

Jordan



A Syrian refugee, with her family in Ramtha, Jordan; UNHCR / J. Kohler / February 2014

Contents

Field Articles

- 71** Evolution of WFP's food assistance programme for Syrian refugees in Jordan
- 74** Meeting nutritional needs of Syrian refugee children and women in Jordan
- 76** UNHCR cash programming in emergencies – implementation and coordination experience during the Syrian refugee response in Jordan
- 78** Aid effectiveness: determining vulnerability among Syrian refugees in Jordan
- 82** Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment
- 85** Managing infant and young child feeding in refugee camps in Jordan
- 89** Postscript
- 90** The situation of older refugees and refugees with disabilities, injuries, and chronic diseases in the Syria crisis

- 93** Experiences of emergency nutrition programming in Jordan
- 97** Women's protection and empowerment programming for Syrian refugees in urban Jordan: challenges and lessons learned

Research

- 101** The social life of nutrition among Syrian refugees in Jordan

Views

- 105** UN and INGO experiences of coordination in Jordan

News

- 107** Experiences on Nutrition in Emergencies Training for Syrian refugees response in Jordan

Agency Profile

- 108** Jordan Health Aid Society (JHAS)
- 110** Jordan Hashemite Charity Organisation (JHCO)



WFP Jordan

Evolution of WFP's food assistance programme for Syrian refugees in Jordan

By Edgar Luce



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reports and acting as the VAM (Vulnerability Assessment and Mapping) focal point. He has more than five years of international experience in agricultural development and humanitarian relief working with NGOs prior to the UN.

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WFP assistance

Since the onset of the Syrian refugee crisis in mid-2012, WFP has been providing food assistance to Syrian refugees in Jordan in a number of ways. WFP began providing food assistance through the provision of hot meals in Zaatari refugee camp when it first opened in July 2012. WFP transitioned to take home rations of dry ingredients by October 2012; this was followed by the provision of paper food vouchers that refugees can redeem in shops from September 2013 including the large supermarkets which opened in January 2014. In non-camp settings, assistance began with hot meals to a few hundred families in transit centres, followed by the introduction of paper vouchers in August 2012. In January 2014, the transition to e-vouchers began in communities and all UNHCR registered Syrian refugees should have an e-card by the end of August 2014. WFP's voucher programme in Jordan is implemented through three established cooperating partners (Islamic Relief Worldwide, Human Relief Foundation and Save the Children International), and a fourth recent addition, ACTED, in the newly opened Azraq camp. This article describes the different types of assistance, how and why they evolved.

Food distributions in Zaatari refugee camp

Following the opening of Zaatari refugee camp in July 2012, WFP distributed hot meals from local restaurants to camp residents twice a day, typically consisting of rice, a protein source such as chicken or meat, together with bread, fruit and a vegetable. This was not sustainable for the rapid influx of refugees that followed (rising from 3,685 individuals

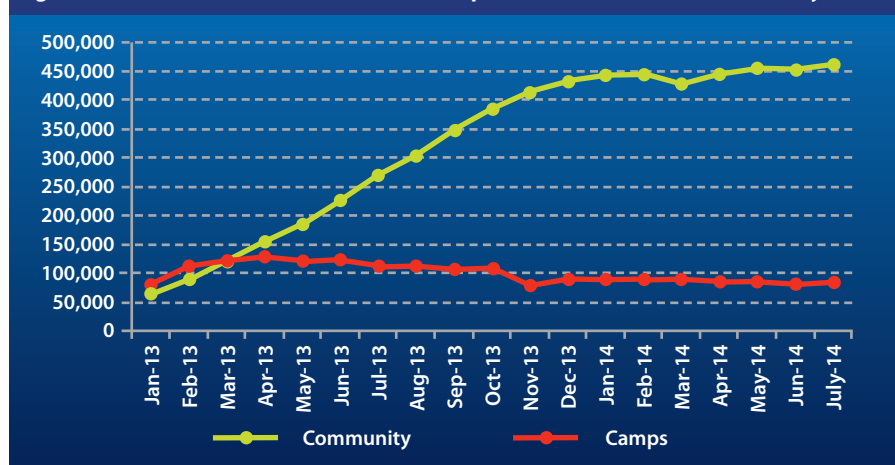
in August 2012 to 129,756 in April 2013). Thus, WFP transitioned to the distribution of dry rations in October 2012, once kitchens with cooking facilities were available for camp refugees to use. The rations, consisting of rice, lentils, bulgur wheat, pasta, oil, sugar and salt, were distributed from dedicated distribution sites to all residents every two weeks. Together with the daily distribution of bread, this provided 2,100 kcal per person per day. UNHCR also provided additional complementary food normally consisting of canned tomatoes, tomato paste, tuna, canned beans and tea through the same distributions.

Paper voucher assistance

The paper voucher modality was introduced for the registered refugees living amongst the host community (August 2012 – 19,000 beneficiaries) and later in Zaatari camp (September 2013 – 104,000 beneficiaries). The introduction of the voucher programme helped bring a sense of normalcy to Syrian refugees allowing them to shop in regular supermarkets for their preferred foods. The vouchers also offered access to a greater diversity of foods with higher nutritional value, including fresh fruits, dairy products, meat, chicken, fish and vegetables. This programme also led to jobs for nearly 400 Jordanians in WFP's partner shops where refugees used their vouchers; more than \$229 million has been injected into the local economy since its launch through till July 2014¹.

¹ Economic impact study: Direct and indirect impact of the WFP food voucher programme in Jordan, April 2014.

Figure 1: Number of WFP beneficiaries in camps and communities (Jan 2013-July 2014)



In Zaatari camp, vouchers were initially redeemed in shops run by 16 partner community-based organisations (CBOs). In January 2014, WFP established two supermarkets in Zaatari camp allowing camp based refugees' food needs to be met entirely through vouchers. WFP gradually decreased the distributions of dry food rations while increasing the value of the vouchers. Now that food assistance has shifted completely to vouchers in camps aside from the daily distribution of bread (due to concerns over the government bread subsidy), each refugee receives WFP monthly vouchers valued at 20JD (US\$28.20). In communities refugees receive the full voucher value of 24JD (US\$33.84) per person per month. This amount is based on the cost of a basic food basket which provides approximately 2,100 kcals per person daily. Ongoing monthly price monitoring conducted by WFP and its partners has shown that food prices in participating shops are similar, and often cheaper, than those in the non-participating stores². Since January 2013, WFP has kept the voucher value constant at JOD24 (US\$33.84) per person per month as food prices have remained relatively constant, even decreasing in some areas of Jordan.³

In April 2014, for the first time in the history of humanitarian assistance, Azraq refugee camp opened with a fully-fledged WFP supermarket along with WFP food vouchers. This meant that

all refugees arriving in the camp could start purchasing their own food immediately.

The number of beneficiaries of WFP's voucher programme increased steadily from 67,500 individuals in January 2013 to 537,000 individuals by February 2014. All registered Syrian refugees living in host communities have been able to redeem their vouchers in 77 designated shops in 12 governorates (July 2014). Shops are contracted by WFP's partners and are located in areas with a significant concentration of refugees. In these communities, the head of the household receives two paper vouchers every month. Each voucher is valid for two weeks and will expire if not used during the validity period. The voucher value varies according to the household size, as each individual receives the equivalent of 24JD (US\$33.84) monthly.

E-voucher programme

WFP assistance to Syrian refugees living amongst the host population in Jordan is now carried out through electronic food vouchers. This programme is implemented through a partnership with MasterCard and a local bank, Jordan Ahli Bank (JAB), under its Corporate Social Responsibility (CSR) programme. E-vouchers function like a pre-paid debit card, with WFP transferring the voucher value directly to the e-voucher on a monthly basis through the partner bank (see Figure 1). WFP has now transferred almost all refugee households to electronic vouchers in

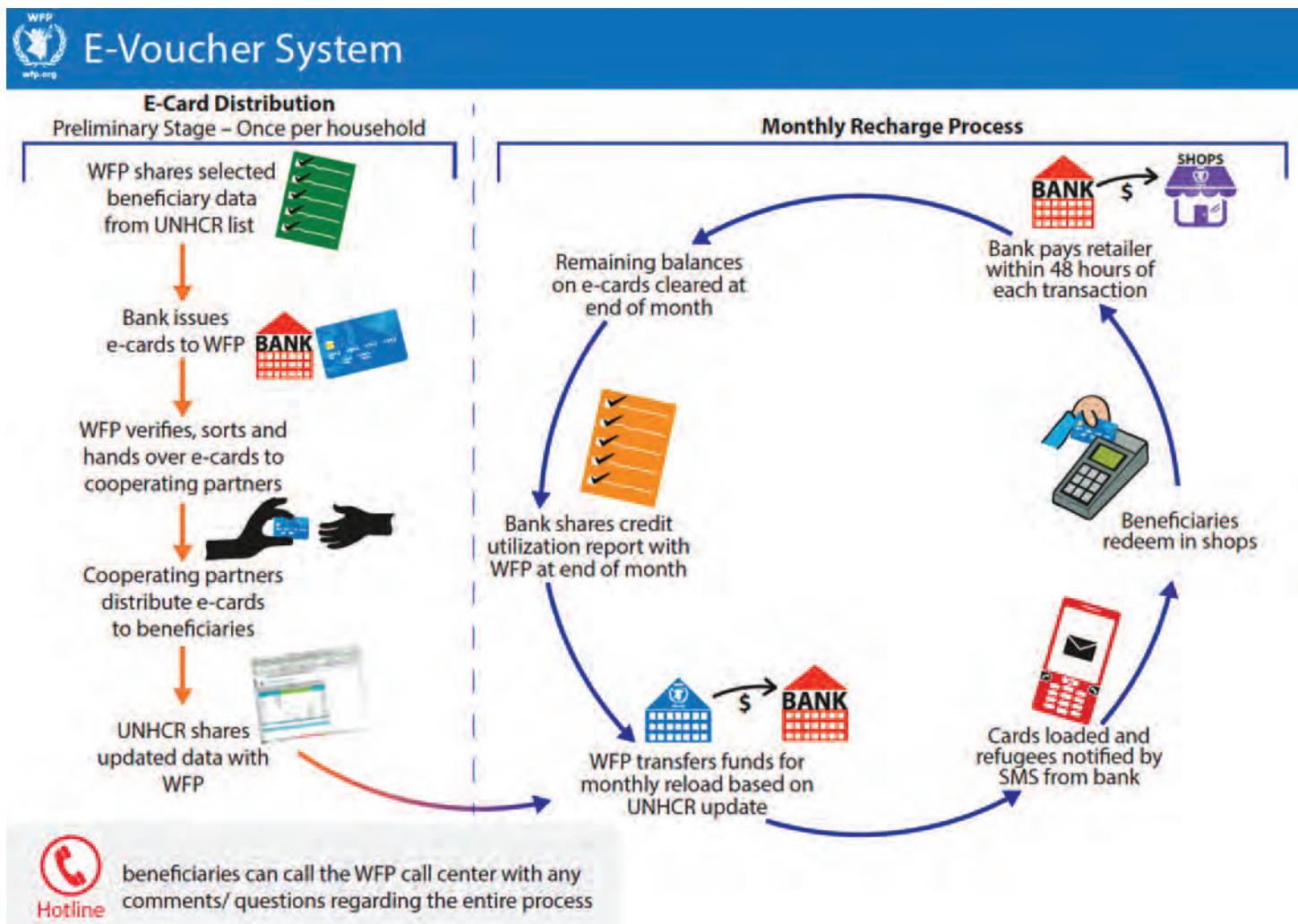
the host communities and started to pilot this approach in camps as well. E-vouchers allow the beneficiaries to spend their entitlements in multiple visits to the shops and are also more discreet and therefore less stigmatising. As the cards are recharged automatically through the partner bank, beneficiaries are no longer required to travel to monthly distributions to receive their food assistance. When making a purchase in the supermarket, refugees must present their e-vouchers together with their matching UNHCR refugee identification card and input their four digit security code – the same process used for regular credit and debit cards.

Key findings and lessons learned

The paper voucher system was introduced as assessments showed that Jordan has a fully integrated market structure with the necessary commercial and physical infrastructure to meet increased consumer demand without affecting its current supply lines and price levels. Furthermore, since Syrian families are accustomed to shopping for their food, vouchers allowed them to continue their regular approach to pur-

² For example, in April 2014, a standard food basket cost JOD21.60 (US\$30.24) in participating stores and JOD21.80 (US\$30.52) in the non-participating outlets. Source: Economic impact study: Direct and indirect impact of the WFP food voucher programme in Jordan, April 2014.

³ Food basket is composed of rice, bulgur wheat, pasta, pulses, sugar, vegetable oil, salt and canned meat.



chasing food, helping to return a sense of normality to their lives while enabling them to select their preferred food items and meet their individual consumption and dietary needs. WFP keeps an open policy regarding what food items are selected; beneficiaries are able to purchase all food items except soda, chips and candy.

The WFP food voucher programme builds linkages between refugees and host communities and helps to stimulate local economies through the promotion of local production and sales. Findings from a recent WFP Economic Impact Study⁴ show that WFP assistance will equate to 0.7% of the Jordanian GDP through the voucher programme in 2014. The voucher programme has already led to some US\$2.5 million investment in physical infrastructure by the participating retailers, created nearly 400 jobs in the food retail sector and generated almost US\$6 million in additional tax receipts for the Jordanian government.

The gradual shift to e-cards brings several important benefits to both Syrian refugees and WFP. These include allowing refugees to spend their monthly entitlements in multiple visits to the shops (paper vouchers have to be spent in one go and only allow two shopping visits per month). This is useful for refugees who have limited storage facilities especially during the hot summer months or limited access to transportation. It also is a much more discreet assistance modality, which is important when living in host communities where tensions are increasing over time. While vouchers in general are more costly than the purchase of bulk commodities, given the transfer value of vouchers has to cover retail prices and is therefore higher per person than the cost of bulk food purchases, much less is also spent on administrative and logistical costs. Thus, with vouchers more total value is transferred to beneficiaries. Similarly, it is impossible to cost the added value for refugees in

making their own household food decisions. With vouchers WFP was able to scale up quickly and absorb the high number of refugees crossing on a daily basis. Thus, vouchers are by far the preferred mode of assistance when compared with in-kind food in Jordan. E-vouchers are even more efficient given WFP does not need to print hundreds of thousands of paper vouchers every month, sort and distribute them through partners, then reconcile all redeemed vouchers. As part of the partner bank's CSR programme, most services are provided to WFP free of charge, including the printing of all cards, loading of the monthly assistance and tracking and reporting.

WFP has a robust monitoring system that covers all activities such as e-cards, paper vouchers, school feeding in camps, nutrition activities. WFP monitors all partner shops, shop owners, prices in both partner and non-partner shops for comparison purposes, beneficiary perceptions, distribution sites and household food security information, such as food consumption scores and coping strategies on a regular basis. Because WFP assists nearly all registered Syrian refugees in Jordan, the prevalence of food insecurity amongst Syrian refugees is relatively low at 6% in communities⁵. Furthermore, food consumption is also high, as 90% have an acceptable food consumption score with only 8% classified borderline and 2% poor.

Initial monitoring findings of the e-card modality showed many Syrian refugees in Jordan are illiterate and thus unable to read and fully understand the voucher programme. In response, WFP created communication materials with illustrated explanations of the e-card process. Monitoring has also shown that shop owners are more satisfied with the e-card modality given they are paid much faster and do not need to track thousands of paper vouchers. Lastly, beneficiaries have explained their content

with the voucher programme in general as they are more able to cover family members with specific dietary needs compared to the receipt of in-kind food.

JAB, WFP's partner bank, is responsible for setting up, maintaining and managing a safe, effective and efficient mechanism for the electronic voucher system through prepaid cards. The bank has established procedures for the control, oversight, monitoring and accounting of the prepaid card system and is responsible for providing, installing and maintaining point-of-sale machines in all selected retailers. The bank is also responsible, if necessary, for establishing bank accounts for all WFP retailers and for producing prepaid cards for each beneficiary household. It is also the role of the partner bank to provide comprehensive and timely reporting on beneficiaries' card use and subaccount activity. The bank has designated an experienced customer support focal team for project implementation, monitoring, facilitation and coordination, while providing WFP and cooperating partners with remote web access for card maintenance and account/transactions information. Lastly, the bank is providing facilities such as help desks, call centres and help lines as well as system training to WFP, cooperating partners and retailers in addition to financial literacy training for beneficiaries.

In addition to the WFP hotline hosted by the bank, all partners have hotlines as an effective beneficiary feedback mechanism - answering questions on locations of distributions and shops, referring beneficiaries to other agency hotlines for non-food related issues, relaying lost e-card or forgotten pin numbers to the bank and counseling beneficiaries on how to use the e-card. On average, WFP receives more than 1,500 calls per month through its hotlines. All partners are also required to operate hotlines as well.

Sustainable funding, including ensuring the timing of donations to meet cash flow requirements, continues to pose challenges for future food assistance. Maintaining the cash flow and ensuring contingency stocks are ready to assist a possible large influx of refugees is extremely challenging when working with a funding horizon of one month. Given the fiscal costs of current refugee operations around Syria, WFP is working with sister agencies and host governments to devise a more mid-term approach to affording Syrian refugees the ability to provide for themselves even in a time of crisis.

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Rein Skullerud/WFP

⁴ Economic impact study: Direct and indirect impact of the WFP food voucher programme in Jordan, April 2014.

⁵ Findings from the Comprehensive Food Security Monitoring Exercise (CFSME) conducted in January 2014, report released July 2014. <http://documents.wfp.org/stellent/groups/public/documents/ep/wfp266893.pdf>

WFP complementary food assistance in Zaatari Camp



WFP, Jordan, 2014

Meeting nutritional needs of Syrian refugee children and women in Jordan

By Henry Sebuliba and Farah El-Zubi



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Background

Due to the prolonged and evolving nature of the crisis in Syria many Syrians have sought and continue to seek refuge in neighbouring countries such as Lebanon, Turkey, Iraq, Egypt and Jordan. According to the population figures of the United Nations High Commissioner for Refugees (UNHCR), there are 618,086 registered Syrian refugees in Jordan as of 18 September 2014¹. Approximately 85% of Syrian refugees in Jordan live within the community, mainly in the governorates of Amman, Mafrqa, Irbid and Zarqa. The remaining 15% of the refugee community live in Za'atri and Azraq camps.

Pre crisis data on Syrian refugees indicated a poor nutrition level for children under 5 (CU5) according to World Health Organisation's thresholds, with an estimated 9.3% wasted, 10.3% underweight and 23% stunted². Micronutrient deficiencies were also found to be common -(anaemia prevalence was estimated at 29.2%), presenting a risk for sub-optimal growth among CU5³.

In order to assess the needs of Syrian refugees in Jordan, WFP and the United Nations Children Fund (UNICEF) conducted the Inter-Agency Nutrition Assessment in November 2012 with the participation of Jordan's Ministry of Health (MoH), the Department of Statistics (DOS), UNHCR, WHO, the United Nations Population Fund (UNFPA), Save the Children International (SCI) as well as other NGOs. The assessment evaluated the nutrition and food security level of Syrian refugees living in both urban/rural areas and camp settings.

