Jordan: a primary health care case study in the context of the COVID-19 pandemic

Rami Saadeh
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Executive summary

This report examines primary health care (PHC) in Jordan in the context of the COVID-19 pandemic between early 2020 and August 2022. PHC, as outlined in the 1978 Declaration of Alma-Ata and further emphasized in the Astana Declaration in 2018 (1), is a comprehensive approach to health that combines governmental and society efforts to strengthen the health care system. Following the Astana Declaration, Jordan has made progress in increasing the number of PHC centres and in expanding services, in addition to developing integrated policies to provide comprehensive and sustainable health services.

By 1 August 2022 Jordan reported 1.72 million confirmed cases of COVID-19 and 14,083 associated deaths (2). Approximately 17% of the population lost their jobs in 2020, raising the unemployment rate to 26%. At the same time, 51% of businesses and enterprises closed temporarily (3). Social, educational and leisure activities were suspended. All but emergency health services were interrupted and only seven hospitals operated during periods of movement restrictions, thus impacting the health and well-being of the population. Vulnerable and disadvantaged populations and patients with special health needs lacked the care they needed and were at a higher risk of developing serious complications. The discontinuity of services was attributed to multiple issues including limited capacity and gaps in training and networking.

During the pandemic response, the Ministry of Health (MoH) did not adopt a well-defined PHC delivery model to maintain comprehensive and continuous basic care for the community. Although the government developed several public health and emergency strategic plans, challenges were encountered in implementation. The MoH oversaw the provision of basic PHC services but several critical services fell far short, including in mental health and rehabilitation services and in chronic disease management. This contributed to disparities in access to care, with those who could not receive care in public hospitals seeking services from private hospitals and centres. Overall, the focus of the MoH on COVID-19 testing, referral and the management of COVID-19 patients detracted from efforts to assess the provision and flow of other services.

The MoH partnered with global organizations to manage the pandemic through the training of health workers on infection control and the management of COVID-19 patients; however, there was a shortage in human resources and a lack of centralized operations networks to monitor the treatment and referral of patients. Although community members, leaders and organizations were partially mobilized, an opportunity exists to systematize the inclusion of these stakeholders to enhance their participation and ensure sustainability.

To improve PHC during future pandemics, there is a need for stronger policy leadership, systems to support the delegation of tasks, and strategic partnerships with global, regional and local stakeholders (4). The MoH is well positioned to lead national partnerships and delegate health care delivery and management of services in collaboration with community members.
Introduction and national context

The aim of the Astana Declaration is to achieve sustainable PHC built on integrated, people-centred health systems that empower individuals and communities and that align stakeholder support with national policies, strategies and plans (1). One of the first countries to adopt the recommendations of the Alma-Ata Conference in 1978 was Jordan, which established PHC as the key to achieving health for all, with health centres as the main building block of the health system (1). This commitment has been important in strengthening the health system to respond to major events. For example, the large influx of refugees, estimated to be over 1.3 million people since 2011, has caused demographic, social and economic changes and impacted the health care system, requiring regular changes and development (5). Reforms have included the development of national humanitarian policies to organize the social and medical services provided to refugees, while maintaining the quality of services.

The emphasis in the Astana Declaration on consolidating the role of PHC in reducing inequalities and improving health equity helped to focus efforts in the COVID-19 pandemic response. By 1 August 2022, the pandemic had resulted in 1.72 million infections and 14 083 COVID-19-related deaths (2). Up to this date, Jordan recorded four major peaks of the virus in November 2020, March 2021, December 2021 and February 2022 (2).

Prior to the pandemic, a total of 677 health centres were distributed to expand health services and reduce inequalities. They included 117 comprehensive centres, 372 primary centres and 188 secondary centres, which together reached every village, town, camp and rural area (6). The services delivered via these facilities improved health care access and contributed to vaccination coverage of 99% of the target population and reduced maternal and child deaths. However, during the COVID-19 pandemic, immunization rates for other diseases (e.g., measles) decreased (7).

The MoH is the major provider for PHC services along with other international organizations. This includes the United Nations Relief and Works Agency (UNRWA), which provides services to over 2 million Palestinian refugees through 24 medical clinics (8, 9). The aims of the National Strategy for the Health Sector (2016–2020) and the Primary Health Care Strategic Plan (2018–2022) have been to develop integrated policies that involve the participation of all health sectors nationwide to provide comprehensive, sustainable and high-quality health services (8, 10). Improvements against indicators in the Global Health Security Index have been reported (11).

