed entity	450 000	300 000
SO2 Composed of Indirect management with a pillar-assessed entity	14 380 000	
Evaluation – cf. section 5.2 Audit – cf. section 5.3	170 000	N/A
Communication and visibility – cf. section 6	N/A	N/A
Contingencies	N/A	N/A
Totals	15 000 000	300 000

4.6. Organisational Set-up and Responsibilities

A Steering Committee (SC) will be formed for the action and will meet at least two times a year to endorse strategic orientations, oversee the action's execution and facilitate implementation of the activities. The SC will be chaired by the Ministry of Health and it will be composed of the Ministry of Planning and International Cooperation, the EU, the implementing partner and other relevant stakeholders that support provision of quality primary health care system in Jordan. The SC will monitor the overall implementation of the action, review progress, coordinate the different results areas and guide the activities to the successful achievement of the action's objectives. It will approve the reports and work plans. In the case of indirect management with entrusted entity, the contracting authority will be the entrusted entity.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action.

5. PERFORMANCE MEASUREMENT

5.1. Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the log frame matrix (for project modality) and the partner's strategy and policy.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

Roles and responsibilities for data collection, analysis and monitoring. The monitoring of project activities and results will be undertaken regularly, in line with the EU Monitoring Framework, tools and reporting formats, to ensure all that targets are met and that lessons learned can be incorporated into other EU-funded actions. National reporting mechanisms and national data and statistics, as well as data from project implementing partners, will be a regular source of data. Monitoring and reporting will be carried out by the Monitoring and Evaluation Officer in coordination with project team. The Quarterly Information Notes (QINs) using the standardised associated tools will be used for regular reporting. The information provided in the QINs will be used to feed the results-based database to develop the annual EU Results Report, which includes records and statistics.

5.2. Evaluation

Having regard to the nature of the action, a mid-term and a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission.

The mid-term evaluation will be carried out for problem solving and learning purposes. The final evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision).

The evaluation of this action may be performed individually or through a joint strategic evaluation of budget support operations carried out with the partner country, other budget support providers and relevant stakeholders.

The Commission shall form a Reference Group (RG) composed by representatives from the main stakeholders at both EU and national (representatives from the government, from civil society organisations (private sector, NGOs, etc.), etc.) levels. If deemed necessary, other donors will be invited to join. The Commission shall inform the implementing partner at least one month in advance of the dates envisaged for the evaluation exercise and missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Evaluation services may be contracted under a framework contract.

5.3. Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements.

6. STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

All entities implementing EU-funded external actions have the contractual obligation to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. To that end they must comply with the instructions given in the [Communication and Visibility Requirements of 2018](#) (or any successor document).

This obligation will apply equally, regardless of whether the actions concerned are implemented by the Commission, the partner country, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU Member States. In each case, a reference to the relevant contractual obligations must be included in the respective financing agreement, procurement and grant contracts, and delegation agreements.

For the purpose of enhancing the visibility of the EU and its contribution to this action, the Commission may sign or enter into joint declarations or statements, as part of its prerogative of budget implementation and to safeguard the financial interests of the Union. Visibility and communication measures should also promote transparency and accountability on the use of funds. Effectiveness of communication activities on awareness about the action and its objectives as well as on EU funding of the action should be measured. Implementing partners shall keep the Commission and concerned EU Delegation/Office fully informed of the planning and implementation of specific visibility and communication activities before work starts. Implementing partners will ensure adequate visibility of EU financing and will report on visibility and communication actions as well as the results of the overall action to the relevant monitoring committees. It is envisaged to pool the funds earmarked for communication and visibility of this specific action with funds dedicated to the same purpose

under other actions in view of maximising the impact of the communication. It is envisaged that a contract for communication and visibility may be contracted under a framework contract.