According to the assessment's findings, Global Acute Malnutrition (GAM or wasting) prevalence rates were found to be 5.8% in camp settings and 5.1% among refugees residing in urban communities⁴. The assessment also found that 4% of Syrian CU5 and 6.3% of pregnant and nursing women and girls were moderately malnourished and recommended the provision of targeted supplementary feeding support for this category. Consistent with the pre-crisis data the assessment also revealed sub-optimal Infant and Young Child Feeding (IYCF) practices among the refugee community in Jordan; just under half of children below 2 years old (49.6% in the camp and 42.7% in the local community) continued to be breastfed.

Programme plan and implementation

As per the recommendations of the 2012 Joint Nutrition Assessment, WFP introduced a Targeted Supplementary Feeding Programme (TSFP) to treat moderately malnourished

Syrian children and women both in camps and in urban communities. This was based on the Memorandum of Understanding between WFP and UNHCR in Jordan which stipulates that WFP is responsible for the management and treatment of moderate acute malnutrition (MAM), while UNHCR is responsible for the management of Severe Acute Malnutrition (SAM).

In addition, distribution of SuperCereal Plus was launched in Zaatari camp for children aged 6-23 months to ensure they had access to age-appropriate food considering they are not readily available in Zaatari camp and can only be purchased in pharmacies.

In June 2013, UNHCR started blanket distribution of a locally procured fortified blended food (Sahaa) to all children aged 6-23 months. This was distributed over a period of three months⁵. In addition, treatment of MAM commenced using the same product until February 2014 when transition to the use of SuperCereal Plus began.

Targeted Supplementary Feeding Programme (TSFP)

Since February 2014, WFP in partnership with Medair, Save the Children Jordan (SCJ) and ACTED have been distributing SuperCereal Plus as part of WFP's TSFP to treat moderately malnourished CU5 and pregnant and nursing women and girls in both the local communities and camp settings. In February 2014, before the launch of the TSFP programme, SCJ conducted a comprehensive Mid Upper Arm Circumference (MUAC) screening of all CU5 and pregnant and nursing women and girls in Zaatari camp. It took 12 days to complete and a total of 13,009 CU5 were screened, amongst whom 27 SAM cases and 164 MAM cases were found.

In addition, a total of 2,515 pregnant and nursing women and girls were screened, of whom 51 were found to be malnourished. Identified cases were contacted prior to the TSFP enrolment days, however SCJ faced challenges in following up on some of the cases due to redundant mobile phone contacts provided by the beneficiaries. In Zaatari camp, SCJ has also recruited community mobilisers/volunteers who are responsible

¹ Source: <http://data.unhcr.org/syrianrefugees/country.php?id=107>

² Syrian Family Health Survey (2009)

³ MOH, Nutrition Surveillance System Report 2011

⁴ Inter-Agency Nutrition assessment Syrian refugees in Jordan host communities and Zaatri camp, 2012

⁵ It was distributed as a blanket for 3 months but a reduced ration for the third month. See article by Save the Children Jordan that describes this support in more detail.



TSFP follow up in downtown Amman

for conducting routine MUAC screenings. CU5 and pregnant and nursing women and girls diagnosed with MAM are issued referral tokens which they presented at MAM treatment sites and have their anthropometric measurements taken to confirm if they are eligible for enrolment to the TSFP programme.

Moderately malnourished CU5 meeting anthropometric admission criteria (MUAC < 125mm and \geq 115mm and no oedema) and pregnant and nursing women and girls with MUAC < 230mm are admitted to the programme. Beneficiaries are provided with a two weeks ration of SuperCereal Plus. Children are provided with a daily ration of 200g/day while pregnant and nursing women and girls receive 250g/day. Follow up visits are conducted every two weeks to replenish SuperCereal Plus supplies, and for beneficiary medical review as well as provision of systematic treatment at health clinics run by the Jordan Health Aid Society (JHAS).

By the end of May 2014, three months following the roll-out of the WFP nutrition programme, SCJ had reached 223 beneficiaries in Zaatari camp (168 CU5 and 55 pregnant and nursing women and girls) out of the targeted 1,510 beneficiaries (1,154 CU5 and 356 pregnant and nursing women and girls).

Estimation of the targets was based on the 2012 nutrition survey findings however it appears that nutrition levels had improved. Consequently fewer children with MAM were identified by WFP partners. Analysis of the performance indicators in the camp reveal that 68% of the target population have been cured, 23% defaulted and 9% transferred to Outpatient Therapeutic Care (OTP).

In both Zaatari and Azraq camps, sensitisation activities are carried out by community volunteers and cooperating partners' staff prior to distribution of SuperCereal Plus and during follow-up visits, in addition to nutrition education sessions conducted at health clinics in the camps.

WFP supports TSFP implementation in the local community through a partnership with

Medair which operates in coordination with the Jordanian Health Aid Society (JHAS) to manage the community component of the programme. Management of acute malnutrition is conducted in each of the six available JHAS health clinics in Amman, Jerash, Ajloun Zarqa, Mafraq and Irbid. The Medair outreach and mobile teams are responsible for screening and referring malnourished children and pregnant and nursing women and girls in the community to JHAS clinics for treatment⁶. Routine sensitisation of the refugee population is conducted by Medair outreach volunteer teams and through the JHAS clinics⁷. A total of 215 beneficiaries including 79 children and 140 pregnant and nursing women and girls have been reached to date (June 2014) and out of these 71% have been cured, 22% defaulted and 7% were non responders.

Blanket age-appropriate food assistance

Age-appropriate food support is provided to children aged 6-23 months in the camps. Each child is provided with 100g/day of SuperCereal Plus on a monthly basis. A total of 8,258 CU5 in Zaatari camp received SuperCereal Plus under this programme in May 2014 (target 13,000). WFP, in partnership with ACTED, are also providing supplementary food to all CU5 in Azraq camp. In May 2014, about 456 newly arrived children were reached. This is lower than the target figure of (1266) as a larger case load of new arrivals was anticipated.

Decision-making regarding approach

In Jordan, Syrian refugees receive their food assistance in the form of vouchers provided by WFP which beneficiaries can redeem in WFP's supermarkets in the camps. However, according to Jordanian law, specialised weaning-foods for young children can only be obtained from pharmacies. This means, that nutritious age-appropriate foods are not available in WFP supermarkets in the camps where beneficiaries redeem their vouchers. Therefore, distribution of SuperCereal Plus rather than food voucher/cash was used for provision of age-appropriate food in camps.

Implementation challenges

Some of the main challenges confronting the implementation of the programmes were related to Syrian refugee children and women's taste acceptance of SuperCereal Plus. This was a product that they had not used or eaten before. However WFP partners (SCJ, Medair/JHAS and ACTED) addressed this concern by holding sensitisation sessions and awareness campaigns about the use and benefits of SuperCereal Plus. This includes carrying out cooking demonstrations, as well as encouraging beneficiaries to add condiments such as honey, fruits, sugar and salt to make the product tastier. As a result, acceptability increased significantly⁸.

Ensuring follow-up of moderately acute malnourished children and women, especially in the community, has proven difficult as they cannot be easily traced through mobile phones, either because they have changed their numbers or are no longer in the country and this has contributed to the observed high default rates.

Conclusion

Preliminary results of the follow-up nutrition survey conducted in refugees living in Zaatari camp and the local community between April and May 2014 are suggesting an improvement in acute malnutrition prevalence rates among Syrian refugees community in Jordan. The 2014 survey findings revealed that GAM rates are at 1.2% in Za'atri camp and 0.8% in the local community, a clear improvement in comparison to the 2012 findings. However, it also showed that micronutrient deficiencies have persisted among Syrian refugees, especially those living in camps. Results showed that anaemia prevalence was at 48.7% among CU5 and as high as 64% among children under 2 years. Anaemia levels remain high in girls and women of reproductive age, standing at 44.7%. These results indicate that anaemia prevalence is critically high and a serious public health concern.

Given the low prevalence of acute malnutrition among Syrian refugees in Jordan, there has been a shift in focus to promote optimal nutrition and integrating cultural practices in complementary nutrition support as well as steps towards integrating malnutrition within the national health system. In any case, it will be essential for nutrition stakeholders in Jordan to continue to monitor the nutrition status of Syrian refugees in Jordan as long as the Syria crisis persists.

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⁵ It was distributed as a blanket for 3 months but a reduced ration for the third month. See article by Save the Children Jordan that describes this support in more detail.

⁶ See field article in this edition of Field Exchange (48) describing JHAS programming in Jordan

⁷ See field article in this edition of Field Exchange (48) describing Medair's programming in Jordan

⁸ See field articles by both Medair and Save the Children Jordan explaining aspects of this programme.

UNHCR cash programming in emergencies – implementation and coordination experience during the Syrian refugee response in Jordan



By Volker Schimmel

Volker Schimmel is UNHCR's Head of Field Office Amman and manages the agency's cash assistance programme in Jordan. He has worked in refugee and displacement situations with UNHCR, UNRWA and OCHA.



UNHCR staff assisting Syrian refugee with their first-time access to cash assistance through iris scanning, Mafrqa, Jordan.

How did we get here?

Over the last decade, two distinct trends have pushed cash-based interventions¹ to the fore of international refugee response operations. The first one is the phenomenon of urban refugees and the second one is the maturity and acceptance that cash assistance has reached of late. Urban refugees, which is an amorphous category mostly describing refugees who do not live in designated camps or sites, have certainly come back into focus with the Iraqi refugee crisis and the Syrian refugee crisis². Historically, urban refugees have always been the core of UNHCR's work, but after decades of resource-intensive and headline-grabbing camp-based responses, this focus needed to be strengthened.³ Currently, UNHCR runs significant urban responses in the Americas, in the Middle East and in Asia and for some years, UNHCR has been working on refining its policy and operations to adapt to these new settings.⁴

Jordan provides a particular example of an urban refugee context as it has been generously hosting both Iraqi and Syrian refugees in large numbers. UNHCR in Jordan was one of the first operations implementing a large-scale cash assistance programme during the Iraqi influx, which is why the operation was able to leverage the existing system swiftly to respond to the Syrian influx. Although Jordan is home to the very large well-known refugee camp of Zaatar, urban refugees make up over 80% of the refugee population in the Hashemite Kingdom.

The maturation and increased acceptance of cash assistance is probably best understood through literature review and the swathes of

publications on cash assistance in the last five years.⁵ The period of expansion can be placed somewhere around 2006 when only six donors funded cash assistance, and 2011 when 41 donors were involved in cash assistance (largely in the context of humanitarian programming). Another manifestation of this trend is the creation of the Cash Learning Partnership (CaLP) initiative (www.cashlearning.org), which should be understood as a successful attempt to promote cash-based assistance through capacity building, research, advocacy and information sharing.

Cash-based interventions run by UNHCR in Jordan

Drawing on the increased acceptance and sophistication of cash-based assistance systems, UNHCR in Jordan has been able to develop a state-of-the-art cash assistance system, which is fully secured through biometric identity verification to prevent fraud. It is unrivalled in terms of cost-effectiveness and efficiency in UNHCR's current operations worldwide.

Despite the fact that there are more than half a million registered refugees dispersed across Jordan, UNHCR in close collaboration with its partner International Relief and Development (IRD), has managed to conduct individual assessments based on home visits for all cases. Between 2012 and September 2014 over 170,000 visits were undertaken⁶. This wealth of information is then used by a case management committee to determine eligibility based on pre-defined criteria. Eligibility is re-assessed at regular intervals (12 months at the most) and

process and impact are continuously measured by quarterly post-distribution monitoring (PDM) exercises.

The delivery mechanism is the ATM network of UNHCR's partner Cairo Amman Bank. The system does not require any card or PIN code; instead the beneficiary has their iris scanned at the ATM itself, which validates the identity and authorises the pay-out without requiring any further action. The system has been widely recognized as cutting-edge and has not had a single fail in trillions of transactions across all accounts at Cairo Amman Bank. As a result, UNHCR has been able to transfer over \$50 million USD to the most vulnerable Syrian refugees in Jordan over a two year period starting in mid-2012. Disbursements have been above \$30 million USD in 2014 alone. Cash transfers allow UNHCR to implement directly rather than to sub-contract work, which means that the programme is one of the most cost-effective models of delivering assistance to refugees at less than three per cent overhead. Thus, not only is it ensured that over \$97 USD of every \$100 USD donated goes directly to the refugees, but the system set up by UNHCR in Jordan ensures that it also goes to those in need – due to the individual assessments – and reaches them without fail – due to the biometrics component of the delivery mechanism.

As of October 2014, UNHCR Jordan was assisting 22,692 families (20,492 Syrian and 2,200 or IRQ, SUD and SOM nationality) with monthly cash assistance. The level of assistance ranges from 7\$5 USD to \$400 USD depending on family size and vulnerability. In 2014, UNHCR was responsible for 75% of the cash transfer volume in Jordan. The total amount transferred to refugees in October 2014 was \$3.1 million USD.

¹ Organisations use different terms for cash assistance. The most commonly used term is cash transfer programmes (CTP), but cash assistance (CA) and cash based interventions (CBI) are also regularly found.

² See for example: <http://www.unhcr.org/516d658c9.html>

³ Merrill Smith. Warehousing Refugees: A Denial of Rights, a Waste of Humanity. World Refugee Survey 2004

⁴ See for example UNHCR's Alternative to Camps Policy: <http://www.unhcr.org/5422b8f09.html>

⁵ DfID Literature Review: <http://4d.dfid.gov.uk/PDF/Articles/cash-transfers-literature-review.pdf>

⁶ Syrian refugees living outside camps in Jordan. Home visit data findings, 2013. Available at: www.unhcr.org/urban

Jared Kohler / UNHCR 2014



Bank employee assisting Syrian refugee in their first withdrawal of cash assistance, Amman, Jordan.

Process and impact monitoring also corroborate this. Moreover, customer satisfaction is high. Refugees consistently report that at a rate of around 95% that the service had functioned without any disruptions or problems. Moreover, if level of assistance is carefully calibrated to ensure that cash assistance is a cash complement, the appropriate usage of cash assistance is high. UNHCR PDMs show that 98% of the assistance is spent on basic needs ranging from rent (84%) to children's needs (8%) to food and health (8%).

In March 2014, UNHCR teamed up with the World Bank for a pilot on welfare modelling⁷, which also included an impact assessment of the cash assistance programme using re-assessment data from follow-up home visits. It produced two important findings. Firstly, the exclusion error of the case management system compared with a welfare modelling system was 1%, whereas the inclusion error was 4.7% for a welfare based approach. Secondly, UNHCR's cash assistance was able to reduce the number of refugees living below the poverty line by 10% across Jordan and in certain Governorates, such as Amman, by up to 15%. The emphasis on the assistance itself often overlooks the additional benefits of this type of programme that is achieved at the same time, in terms of protection of refugees. An interesting study in 2012, which included Jordan, showed how critical cash assistance is in order to enhance the protection of refugees, particularly in non-camp settings.⁸ Protection is first and foremost ensured by not stigmatising the refugee through, for example, distribution of in-kind assistance at designated centres. Since urban refugees are rarely assisted with shelter

support, contrary to refugees in camp settings, cash assistance enables them to secure their dwelling and household and avoid exploitation. Cash assistance effectively makes any refugee a customer and participant in a market, who is able to act and make decisions as any other citizen of their country of refuge would.

Certainly, cash assistance projects – even if they are as advanced as UNHCR's Jordan programme – can always be improved. One avenue that is currently being worked on by UNHCR in close collaboration with the World Bank is to move away from the resource-intensive case management approach of the decision-making and to apply instead a system of modelling with safeguards. This would ensure good targeting based on minimal information that can be collected during registration with UNHCR, which includes biodata, information about the family composition, professional, educational and social background as well as current location. It would eliminate the need for, and overhead of, a home visit – and mitigate any exclusion errors through safeguards (including a home visit) and an appeals system. An extension and roll out of this is through the inter-agency vulnerability framework (or VAF) which is currently being elaborated in Jordan. The framework combines modelling and criteria-based decision making elaborated by key partners in the refugee response, including UN agencies, international non-governmental organisations, donors and refugees.

The second area of innovation is the plan to connect the payment system in a highly secured and encrypted manner to UNHCR's registration database, which is also based on the same system for biometric identity verification. Once this connection is in place, it will allow any partner in the refugee response to deliver cash assistance through the bank whilst always relying on the most recent registration information as updated by UNHCR. This will eliminate the problem of outdated data being used by partner organisations, who only collect the information during the assessment stage, but are often not able to respond to changes in registration status over time, thereby at times serving refugees who are no longer registered.

Coordinating cash assistance in a refugee response

There is an emerging body of literature on coordination of cash interventions in humanitarian settings.⁹ The case of Jordan is no exception.

The so-called Cash Working Group was one of the first coordination groups to be created in 2012 in order to harmonise the refugee response in Jordan. Over the course of the next two years, important strides forward were made. The Working Group elaborated common criteria for eligibility, a joint PDM system, a referral mechanism, a system to check against and prevent cases of duplicate assistance, as well as a Minimum Expenditure Basket. It also set out a strategic workplan, defined levels of vulnerability across the population and developed the broader targeting methodology under the VAF. However, many challenges for coordination remain – partly due to the fact that cash provision as a response modality has been used to provide support for multiple sectors in Jordan over the course of the crisis. In response, any conditional cash assistance was managed not through the Cash Working Group, but the working group covering the 'conditionality'. As such, cash for rent, for example, started to be managed by the Shelter Working Group from 2013. This means that the value and *raison d'être* of a Cash Working Group has been gradually diminishing. Furthermore, it is still a formidable obstacle to align levels of assistance, which is partly due to the fact that projects are usually defined by the budgets first and by the coordination standards second. This issue can and should also be explored further from a Good Humanitarian Donorship (GHD) perspective¹⁰.

Overall, however, the cash coordination system in Jordan should be considered a success, as it has managed to create a baseline, shift the inter-agency operation towards an evidence-based way of programming and created standards for each stakeholder – including donors – to follow and enforce in order to ensure an equitable and predictable assistance system putting the protection and needs of refugees first.

Conclusion

In a context of large-scale urban refugee response, cash as a modality is here to stay. It is not only a very fast and cost-effective way to deliver assistance, but, if designed well, also ensures very efficient use of humanitarian funding. UNHCR's Jordan operation has in many ways proven this and set a standard for future implementation, whilst emphasising the need to continuously innovate and iterate in order to maximise cost-effectiveness and efficiency of protection and assistance delivery to refugees across the globe.

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Syrian refugee using iris scan technology to withdraw monthly cash assistance, Amman, Jordan.

Jared Kohler / UNHCR 2014

⁷ Modelling means applying econometric and statistical methods in order to arrive at ways of predicting the welfare of a family through proxy means testing. It uses a sample of households and detailed information of their vulnerability and then tests for the strongest predictors of poverty. These could be family size, size of the dwelling, single parent households, etc.