Jordan provides national health care coverage across multiple services in public hospitals and health centres. The insurance provided by the MoH covers most medical services, such as PHC, medication, treatment and surgery. In addition, a large proportion of the population is insured through the Royal Medical Services, which participate in providing primary care services through field clinics and
eight comprehensive health care centres (8). The refugee camps are also completely covered and served by nongovernmental organizations (NGOs) and international organizations that provide a variety of PHC services and some advanced health care services, insuring 2.5% of the population. The Health Insurance Fund supports vulnerable groups and those with special medical conditions. Nationwide, however, only 41.7% of citizens are covered by health insurance (8). For insured citizens, the co-payment for services stands at 10% of the health care cost, whereas uninsured citizens pay the full amount for both public and private services (8).

Government financing of health services is mainly from tax revenues, which provides 77.5% of the health care budget through the Ministry of Finance and Planning and the Ministry of Social Development (12). Funding allocations for PHC account for 16% of the health care budget, with larger proportions allocated to secondary and tertiary health services. These levels of the health system also receive a higher percentage of health personnel and fewer health professionals are recruited in PHC positions (8).

There are major discrepancies between different regions for insurance coverage, health service capacity and workforce. For example, rural areas suffer from a lack of specialized services and weak referral mechanisms, with major shortages in specialists and health care providers in remote and disadvantaged regions despite the existence of government incentives. Rehabilitation services, including occupational therapy, speech and language therapy, and counselling and psychosocial support, are particularly limited. The WHO has stressed the importance of including these services in national PHC services and has recommended their inclusion in the National Strategic Plan (NSP) (1).

In the first two years of the COVID-19 pandemic, PHC centres were able to rearrange services and implement infection control measures within a short period of time and resume their services. For instance, after the introduction of movement restrictions across Jordan in March to May 2020, PHC centres were the first health facilities to resume services and basic care, including vaccinations, prenatal care and urgent care. These services were fully restored with the addition of precautions around social distancing and the use of personal protective equipment (PPE).

**Methodology**

**Scope and approach**

This case study was designed to reflect the three critical components of the Astana Declaration: 1) primary care and essential public health functions; 2) multisectoral collaboration and 3) community engagement and their implementation during the COVID-19 pandemic. The research employed quantitative and qualitative methods to document the plans, efforts, achievements and challenges against these three PHC components. A key
focus of the case study is on how PHC was mobilized to manage the effects of
the pandemic on health care services and what is needed to strengthen the
resilience of the system to future emergencies.

Data preparation and analysis

A literature review was conducted involving searches in Google, PubMed and
Medline. Policy documents were also sought via stakeholder recommendations.
Stakeholder consultations with 10 policy-makers, programme managers,
academics and heads of department at the MoH were also conducted. Data
generated from the literature review and the stakeholder consultations were
aggregated and analysed thematically.

How primary care and essential public health
functions are responding to COVID-19

Scaling up and managing critical emergency services

The Jordanian government, with the support of the WHO, directed efforts to
manage the impact of the pandemic on the health care system and maintain
routine services by supporting and enhancing PHC capabilities. The European
Union (EU) granted €43 million to support the efforts of the WHO in strengthening
PHC in Jordan, of which €14 million was assigned to support the national COVID-19
preparedness and response. The implementation of this grant was under the
Jordan Health Programme for Syrian Refugees and Vulnerable Jordanians, and
included provisions for: 1) vaccinations and immunization, surveillance, and
COVID-19 preparedness and response, and 2) the public health system and
sustainable health financing (13, 14). The grant targeted the most vulnerable
populations mainly to provide them with required vaccinations and diagnostic
tests for COVID-19, which were facilitated through the purchase of several fully
equipped vehicles to distribute the vaccines to target groups. At the time of
writing, it was unclear how efforts supported under this initial grant could be
sustained.

