

UNRWA JORDAN: *Delivery of Health Care in the Context of Displacement of Palestine Refugees Registered in Syria (PRS)*

RESEARCH METHODS AND INPUT

The preliminary findings presented in this brief are based on the outcomes of 32 stakeholder interviews at Jordan Field Office conducted between January 15th-24th, 2017. The stakeholders were from three UNRWA primary health care facilities and country level office. The findings are also based on a group model building session with key UNRWA staff members in Jordan field in May 2017. To protect participant confidentiality and anonymity, as well as stimulate constructive discussion and engagement with research findings, generic summary messages are presented here. More detailed analysis linked to outputs from the group model building session will follow in due course.

BACKGROUND

The ongoing Syria conflict has forced significant displacement of Palestine refugees from Syria (PRS). As of December 2016, a total of 16,852 PRS were registered in Jordan significantly lower than the 32,042 PRS estimated to reside in Lebanon (UNRWA, 2017a) mainly due to the Jordanian government officially halting migration early on in January 2013 (Amnesty International, 2013). Although the number of PRS contributes to a small proportion of the overall population of Palestinian Refugees in Jordan, concentrations in some areas – e.g. Irbid and Zarqa - have created some pressures on service delivery (UNRWA, 2016, unpublished data).

Jordan hosts the highest number of Palestinian refugees in the Middle East: 2,286,643 PRJ (with a dependency ratio of 50.3¹⁻² reported in 2016) already resided in the country prior to the escalation of the Syria conflict (UNRWA, 2017b).

Because most PRJ are fully-fledged citizens, 96% and 85% of those living inside and outside camps respectively hold a Jordanian National ID number, and most of them enjoy the same political and civil rights as non-refugee Jordanians (Tiltnes A. & Zhang H., 2013).

Given PRS represent only a minor proportion of PR in Jordan, the UNRWA health system ‘absorbed’ the additional patient and care burden, making only minor adjustments when challenges to health care provision arose. Two issues were notable in this regard: difficulties in registering newly arrived PRS (specifically politically, socially and economically vulnerable populations) and limited capacity and resources to provide needed mental health and psychosocial support. While responding to these unanticipated issues, the UNRWA health care system also provided routine services for the PRJ population and embarked on a series of health care reforms aiming at managing the increasing burden of non-communicable diseases. Several reforms were implemented, most notably a

reconfiguration of primary care provision towards a ‘family health team’ model and the introduction of a computerized health management and record system.

WHAT HAS BEEN DONE TO ADDRESS THE PROBLEM?

The demands of the displaced PRS could be met and contained within the available health care system with support and coordination from other agencies, including NGOs and governmental health care providers. UNRWA staff also noted that the introduced health care reforms, particularly the electronic record and appointment system, proved useful in managing the additional patient load during peak PRS displacement.

To facilitate service provision for refugees without registration cards, the Health and Relief and Social Services departments joined efforts to issue service cards. Social workers were tasked with canvassing communities, assessing people’s needs and then signposting persons to relevant registration and health care services. In the case of patients who are vulnerable and at risk of deportation³, the Protection Division within UNRWA, formally established in 2016, was also tasked with facilitating patient access to secondary and tertiary care facilities. To meet the needs of PRS populations, specifically those most exposed to trauma and living in vulnerable conditions, mental health services were gradually introduced with the help of humanitarian agencies. In 2015, GIZ trained 25 focal points in the provision of psychosocial support services.

¹ A high population dependency ratio indicates a high economic burden of the economically unproductive children and old people on the households. The dependency ratio is calculated by dividing the total number of children below the age of 15 and the elderly above the age of 65 by the number of adults aged 15 to 64.

² In 2015, Jordan total Dependency ratio was at level of 64.78 per 100 population 15-64 (KNOEMA, 2017)

³ By the end of 2016, 87% of PRS were categorized as vulnerable or extremely vulnerable (UNRWA, 2017a). Vulnerable people are at-risk groups facing one or more of the following difficulties: having legal documentation issues, living below poverty line, being a woman or a child victimized by violence and/or abuse including GBV or facing social exclusion due to disability.