⁸ www.cashlearning.org/downloads/EXAMINING-PROTECTION-AND-GENDER-IN-CASH-AND-VOUCHER-TRANSFERS_Summary_March2013.pdf

⁹ See for example: http://www.cashlearning.org/downloads/120618%20Groupe%20URD_Cash%20coordination_comparative%20study_Final.pdf

¹⁰ <http://www.goodhumanitarianandonorship.org/>

Aid effectiveness and Vulnerability Assessment Framework: determining vulnerability among Syrian refugees in Jordan

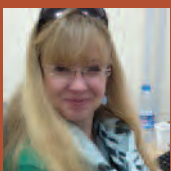
By Hisham Khogali, Lynnette Larsen, Kate Washington and Yara Romariz Maasri



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The current VAF development team consists of Kate Washington, Harry Brown, Marco Santacroce and Carolyn Davis. The work of the VAF team has been overseen and supported by Alex Tyler and Volker Schimmel of UNHCR. WFP and UNICEF have also provided essential support throughout the development process.



Syrian children in their new housing unit in Irbid, Jordan

Georg Schaumberger/NRC

The conflict in Syria, which began in 2011, has continued to create a worsening refugee situation. There is currently a growing population of 3,033,972¹ registered refugees in surrounding countries and the region. Realising the challenges that this number of refugees posed combined with the need to be more effective, UNHCR's Field Information Support Services section launched a project entitled 'Design and implementation of the framework for humanitarian aid effectiveness.' The main objective of this UNHCR initiative is to improve aid effectiveness, by ensuring a needs-based and principled approach to humanitarian response. In order to achieve this objective, UNHCR and its partners needed to work together, at country level, to agree on and put in place mechanisms for:

- Definition of vulnerable groups/households in need of assistance, and agreement on minimum sectoral data to inform this definition with partners
- Identification of vulnerable households
- Development of shared tools (database and data entry form) for the tracking of assistance provided by UNHCR and partners, agreement on data consolidation, and protection, data ownership, sharing/access agreement with partners

The process was driven by two factors. First, an interest in providing the right support to vulnerable people; for example, was it enough to provide the same support to all disabled people when their vulnerabilities may actually have required some differentiation in the type of support they received? Second, it was highly likely that there would be a reduction in resources available as the crisis continued and other crises around the world emerged; a better targeting mechanism would be needed to determine eligibility for limited aid.

The project approach

In order to test the concept of a vulnerability analysis framework, piloting was undertaken in Jordan in both the refugee camp context (specifically Zaatari camp) and with refugees in urban areas of the country. The pilot focused on health and cash assistance. The project was planned in three phases. These were:

Phase 1: Scoping and coordination:

Identification and engagement of key stakeholders, review of existing vulnerability assessment methods, set up and meeting of steering group.

Phase 2: Facilitation and design:

Support to sector leads to develop a vulnerability assessment strategy, database and data entry tool design

Phase 3: Lessons learned and recommendations:

Document a lessons learned exercise UNHCR approached ACAPS² to support the project as a non-operational entity in the region, i.e. without any assistance programming. Furthermore, ACAPS have specific assessment expertise and experience and had enjoyed previous successful partnerships with UNHCR. Support by ACAPS included the deployment of an assessment expert to work in country with UNHCR and all relevant partners in a collaborative manner to define vulnerability based on emergency life-saving needs, and specifically to define

¹ As of 17 November 2014, <http://data.unhcr.org/syrianrefugees/regional.php>

² ACAPS is the Assessment Capacities Project: it supports and strengthens humanitarian capacities to carry out coordinated assessments before, during and after crises. Through development and provision of innovative tools, know-how, training and deployment of assessment specialists, ACAPS aims to contribute towards a change in the humanitarian system's current practice with respect to needs assessments.

eligibility criteria for refugees receiving assistance, in the health and cash assistance sectors (as a starting point).

Phase 1: Scoping and coordination

This phase took place in the second half of 2013. UNHCR has an established methodology for assessing vulnerability. This method, using the Specific Needs codes³, was applied in the Syrian refugee context as in other contexts where UNHCR works. This 'group' approach has a number of key weaknesses including:

- Generalisations about vulnerable groups tend to exclude those that are generally not thought of as vulnerable, e.g. at a workshop in Zaatari camp, the issue of men being vulnerable particularly to violence, but also their potential to commit violent acts due to unemployment, was raised. In addition, in the context of Jordan, adolescent girls are particularly vulnerable (e.g. to becoming child brides). Yet neither unemployed men nor adolescent girls are included in the specific needs codes of UNHCR.
- Generalisations about vulnerable groups also fail to recognise that not everyone in a vulnerable group is equally vulnerable (UNHCR addresses this through exclusion criteria in the cash programme).
- A group approach is one dimensional and cannot capture the fact that a household or individual can be in more than one disadvantaged group at a time, i.e. potentially having greater vulnerability.
- A group approach also does not explain why someone is disadvantaged; an elderly person is not vulnerable because they are old, but perhaps because they are isolated



A Syrian refugee family tells a UNHCR staff member about life in a tented settlement.

UNHCR/J. Kohler/February 2014

- or lack resources to maintain themselves.
- The approach also does not take account of the temporal and spatial aspects of vulnerability; people can move in and out of vulnerability, e.g. a Syrian refugee who gains employment becomes less vulnerable, or refugees with proximity to services may be less vulnerable than those further away.

Initial reviews of secondary data and meetings with partners of UNHCR, both in health and cash assistance, revealed that different systems were being used for identifying vulnerability. This was particularly true in the case of cash assistance where a number of partners had adopted a scorecard approach. However, different scorecards were used by different partners. The score card approach provided a more transparent approach to determining vulnerability and enabled a multi-dimensional approach that incorporated both vulnerable groups and potential coping strategies/vulnerabilities. However, the scoring of cards created divisions amongst partners for whom there was no standard scoring mechanism⁴. This difficulty in agreeing scoring may have been exacerbated by organisational mandates⁵. It is also important to recognise that different organisations had different objectives for their cash assistance programmes, with some adopting a one off emergency assistance approach and others (e.g. UNHCR) adopting a three month (renewable) cycle approach. Cash assistance may be conditional or unconditional. Scorecards also rarely took into account access to services as a key vulnerability determinant.

In order to ensure a common understanding of vulnerability, the following three characteristics of vulnerability were proposed and agreed in initial meetings/workshops with partners. Namely that vulnerability is:

- multi-dimensional and differential (varies across physical space and among and with in social groups)
- scale dependent (with regard to time, space and units of analysis such as individual, household, region, system)
- dynamic (the characteristics and driving forces of vulnerability change over time).

These principles underpinned Phase 2: the facilitation and design of a vulnerability analysis system.

Phase 2: Vulnerability Analysis Framework: developing an inter-agency approach

After a two-month hiatus during the development of the annual Refugee Response Plan (RRP 6), work on the Vulnerability Analysis Framework project resumed in mid-November of 2013. Meetings with UNICEF and WFP led to a decision to broaden the scope of the project beyond the Cash Assistance working group and invite the participation of a wider range of stakeholders in its development. Following informal presentations of a proposed approach to groups of United Nations (UN) agencies, international non-governmental organisations (INGOs) and donors, an inter-agency steering committee, (consisting of five UN agencies, five INGOs and two donors) was established to guide further development of an assessment methodology and implementation⁶.

Throughout discussions with potential new partners, the key objective of the project remained the development of a standardised approach to assessing household vulnerability to support equitable programmatic decisions. A standard list of approximately 10-15 household indicators of vulnerability, developed by the humanitarian community through existing sector and inter-sector coordination mechanisms, would be used by UNHCR and other agencies in determining eligibility for assistance. However, it was stressed that while a household vulnerability 'score' could be used as a factor in decision-making, it should not be the sole criterion used in decision-making. Furthermore, the final decision on allocating any assistance would always rest with the individual agency responsible for managing the particular intervention. Because vulnerability is not a static concept, the frequency with which a re-assessment would be carried out was identified as one of the critical considerations in operationalising the exercise. Additional risk analysis would be carried out throughout the project

³ The UNHCR Specific Needs Codes categorise refugees into groups such as unaccompanied minors, disabled etc.

⁴ More specifically the weighting of scorecards was different.

⁵ Organisations weight vulnerabilities based on the objectives or specific persons of concern that they wish to target.

⁶ Steering Committee Members: CARE, Danish Refugee Council, Handicap International/Help Age, Première Urgence - Aide Médicale Internationale, Reach, WFP, WHO, UNICEF, WHO and, UN Women.

UNHCR/J. Kohler/February 2014



Abu Khaled shows the well his family uses for non-potable water in Irbid.



WFP/Dina Elkassaby

development process to identify any potential harmful impacts of the assessment on households, for example, the potential impact on marginal populations who fail to qualify as the least vulnerable but for whom assistance may be a critical factor in preventing a deterioration in circumstances over time.

Generating a relative household vulnerability 'score' would be done through a mix of sector-based and cross-cutting quantitative and qualitative indicators. Linking to location data for each household would enable agencies to analyse the data by vulnerability level, programming sector and geographic areas. It was proposed to start with data collection through the UNHCR registration and re-registration process and home visit data, with an eventual expansion of the collection process to, for example, selected NGOs, in order to speed up the development of a significant body of information. The project would also focus initially on refugee households outside the established refugee camps because of both the larger size of the target population and high levels of assistance still being provided in the camp setting. The data would be centrally stored and made available to participating agencies subject to normal concerns for privacy and sensitivity of data. Linking the data to UNHCR's Refugee Assistance Information System (RAIS) would eventually enable analysis of humanitarian assistance effectiveness in reducing or preventing vulnerability by establishing a household record of assistance to be matched against a vulnerability profile.

Developing 'indicators' of vulnerability

To increase awareness of the project and initiate the development of vulnerability indicators, a day-long workshop in February 2014 brought together representatives of sectors and sub-sectors to draft list of approximately 25 indicators from which a final (shorter) list would be culled. Although the seriousness with which all the participants approached the work was impressive, the groups achieved varying degrees of success in fleshing out indicators. Some groups were able to reach a more detailed articulation while others struggled to move beyond the discussion phase. Although most participants felt the task was a challenging one, comments from several participants indicated appreciation for the consultative approach chosen. The exercise, in addition to providing an important first step in the development of indicators, also helped to

solidify the image of the project as an inter-agency initiative and one that would provide useful tools and information for a broad range of humanitarian actors.

Definition of vulnerability and framework outcomes

The February workshop also established a working definition of vulnerability for the Syrian Refugee Crisis in Urban areas of Jordan: "the risk of exposure of Syrian refugee households to harm, primarily in relation to protection threats, inability to meet basic needs, limited access to basic services, food insecurity, and the ability of the population to cope with the consequences of this harm". Using this as a basis for defining the scope of the Vulnerability Assessment Framework (VAF) that is being developed, the VAF inter-agency steering committee is overseeing the VAF development process which will have the following outcomes:

- Data against VAF indicators are collected at the registration stage by UNHCR and during home visits by UN agencies and NGOs, and are uploaded into a central database.
- With the data regularly updated, the data base will generate a 'vulnerability profile' for each refugee household, based on thresholds of 'extremely vulnerable, very vulnerable', etc.
- Partners are able to access the database and conduct queries, while ensuring that confidentiality and protection rules are respected, e.g. query: percentage or number of extremely vulnerable refugee households in Irbid governorate, or a district of Irbid.
- Partners will be able to conduct sector-specific queries, to help them better target

their assistance by geographical area and household level, prompting further technical assessments.

- Partners who have identified beneficiaries for individual household assistance are able to check the 'vulnerability profile' of that household against the database, by uploading a list of unique identifiers (e.g. UNHCR or Ministry of Interior registration number). They may then be able to modify their decision of whom to assist, based on the vulnerability profile.
- The VAF should reduce duplication of assistance. Partners are encouraged to log assistance they have provided to a refugee household in the database. If partners are systematic in this entry, other partners can then see which households have already been assisted in the database, when searching for the unique identifiers.
- Through periodic reports, the humanitarian community will be able to monitor trends in vulnerability by geographical area, informing broader strategic processes, such as the Regional Response Plan.

Ultimately, VAF data will provide a comprehensive picture of vulnerability among refugees that may be used for advocacy purposes and for planning and prioritising of aid interventions.

Progress to date

The VAF process is multifaceted and a number of key components have been developed, piloted and rolled out, these include:

- In March 2014, an inter-agency participatory assessment was conducted with Syrian refugees, through 70 focus groups, with responses disaggregated by age, gender and disability. The VAF indicators were included in the discussions of refugee priorities/key concerns, and perceptions of their own or their community's vulnerabilities.
- An assessment tool was designed using the VAF indicators identified in the February workshop.
- A World Bank team has conducted a detailed analysis of indicators used by

⁷ UNHCR's registration software programme (database application) used in more than 70 countries, see: <http://www.unhcr.org/pages/49c3646cf5.html>

⁸ A software development phase when software features are complete.

WFP/Dina Elkassaby



ECHO and WFP provide food vouchers to Syrian refugees in Jordan, Save the Children manages distribution at Zaatari camp.

UNHCR for Cash Assistance decisions, using proGres⁷ and Home Visit data. From a welfare perspective, this provides an objective validation of many of the VAF indicators.

- Standard Operating Procedures (SOPs) on how the tool could be applied have been drafted by the VAF team.
- A Communication strategy for both partners and beneficiaries has been developed, and a Communications Specialist was brought on board to implement the initial phase.
- The VAF data collection tool was piloted and rolled out in June with over 15,000 households having been interviewed to date.

Throughout July-September, building on the work of the World Bank, econometric analysis of the VAF data was conducted and a VAF Welfare model that identifies the characteristics of vulnerable households was developed. This model uses predicted expenditure as a proxy for welfare and provides a mapping of the vulnerability spread across those households that have been interviewed. Data collection is ongoing with UNHCR, through implementing partner International Relief and Development (IRD), interviewing approximately 5000 new households a month.

In August an inter-agency appeals mechanism workshop was held and an appeal mechanism and interface designed. This appeals mechanism is now being piloted in cooperation with the WFP. Refugees can appeal for re-instatement in the WFP food assistance programme, following cuts made to the beneficiary list based on criteria developed as a result of the WFP Comprehensive Food Security Monitoring Exercise conducted in December 2013/January 2014. In October, an appeals database in RAIS was developed by UNHCR and launched in beta version⁸ to assist in the process.

Refugees can cook dry food rations in one of 250 communal kitchens set up by UNHCR in Zaatari camp.



WFP/Dina Elkassaby



Abu Nasser and his family having fled Syria, lives in a single room near Jordan's southern city of Karak. About half of the Syrian refugees in Karak report not having adequate water and sanitation.

UNHCR/J. Kohler/February 2014

A user interface module in the RAIS is being developed by UNHCR, to allow updating of vulnerability scoring at the household level, access to interested partners to inform assistance decisions, and from which vulnerability trends analysis can be extracted.

The VAF team also facilitated an additional participatory interagency inter-sectoral workshop in October 2014 to elaborate Sector Based Vulnerability Assessment Rules that will complement the Welfare/Vulnerability Assessment model. The workshop built on work conducted in Lebanon to define sector level vulnerability decision trees. Each sector was tasked with looking at the multiple data points available from the VAF questionnaire and UNHCR home visit form in order to identify and then articulate sector specific indices of vulnerability and develop weights for each, which allow a sector level calculation of vulnerability. This sector level scoring is still under review but will allow for a more nuanced picture of household vulnerability. For example, VAF partners will be able to access information that tells them a household's overall vulnerability score but also a breakdown of relative vulnerabilities by sector. This should allow for programmatic decisions to be made on the most appropriate types of intervention and acknowledges the holistic and interlinked nature of vulnerability.

Risks and safeguards

Given the impact that the household vulnerability score could potentially have on the assistance received by a household, it is important that the nature and limitations of the data are clearly understood by all actors and that safeguards are included in the framework to minimise the risk that data are misused. Discussions with the Protection Unit in UNHCR have also taken place throughout the process.

The assessment process needs to be carefully considered to minimise exclusion risk, i.e. the risk that households or segments of the refugee population are excluded from the process or their level of vulnerability is incorrectly categorised and they are excluded from receiving assistance. One example of a mitigating action which has been developed and is being piloted (see above) is an appeals process by which households can contest any changes in the provision of assistance based on VAF vulnerability scores. This will continue to be articulated at a sector level as the VAF is rolled out.

Additionally, there is a risk that refugees those without support, may eventually become vulnerable so that there is a need for periodic re-assessment or other means by which to identify changing household circumstances.

As stated above, the VAF process minimizes risk of exclusion for refugees through

- 1) appeals process, or fast-tracked reassessment for border line cases
- 2) periodic update of vulnerability status
- 3) quality assurance of data collectors and database.

It is important to highlight that the VAF will not replace the need for sector-specific detailed needs assessments, but will assist in streamlining planning of such assessments and/or programmatic interventions by, for example, identifying geographical areas where a large number of cases with a sector-specific 'flag' are located.

VAF validation plan and roll out

Finally, the VAF steering committee is now articulating a validation plan that will review and validate the different components of the Welfare/Vulnerability model and the Sector Level rules before the VAF is fully rolled out to partner organisations. The validation plan will use a participatory and inter-agency/inter-sector approach. Further consultations with refugees to review vulnerability indicators and indices will be conducted. Additionally, multifunction teams will conduct 'blind' visits to a randomised selection of households (across the vulnerability thresholds) that have undergone VAF interviews and scoring to assess the accuracy of the models and rules. On the basis of the results of these validation activities, the steering committee and a peer review committee of other vulnerability specialists from the region will sign off on the VAF models and the full set of VAF tools will be made available to partners.

Currently, the VAF aims to be fully operational and launched in January 2015. During an initial six month period there will be a VAF oversight committee who will monitor the use of VAF tools and VAF data by partners. By June 2015, Phase 3 of the process will be conducted with a full review of the process to date, revision of the models or rules as necessary and the documentation of lessons learnt and recommendations.

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Refugee women in the north of Jordan

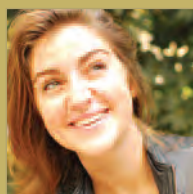
Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment

By Gabriele Fänder and Megan Frega



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Background

At the start of 2012, there were only a handful of Syrian families who had taken refuge in Jordan. By September of the same year, the number of refugees had increased to about 45,000; one year later, it had grown by half a million. Conflict and violence in Syria drove hundreds of thousands into neighbouring nations, without resources or means to survive. The sudden population influx and need for basic items, food, shelter, and health care for over half a million people exacerbated the existing problems of scarce resources.

Prior to the Syrian crisis, infant and young child feeding (IYCF) practices were poor in the region evidenced by low exclusive breastfeeding prevalence for infants less than 6 months¹ and high anaemia prevalence rate among children of toddler age.² According to FAO (2011)³, early initiation of breastfeeding amongst mothers in Syria was very low at 32%, while reports on the national level indicate a prevalence of 46%⁴. The most recent figures report exclusive breastfeeding prevalence at 42.6%⁵ and only 37% of children 6-9 months of age had been introduced to complementary foods⁶. Early initiation of breastfeeding and exclusive breastfeeding amongst infants less than 6 months of age is significantly lower in Jordan, at 39% and 22% respectively⁷. These findings suggest inadequate pre-existing health and nutrition preventive behaviours, especially poor infant and young child feeding practices, amongst both the refugee and host populations.