At an early stage of the pandemic, the government prepared protocols for the
management of confirmed cases of COVID-19, whether those who were infected
were residents or travellers. Strict rules were applied for the isolation of infected
patients and cadres, in addition to establishing fixed COVID-19 testing stations
in health centres and hospitals affiliated with the MoH (15). Several committees
were established, including the National Epidemic Control Committee (NECC)
that comprised experts from the MoH, academia and the Royal Medical Services
(RMS), and which met periodically to oversee the latest developments in the
pandemic and to provide recommendations to decision-makers preparing the
National COVID-19 Preparedness and Response Plan (16). Their feedback was
helpful in taking decisions related to movement restrictions and the suspension
of public services, border restrictions and other measures to protect the public. The MoH also established a comprehensive online response service, available via the MoH website, which guided Jordanian citizens on basic, urgent and common needs among the population (17).

To support COVID-19 control measures, the MoH increased the capacity of the National Public Health Laboratory (NPHL) for Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) molecular testing, and it opened several laboratories across the country for COVID-19 testing. The number of epidemiological investigation teams reached nearly 400, fixed testing stations in public health centres and hospitals were established, and random checks of citizens was expanded, especially where overcrowding was expected (6). The government planned to sustain and maintain infection control and prevention programmes throughout all health facilities of the MoH. However, challenges were faced in equipping the infrastructure with computer systems and connectivity for crisis management programmes inside and outside the MoH and with the concerned authorities at the national level, which hindered the surveillance of infections. In part this challenge related to low levels of funding and prioritization. An effective and advanced information system is needed to identify, detect and communicate the spread of infections, health demands and service shortages (18), and to avoid incidences like the Salt public hospital catastrophe in 2021 when an oxygen outage led to patient deaths (19). Encouragingly, the MoH developed a Health Information System Strategic Plan (2019–2023) in an effort to harmonize data systems, unify the activities of health care providers and eliminate fragmentation (20). Another advancement for PHC provision has been the preparation of a follow-up and evaluation plan for PHC within the MoH strategy. The aim is to enhance the quality of services provided and to ensure that new initiatives align with the monitoring and evaluation plan for PHC programmes as determined in the Ministry’s strategy of 2023–2027 (10).

PHC was included in emergency response actions through collaborative work between the United States Agency for International Development (USAID) and the MoH. Through this partnership, activities were undertaken to prepare public and private hospitals and private clinics to identify and manage COVID-19 cases, to expand infection prevention and control (IPC) measures, to strengthen testing to control the spread of the virus, and to implement public communication campaigns to promote mask wearing and social distancing (21). This initiative included the training of more than 9000 health care providers from public and private facilities on how to screen, triage and care for COVID-19 cases. Over 1100 health care workers were trained on how to apply appropriate IPC precautions to limit the spread of the virus in their facilities. In addition, an assessment was conducted of 34 public, private and university laboratories that conducted COVID-19 tests to identify logistical and practical needs and to develop action plans for effective testing (21). Another collaborative effort included the development of the national-level COVID-19 Emergency Response Project with the World Bank in April 2020, which used a multiphase programmatic approach for the pandemic preparedness and response effort and received total funding of US$ 20 million. The aim of the project was to strengthen local systems for public health preparedness (5).
Continuing essential services

Efforts were led by the MoH to facilitate the continuity of routine PHC programmes and community health services. IPC/WASH strategies were implemented, together with training on how to manage COVID-19 cases and IPC procedures for health personnel affiliated with the MoH, university and private hospitals, local associations and volunteers (22). Public PHC centres continued to provide essential services of disease surveillance (especially for COVID-19), emergency care and first aid, maternal and child health, mental health, immunization, family planning and the treatment of infections, which helped many community members to receive the care they needed (10). The MoH also adopted a Stakeholder Engagement Plan (SEP), with the intention to acquire consultations, advocacy and the support of PHC stakeholders in addressing the challenges and issues that could emerge during a crisis (23).

Despite these efforts, the continuity of quality health services was disrupted. It was reported that 17% of children under 5 years did not receive their basic vaccinations and 23% did not get access to medical attention for illnesses during the pandemic (3). The interruption of health services restricted access to care for many patients. As such, COVID-19 regulations impacted the health of several high-risk groups, such as elderly patients, and those living with disabilities, suppressed immunity, lung infections and noncommunicable diseases (NCDs) such as diabetes and heart disease. The interruption to regular care and the provision of medication affected the management of chronic conditions, with patients put at a higher risk of serious complications (18). In the long term, these impacts may contribute to a higher disease burden and to reduced performance against universal health coverage (UHC) indices (24).