PRS displacement into Jordan tested the preparedness of the UNRWA health system

ONGOING CHALLENGES

The above changes to registration processes and health service delivery supported the continuity of health provision to those for whom UNRWA is responsible. During interviews and a group model building session with staff at all health system

levels in Jordan, UNRWA staff articulated the following challenges still to be addressed:

RECOMMENDATIONS

1- An audit of current pharmaceutical procurement to identify points of delay – including potential quality assurance measures of medicines and communication of results with health care professionals.

2- Given current issues in hiring, a review of human resource policies with careful consideration of alternative means of hiring, including contractual agreements with staff.

3- Clarification is needed on decentralization of decision-making and how this translates to devolution of budgets to local levels (also how/when approvals from the Field Office are really needed); this may lead to improved operational efficiency.

4- Revision of hospitalization policy to be further pursued.

5- Audit and development of UNRWA's coordination mechanisms and capacity – including consultation and meaningful engagement of community actors – to identify and tackle pressing socio-economic and political difficulties.

1. **Delays in medication supply:** participants noted delays in the supply of medicines to health facilities. Available stocks are depleted more rapidly as more PRS patients present at clinics, leading to stockouts. When medicines are unavailable, patients are asked to return to the facility on later dates, and some may experience an interruption in treatment. Health care professionals additionally noted that there is a perception of lower quality of medicines amongst staff due to the change in pharmaceutical suppliers.

2. **Limited human resource capacity:** Facility and area managers noted that hiring new staff was currently not possible. With pressures leading to several staff members taking extended leave, this was placing additional pressure on remaining staff and eroded motivation.

3. **Limited devolution of decision-making powers:** Facility and area managers noted they had limited powers to either hire additional staff or redistribute staff to other clinics. Direction on these issues is rather provided at field office level. There is limited budget devolution to area and facility levels, thus managers are not able to solve local level issues immediately.

4. **PRS-PRJ differences in hospitalization reimbursement policy :** Reimbursement of tertiary and secondary care presents challenges for PRS due to the current UNRWA reimbursement policy. PRS patients are expected to make initial payments or co-payments; however, in the absence of income, patients either delay admission to hospital or forego it completely potentially complicating their medical conditions. The PRS reimbursement policy contrasts with that for PRJ, the latter do not have to pay up front for services if the cost is within the coverage limit. This issue has recently been discussed and a policy change has been implemented via coordination with RSS allowing UNRWA to directly pay hospitals upon patient admission.

5. **Socio-economic and political difficulties:** Coordination between UNRWA and other agencies proved promising, however, it needs to be fostered and targeted towards addressing endemic issues. Health care staff and community members noted that UNRWA is the principal agency providing health and social services; nevertheless, current efforts are aimed at solving symptoms of wider

social problems – e.g. populations living in camps are most vulnerable, with limited opportunities or rights to engage in income generating activities. This is challenging for communities and exacerbated by recent threats of discontinuing UNRWA's educational program.

REFERENCES:

- Amnesty International. (2013). *Growing restrictions, tough conditions: The plight of those fleeing syria to jordan*. Retrieved from United Kingdom: <https://www.amnestyusa.org/wp-content/uploads/2017/04/mde160032013en.pdf>
- KNOEMA. (2017). World Data Atlas. Retrieved from <https://knoema.com/atlas/Jordan/topics/Demographics/Dependency-Ratios/Total-dependency-ratio-0-14and65-per-15-64>
- Tiltnes A. & Zhang H. (2013). *Progress, challenges, diversity: Insights into the socio-economic conditions of Palestinian refugees in Jordan*. Retrieved from Norway: https://www.unrwa.org/sites/default/files/insights_into_the_socio-economic_conditions_of_palestinian_refugees_in_jordan.pdf
- UNRWA. (2017a). *annual operational report 2016 for the reporting period, 1 january - 31 december 2016*. Retrieved from Amman, Jordan: https://www.unrwa.org/sites/default/files/content/resources/2016_annual_operational_report_web.pdf
- UNRWA. (2017b). *Health Department Annual Report 2016*. Retrieved from https://www.unrwa.org/sites/default/files/content/resources/2016_health_department_annual_report.pdf