Breastfeeding practices need to be protected during emergencies; it is well known that infants who are not breastfed are at a manifold higher risk of morbidity and mortality than breastfed children⁸. Breastfeeding is emotionally and psychologically restorative to women under stress. A woman's body is designed to feed and nurture her child even under difficult circumstances. In emergency situations, appropriate and safe IYCF practices are less likely than under stable conditions. Bottle feeding comes with increased risks; poor water quality, an inability to sterilise the bottle/nipple, artificial ingredients in breastmilk substitutes (BMS), and lack of sustainability, can all contribute to poor nutrition and health in infants dependent on BMS.

Early IYCF assessment

Medair arrived in Jordan at the start of the Syrian crisis in 2012, to respond to the growing public health and shelter needs. From the start, IYCF and nutrition were identified as a large public health need that was not being covered by other agencies. Medair chose to focus efforts on IYCF to prevent a rise in malnutrition as the crisis deepened. At the beginning of the IYCF project, Medair explored

IYCF practices among Syrian refugee mothers through individual interviews and focus group discussions in November 2012 to probe community perceptions and practices. An assessment in November 2012 set a baseline for IYCF indicators to monitor the project.

The November 2012 assessment found that Jordanians and Syrians had similar misconceptions surrounding breastfeeding. Few mothers or caretakers understood the benefits or importance of exclusive breastfeeding for infants for the first six months. Refugees often reported they exclusively breastfed but on probing, were found to give other fluids to their infants. Another common misconception was that bottle feeding was preferable, and that stress on a woman's body prevents her from breastfeeding. Older generations with poor education on the benefits of breastfeeding often counsel younger women to give BMS, and younger women almost exclusively follow this advice. Misconceptions amongst caregivers and mothers during the discussions included poor advice, telling women to "give water and herbs," or that "breastmilk alone is insufficient for infants," and "traditional approaches are preferred."

Additional assessments found that medical staff in local clinics and hospitals often gave wrong or conflicting advice about breastfeeding to caretakers, contributing to poorer nutrition and breastfeeding practices. Many hospitals and clinics often did not emphasise the importance and nutritional benefits of colostrum⁹ after delivery. Some doctors advised women that breastmilk alone was not sufficient, depending on the women's diet or personal nutrition.

IYCF programme

In 2012, Medair began the IYCF project through a partnership with the Jordan Health Aid Society (JHAS), a national NGO¹⁰. The purpose of the project is to protect children under five years and pregnant and lactating women (PLW) by screening for malnutrition and educating caregivers about IYCF practices. The project focuses on education on exclusive breastfeeding for expectant mothers, targets

¹ UNICEF http://www.unicef.org/infobycountry/syria_statistics.html, http://www.unicef.org/infobycountry/jordan_statistics.html

² WHO http://who.int/vmnis/anaemia/data/database/countries/jor_ida.pdf

³ WHO, Nutrition Country Profile, <http://apps.who.int/nutrition/landscape/report.aspx?iso=SYR&rid=161&template=nutrition&goButton=Go>

⁴ http://www.unicef.org/infobycountry/syria_statistics.html

⁵ http://www.unicef.org/infobycountry/syria_statistics.html

⁶ International Baby Food Action Network, 2011

⁷ http://www.unicef.org/infobycountry/syria_statistics.html



Male focus group

Megan Freya/Medair, Jordan, 2013

mothers with infants less than 6 months of age to encourage exclusive breastfeeding, and targets mothers with children less than 2 years to encourage the correct and timely introduction of complementary food.

Working in collaboration with JHAS in northern Jordan, Medair began education and promotion groups in JHAS clinics and in mobile clinics in the surrounding areas. Each of the six fixed clinics and one mobile clinic are staffed with a nutrition officer who is responsible for IYCF promotion and breastfeeding counselling and oversees the management of acute malnutrition in the related health clinic. During 10 months of project implementation, 4,690 PLW received IYCF education and 919 mothers engaged in breastfeeding counselling sessions. Medair also delivered training on IYCF, malnutrition screening and malnutrition treatment to health staff, doctors, technicians and nurses from six JHAS clinics outside Zaatari camp, one JHAS clinic inside Zaatari camp and one mobile clinic. The partner clinics are located in Amman (2), Zarqa, Mafraq, Ramtha and Irbid. The mobile clinic covers the South of Jordan (Karak, Madaba, Tafila, Ma'an, Aqaba).

Community networking

In 2013, Medair incorporated a community networking component into the programme that employed volunteers to educate the refugee community on IYCF practices and to screen for malnutrition. Many of the Jordanian volunteers educating the refugee communities were equally unaware of the importance of exclusive breastfeeding, and appreciated the training for their own families. Training took place in the JHAS training centre in Amman or in the Medair office in Mafraq (North Jordan). Community volunteers initially received three days of training on IYCF, nutrition including acute malnutrition, BCC (Behaviour Change Communication) and general health and hygiene topics, specifically preventable communicable diseases. Every month, community volunteers gather in their relevant service area and receive refresher training on these topics.

The community component involves 35 Medair volunteers who conduct house-to-house visits with stand-up education presentations to

teach and train entire families. Community volunteers include Syrian and Jordanian men and women, who work to a weekly target of 50-58 household visits. All volunteers receive a weekly incentive and transportation costs upon submitting a weekly work report. The programme coverage area is the six northern governorates of Jordan (Amman, Zarqa, Mafraq, Irbid, Jerash and Ajloun). Over the course of 10 months, 4,977 PLW received IYCF education, and 31,485 caregivers were reached with IYCF and health promotion education through the community project. Each family is taught and counselled depending on the ages of their children, so mothers receive advice on complementary feeding, breastfeeding, and infant nutrition as appropriate. Families also receive information on where to go for additional services, where to get food vouchers, how to enrol in cash-assistance programmes, and were to find additional health services.

Medair also establishes small, individual support groups, so that mothers have the opportunity to sit together and learn from one another. At this point, only two regular mother support groups are fully functioning in Zarqa Governorate. Other groups meet sporadically in all programme areas. The interest to meet and participate in mother groups is very high; sometimes up to 50 women try to participate in one gathering. One of the recommendations emerging from the Medair programme will be to scale up mother support groups in terms of enabling regular meetings of the same small group, to better facilitate learning and influence behaviour change.

Mothers who are unable to breastfeed are referred to Medair partner clinics for professional support. A qualified midwife or an obstetrician/gynaecologist specialist checks mothers to establish reasons for not breastfeeding. Mothers who are willing to re-lactate receive relevant breastfeeding support. Unfortunately, for those mothers who cannot or do not want to breastfeed, there is no support for BMS supply facilitated by any health facility outside Zaatari camp. Security issues surrounding BMS targeted distribution in the camp (see below) have dissuaded community service providers from getting involved in BMS distributions. Infant formula is expensive; a 250g tin costs 5 JOD (7USD) and lasts 4-5 days. As a result, many mothers use cheaper milk powder instead.

Programme coverage and impact

Since the inception of the programme, communities in general, including males and fathers, have been receptive and open to education and learning. Many families have requested additional information about IYCF from volunteers and are eager to learn more. Medair's project covers 60% of the refugee population in the northern governorates, where, as shown earlier, over 30,000 mothers and caregivers have received promotion and counselling on IYCF (average contacts to May 2014¹¹).

A follow up Medair survey was carried out in March 2014 to examine project impact. The

sampling frames involved:

- 31,485 caregivers who were visited by the Medair IYCF volunteers between November 2013 and April 2014 and had received breast feeding education.
- 128 caregivers with infants less than 6 months were included in a 24 hour dietary recall to assess breastfeeding status.

The survey showed an increase in breastfeeding knowledge but not an improvement in breastfeeding practice. Knowledge amongst mothers of at least two benefits of breastfeeding had increased from 49.5% (November 2013) to 71% in the community and 91.2% in the health facility setting (March 2014). However, exclusive breastfeeding practice among the mothers who knew about breastfeeding recommendations showed no change (24.2% community survey and 25% health facility based, March 2014) and in fact, was worse than the pre-crisis national prevalence in Syria (42.6%¹²). These findings show that while a large percentage of families in Jordan have been successfully educated on the benefits of breastfeeding, more time and other measures to address social and cultural barriers are needed actually to effect nutrition behaviour changes.

Among the 91 mothers of infants less than 6 months who were not exclusively breastfeeding, more than half (64.8%, n=59) fed their baby with infant formula, followed by other liquids including water (20%), traditional soup and liquid (16.5%), and raw milk (15.4%). Data from one health facility showed similar results, finding that 44.4% of caregivers who were not exclusively breastfeeding fed their baby infant formula.

Treatment of moderate acute malnutrition (MAM)

To treat MAM in children below 5 years of age and PLW, as implementing partner for WFP, Medair has been distributing Super Cereal Plus in a targeted supplementary feeding programme (TSFP)¹³. Mothers were initially reluctant to eat this food or give it to their malnourished child, thinking it might cause them harm. However, Medair began cooking demonstrations during distributions at local clinics to show the women how to prepare the food, even eating some with them. The demonstrations have helped remove the stigma of this 'refugee food'. As soon as the Super Cereal Plus was cooked during demonstrations, children would start eating it, finishing the whole test portion in no time at all. The same applied for reluctant PLW, once they tried

⁸ Bahi R, et al. Bull of WHO 2005;83 (6):418-426

⁹ Colostrum is the breastmilk produced during pregnancy and immediately after birth. It is low in fat, and high in carbohydrates, protein, and antibodies. It is low in volume and provides concentrated, highly digestible nutrition to the newborn.

¹⁰ See profile of JHAS in this edition of Field Exchange

¹¹ Mothers with breast feeding difficulties, with sick children and with malnourished children have received several follow up visits during the programme period. This also includes mothers who are malnourished

¹² UNICEF, http://www.unicef.org/infobycountry/syria_statistics.html

the cooked food they all agreed it was quite possible to eat it. However, everyone unanimously agreed it needed sugar to improve the taste. During cooking demonstrations, beneficiaries themselves who had recovered through eating the product, advocated for its use and gave tips on how to improve its taste.

Acute malnutrition screening

Since 2012, screening for acute malnutrition has been undertaken by Medair and community workers, targeting PLW and children under five years. The number of children with acute malnutrition identified through screening is very low, much lower than the expected rate according to the nutrition survey findings in 2012. Out of 46,383 children screened in clinics and communities during the 11 months project period, only 69 severe acute malnutrition (SAM) cases and 124 MAM cases were identified. Out of 10,088 PLW screened during the 11 months project period, 457 were identified as acutely malnourished.

Challenges

BMS donations and supplies

The culture of bottle feeding in Syria and Jordan was perpetuated through the untargeted distribution of breastmilk substitutes (BMS) in the early days of the response and the concept that poor diet among lactating women negatively impacted on their ability to breastfeed. Especially during the first phase of the influx of refugees into Jordan (end of 2012 and through the first half of 2013), many non-governmental organisations (NGOs), community-based organisations and well-meaning donors from Gulf countries distributed huge amounts of BMS to refugees in camps and host communities. BMS products were not distributed according to assessed needs, for example to mothers who were unable to breastfeed. BMS were usually included as a general item in food baskets distributed to refugee families. Those distributions were in general 'once-off' distributions with no provision for sustained supply to infants established on these products.

In order to regulate these BMS distributions, the Nutrition Working Group in Jordan developed Standard Operating Procedures on Distribution and Procurement of Infant Formula and Infant Feeding Equipment¹⁴. Those guidelines were pro-

moted within the wider NGO community and to donors. From that point onwards, donations were streamlined through UNHCR and all BMS donations stored in a warehouse in Northern Jordan. Managing donations created a large amount of work for the Nutrition Working Group who had to decide what to do with the donations, which far exceeded the need for BMS. At one point, the Nutrition Working Group had to decide what to do with thousands of boxes of different BMS types and milk powder in storage.

For Zaatari camp, to meet the needs of non-breastfed infants, clear protocols were developed for the supply of BMS. Mothers are individually assessed by a qualified midwife from an appointed clinic (run by the national NGO, Jordan Health Aid Society (JHAS)¹⁵. Where BMS supply is indicated, the mother obtains a written prescription for BMS, which is supplied at designated distribution points. Outside the camp, managing BMS has proven to be more complicated. Refugees are widespread across all six northern governorates and it is more difficult to find specialised clinics across those Governorates who not only have the expertise to qualify mothers for BMS distribution, but also to facilitate supply. Experience related to riots and attacks on distribution points in the camp related to BMS¹⁶ have prevented clinics outside the camp agreeing to store BMS products and be part of a BMS distribution.

Expectations of aid

One of the challenges Medair faces in programming is the need to distribute physical aid along with education. Refugees often expect physical aid - cash, hygiene items, kitchen equipment, etc. - and struggle to see the importance of education without accompanying in-kind assistance. Community volunteers are received with suspicion if they come to "only talk". Initially, families don't see the importance of education and promotion related to IYCF. To respond to this demand, volunteers have begun to distribute spoons, cups, and breastfeeding shawls to women with children under 6 months of age, as well as hygiene kits to mothers with children under 2 years. Beneficiaries put the need for cash above all other needs, sometimes failing to recognise the importance of other initiatives. Donors, stakeholders, and medical staff also typically see IYCF support approach as a 'soft' approach without much impact.

The timeline for aid delivery is a challenge. In emergencies, short intervention timelines and quick impact programmes are preferred. As reflected earlier, behaviour change requires a longer term approach.

Discussion and recommendations

To tackle social and cultural barriers and increase effectiveness of IYCF promotion in Jordan, additional mother support groups and learning groups need to be incorporated into the education process. Community led and sponsored support groups with cooking demonstrations, continual learning discussions, and referral information should be held regularly.

Doctors and health staff must be targeted as they are the primary source of information for refugees. Doctors must encourage breastfeeding among patients and hospitals must have delivery staff who promote good feeding practices. Mothers must also be informed through antenatal care visits about the importance of exclusive breastfeeding and the benefits of breastmilk versus infant formula. The Jordanian Ministry of Health is a critical partner to champion key IYCF messages within the country. Messaging through radio, television and newspapers about health and hygiene practices must permeate both the Jordanian population and the refugee community. Hygiene materials should be distributed along with messaging to enable long-term behaviour change.

UNICEF has requested that Medair begin to champion their baby friendly hospitals initiative (BFHI), which will seek to train health workers on the importance of immediate breastfeeding after delivery. None of the clinics which Medair supports has BFHI status, however, this is planned in the next stage of programming.

With regard to the needs of non-breastfed infants, the provision of targeted supplies of BMS in the community setting is a particular challenge and remains an outstanding gap.

During every training session, whether with communities, volunteers or medical staff, Medair have found that participants are excited to learn about how important IYCF practices are and want to learn more. Technical support material in Arabic tailored to the context of the Middle East would greatly help training delivery.

For long-term change to happen, the approach must continue to be community led and focused on the needs of poor, vulnerable families. Physical aid should accompany health messaging and education. Prevention programmes over curative interventions should lead the response.

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¹³ See article by WFP for more details on the TSFP.

¹⁴ Available from: <http://data.unhcr.org/syrianrefugees/regional.php>

¹⁵ See article by JHAS and profile of the agency in this edition of Field Exchange.

¹⁶ See the article by Save the Children Jordan that elaborates on these BMS problems in Zaatar camp.



A group teaching session in the IYCF caravan

Managing infant and young child feeding in refugee camps in Jordan

Save the Children Jordan, 2013

By Sura Alsamman



Sura Alsamman is nutrition supervisor at Save the Children Jordan, responsible for the overall all coordination of the IYCF technical functions and activities in camps and south of Jordan. Previously she worked in various maternal and child nutrition programmes.

Save the Children Jordan (SCJ) is a registered Jordanian NGO established in 1974, with Her Royal Highness, Princess Basma Bint Talal as the Chairperson of the Board. SCJ is part of and the only Arab member of the 30 Save the Children organisation members operating in 120 countries worldwide. In Jordan, SCJ develops much needed national programmes that focus on creating sustainable results where every child attains the right to survival, protection, development and participation.

Since the beginning of the emergency in Syria, over 500,000 Syrians have crossed the borders into Jordan and are either hosted by the Jordanian community or residing in refugee camps. The first refugee camp in Jordan was Zaatari, administered by the Government of Jordan-appointed Syrian Refugee Camp Directorate (SRCD), with the support of UNHCR. More than 350,000 Syrians have been registered in Zaatari camp since its opening in July 2012. A large number of refugees have subsequently left Zaatari camp to urban and rural areas in Jordan.

At the beginning of the emergency, a number of assessments were conducted to determine the health and nutrition needs of the refugees, including The Inter-Agency Nutrition Assessment conducted in November 2012¹. This recommended strengthening the awareness, promotion, and protection of optimal infant and young child feeding (IYCF) practices through preventive and nutrition promoting services.

Prior to the crisis, IYCF practices were already poor in Syria. According to the MICS² survey of 2006, the prevalence of early initiation of breastfeeding was 46%, and the prevalence of exclusive breastfeeding in infants under 6 months of age was only 43%. IYCF indicators were not favourable in Jordan either; the 2012 DHS³ showed that in the past few years, exclusive breastfeeding rates have dropped from 27% to 23%. In Zaatari camp in Jordan, there was a high demand for infant formula early in the crisis response. Whilst only a small percentage of women requesting supplies were physiologically

unable to breastfeed, common use of infant formula pre-crisis among the Syrian refugees, coupled with untargeted and unsolicited distribution of infant formula in the early humanitarian response and high levels of stress and anxiety among women, fuelled this demand.

In late 2012, a Nutrition sub-working group (Nutrition SWG) was established as a sub-group of the Health Working Group, initially chaired by UNHCR and co-chaired by Save the Children Jordan (SCJ) from November 2013. Initial advocacy and response initiatives involved the development and sharing of two key guiding documents through the Nutrition SWG, namely:

- Guidance Note on Appropriate Infant and Young Child Feeding Practices in the Current Refugee Emergency in Jordan (26th of November 2012)⁴.
- Standardised Operating Procedures (SOPs) on Donations, Distribution and Procurement of Infant Formula and Infant Feeding Equipment in the Current Refugee Emergency in Jordan (26th of November 2012)⁵.

Save the Children Jordan programme

Breastfeeding in an emergency is known to be the safest way to protect infants and young children from an increased risk of infection and from becoming malnourished. Breastfeeding support was a key recommendation of Inter-Agency Nutrition Assessment (as above). Given this, SCJ launched the Infant and Young Child Feeding in Emergencies (IYCF-E) programme in Zaatari camp in December 2012, after completing a technical training supported by Save

the Children US. The programme was funded by OCHA, Save the Children US, UKAid and the German Cooperation-Save Germany. It aimed to reach 90% of pregnant and lactating women (PLWs) and children under 5 years in the camp. At the time (November 2012), the camp population was estimated to be 45,000⁶.

The programme's main goal was to promote, protect, and support appropriate IYCF practices, including early initiation of breastfeeding within 1 hour of birth, exclusive breastfeeding for infants under 6 months, and appropriate and timely introduction of complementary food along with breastfeeding after 6 months.