Further, vulnerable populations, pregnant women and patients with physical and mental illnesses were not only influenced by the reduction of services, but they were also deprived of activities, education and opportunities for learning and empowerment. Most projects concerned with youth, women, the elderly and those with special needs were suspended to limit the spread of COVID-19 among such communities. Moreover, fear among the community of bringing the infection home contributed to higher levels of stress that led to other problems, such as violence, depression and behavioural issues (5, 25). Supportive care for patients with disabilities and chronic diseases was also interrupted at the beginning of the pandemic, when the government was overwhelmed by setting strategies to control the infection and when community organizations were not included in health care provision for their members. Data collected during the crisis show that 88% of individuals with disabilities and 50% of the elderly stopped receiving their regular check-ups and the medical care that they needed (25).

The continuity of services was also impacted by limited capacity of emergency response personnel, as well as issues in the preparation of the necessary MoH emergency centre, in suboperation centres in governorates, and in linking these to the main centre (5). These challenges can be attributed to the lack of previous experience with health emergencies and insufficient emergency training for the health workforce and policy-makers.
The pandemic experience shows that the country needs an integrated and more efficient PHC delivery model that uses the available capacity of the system through coordinated action from a multisectoral team of providers, including the private sector, NGOs and community stakeholders. This will facilitate the provision of comprehensive and continuous basic care to the community that is not interrupted during public emergencies (4, 26). This integration should occur at the organization level through coordinated provider networks overseen by the MoH, which provide health information exchange and other population-related care services. In this way, patient information can be shared efficiently and securely among health care providers. Organizations will be able to grow and build more partnerships, gain patient trust and improve their coordination with the MoH. It is also imperative to allow community-based organizations to care for vulnerable groups in the population and report their activities to the MoH through an appropriate information system.

Managing referral systems to ensure appropriate distribution of service load

During the COVID-19 pandemic, Jordan announced an emergency status that required hospitals and health care centres to shut down during curfew periods and only accept emergency cases (16). All governmental hospitals – except seven that were assigned to receive COVID-19 patients – suspended regular services when the number of confirmed cases rose significantly and only admitted emergencies (23). However, during these periods of service suspension in public hospitals, PHC centres continued to provide regular services, while abiding to government protocols and applying the recommendations of the MoH for infection control and safety (16). The national emergency plan included public health protection strategies to ensure the safe provision of health services through the establishment of specific roles, responsibilities and safety rules for PHC and hospital-based health care workers and other key workers (23).

To support the mission of PHC centres, the MoH established mobile clinics to treat minor illnesses and injuries. However, PHC centres were the only facilities to refer suspected cases of COVID-19 and the only source to dispense medication to chronic disease patients and those on a regular medication regime during peaks of the virus, when hospitals were closed for regular services. PHC centres also offered an online order and home delivery service system for medication (23).

Although the government financed PHC centres and provided them with updated protocols and regulations, there was no assessment mechanism to evaluate the effectiveness of PHC service delivery in meeting the needs of the public and in supporting the health care system to manage the pandemic. The MoH used the media (TV, social media and the MoH website) extensively to update the public about available services (10, 17), yet at times demand surpassed the expected number of patients and resulted in overcrowding in emergency departments, drugs dispensing and laboratory testing.
Service flow was often interrupted due to staffing problems, particularly in 2020, when only 5% of medical and laboratory staff were engaged in the pandemic response to decrease the exposure of health care workers to COVID-19 patients (5). Nonetheless, many medical personnel were infected with the virus and the rapid replacement of staff by the administration was inadequate to fill the human resource gap. Over the course of the two years from the beginning of the pandemic, several PHC centres and hospitals were impacted by absent health care workers, and unfortunately there was no governmental recruitment of new employees due to the emergency which further hindered the flow of care.