Mother-baby friendly spaces

The IYCF programme started with the establishment of the first of three caravans serving as a mother-baby friendly space (safe haven). The caravan engaged a team of five trained IYCF counsellors responsible for individual counselling sessions and follow up, five educators responsible for group education sessions and 10 supporting Syrian community mobilisers.

¹ Inter-agency nutrition assessment Syrian refugees in Jordan host communities and Za-atari camp. Final report. January 2013

² Multiple Indicator Cluster Survey (MICS), Syrian Arab Republic, 2006 http://www.childinfo.org/files/MICS3_Syria_FinalReport_2006_Eng.pdf

³ Demographic and Health Surveys (DHS) for Jordan, 2012. <http://dhsprogram.com/what-we-do/survey/survey-display-403.cfm>

⁴ Available at <http://data.unhcr.org/syrianrefugees/regional.php>

⁵ Available at <http://data.unhcr.org/syrianrefugees/regional.php>

⁶ Current estimates of Zaatari camp population are around 90,000 people (June 2014)

An individual teaching session



Save the Children Jordan, 2013

A simple rapid assessment was conducted in the first few days of operation in Zaatari camp, to explore the prevailing infant feeding practices and challenges faced by PLWs and caregivers. This exercise allowed SCJ to better design the counselling and education sessions in the programme; it was not intended to provide a full dataset or statistical analysis. The assessment highlighted many misconceptions among mothers including mothers believing they don't have enough breastmilk/mothers convinced that breastmilk is drying up due to stress/mothers believing that breastmilk is not enough for infants in the first few days of life. The rapid assessment indicated the need to emphasise the importance of exclusive breastfeeding and the correct timing of starting complementary feeding.

The assessment also identified cases of breastfeeding difficulties, like engorgement and mastitis, which counsellors started following up with immediately.

As the camp population rapidly increased, and in partnership with UNICEF, two new IYCF caravans were established to cover all 12 districts in the camp. Eight new staff members joined the team to support in following up with mothers. The IYCF caravans are located in districts 3, 4 and 8, next to the three main schools in the camp. Based on the camp population distribution, those caravans are reachable to most mothers. Each caravan currently has an educator and a Syrian caravan assistant on a daily basis, along with the counsellor and community mobiliser

assigned for each district. On average, 120-150 mothers visit the three IYCF caravans on a daily basis. Some mothers attend daily, others weekly as they wish. On average, there are 150 new visits to the caravans per week.

The caravan is promoted as a safe space for breastfeeding, where privacy and support is provided for all pregnant women and mothers with children under 5 years. Education sessions are held in the caravan on a daily basis from 9:00am till 3:00pm covering topics such as nutrition for PLW, the importance of breastfeeding, complementary feeding, and feeding during illness. Initially, infants who were using infant formula attended the paediatrician, but now are directed to the IYCF caravan also. A nutrient dense snack (high energy biscuit) and a bottle of water are provided to mothers as incentives to visit the caravan and to highlight the importance of nutrition and fluids for breastfeeding mothers. Breastfeeding shawls for privacy (provided by UNHCR as a gift in kind) were also distributed to lactating mothers. A bottle/cup amnesty activity also operates in the caravan, where mothers are encouraged to exchange any feeding bottle they have for a measured cup which is considered safer, more hygienic and easier to clean.

In order to respond to mothers concerns, IYCF educators follow up with the various health issues arising in the camp. For example, food safety and hygiene was emphasised when diarrhoea cases increased and the importance of early initiation of breastfeeding was emphasised when cases of jaundice were identified in newborns. In addition, the IYCF educators participate actively in the sensitisation and mobilisation for the different immunisation campaigns.

Over 18 months of operation (Dec 2012 to May 2014), the programme has reached 15,600 mothers through the caravan and tent counselling sessions in Zaatari camp. Non-breastfed infants are supported through individual counselling sessions. A high proportion of the mothers attend with children under 2 years of age.

Community mobilisers

From the early stages of implementation, community mobilisation was identified as one of the main components of the programme. It was agreed that each Jordanian staff (counsellor/educator) would closely work with a Syrian mobiliser who was chosen based on their background (nurses, college graduates) and how well they knew the camp community. The mobilisers main responsibilities are to identify mothers who need breastfeeding support and help in spreading the IYCF messages. If they encounter mothers using infant formula, they direct them to the IYCF caravans, or refer to a counsellor to investigate relactation, or at a minimum, ensure that are preparing infant formula as hygienically as possible. It is clear that having Syrian mothers as part of the team and communicating the same messages makes it much easier to communicate with the refugees and discuss their beliefs and misconceptions around infant feeding

Box 1 Community mobiliser – success story

Sara is one of the community mobilisers working with the IYCF team in Zaatari camp. Sara decided to join the team after her successful experience in breastfeeding her youngest child and seeing how this affected his health compared to his four older sisters.

Travelling with her four daughters, Sara arrived at the camp in the heat and dust of July 2012. As the days passed, Sara gradually settled in, amongst relatives and neighbours. She learned to cope in a difficult environment, with insufficient food supplies and inadequate accommodation conditions. Sara first visited us one cold December morning in 2012, as a result of an outreach campaign we conducted in the camp. She was pregnant with her fifth child. When she first came, she expressed her concern regarding sanitation in the camp and access to clean water. She did not possess sufficient knowledge about the benefits of breastfeeding her child. This applied to both her and the community as a whole.

With her delivery date approaching, the IYCF counsellors' visits to Sara increased. She was taught the different positions for breastfeeding, the signs of proper breast attachment, the importance of colostrum (the first milk produced by a mother on giving birth), as it is rich in immunologically active cells, antibodies, Vitamin A and other protective proteins, and much more. After Sara's discharge from the hospital on giving birth, IYCF counsellors from SCJ continued to visit her on a weekly basis to monitor the progress of the baby's health and weight, provide emotional support for her, and answer any questions or address concerns she may have.

"For the first six months, I exclusively breastfed Tamer, as I had been advised; he is the only child I exclusively breastfed and I can clearly see the difference in comparison to his four older sisters. He is more resistant to diseases and infections, and is more alert and active. In addition, I myself experience great joy when I breastfeed him, I tend to transition into a state of serenity, tranquillity and bliss. A state that in a camp environment is unattainable."

Even as Tamer grew, Sara continued to visit the IYCF caravan as often as possible. She would relate her story to other pregnant and lactating mothers and her enthusiasm was infectious. Sara has become our ambassador in Zaatari Camp. She is such a strong advocate of breastfeeding and so we are happy to have her among our team of Syrian camp mobilisers.

One of the IYCF caravans in Zaatari camp



Save the Children Jordan, 2013

practices. Difficulty following up with mothers was one of the major challenges we faced at the beginning; families were constantly changing their locations in the camp (moving to a higher area, closer to the market, next to new arriving relatives). With no contact information other than the address given in the initial visit, it was very difficult to reach the mother again. However, with the help of the community mobilisers team and their connections with street leaders, the team were able to reach many of these cases. A case study regarding one community mobiliser's experiences is included in Box 1.

Coordination with partners and health facilities in the camp has also played a key role in disseminating IYCF messages. Through agreements and Memoranda of Understanding (MOUs) with different partners, IYCF educators have the opportunity to reach mothers and conduct sessions in clinics and women/youth centres. Recognising that contact with mothers immediately after birth increases the possibility of exclusive breastfeeding and early initiation, IYCF counsellors provide counselling sessions on a daily basis in the two health facilities providing delivery services in the camp.

Acknowledging the impact of the messages communicated by health providers, and noticing some cases of misinformation from health staff in the field clinics, it was crucial to ensure that unified IYCF messages were delivered by all doctors, midwives and nurses. Key information includes the importance of colostrum and early initiation of breastfeeding, duration of exclusive breastfeeding, timely introduction of complementary feeding, and indications for prescription of infant formula (medical indications and where infants are not breastfed, see below). To address these issues, an orientation session was conducted for all health providers on IYCF; key messages were also circulated through the health coordination meeting. Due to the high staff turnover in such situations, continuous follow up remains a necessity to ensure a unified message.

The difficulties in managing infant formula

Monitoring infant formula prescription and dispensing has been a major challenge from the beginning of the crisis response in Jordan. Characteristics of optimal IYCF practices and the provisions of the International Code of Marketing of Breastmilk substitutes (BMS) were relatively

unknown. Controlling BMS (typically infant formula) supply was a new concept among national health staff and caregivers, especially given that infant formula use was the norm for the Syrian community pre-crisis. Hence most of the caregivers argued it should be part of the ration or distributed for every family with children under 2 years of age. Field hospitals received donations of infant formula, bottles and teats and were distributing them for all mothers.

Infant formula prices are relatively high. Many mothers who received it opted to sell it in the camp streets or sent it outside to be sold in the community (it was clearly seen for sale in the camp market). To reduce distribution channels and ensure targeted distribution, UNHCR followed up on this issue. A series of meetings were held with different health providers to ensure that there was a system in place to manage the process of supply provision of infant formula. It was agreed that only one health facility would be responsible for dispensing infant formula and a protocol was established regarding individual assessment of need and supply method (see Box 1). It was very important for SCJ to make sure that IYCF caravans were not involved with any kind of BMS prescription or dispensing. Within a few days of starting the new process, however, it was clear that the refugees were not happy with it. Angry men would gather at the health facility and demand infant formula. In addition, they restrained their wives from taking the physical examinations. Many infant formula packs were taken by force and the midwife received several threats of attack.

Sensitisation was critical for calming the situation. Mothers and caregivers were referred to the IYCF caravan for education sessions on the importance of controlling this prescription process and the dangers of artificial feeding in emergencies. IYCF educators were present on a daily basis in the health clinic explaining the importance of breastfeeding and superiority of breastmilk. But it was also clear that further security precautions needed to be in place. It was decided to have the prescription and dispensing in two different locations - the examination and prescription undertaken in the health clinic and the distribution at another more secure location. Once both locations were identified (this took some time), it was agreed that an IYCF staff member would be present in each facility to support and monitor the process. A database was developed to keep track of mothers receiving infant formula (names, ages, ration card number) to avoid duplication, to allow regular follow up to ensure hygienic and correct preparation of the infant formula and to explore the possibility of re-lactation. Even with the strict prescription criteria, infant formula tins were being sold in the camp market. Thus it was agreed with staff based in the dispensing site to open each tin

Box 1 Community mobiliser – success story

Infant formula is prescribed based on any of the medical indications for infant formula use as recommended by WHO⁷ or when physical examination of the mother finds there is no breastmilk supply.

All mothers requesting infant formula are required to undergo a physical examination by a midwife to determine if there is breastmilk supply. This includes mothers who have never breastfed. If the midwife determines that there is no breastmilk supply, the mother is prescribed infant formula. If the mother is found to be able to breastfeed based on physical examination and is found to have good milk supply, then she is not supplied with infant formula. In practice, in most cases where mothers are already using infant formula, there is not a 'good' supply of breastmilk, and these mothers are generally prescribed formula.

If the mother is interested in relactation, the counsellor follows up with her regularly and gradually decrease the quantity of infant formula provided. If the mother does not have breastmilk supply and is not interested in relactation, then she keeps visiting the midwife on a monthly basis to receive the infant formula prescription.

Infant formula is provided for infants until 12 months only.

Weighing infants on a monthly basis would be a useful additional indicator to inform and monitor infant formula prescription. Unfortunately growth monitoring is not yet in place, but its implementation is under discussion.

⁷ Acceptable medical reasons for use of breast-milk substitutes. WHO/NMH/NHD/09.01. WHO/FCH/CAH/09.01. http://www.who.int/maternal_child_adolescent/documents/WHO_FCH_CAH_09.01/en/

Cup for bottle exchange in the IYCF caravan



Save the Children Jordan, 2013

once the mother received it. This mechanism worked well, as no one was then willing to buy an already opened tin of infant formula.

Infant formula donations and their untargeted distribution remain a challenge. Although the SOPs (see earlier) have been circulated, shared and discussed with all partners, individual donations of infant formula still find their way to the camp. It is worth noting that many mothers are refusing the donations or returning any quantities they receive as they are exclusively breastfeeding. Street leaders from the community approached the clinic a few months ago with quantities of donated formula; they wanted to leave it with the midwife as she would know who actually needs to receive it, which shows that the community is now aware of the risks of such distributions. An average of 10 new mothers is prescribed formula on a weekly basis. With the opening of a new refugee camp (Azraq camp) in Jordan in April 2014, many lessons have been applied from the experiences in Zaatri camp. A system for infant formula provision has been in place from the beginning. Upon prescription, mothers are given specific dates to go and receive the infant formula, the dispensing takes place twice a week, and a list is communicated each time from the prescription to the dispensing site to avoid any confusion. As of September 2014, 226 mothers are prescribed infant formula in Zaatri camp (camp population 79,708), 28 mothers in Asraq camp (approx. 13,000 population) and 7 mothers in Emarati Jordanian camp (EJC) (about 4000 population) (see below).

Complementary feeding

During the early days in Zaatri camp, the food ration was provided by WFP along with a complementary ration by UNHCR. People complained about lack of diversity, but the main concern from a nutritional point of view was meeting the needs of children aged 6-23 months. Mothers were constantly complaining that the ration didn't include anything adequate for this age group, and not everyone in the camp had the ability to buy fruit and vegetables.

The need for a fortified food suitable for children 6-23 months was agreed and WFP sought procurement of international supply of Super Cereal Plus. Due to complications in procurement that delayed supplies by seven months (see below), UNHCR, UNICEF and SCJ stop-

gapped with an intended short term (4 month) blanket distribution of a local fortified porridge, targeting children 6-23 months (March - June 2013). Four packs of 250g each were provided for each child on monthly basis. Special cases, such as cerebral palsy children, were also included in the distribution. The distribution itself was a challenge as many security concerns were raised regarding families with older children who would not receive the product. Careful sensitisation was undertaken to inform the community and explain to them the importance and rationale of the product for this specific age group. The local complementary food was well received by families but was expensive. It was not available to purchase in the camp markets. Three cycles were completed but the fourth did not happen due to inadequate funds.

Referral and management of acute malnutrition cases

A mid upper arm circumference (MUAC) screening conducted by the SCJ team during the complementary food distribution period found a global acute malnutrition rate (GAM) rate of 2.6%. Since malnutrition was not a major concern in Jordan pre-crisis, there were no clear national protocols or referral pathways. The Nutrition SWG developed a national protocol, which was later adopted by the Ministry of Health, and drafted a letter requesting permission to import RUTF (Plumpy'nut) and fortified blended food (Super Cereal Plus). In reality, product approvals and releasing of the products from customs took more than six months. Thus the identified cases had to be managed using other interventions. Severe acute malnutrition (SAM) cases were referred to the MSF hospital inside the camp and moderate acute malnutrition (MAM) cases were provided with the locally procured fortified food porridge and followed up by IYCF counsellors. The local fortified had a very good nutritional profile, and mothers were constantly instructed on preparation methods and number of meals to offer per day.

Eventually in January 2014, Super Cereal Plus was officially approved by the Jordan Food and Drug Administration (JFDA) and in partnership with WFP, SCJ launched the Supplementary Feeding Programme (SFP) in Zaatri camp. A blanket distribution for children 6-23 months is currently taking place on a monthly basis, and a targeted distribution with regular

follow up is conducted for MAM cases twice a month. The Super Cereal Plus is not well accepted by the children compared to the local fortified porridge that was initially provided.

Outside Zaatri camp

As of July 2013, the SCJ IYCF programme was also providing services to the Emarati Jordanian camp (EJC) and to the host community. EJC is a relatively small camp compared to Zaatri with a population of only 3,600 refugees. The process of monitoring infant formula was also difficult at the beginning, as the clinic was providing infant formula on a weekly basis to all families with infants under 1 year of age. It took a while to convince the management and the health providers of the need to control this, and the adverse effect it could have on infant's health. The IYCF midwife is now responsible for prescribing the infant formula and only seven mothers are now receiving supplies on medical grounds. Given the small camp population, SCJ is able to follow up with all infants under 1 year in the camp. Overall, 30-40 mothers receive IYCF counselling on a daily basis in the IYCF caravan. By working closely with the clinic, SCJ ensure that each infant below 6 months is being followed up by the IYCF counsellor in the camp.

Discussion

After 16 months of implementing IYCF in the camps and host community, we have successfully reached 29,000 PLW (new visits or first counselling contacts) and 40,000 children under 5 years (total contacts). More than 47,000 beneficiaries (mothers, fathers, and grandmothers) have attended the IYCF sessions conducted in different partner's locations.

It is becoming clear that building capacity and cooperation with health providers on communicating a unified IYCF message plays a crucial role in convincing mothers of the importance of breastfeeding and early breastfeeding initiation. Higher rates of exclusive breastfeeding are noticed among mothers who are regularly followed up by IYCF counsellors, and anecdotally, many are noticing the lower incidence of diarrhoea and respiratory infections compared to other non-breastfed infants.

In terms of meeting the needs of infants dependent on infant formula, greater control on the implementation of the International Code of Marketing of BMS by the Ministry of Health would have been very helpful. Uncontrolled distribution of infant formula early in the crisis was a great cause of tension with the community; if the community had been informed of the procedures and guidelines from the beginning, we could have avoided many problems. This is what is currently being done in Azraq camp and there have been no problems. Now, in Zaatri camp, the needs of formula fed infants are being met - supplies are always available, there is a clear referral pathway and system in place for mothers who need formula and there is follow up of infants.

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By Ann Burton, Senior Public Health Officer UNHCR Jordan

The articles by Medair and Save the Children highlight the challenges in protecting and promoting sound infant and young child feeding (IYCF) practices in a humanitarian emergency. Much of the guidance on IYCF has been developed for resource poor settings. Infants in these settings who are not breastfed have a much higher risk of dying. This risk is exacerbated by the upheaval generated by emergency settings. There have been few articles published on experiences of IYCF in emergencies in low to middle income countries, such as Jordan. Acute malnutrition prevalence amongst Syrian refugees in Jordan is low and not considered a public health problem, and mortality rates are low and stable; regardless there is always an important need to promote sound IYCF practices for optimal infant and young child health outcomes.

Alsamman and Fander et al highlight the poor IYCF practices both in Syria and in the refugee hosting country, Jordan, prior to the refugee influx. Though it is critical to try and protect breastfeeding throughout all stages of the refugee programming, this has been made much harder by the poor practices pre-conflict, the low level of knowledge amongst many humanitarian actors, including medical and nursing staff, and the misconceptions around breastfeeding. There were many non-traditional actors involved in the response most of whom had not been exposed to the Code or the Operational Guidance on IYCF in Emergencies (IYCF-E). Though health and nutrition programme managers from international organisations were well-versed in the current recommendations about the use of breastmilk substitutes (BMS), doctors and midwives providing services were not generally very supportive of breastfeeding or easily succumbed to pressure from mothers and family members to provide infant formula. Practices surrounding delivery were also not conducive to early initiation, with the infant often separated from the mother and started on other liquids. This highlights the need to not only target humanitarian service providers with training in key beneficial IYCF practices but also, in the medium to longer term, to strengthen the IYCF component of medical and nursing school curricula and revitalise the Baby Friendly Hospital Initiative.

Unsolicited donations of BMS continue at the time of writing. Fortunately, the Standard Operating Procedures on Distribution and Procurement of Infant Formula and Infant Feeding Equipment¹ put in place in November 2012 by the Nutrition Sub-working Group (and updated in May 2014) meant that many donations came to the attention of the nutrition

actors and measures could be taken to minimise the risks associated with such donations. However, as pointed out by Flanders et al, this was very time consuming at a time when there were many other pressing priorities. Furthermore, if the NWG had been consulted prior to the donation, a request would have been made for other food or non-food items, such as age appropriate complementary food in place of infant formula.

There were many donations and distributions of BMS outside of the health system demonstrating that advocacy and training needs to also target other sectoral actors in addition to those working in health and nutrition. Non-traditional actors, especially the military and emerging humanitarian actors, also need to be made aware. As these actors expand their geographical scope into other crisis-affected parts of the world - many of which have considerably higher malnutrition rates and poorer hygiene and sanitation situations - the effects of indiscriminate use of BMS on infant morbidity and mortality would be much more severe.

Another key challenge in the Syrian situation and detailed by these two articles is how to support non-breastfed infants and their mothers to ensure optimal growth and wellbeing but without undermining key messages in support of breastfeeding. Much of the focus of IYCF programming has been support to breastfeeding mothers or relactation. Alsamman has outlined the support in camp settings in Jordan to non-breastfed infants. In non-camp settings, this has been very difficult to put in place. Most refugees access Ministry of Health services and apart from ad hoc support to some women, non-governmental organisation (NGO) service providers are not in a position to meet the demand for infant formula which would entail assessment of women for their ability to breastfeed, prescription and dispensing when indicated and support to non-breastfed infants. Their reluctance to get involved has also been influenced by security concerns based on the experiences in Zaatri Camp outlined by Alsamman. In Jordan, infant formula is only available through pharmacies and is therefore not available through the WFP-supported food voucher schemes, which has also limited formula use in out-of-camp settings.

Recognising that there are mothers who will not be able to breastfeed and who will have difficulties affording formula, the Nutrition Working Group is exploring the option of referring mothers who are unable to breastfeed (after assessment by a midwife trained in IYCF) for cash assistance so that they can purchase formula themselves. This would be combined

with the additional support and follow up needed for non-breastfed infants but will reduce the likelihood of the potential problems associated with actual formula distribution. The different approaches in the camp and non-camp settings in Jordan have resulted in formula feeding being considerably more common in out-of-camp infant refugees compared to those living in the camp (16.1 % of those 23 months and under had received formula in the preceding 24 hours versus 9.8% respectively).² Though the more restricted access in the camp to BMS and the IYCF programming are no doubt significant factors, more research is needed on the determinants of infant feeding choices in displaced populations. Are displaced women choosing to breastfeed because of economic necessity as well as convenience and if so how can these factors be used to promote breastfeeding in similar situations?

Lastly, more consideration needs to be given to the question of informed choice in infant feeding practices and to what extent humanitarian actors should withhold support for formula feeding in women who have made a truly informed choice. Are humanitarian actors prepared to support this approach in settings where the choice to formula feed - though not optimal - does not carry the same health consequences as in other settings? Even though the Operational Guidance on IYCF-E promotes the minimisation of the risks of artificial feeding, this is not always given the attention it needs in IYCF programming. Furthermore, the tendency is to focus on mothers who cannot breastfeed and not those who choose to not breastfeed. The economic considerations of an informed choice approach are also considerable. Infant formula is an expensive commodity and it is unlikely that limited humanitarian funds could be used to support provision of formula in a situation where a woman has chosen to formula feed. Indiscriminate distribution of BMS and unsolicited donations should still be managed as per the Operational Guidance on IYCF-E but should a harm minimisation approach be considered in some settings? The Syrian refugee situation, with most refugees fleeing to low - middle income countries, has raised these questions and is challenging actors to review thinking on this issue.

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¹ Available at the UNHCR Syria response, portal: visit <http://data.unhcr.org/syrianrefugees/regional.php>

² Preliminary findings Interagency Nutrition Survey of Refugees in Zaatri and Out-of-Camp settings, May 2014 (unpublished)

The situation of older refugees and refugees with disabilities, injuries, and chronic diseases in the Syria crisis

By Lydia de Leeuw



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Thanks to Becky Achan, Technical Advisor on Inclusion with Handicap International and HelpAge International in Jordan, who helped conceptualise and develop the article outline.



Assisting the most vulnerable in the Syria crisis

The conflict in Syria was triggered by protests in mid-March 2011. Now, three years later, it has evolved into a complex and protracted humanitarian crisis, spilling into neighbouring countries and the wider Middle East region. Nearly three million people have fled Syria and an estimated 9.3 million people are in need of humanitarian assistance across the region. Most refugees live outside of camps in different urban and rural settings. The scale of the Syria crisis is stretching the capacity of humanitarian actors to ensure and maintain standard quality assistance that address specific vulnerabilities and needs. A global partnership between HelpAge International and Handicap International led to a decision to address this recurrent issue by initiating a Syrian crisis-focused inclusion programme. The programme is aimed at facilitating the implementation of a principled, inclusive and accessible humanitarian response for the most vulnerable, especially older refugees and refugees with disabilities.

The inclusion team consist of three experts: one Inclusion Advisor in both Jordan and Lebanon and a Programme Manager at regional level. Their inclusion mainstreaming work focuses on:

- Capacity building of humanitarian actors to design and implement programmes and activities that are inclusive towards older refugees and refugees with disabilities.
- Providing technical support to humanitarian actors on age and disability inclusion.
- Advocacy and awareness raising on inclusion issues with the coordination structures (working groups, task forces, coordination meetings) and towards donors and authorities.

- Leading coordination on age and disability related issues through the Disability & Older Age Working Group in Lebanon, and the Age & Disability Task Force in Zaatari camp (Jordan).

The main aim of inclusion mainstreaming work is to enhance inclusiveness of the overall response towards the most vulnerable groups, i.e. the persons excluded from services or response and more specifically, older refugees and refugees affected by an injury, disability or chronic condition – as these groups of individuals are most likely to be excluded or invisible. Rather than creating parallel targeted activities and services, the programme seeks the integration of age and disability considerations into the programming of all responding actors.

Vulnerability assessment approach

At the operational level, Handicap International has a distinct approach toward targeting the most vulnerable among the refugee population in Jordan and Lebanon. Using its trademark *Disability and Vulnerability Focal Point* mechanism (DVFP), the organisation effectively reaches out to refugees at community level and seeks to address the gaps which lead to a lack of access to, or exclusion from, services, which could further lead to increased vulnerability. First, mapping of the context – including available services – is done. Based on that mapping, vulnerability profiles are determined for the different contexts. Both the vulnerability of the household and individuals are taken into account. Subsequently, there are four entry points for new cases to be assessed by Handicap International: via a hotline, through fixed point (Handicap International centre established within community facilities),

through referral from outside (including community focal persons), and on-the-spot identification by outreach teams.

For assessing the vulnerability, Handicap International looks at the interaction between personal factors (such as age, gender or disability) and environmental factors (such as access to services or the availability of an assistive device when required). Handicap International assesses basic needs (food, shelter, water, sanitation and hygiene (WASH), health, household essential items, education) as well as specific needs (physical and functional rehabilitation, psychosocial support). Once the person is assessed, the Handicap International referral focal point decides on possible internal and/or external referrals. As much as possible, Handicap International tries to refer to the services that already exist, to avoid duplication. However, whenever the service is not available or is of insufficient quality, Handicap International can provide complementary direct services (see below) which vary depending on the context and the identified gaps. Referrals not only provide information but also establish a connection between the individual or household and the external actor receiving the referral.

Handicap International can directly provide identified beneficiaries with physical and functional rehabilitation and psychosocial support services, as well as with emergency livelihood support such as cash assistance. The cash assistance is unconditional, to support the most vulnerable households to meet their basic needs, including food and shelter. In the Bekaa region of Lebanon, Handicap International also provides newcomers – refugees who have been in the country less than 30 days – with essential house-



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Hameeda Salamat (65) sits in the family's apartment in Irbid. "I have diabetes and high blood pressure," explains Hameeda. "I didn't receive any medication here in Jordan so we have been buying medicine with our own money. But the new medicines I received were different and made me sick." Saadiyeh recalls: "She was very sick for a week. Then the hospital made sure she got back to using her old medication, which she had been using for seven years already. After that she became better." Despite being registered with UNCHR, the family was not aware that they are entitled to get the medication for free, using the proof of their UNHCR registration. The Handicap International mobile team provided the family with information regarding their access to free medication.



©L. de Leeuw /Handicap International – HelpAge International, Tripoli, Lebanon, 2014

Ahmad KhairBirjawi (67) takes a rest after doing rehabilitation exercises with a Handicap International physiotherapist (Abu Samra, Tripoli, Lebanon). Ahmed suffers from diabetes and cardiovascular disease. Complications of his diabetes led to the amputation of his lower right leg in 2006. Because of the fighting in his hometown, he and his family were forced to flee to Lebanon. Even though the sun is shining outside, their place is cold and humid. Ahmed doesn't go outside much. As the family lives on the second floor, it is extremely difficult to carry Ahmed down the stairs, so he normally doesn't get to leave the building. A small plateau outside the front door of the apartment is the only outside space that is accessible for Ahmed. "We are looking for another place to live, somewhere where there is an equal bottom floor so that he can go outside," says his wife, Ilham.



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Salem Kasha (35) with his wife and children live in a small apartment in El Mina, Tripoli, Lebanon. Salem was injured in a bombing close to his family home in Aleppo. He is now receiving rehabilitative care for his injuries, provided by Handicap International. Still faced with pain and limited mobility, Salem is unable to work. The lack of an income is an increasing problem for his family. "I have problems moving my right hand. Now I cannot work because of my hand, and I don't know what to do anymore. I feel desperate. We have registered ourselves as refugees, but do not receive any support." Without an income, the family's financial reserves have finished, and paying the rent has become impossible. "I am asking the landlord to wait for the next payment," says Salem.

hold items. This in kind support for newcomers is harmonised throughout Lebanon. The package is comprised of a hygiene kit, a kitchen kit, a baby kit (if needed), mattresses and blankets. The World Food Programme (WFP) complements all Handicap International's Household Essential Items kits in Bekaa with a food parcel.

Hidden victims of the Syria crisis

Extensive operational experience of Handicap International and HelpAge International has shown that people with disabilities and older people are often overlooked in crises. Due to a variety of obstacles they often face particular difficulty in accessing humanitarian assistance, especially when the available services or facilities are not adapted and not accessible or suitable for them. At the same time, due to their age, serious medical condition and/or disability, these groups are often disproportionately affected by crisis and displacement. Mainstream health responses in humanitarian crises largely fail to address the needs of those with manageable chronic health conditions. People living with non-communicable diseases may face limited access to care and interruption of their treatment. The subsequent interruptions in their treatment can result in severe complications, including stroke (due to hypertension) and gangrene foot or blindness (due to complications of diabetes), which inevitably leads to increasing levels of morbidity, disability, and mortality. During displacement, people – in particular older people – who have specific nutritional needs may face challenges in accessing the food they need. This can lead to both qualitative and quantitative malnutrition. Refugees living with a disability can face protection risks and increased vulnerability due to lack of physically accessible emergency services, breakdown in their support system, or the loss of assistive device(s).

As in many other crises, the Syria crisis response was hampered by a lack of disaggregated data on older refugees, and refugees living with a disabilities, injury, or chronic disease. Therefore, in late 2013, HelpAge International and Handicap International undertook a study in Jordan and Lebanon aimed at creating robust evidence and data on the numbers and basic and specific needs of older refugees and refugees living with an injury, impairment or chronic condition¹. The study also compared the needs of these often marginalised groups to the needs of the wider refugee population in these countries.

For the data collection, 3,202 refugees were surveyed in seven governorates in Jordan and Lebanon. All members of households were enumerated, interviewed and screened. Older people were identified as those aged 60 years and above. The survey found that 22% were affected by an impairment, of which 6% were affected by a severe impairment. One in five surveyed refugees was living with more than one impairment. Older people were disproportionately affected by impairments, with a staggering 70% of those aged above 60 years presenting with at least one impairment. Older people were also almost twice as likely as children to present with intellectual impairments. In the study it was found that of the surveyed refugees, 15.6% were affected by chronic disease. An age analysis showed there are three main profiles affected: people aged up to 30 years, of whom 10% are affected by chronic diseases; those aged 30-50 years, of whom 30% are affected; and those aged 50 years or over, of whom half

¹ Hidden victims of the Syrian crisis: disabled, injured and older refugees. Jointly published by HelpAge International and Handicap International. 2014

are affected. This profile of different age groups and prevalence of chronic conditions can be instrumental to inform the design and delivery of health services in the Syria response.

The Syrian conflict has been noted for its highly disabling impact on the Syrian population due to the levels of conflict related injuries. This was confirmed by this study in which 5.7% of surveyed refugees have a significant injury, i.e. one that has an impact on body function and hence a potentially disabling effect. The overwhelming majority – 4 out of 5 injuries – was directly caused by the conflict. This means that in Jordan, 1 in 15 Syrian refugees have been injured as a result of the war. In Lebanon this is 1 in 30 refugees. Consistent with the nature of the conflict, bombing, shrapnel wounds and gunshots account for a large proportion of injuries (58%). Additionally, of those reporting injury, 25% resulted from accidents such as falls and burns – accidents that become more common by living in homes damaged by the conflict or fleeing attack.

Humanitarian implications of the existing needs

The prevalence of chronic diseases among Syrian refugees in Jordan and Lebanon (15.6%) tells us how widespread the needs in this regard are. In Jordan and Lebanon, the three most common reasons for refugees seeking healthcare result from chronic conditions, specifically diabetes, cardiovascular conditions and lung disease. Despite this priority need, many refugees face insurmountable challenges in covering the cost of accessing health services. In Lebanon, some refugees stated that they were unable to afford the cost of transport to health centres, let alone the required 25% contribution to their hospital bills. Several chronic conditions also imply day-to-day expenses, such as the cost of needles, blood glucose test strips or syringes.

Besides the financial barrier, there is also a gap in the quality of the management of chronic diseases in Jordan and Lebanon. A health as-

essment carried out by HelpAge International found there was almost no health education for patients, there was limited capacity among health staff to assess patients with chronic diseases properly, limited services available to support early screening for chronic diseases such as diabetes and hypertension, and no proper monitoring with laboratory tests or follow up. Finally, there is a gap in terms of prevention; much more can be done to raise awareness around healthy living and diet. HelpAge International and Handicap International are working with local partners to improve prevention, as well as identification and referral of those with non-communicable disease, and to support the national health systems to improve levels of care.

With regard to the humanitarian implications of injuries among Syrian refugees, it is clear that the need for care and assistance reaches far beyond the emergency response. Many injured refugees are struggling to find long-term physical rehabilitation care, as well as post-operative care. There is a lack of complete post-operative care. Handicap International's intervention, providing physical rehabilitation services, is not enough without other actors helping. The limited availability of physical rehabilitation support is a worrying issue. Where physical rehabilitation care can mitigate the development of potentially permanent disability, the lack thereof can lead to the worsening of existing injury-related health conditions. Handicap International's interventions have revealed high numbers of injuries leading to amputation, as well as spinal cord injuries caused by shelling and gunshots, which result in serious and sometimes permanent impairments. Beyond immediate health care, these complex injuries require long term physical rehabilitation, psychological support, and for those with permanent impairments, sometimes lifelong care.

Recommendations

Humanitarian actors and national systems struggle to cope with the high numbers of injuries, chronic conditions and impairments, and the

continuous influx of new refugees. The mid and long term implications of injuries among Syrian refugees require that national and international health care providers work together in a collaborative effort to address the current needs of this population, but also prepare for the longer term financial and human resource requirements needed to prepare health systems, families and communities to ensure adequate support. In particular, all stakeholders need to prioritise long-term physical rehabilitation care and post-surgical care adequately, according to the prevalence and types of injuries inflicted.

Furthermore, it is critical that long term health planning in Jordan and Lebanon takes account of the need for prevention, monitoring and regular treatment for non-communicable diseases to avoid heightened levels of both impairment requiring further care, and ultimately to reduce levels of morbidity and mortality. This could be done through awareness raising around healthy living and diet, health education for patients, capacity building among health staff to properly assess patients with chronic diseases, increased early screening or monitoring of chronic diseases such as diabetes and hypertension, with laboratory tests or follow up.

Current and past experiences indicate that overall, a 'twin-track' approach to addressing basic and specific needs of refugees affected by injury, impairment or chronic disease, provides the best safeguard for equal access to services for all. In a twin track approach, actors ensure that – on the one hand – they integrate refugees with specific needs into their mainstream programming to the largest extent possible and – on the other hand – where necessary, activities are designed to target people with specific needs separately. For example, a refugee in a wheelchair should be able to access latrines in a camp like everyone else (accessible WASH design – mainstream approach) but might also require physical rehabilitation support for his legs amputation (targeted activity by a specialised agency). Both targeted and mainstream activities are essential to ensure the full integration of refugees with specific needs in the overall humanitarian response. In the Syria response there have been many good examples of both targeted and mainstream responses. However, with the current needs, a continuation and expansion of both is required.

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Saadiyah (47) is working on a dress in Irbid, Jordan



Preparing for a Super Cereal Plus porridge demonstration

JHAS, Jordan, 2014

Experiences of emergency nutrition programming in Jordan

By Ruba Ahmad Abu-Taleb



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The founding team of the Jordan Health Aid Society (JHAS) in 2005 comprised Jordanians keen to enforce local leadership in order to respond effectively to humanitarian needs of vulnerable population groups (see a profile on JHAS in this edition of Field Exchange). One of the earliest humanitarian calls to which JHAS responded was the Iraqi crisis. Since then, JHAS has increased its experience, expertise and collaborative working relationships to respond to different humanitarian emergencies in the Middle East and North Africa (MENA) region. JHAS missions have included emergency response teams comprising experienced medical and non-medical supporting staff deployed to the Gaza strip, South Sudan, Yemen and Libya.

Over the years, JHAS had established a solid network of primary static and mobile health care clinics in Jordan where different primary medical and health services have been incorporated. With the onset of the Syrian crisis in March 2011, humanitarian and health aid responses in Jordan began a new chapter. In the earliest stages of the Syrian crisis, humanitarian aid was provided to assemble refugee camps and to support emergency/life-saving aid. However, access to quality nutrition among refugees with specific nutritional requirements, such as pregnant and lactating women (PLW) and infants and young children, was limited since only general food rations were provided. At the same time, food insecurity due to social, health and protection issues was an identified problem but remained unresolved. The situation became even more complicated with refugees' urbanisation, as resources like food coupons had to be exchanged for shelter and other basic survival needs. According to UNHCR registration records, the total number of Syrian refugees in Jordan had reached 597, 328 by June 2014 of which only 16.26% are hosted in refugee camps. The remainder of Syrian refugees have settled within host communities.¹

With the escalation of the Syrian crisis, agencies with experience of humanitarian nutrition programme implementation, such as MEDAIR and Médecins Sans Frontières (MSF), pointed out critical issues that could aggravate the already complex and challenging nutritional situation of the refugee population, such as poor shelter conditions, limited general food rations, cold winters and very poor hygiene conditions, which commonly predispose to impaired health status. Appropriate nutrition programming during the early stages of the Syrian crisis was constrained by a lack of updated data on malnutrition prevalence amongst the Syrian refugees. National pre-crisis data from Syria (2009) recorded a preva-

lence of 12% wasting, 10% underweight and 28% stunting which while not ideal, were not at emergency levels. However, given the unfolding situation, it was clear that there was a need for an up-to-date nutrition survey for this refugee population.