Furthermore, there were no care quality teams specialized in monitoring the flow of patients who could report and inform the government about any issues. The private health sector remained open and fully functioning, which helped to reduce the burden on public services. However, many private clinics, hospitals and laboratories became overcrowded during periods of service suspension in public hospitals. The MoH’s PHC Strategic Plan (2018–2022) (10) includes an item to involve the private sector in an integrated reporting system for communicable diseases, especially during emergencies, but this had not yet been implemented at the time of the pandemic. The Plan also includes a programme to train and educate community members on respiratory diseases and mental health, however, which resulted in the successful training in 2021 of 40 community representatives on respiratory diseases and 300 on mental health. This training programme is still ongoing.

**How multisectoral policy and action are responding to COVID-19**

The responsibility of managing health crises and the associated impacts should be shared among a wide group of entities, including academic institutions, health organizations, the medical private sector, and community organizations and their members. An example of this cooperation is the Partnership for Quality Medical Donations, which developed coordinated efforts with the MoH to closely monitor trends in vaccine distribution during the pandemic (3).

The PHC Strategic Plan (2018–2022) (10) highlights the importance of multisectoral partnerships for effective COVID-19 management and the achievement of the Sustainable Development Goals (SDGs). In 2021 the MoH established a department for Follow-up and Evaluation within the Department of PHC that was responsible for evaluating the strategies and plans for PHC and the COVID-19 response. In addition, the Crisis Management Unit of the MoH developed a Strategic Preparedness Plan for Health Disasters that relies on the comprehensive participation of all partners involved in public health and safety. The Crisis Management Unit plans to train employees on disaster management; to prepare executive disaster plans for health directorates, hospitals and comprehensive health centers; and to implement a National Health Emergency Response Plan prepared in coordination with the National Center for Security and Crisis Management (27).
To protect vulnerable populations and support their needs during health emergencies, Jordan has adopted strategies to achieve the SDGs for health and “Health for All” by increasing the efficiency of public health expenditure and by securing extra funding for health. This funding is expected to support many of the health care sectors and services that are currently underserved and need improvement (28). Examples of these services are sexual and reproductive health, mental health, allied health areas like occupational health and physiotherapy, and health care management and treatment services for NCDs (29, 30). In addition, WHO EMRO is addressing the impact of socioeconomic drivers of health through Vision 2023 (31). In this strategy, WHO EMRO indicates that by implementing key strategies around equity in health, setting health priorities, developing multisectoral partnerships and ensuring community engagement, many of the SDGs could be achieved in the region and health care in many of its countries would improve significantly (31).

These key strategies outline mechanisms to promote multisectoral collaboration to incorporate health in all policies, thus achieving health equity with high standards of care that leaves no one behind. Multisectoral collaboration among different sectors is a key factor in delivering national protection and response strategies during crises. However, it is important that such partnerships are supported through pooled budgets across all national sectors and that funded projects work towards shared goals (32). The outcomes from supporting programmes with shared aims have been shown to be more efficient and cost-effective, and they lead to mutually beneficial cross-sectoral investments and optimized public spending (32).

Multisectoral action during the pandemic response involved collaboration across shared services, information, policies and efforts. For example, the Ministry of Social Development worked with the Ministry of Labour to protect workers from infection and at the same time provided financial assistance to meet their basic needs. Moreover, the National Social Protection Strategy 2019–2025, which receives technical and financial support from UNICEF, includes strategies to maximize the social protection of citizens (33). The Ministry of Industry also supported social protection efforts during the pandemic by providing assistance to daily wage workers and the elderly.

To facilitate communication between the government and citizens, and to distribute important messages about the transmission of COVID-19 and prevention measures, the Ministry of Communication worked with many ministries including the MoH and the Ministries of Education, Youth, Social Protection and more using different communication tools. For example, the Ministry of Primary and Higher Education transferred education online to enable students to interact directly with their instructors, while parents were allowed to interact through social media. It is noteworthy to mention that such modifications and collaborative efforts were adopted quickly at the beginning of the pandemic, which helped to reduce the adverse impact of the social and economic restrictions.
How communities are responding to COVID-19

To facilitate the integration and participation of the local community, health committees were formed in community and PHC centres that, along with other partners, were in charge of communicating the messages of the government on COVID-19 precautions and the importance of the vaccine (6, 8). During periods of movement restrictions, the interruptions to public health care services resulted in widespread frustration among many patients and community members, particularly among low-income families who could not afford the cost of private hospitals and among patients with chronic diseases. The movement restriction orders inhibited public participation in activities, especially at the beginning of the outbreak, when most people felt measures were temporary and when trust levels in the government were higher.