In November 2012, a nutrition survey of Syrian refugees in Jordan found a 5.1% prevalence of wasting² among children under five years in host communities and 5.8% in Zaatar camp (the main camp for Syrian refugees in Jordan), 8.2% stunting in host communities and 15.9% in Zaatar camp, and 2% underweight in host communities and 6.3% in Zaatar camp³. Although these results were not a trigger for 'emergency' nutrition interventions, they did raise concerns amongst the nutrition group of humanitarian agencies working in Jordan, about the need to maintain systematic screening and surveillance, especially for vulnerable population groups such as children and PLW. This was especially a concern as refugees continued to arrive in Jordan in ever increasing numbers. In line with this thinking, integration of medical nutrition services into primary health care seemed a sound approach to facilitate early diagnosis of malnutrition, thereby helping prevent an increased prevalence of acute malnutrition.

Programming through partnership

JHAS and MEDAIR partnered in 2013 to implement a comprehensive programme on Community-based Management of Acute Malnutrition (CMAM) and Infant and Young Child Feeding (IYCF) practices. Initially, the JHAS-MEDAIR partnership introduced screening for acute malnutrition indicators to the primary medical practice within JHAS clinics in January 2013. This was preceded by a comprehensive IYCF/ CMAM training in December 2012 of selected staff (medical doctors, nurses, midwives, health educators and community outreach workers). From January to October 2013, MUAC only was used in screening. Weight for height (WFH) was added to screening in October 2013 in preparation for implementing the outpatient therapeutic programme (OTP) and the supplementary feeding programme (SFP), since both use WFH as an admission criterion and for follow-up. JHAS, with technical support from MEDAIR, has become a lead agency in Jordan with capacity to implement this type of programme.

¹ Source: data.unhcr.org, 2014

² Based on weight-for height (WFH)

³ Inter-agency nutrition assessment Syrian refugees in Jordan host communities and Zaatar camp. Final report. January 2013. Available from UNHCR Syria response online portal at <http://data.unhcr.org/syrianrefugees/country.php?id=107>

Table 1: Preliminary results* of blood Hb status survey in targeted groups within camp and urban settings

	Zaatari Camp	Non-camp (urban) settings
Women 15-49 years	45.0 %	31.0 %
Children under 5 years	49.0 %	25.9%

*Reported figures in the table are preliminary and final results are yet to be officially reported.

Table 2: Admission and discharge criteria to inpatient care (SAM with medical complications)

	Admission criteria	Transfer to OTP/SFP
Children 6-59 months	<p>WFH < -3 z score or MUAC < 11.5 cm PLUS any of the following medical complications:</p> <ul style="list-style-type: none"> Anorexia Intractable vomiting Convulsions Lethargy, not alert Unconscious Lower respiratory tract infection High fever Severe dehydration Severe anaemia Hypoglycaemia Hypothermia 	<p>Medical complications stabilised</p> <p>Successful appetite test</p> <p>Children transfer to either OTP or SFP depending on their anthropometric status</p>
	Bilateral pitting oedema ++ or any grade of bilateral pitting oedema with severe wasting.	

Table 3: Admission and discharge criteria for OTP (SAM without medical complications)

	Admission criteria	Discharge criteria
Children 6-59 months	<p>WFH less than -3 z scores and/or MUAC of less than 11.5cms</p>	<p>Children are discharged according to their admission criteria:</p> <ul style="list-style-type: none"> WFH greater than -3 z scores at two consecutive visits and/or MUAC greater than or equal to 11.5 cm at two consecutive visits
	Bilateral pitting oedema + and ++	<ul style="list-style-type: none"> 15% weight gain (from admission weight when free of oedema) No oedema for two consecutive weeks Clinically well and alert
	Discharged from inpatient care	Anthropometric discharge criteria as above

Table 4: Admission and discharge criteria for SFP (MAM cases)

	Admission criteria	Discharge criteria
Children 6-59 months	WFH less than -2 z scores and greater than -3 z scores	WFH greater than -2 z scores at two consecutive visits
	MUAC less than 12.5cm and greater than or equal to 11.5cm	MUAC greater than or equal to 12.5 cm at two consecutive visits
	Discharged from OTP	Children discharged from OTP should stay in the SFP for a minimum of 2 months
	Discharged from inpatient care	Children discharged from inpatient care* should stay in the SFP for a minimum of 2 months
PLWs	MUAC less than 23cm for pregnant woman in second or third trimester	MUAC greater than or equal to 23 cm at two consecutive visits or when the infant becomes 6 months**
	MUAC less than 23cm for lactating women with infants younger than 6 months	Infants aged 6 months and older should be assessed by MUAC and referred appropriately

* Children stay in inpatient care until their medical condition has stabilised. Afterwards are discharged into OTP or SFP according to their anthropometric (MUAC/WFH) indicators.

**If a mother is compliant with the programme but has remained malnourished for more than 4 months, complicating medical conditions or social aspects are investigated and necessary support provided.

A number of agencies, including UNHCR, UNICEF, WFP and Centres for Disease Control and Prevention (CDC), collaborated to plan and implement another nutrition survey in April 2014. JHAS, in partnership with MEDAIR, participated in supervising survey teams and in the data collection component. The survey targeted Syrian refugee children (0-5 years old) and women of child bearing age ((CBA); 15-49 years old). The survey measured MUAC, WFH and blood haemoglobin (Hb) status. In addition, respondents were asked questions about food security status, water, sanitation and hygiene (WASH) conditions of refugee families, as well as polio and measles vaccination coverage. Preliminary results⁴ indicate alarming levels of iron deficiency anaemia among women and children within both camps and urban settings (see Table 1). Global acute malnutrition (GAM) rates were relatively low: GAM (MUAC based) prevalence was 1.5% inside Zaatari camp and 0.4% outside the camp (urban setting). However, findings for many other indicators that directly or indirectly impact on nutrition – anaemia prevalence, compromised food security, IYCF practices, shelter and WASH conditions – all confirmed concerns of a risk of a worsening nutritional status of the Syrian refugee population. Thus, the nutrition sub-working group is currently looking for opportunities to scale up nutrition programmes and introduce other potentially needed interventions.

After almost 18 months since JHAS started applying malnutrition screening in clinics, JHAS has become the sole agency in Jordan to implement SFPs within urban settings and a comprehensive OTP within camps and urban settings, with ongoing technical support from UNHCR and MEDAIR. The SFP began as a targeted programme (malnourished children under 5 years and PLW) and in June 2014, was expanded to both blanket and targeted programming (through the addition of all children less than 5 years in JHAS clinic and outreach settings).

Capacity development

Over 100 national and international non-governmental organisations (NGO) and partners of UN agencies have been working in Jordan in response to the Syria crisis. The

partnership between UNHCR and JHAS has further strengthened the capacity of JHAS to become the first line healthcare provider for the Syrian refugees in Jordan. JHAS staff have regularly attended national health sector meetings and sub-working groups, which has allowed JHAS to participate in identifying key strategic areas for humanitarian interventions in health and nutrition.

The credibility of JHAS has been enhanced by participation in a number of trainings. MEDAIR has conducted trainings on CMAM and IYCF for health workers in JHAS on a regular basis. At Nutrition Working Group level, JHAS attended training on SFP implementation organised by WFP for partner agencies. At the regional level, selected JHAS staff attended a Middle East and North Africa (MENA) Region Nutrition in Emergencies training. While these trainings have been technical in nature, they have also equipped trainees with an understanding of the protection rights of refugees, as well as the need to be considerate of specific social, cultural and psychological characteristics of those accessing services.

Implementation of the nutrition programmes

Guidance development

Although prevalence of acute malnutrition has been low, the Nutrition Working Group⁵ advocated for preparedness measures, such as drafting context-specific guidelines and standard operating protocols for the treatment of acute malnutrition and anaemia. The Nutrition Working Group assembled a task force consisting of JHAS, MEDAIR and Save the Children Jordan (SCJ) to draft operational guidelines for the integrated management of acute malnutrition and management of iron deficiency anaemia in pregnancy.

The CMAM programme

Syrian refugee children and PLW have been regarded as the most vulnerable population group and therefore, are the primary target group in the CMAM programme. The pro-

⁴ Results pending (June 2014). Check for updated availability at <http://data.unhcr.org/syrianrefugees/regional.php>

⁵ Nutrition is covered in a sub-working group of the Health Working Group. It is co-chaired by UNHCR and Save the Children Jordan.

Box 1 Mobile JHAS clinic services

- One fixed mobile medical unit (MMU) with scheduled trips within southern governorates of Jordan (Tafilah, Kerak, Ma'an, Aqaba, Qatranah and Madaba). This unit provides primary medical care and facilitates secondary referrals through defined local stations in southern governorates. CMAM services are completely supported through the MMU.
- One community outreach team consisting of 10 community health workers, responsible for liaising between refugee population and JHAS in terms of health care services' provision and UNHCR registration issues.
- One medical team deployed once weekly to remote areas of Jordan (those not covered by the MMU schedule). This team responds to requests from local communities to implement a 'Free Medical Day'⁶.



Breastfeeding support in an urban clinic in Amman

JHAS, Jordan, 2014

programme has focused on community mobilisation to maximise coverage, access and compliance. JHAS clinics and outreach settings have been able to integrate management of acute malnutrition into their daily working schemes.

The four main elements of the CMAM programme are management of moderate acute malnutrition (MAM/SFP), management of severe acute malnutrition (SAM/OTP), inpatient management for severe acute malnutrition with medical complications (SAM/SC) and community outreach. Admission and discharge criteria are reported in Tables 2, 3 and 4.

SFPs and OTPs operate in both Zaatari camp and urban settings. In Zaatari camp, JHAS/UNHCR supports the OTP while SCJ/WFP supports the SFP. Outside the camp setting, mobile JHAS clinics are employed for remote areas or where transport for patients is unavailable, through which CMAM services are made available or accessed (see Box 1). Within urban settings, JHAS in collaboration with UNHCR and MEDAIR, support nine OTP/SFP sites. This comprises six JHAS static clinics, one MMU, and two OTP/SFP sites in Jerash and Ajloun implemented by local community based organisations (CBOs) (therapeutic and supplementary food provision happens once weekly at each CBO site). Other mobile services screen for malnutrition using MUAC tapes and refer to the nearest JHAS clinics.

Both WFH and MUAC criteria are used to assess children and a thorough medical evaluation is conducted on admission. Medication and OTP/SFP foods (Ready to Use Therapeutic Food (RUTF) for SAM children and Super Cereal Plus for MAM children and PLW's) are prescribed

according to standard protocols. Therapeutic and supplementary food commodities have been approved for use in both camp and non-camp settings, which has made it possible to facilitate integrated CMAM programmes in both contexts.

For SAM children in particular, physical examination also aims to identify acute medical conditions requiring hospitalisation. Where such cases are identified, JHAS facilitates the referral process through an established network with affiliated MoH hospitals. JHAS focal points in each hospital follow up with admitted cases and provide timely feedback. Malnourished SAM or MAM children with chronic illnesses are treated as outpatients, in close cooperation with JHAS nutritionists for potential nutritional support needed. Anthropometric evaluation and monitoring of PLW's is conducted solely through MUAC measurements.

In all urban JHAS clinics and in Zaatari camp, a specific day of the week has been assigned for OTP/SFP RUTF prescription/RUSF provision. However if a SAM child is identified within the week, s/he receives medical and nutritional assessment and a RUTF ration until the nominated attendance day. On attendance, patients are followed up and monitored and there are Super Cereal cooking demonstration sessions. It appears that the exchange of experiences between SFP and OTP clients has improved SFP compliance, i.e. reduced defaulting.

Management of iron deficiency anaemia in pregnancy

As part of standard antenatal care visits, pregnant women in JHAS clinics are screened for their blood Hb status. A blood Hb level less than 11

g/dl is classified as moderate anaemia, whereas, a blood Hb status less than 7.9 g/dl is classified as severe anaemia. In the latter case, a pregnant woman will be directly referred for urgent medical care through JHAS affiliated hospitals. According to operational guidelines developed by the Nutrition Working Group, pregnant women receiving antenatal care within JHAS clinics receive supplementary doses of iron and folic acid starting from the second trimester of pregnancy until 6 months postpartum (see Table 5). Pregnant women remain under close medical supervision, in case dosage alterations are needed. To date, there has been no specific programme regarding anaemia in children less than 5 years, however this has been integrated into the Nutrition Working Group strategy for 2014.

Programme figures

A relatively low number of children have been diagnosed with SAM or MAM in 2014 in both urban JHAS clinics and Zaatari camp (see Tables 6 and 7). This accords with the 2014 nutrition survey data. Given the relatively low caseload in Zaatari camp, JHAS in coordination with SCJ have had capacity to conduct regular counselling visits for SAM patients, especially those missing their distributions. This has allowed caregivers to discuss any constraints they have in programme participation with JHAS staff.

Interestingly, PLW's have so far represented the majority of SFP beneficiaries. This has raised several questions around food security and protection issues. This relatively high caseload of malnutrition amongst PLW is mirrored in their

⁶ A free medical day is a term used to describe the activity of providing primary medical care free of charge. This term is used by different community based organisations in Jordan.

Table 5: Guidelines for iron supplementation to pregnant women

Age Groups	Indications for supplementation	Dosage schedule	Duration
Pregnant women	Universal supplementation	Iron: 60 mg/day Folic acid: 400 µg/day	6 months in pregnancy
Lactating women	Where anaemia prevalence is above 40%	Iron: 60 mg/day Folic acid: 400 µg/day	6 months in pregnancy, and continuing to 3 months postpartum

Table 6: Malnourished children and PLW's enrolled in urban programmes

	Indications for supplementation
	Accumulative 2014 (week 25, June 2014)
Children with MAM	56 children still in SFP
Children with SAM	6 boys in OTP 2 girls in OTP
Malnourished PLW	88 pregnant women and 78 lactating women in SFPTP6 boys in OTP

Table 7: SAM children enrolled in OTP* within Zaatari camp

	Accumulative 2014 (week 25, June 2014)
Number of SAM children in Zaatari camp	23 boys in OTP 23 girls in OTP

*JHAS only implements OTP in Zaatari camp. The SFP is implemented by SCJ, hence figures are not presented here

blood Hb status. The prevalence of iron deficiency anaemia (IDA) among pregnant women screened for their blood Hb status within JHAS clinics in 2014 is reported to be 43.16%. The cultural propensity to early marriage may be partially contributing to compromised maternal health, as a pregnant teenager faces increased demand for nutrients to support both foetal growth and adult maturation.

Challenges and observations

A number of challenges were encountered as MUAC screening was rolled out amongst JHAS health workers in JHAS clinics and outreach settings. Both health practitioners and beneficiaries were unfamiliar with MUAC measurement, resulting in poor MUAC measuring accuracy. This was often compounded by caretakers having difficulty in calming the child or getting the child to expose the whole of their arm, especially in cold weather conditions. In addition, given the very low initial caseload, some practitioners questioned the value of MUAC as an accurate indicator of malnutrition, especially when some children who looked pale, weak or detached were found to have a normal MUAC measurement.

Another challenge faced by JHAS teams was fostering sufficient understanding of CMAM/IYCF concepts, especially when there was a significant delay in getting the therapeutic and supplementary foods approved and released in Jordan. The first step in procuring the therapeutic and supplemental food commodities was to decide, at Nutrition Working Group level, which products were needed. Procurement of Super Cereal Plus (for SFP) and Ready to Use Therapeutic Food⁷ (RUTF) (for OTP) was agreed. WFP was responsible for securing MoH approval to procure Super Cereal Plus. Although MoH approvals were granted later than expected, the considerable delay in launching the SFP was largely due to delayed custom's release of Super Cereal Plus and time taken to secure the necessary Jordan Food and Drug Administration (JFDA) approvals. As a learned lesson, the Nutrition Working Group contacted all authorities prior to international procurement of RUTF in order to avoid any further delay in implementing the OTP. As a result, RUTF procurement and JFDA's approvals all went smoothly without significant delays.

The delays in SFP and OTP programming due to supply issues required stop-gapping at



An urban clinic in Amman

an operational level. The majority of children and PLWs identified as malnourished were regular patients at JHAS clinics so that retrieving their records and getting in contact with them was possible once therapeutic and supplementary foods had become available. Although JHAS teams were able to overcome the problem of refugees changing residence by referring to the nearest JHAS clinic and exchanging patient data, a few patients were untraceable and therefore dropped out because of disconnected phone numbers.

A challenging part of outreach work has been trying to support young mothers around breastfeeding. Given the cultural norms in Syria, girls become mothers at a very young age and are usually put under pressure to wean female infants to increase the chance of becoming pregnant, hoping that the next child will be a boy. Community outreach workers also report that refugees' interest in, and acceptance of, nutrition education is compromised. This is particularly the case in refugee extended family contexts, where cash and shelter needs are prioritised over other needs including health and nutrition.

Lessons learned

The partnerships with UNHCR and MEDAIR have given JHAS a wealth of expertise to invest in future sustainable national action plans for the management of acute malnutrition. However, the skills of health and nutrition professionals at JHAS still need to be strengthened to meet the needs of different targeted populations.

As JHAS had taken the lead role in screening for malnutrition within urban settings, refresher trainings and frequent supervision visits to health workers has provided strong motivation for JHAS staff.

Although screening and health education has gradually been improving, patient compliance with the SFP/OTP programmes has been difficult to achieve. JHAS nutritionists working in clinics have therefore linked each patient with MEDAIR community outreach volunteers. This has allowed for follow up and communication beyond the clinic setting and contributed to better understanding amongst mothers and caretakers of the underlying causes of malnutrition and how to address them.

Other efforts to improve SFP and OTP performance have included caretakers' focus group discussions and cooking sessions in JHAS clinics to demonstrate optimal Super Cereal cooking methods and recommended consistency. Mothers used to undercook the Super Cereal Plus which negatively affected its taste; satisfaction of mothers and children with Super Cereal Plus has now improved. In Zaatari camp, focus group discussions and linkages with outreach workers have hugely improved caretakers' compliance with SAM treatment programmes. Caretakers are asked to return empty RUTF/Super Cereal Plus packets as one marker of compliance. This has, in turn, been reflected in improvement in the health status of SAM children and an increased numbers of caretakers presenting to JHAS clinics asking to have their children screened for malnutrition.