At the time of writing, a thorough evaluation of the disruption imposed on health services in 2020–2022 had not yet been delivered. However, a multisectoral rapid needs assessment for COVID-19 was conducted in 2020 through collaboration between UNICEF, the United Nations High Commissioner for Refugees (UNHCR), and the World Food Programme (WFP), involving 1124 households, including Syrian refugees. The findings of the survey show that 14% of respondents did not know where to seek treatment if they showed symptoms of COVID-19, more than half (52%) needed health services (among whom nearly a fifth (19%) faced challenges in accessing health care facilities), and two-thirds (66%) needed medicines (among whom almost a quarter (24%) faced challenges in getting them). These obstacles were mostly encountered by female-headed households, those living in informal tented settlements (ITS) and among non-Jordanians (35). Health care officials in the government and experts consulted for this case study observed weak community participation.

Efforts to respond to community needs included the collection and reporting of patient complaints through a hotline. These were referred to the central MoH and other medical facilities directed by the MoH such as public hospitals, health directorates and health centres, as well as the Family Protection Department (police) and private hospitals. This mechanism enabled the MoH to follow up by updating the individual in question via phone messages (23). Moreover, the MoH formed a permanent committee, composed of the heads of six directorates, that analysed such feedback from the public and considered solutions to reduce recurrent complaints (23).

Recognizing an opportunity for the community to be more involved, the government, in collaboration with international entities, established a national strategy to improve community empowerment. This strategy established, for example, a COVID-19 Youth Volunteers Taskforce, which was a partnership between the Ministry of Interior, the United Nations Development Programme (UNDP) and the Government of Norway. The aim of the initiative was to encourage youth to contribute to COVID-19 response efforts and feel responsible towards their community. Another example is the launch of several small grants by the Ministry of Environment and UNDP to support the local community to cope
How communities are responding to COVID-19

with the pandemic and achieve the SDGs. These grants helped the public to comprehend the effects of the pandemic on the local community and coordinate efforts (36).

The MoH also introduced strategies for community inclusion through the establishment of Community Health Committees, which encourage community members to explore, use and participate in health care services and advocate community needs, especially during emergencies (6, 10). Although national plans included the formation of these committees before the pandemic, their implementation was not obvious during the pandemic, probably because of competing priorities. In addition, the national policy adopted by the Crisis Management Unit of the MoH clearly states that disaster preparedness and management is a national requirement and the responsibility of all members and institutions (27).

Another approach adopted by the MoH to engage communities resulted in the implementation of IPC/WASH programmes in PHC centres and hospitals. These programmes were designed to help communities to understand and comply with safety precaution measures during emergencies. The health workforce also benefited from these measures and were held socially accountable for following them (36). Lack of compliance, especially by health care personnel who were mandated to wear PPE at all times, could result in fines. Accountability was imposed at every level of society, including senior government officials (37).

NGOs and international organizations played a vital role in empowering the community through awareness-raising activities and service provision. UNICEF, for example, continued to provide families with WASH services, school health services, vaccinations, medical and dental examinations, and health education during the course of the pandemic in 2020–2022. Moreover, community-based organizations (CBOs), which are smaller organizations operating at the local level, were also active through education, awareness and simple interventions to facilitate equity-informed responses by community members. Religious leaders and public figures, together with social workers, were involved in the effort to increase awareness about COVID-19 preventive measures such as social distancing and IPC practices (15). These community representatives presented information via religious ceremonies, community activities and services, and public speeches within TV programmes, which demonstrated that transparency of information is the responsibility of all increasing social accountability within the pandemic response (37).

The government provided communities with health awareness messages through different channels, emphasizing the importance of healthy behaviours to protect individuals from COVID-19 infection in different social settings. Messages were shared by the MoH, local and international NGOs, and academic institutions. The channels used by these entities included public and private mass communication channels (e.g., TV, radio), social media and preachers from religious institutions. Yet not all citizens were equally able to understand and access these messages. The impact of these communication attempts were
unclear at the early stages of the outbreak in 2020, but acceptance did improve as the pandemic progressed, especially when fatality rates increased and many lost their loved ones. For community engagement during future emergencies, these channels of communication should be coordinated systematically with levels of the health care system and they should be connected to public information systems to avoid fragmentation of information, the spread of misinformation and public confusion.

Indeed, community engagement is not easily achieved without proper communication. To this end, the MoH, with the support of WHO, prepared a communication plan for emergencies. UNICEF supported community awareness programmes, for example by disseminating more than 30 000 posters about COVID-19 and 30 000 others on sanitation in schools, and by presenting five animations to school children on topics related to PHC centres during the pandemic (10). The aim was to help younger generations understand future pandemics and to establish active roles among communities in IPC.

Further funding and self-governance of community organizations will be essential to improve future pandemic preparedness and to ensure that community members are empowered in decision-making (39). Funding should be independent and separate from any external policies to strike a balance between the priorities of the government and community needs (39). The establishment of a specialized unit at the MoH might help to guide community engagement activities and oversee the work of community organizations, with a focus on tackling complex problems, improving engagement skills among the health workforce, and addressing misinformation. The MoH has commenced such efforts through the initiation of the Healthy Villages Programme, which aims to empower disadvantaged communities to improve their health and well-being (6). In addition, the MoH also plans to include community organizations in disease prevention and surveillance (23), efforts that are likely to improve community involvement in health care planning and management.

**Conclusion and lessons learned**

Despite MoH-led efforts to facilitate the continuity of routine PHC programmes and community health services, there is a need for greater government interest. NGOs are filling the gaps in programmes related to primary care and all sectors rely on these entities to implement PHC strategies. Several weaknesses emerged during the COVID-19 pandemic due to unsustainable service provision, issues around the continuity of funding and challenges related to the social determinants of health - all key enablers of a resilient health care system during emergencies. In 2020–2022, Jordan experienced the suspension of essential services, poor utilization of available resources and capacities, low engagement of community members and organizations, and inequitable distribution of service loads and referrals.
Findings suggest that national and global collaborations to build capacity were not effectively utilized. Efforts were fragmented and uncoordinated, not only in governmental sectors, but also at the community level. However, there were examples of successful partnerships that should be documented, strengthened and considered as part of national strategic planning. Such collaborations were mostly enforced by the government on the private and academic sectors to support the treatment of and service provision for COVID-19 patients. Collaborative, multisectoral responsibilities could form part of national plans and be clearly stated and communicated to all sectors, so that all stakeholders understand their responsibility without participation being enforced.

Strengthening PHC-oriented systems is key to achieving UHC and to the continuity of basic services during public health emergencies. Although Jordan has been successful in adapting some PHC levers, including community engagement and stakeholder partnerships, key aspects of UHC and the SDGs have not been prioritized or considered fully in the national health strategy (40). Many of these PHC levers cannot be operationalized without clear governance and leadership roles and without proper financing (41), and these were not optimized during the pandemic. COVID-19 has revealed flaws in the health system including weaknesses in the delivery of health services.

The MoH is well placed to guide health system improvements and empower other partners. The MoH oversees delivery of health services to the population and has the authority to transform health-related policies into action, integrate PHC into the health system, and prioritize and address community needs (40). In addition, the MoH can mobilize financing and enhance the allocation of budgets to support the integration and adaptation of PHC models to improve coverage and equity, especially among disadvantaged and vulnerable populations. There is an opportunity for the MoH to lead accelerated efforts, including to record funds for health in the national budget, and to align national financial management systems (1). Any new funds allocated to support PHC should consider some elements that were missing in the COVID-19 pandemic response. This includes adapting and implementing digital technologies in health provision and networking, women’s access to sexual and reproductive health, and services related to mental health and well-being (38).

PHC has advanced considerably. Nevertheless, there are opportunities to enhance the quality of health care provided to the population. Continuous government funding is critical to improve patient care and to meet community needs.
References


This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, in collaboration with the WHO Regional Office for the Eastern Mediterranean (EMRO) and WHO country offices. In 2015, the Alliance commissioned the Primary Health Care Systems (PRIMASYS) case studies in twenty low- and middle-income countries (LMICs) across WHO regions. This case study builds on and expands these previous studies in the context of the COVID-19 pandemic, applying the Astana PHC framework considering integrated health services, multisectoral policy and action and people and communities. This case study aims to advance the science and lay a groundwork for improved policy efforts to advance primary health care in LMICs.