The low caseload of acute malnutrition in Jordan in camps and urban settings has provided room for gradual capacity building of JHAS health and nutrition professionals. The experience from this relatively small scale CMAM will be a solid base for JHAS to scale up programming for any nutrition emergency.

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Teaching how to prepare Super Cereal Plus in an Amman clinic

⁷ Plumpy'nut

Women's protection and empowerment programming for Syrian refugees in urban Jordan: challenges and lessons learned

Marfaq-Zaatri

By Melanie Megevand, IRC



Melanie Megevand is IRC's Women's Protection and Empowerment Programme Advisor, and has worked in Jordan since May 2012. She established the IRC's emergency response for Syrian refugees in Jordan which include child protection services, reproductive health services and women's

protection and empowerment programmes. She has worked in emergency child protection and GBV programming in Africa, the Middle East and the Haiti for the past 8 years.

First and foremost, the author extends heartfelt thanks to the Syrian women and girls who have spoken here and trusted IRC with their stories. Their experiences, strength and resourcefulness reflect they are much more than victims of violence but are the cornerstone of families, communities and societies. She has profound respect and admiration for her IRC WPE colleagues and volunteers, IRC partners and counterparts, for their dedication in this immensely challenging area of work.

All the names of those quoted in this report have been changed to protect their identity, unless otherwise consented.

"We ask for humanity – for people to treat us like human beings."

Nada, age 35, Jordan

Background

The IRC has implemented Women's Protection and Empowerment (WPE) programmes in Jordan since 2007 as part of its emergency response services to Iraqi refugees. Over the years this transitioned from direct programming to supporting community based organizations (CBOs) to deliver services and longer term capacity building efforts with government institutions around Gender Based Violence (GBV). However, in the spring of 2012 IRC's partners became quickly overwhelmed with the pressing and growing needs of Syrian women and girls pouring into the country at which point the IRC re-established its direct response in parallel to continued support to partners. Almost four years into the conflict, nearly four of every five people who have fled Syria in the past three years have been women and children.

In the course of rapid GBV assessments conducted in mid-2012 in Jordan and Lebanon by the IRC, Syrians expressed profound distress over the loss of everything that had made their previous lives normal. Systematic accounts of women and girls being attacked in public or in their homes in front of family members, accompanied by attacks in which women and girls

were kidnapped, raped, tortured and killed, has left not only visible physical wounds but profound emotional and psychological scars on both survivors and Syrians at large. Conversations with hundreds of Syrian women and girls, men and boys throughout the region from May to June 2014 supplemented by interactions with thousands of women and girls since the Syrian crisis began within Jordan, Lebanon, Syria, Iraq, and Turkey, where the IRC works underline and substantiate the findings of 2012. When asked "what are the biggest challenges you are facing", Syrian women and girls reveal three overarching themes of shared experiences with regard to the nature and regularity of the violence they face simply because they are female: the impact GBV has on accessing any and all aid; the complex interplay between the multiple daily threats to their safety and psychosocial wellbeing, and the tremendous adversity they face in their intimate circle, community and society at large.

Impact of GBV on access to aid by women and girls

First, the daily reality of sexual exploitation and extreme levels of harassment creates an environment in which Syrian women and girls reveal

being constantly fearful walking to school, the store, the latrine, or anywhere else to access services, detailing how each exposes them to threats of harassment and assault. Women and adolescent girls speak of feeling exhausted by the daily negotiations for physical and sexual safety to secure food and water, shelter and clothing. Women and adolescent girls told the IRC about being sexually harassed and exploited by individuals charged with delivering humanitarian aid or by those in positions of relative economic and/or political power in their own communities. They report being asked to engage in "special friendships," sex, and marriage, by leaders in camps, staff in CBOs, religious leaders, community leaders, employers, and others. Outside camps in urban areas, where refugees are spread out, restrictions on mobility limit women and girls' ability to access goods and services provided by the government and/or humanitarian organisations.

The psychological, physical, and economic consequences of this harassment are not always visible. Psychological consequences, such as shame, settles deep into the women's and girls' consciousness. Economic opportunities are lost

because women and adolescent girls must curtail activities outside the home to protect themselves from additional abuse. As the international community fails to ensure that all services take into account the specific needs and challenges women and girls face in accessing services, they have developed coping mechanisms responding to harassment by changing their behaviour, opting to stay home instead of leaving their house or tent, further disenfranchising them from access to services. While freedom of mobility was somewhat limited for many women and girls prior to displacement, they are unanimous in saying that increased fear of sexual assault and harassment has placed even further restrictions on displaced women and girls as traditional norms place a heavy and potentially dangerous responsibility for family honour on women and girls. Men and boys we spoke with

concur, explaining that they are raised with the understanding that it is their duty to defend the honour of their families even when it can result in severe and fatal repercussions for women and girls, as the mere suggestion of impugning that honour permits men to commit so-called honour crimes. A recent report commissioned by UNHCR which surveyed 135 female heads of households taking refuge in Egypt, Jordan, and Lebanon showed that approximately half of the women interviewed left the house less in their host country than when they were living in Syria.¹ Women reported feeling isolated and imprisoned in their own homes.² Further, 60% of women expressed feelings of insecurity, and one in three women stated that they felt too scared or overwhelmed to leave their homes at all.³

The vast majority of women and girls are reluctant to seek help when harassed, fearing for their safety or the safety of their families, as well as possible deportation or retaliation by their host community. For those abused by landlords or employers, their greatest fear was losing their income or their home. As a response to these threats, their world becomes smaller and lonelier, but not necessarily safer.

Domestic violence

Second, women and girls shared with us that their homes are not places of refuge and they speak of increased incidents of domestic violence. Indeed, over the past year in both Jordan and Lebanon, more than 70% of violent incidents reported to IRC WPE staff happened in refugees' homes. Of those incidents, 80% were perpetrated by an intimate partner or someone known to the victim.⁴ Women and adolescent girls share with us their perception of increased physical and emotional violence from their husbands since fleeing Syria attributing this "yelling and beating" as men's way of coping with the stress of trauma and of being a refugee. One woman told the IRC:

"My husband beats me, and I think this stems from a psychological problem...he is relieving the stress because he is beating me."

Mona, age 21, Lebanon.

Other women speak about the lack of employment opportunities available for their husbands, resulting in their inability to fulfil their traditional role as the family provider:

"Men are becoming angry – they can't provide for their family. My husband wasn't a smoker – now he is. He is extremely irritated all the time and takes it out on the kids. He is violent towards the kids; he is violent towards me."

Farah, age 38, Jordan.

Others perceive causes of the increased physical and emotional abuse due to the fact that

"when a woman goes out to do the shopping or get coupons, he isn't grateful. No, he is the opposite. He gets angrier, making comments like: "You didn't cook; you didn't work today. His anger increases."

Haifa, age 41, Jordan.



Zaeemah, age 34, Jordan

"I want my voice to be heard everywhere – so that everyone can feel with us."

In late 2013, I fled Syria after my husband was briefly detained. In Jordan, our once loving relationship quickly grew tense and my husband became more violent. It is illegal for him to work and growing frustrated with his inability to provide for their family, he began hitting me and our children. I've lost all respect for him because of how he treats our children. I have so much love for my children – they have missed out on a lot of things, and I blame him for not being able to help them and not treating them well. When he is hitting me or them I just cry a lot – I try not to, but I do. "Despite taking contraceptives, I recently learned that I am pregnant. I feel suffocated. My husband can't handle any more kids. We both felt that we did not want to have another child with each other. I've tried to get an abortion, but here it isn't allowed. I see similar situations happening with my neighbours and relatives. I still have hope – every moment I feel guilty that I can't help my husband and I know deep down I still love him, but for now...the world is dark."



Women also mention other refugee realities: men being frustrated by the lack of privacy to engage in sexual relations with their wives, a sense of hopelessness regarding the future, and constant concern over meeting basic needs for the household (i.e., rent, food, water, shelter, clothing, and health care costs). One woman noted:

"I have to think with my husband how to pay the rent...we are always fighting, especially because of these living conditions."

Samira, Age 19, Turkey.

The physical and emotional toll of this violence on women and adolescent girls impacts every aspect of their lives keeping them isolated, afraid and dependent on those who abuse them. Despite the stark impact of domestic violence, the humanitarian community has been reluctant to address it, seeing such violence as a private matter outside the scope of traditional aid mandates. This hesitancy must stop. Aid is systematically organized and filtered through heads of households (who are almost always male). Yet women and girls repeatedly disclose incidents of domestic violence citing leverage and control of access to services as part of their abusers' tactics.

Women need programmes that confront this reality. This in turn requires a change in both

¹ We Just Keep Silent – Gender-based violence amongst Syrian refugees in the Kurdistan Region of Iraq, UN WOMEN (April 2014) <http://uniraq.org/images/documents/We%20Just%20Keep%20Silent%20final%20English.pdf>

² See the Syria Regional Refugee Response Inter-Agency Regional Sharing Portal. <http://data.unhcr.org/syrianrefugees/settlement.php?id=176&country=107®ion=77>

³ We Just Keep Silent – Gender-based violence amongst Syrian refugees in the Kurdistan Region of Iraq, UN WOMEN (April 2014) <http://uniraq.org/images/documents/We%20Just%20Keep%20Silent%20final%20English.pdf>

⁴ This information comes from the Gender-based Violence IMS using the Gender-based Violence IMS Classification Tool, which consists of six types of gender-based violence, their definitions, and a standardized approach for classifying incidents.

the scale of programming and the approaches being used. On-going domestic violence cannot be addressed by programmes that treat violence against women and girls as a one-time occurrence, with discrete one-off interventions to heal wounds or prosecute perpetrators. All sectors of aid must take stock of the hostile dynamics that fuel domestic violence when aid remains head of household centric.

Early and forced marriages

Third, Syrian women and girls talk about early and forced marriage in the specific context of conflict, displacement and dwindling resources. While acknowledging that early marriage is a customary practice in Syria, Syrian adolescent girls explain that the way in which marriage is carried out has changed since the conflict as they are forced to marry at younger ages, mar-



Sabeen, age 15, Lebanon

One day I came home to my father arguing with my mother, saying it was time for me to get married. He wanted to arrange a match with my cousin, putting me under a man's protection and reducing the family's financial burden. I told my father that I didn't want to get married – that I didn't love this man, and my mother said she thought I was too young. However, less than a week later I was called into the house and found a Sheikh waiting with my father and future husband. We were wed right there and then – it was a total shock for me, but I wasn't able to do anything to stop it. I had such big dreams – I wanted to be a fashion designer, but now I'm trapped in this marriage-which for me is like a prison. I am not allowed to go to school, I feel depressed. I used to ignore what is happening inside me, but all of these feelings are accumulating, and I am afraid I will explode."

rying men who in other circumstances would not have been considered suitable, are exposed to more violence in and out of the home, and find it increasingly difficult to access services such as healthcare and education once married.

"In my case, I got married really young [at 13]. It's very hard for me to get pregnant. It was really hard to get a child; I had 5 miscarriages.

I am now in debt because I paid for the injection to get pregnant...My husband wants to divorce me."

Zain, age 18, Lebanon.

Fear for refugee girls' safety exacerbated by overcrowding in homes and tents, financial considerations, and questions parents and girls have about the utility of girls attending school in the host country strongly influence the justification for early marriage. Women and adolescent girls, and in some cases men as well, said if there were other options available, these early and forced marriages would not take place or at least be delayed.

There can be no question that displacement from Syria, compounded by obstacles to education, contributes to early marriages and doubles the threat for adolescent girls already experiencing dangerously challenged lives. Yet, the consequences of early and forced marriage are not only are traumatising; they can be fatal. The newly married girl faces a host of challenges including ongoing displacement, difficulties in dealing with the responsibilities of marriage and taking care of the household, physical and emotional abuse inflicted by their husband or husband's family, and difficulty conceiving or experiencing health complications associated with adolescent pregnancy. Pregnancy is consistently among the leading causes of death for girls aged 15 to 19 worldwide,⁵ and girls younger than fifteen are five times more likely to die in childbirth than women in their twenties.⁶ In addition, domestic violence poses a significant danger for married adolescent girls. In many instances, married women and adolescent girls report that these challenges become grounds for divorce. Because divorce represents a stain on the sense of family honour, violence against the woman or girl may increase and her social mobility is further restricted.

"My father does not allow me to go out because I'm divorced and I need to protect my honour. Neighbours look at me when I [do] go out, even to a close place, as if I'm eccentric. I always hear that they talk badly about me. My eldest brother hits and insults me if I insist on going out."

Haya, age 16, Syria

IRC Women's Protection and Empowerment programme

Syrian women share with us their fear for the safety of their daughters and often make choices meant to protect them in the short term, knowing these decisions could harm them in the long term. The reality is these women do not have clear or easy choices to make for themselves or for their children. The IRC Women's Protection



A Syrian woman and her niece in a refugee camp in Jordan

and Empowerment programme provides services to an average of 2000 women every month in Jordan. Its design combines prevention, empowerment, response and coordination activities, guided by the use and triangulation of multiple assessment tools including safety audits, service mappings, community mappings, focus group discussions and individual interviews. Primarily conducted with Syrian women and girls (although men and boys are also consulted) the tools are specifically tailored to outline the main needs, challenges and barriers in availability and access to services, as well as dynamics of GBV that women and girls face. The IRC plays an active coordination role working with national and sub-national working groups, governmental departments, as well as local and international humanitarian organisations to ensure women and girls' needs are taken into account across humanitarian sectors, and that services for GBV survivors are comprehensive.

Providing quality survivor-centred services including case management, and psychological support is the bedrock of IRC programming. These confidential services were initially embedded in amongst the first fully female staffed primary and reproductive health clinics in Ramtha and Mafraq and continue to be at the core of our programming in 2014. As we gained the valuable trust of the Jordanian and Syrian communities, we were able to expand our services at the request of women and girls within the urban communities of Irbid, Rmatha and Mafraq through the establishment of women centres that serve as "safe spaces" where both refugee and host country women and girls can attend.

⁵ See International Centre for Research on Women. *Child Marriage Facts and Figures*. <http://www.icrw.org/child-marriage-facts-and-figures>

⁶ See International Centre for Research on Women. *Child Marriage Facts and Figures*. <http://www.icrw.org/child-marriage-facts-and-figures>



A Syrian refugee girl paints at a children's play area at an IRC women's center at Za'atari camp.

The IRC was subsequently asked to lead similar programming in Za'atari camp for women and girls. Women and girls have told us that without these spaces, many women and girls would not be allowed to go anywhere. The IRC Centres focus on strengthening informal support networks among women and girls to promote coping with the trauma of displacement, and building on the resilience of women and girls to support community-based protection mechanisms. The IRC supports a broad range of group psychosocial activities in the form of skills trainings, information sessions, non-formal education, reproductive health classes and other trainings that are designed, informed, and led by women and girls in the safe space. These Women Centres serve as entry points for survivors of physical and sexual violence where they will not face the stigma attached to being a survivor of violence and by extension, promoting help-seeking behaviour. Survivors can report incidents confidentially, and access services including counselling and healthcare. Age-appropriate services and support in the same centre are available. In Jordan over 11,000 women and girls have taken part in healing activities or services at IRC-supported centres in 2013 and more than 6,000 women and girls have received psychosocial support from IRC psychologists.

Cash assistance to mitigate risks

Sexual exploitation, early and forced marriages and unprecedented levels of domestic violence were identified by women and girls, as well as men and boys, as triggered by lack of economic means and opportunities for women and girls. In response and following IRC safety audits and community based safety planning, cash assistance was identified as a response to reduce multiple risks for women and girls. IRCs cash assistance programme, which uses ATM bankcards, provides families up to 120 Jordanian Dinars per month (about USD \$180) for six months. It has benefitted over 2,400 refugee families to date. In addition, over 13,400 "dignity kits" consisting of sanitary napkins, soap and other essential items have been distributed to women and girls of reproductive age. During the winter months, special-

ized kits are provided to help vulnerable families make it through sub-zero temperatures.

Supporting and increasing women and girls' decision-making power and their access to, and control over, economic resources are a key aspect of IRC's prevention efforts particularly in urban settings. This material and financial support mitigates and aims to contribute to reducing the risk of domestic violence, sexual and other forms of exploitation as well as other harmful coping mechanisms. Given the current challenges facing Syrian women and girls economic activities alone – without giving due attention to protective mechanisms – can create additional violence if men feel threatened by women's new economic status, and if women are expected to manage sums of money that may put them at risk in the community without support on how to safely do so. Supporting women to access and control money therefore provides an important part safety measure and the experience shows risks can be addressed through partnership with women and informed programmes.⁷ Participating in social and economic activities creates protective mechanisms for women and girls – allowing them to rebuild social connections and networks

that have been severed because of conflict. Women and girls networks gives them a rare space and opportunity to talk amongst themselves – without supervision or control from others in their lives – about their specific issues and problems, and often serves as a place of support and healing. In addition, expanding economic opportunities can be a protective factor as it allows women and girls to avoid harmful economic activities leading to sexual exploitation.

Conclusions

The international community has been promising for years to bring the interests of women and girls from the margins of service provision to the mainstream of humanitarian programming. An apparent and understandable sense of hopelessness is setting in for many Syrian women and girls as we fail to act. Critically, for women and girls the need is for immediate action not only to make women and girls safe from exploitation and abuse, but empowered to be active participants in their homes, communities and their own lives. The humanitarian community's will to prioritize the needs of women and girls in both word and deed is the most critical key to success as we are all accountable for bringing women and girls from the margins of service provision to the mainstream of humanitarian programming. Women and girls' voices must be a key force in driving humanitarian action. UN agencies, non-governmental organisations, host and donor governments must seek out and value women and girls' perspectives across all services and be held accountable for applying the minimum standards as laid out in the Interagency Guidelines for the Prevention and Response to GBV.

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⁷ IRC Gender discussion research brief <http://gbvresponders.org/empowerment/eae-evidence/> Economic household discussion group tools: <http://gbvresponders.org/empowerment/eae-tools-resources/> IRC Gender discussion research brief: <http://gbvresponders.org/empowerment/eae-evidence/> and Economic household discussion group tools: <http://gbvresponders.org/empowerment/eae-tools-resources/>



IRC volunteer Rania speaks with a Syrian refugee at a refugee camp in Jordan. Rania is a Syrian refugee who meets with as many as 50 families per week to inform them about available programming and support in the camp.

The social life of nutrition among Syrian refugees in Jordan

Sakiah Malkawi/WFP, Jordan, 2014



As the ENN embarked on developing this special edition of Field Exchange in September 2013, it was clear that most of the articles would describe the experiences of programming staff. We wished to redress the balance a little by featuring refugee and host population social experiences of the multi-faceted area of nutrition. Given very limited resources, this capture could only extend to the collation of a small number of individual refugee experiences in Jordan. We engaged two enthusiastic anthropologists, Luigi and Raymond, and an equally enthused volunteer graduate, Tara, to undertake this work and add a fresh perspective. This article shares what they found and their personal reflections on what they saw and heard in the process.

As the authors state at the outset, this is not a study of a representative sample of affected refugees and no conclusions should be drawn regarding the nature and impact of the response in Jordan; there is extensive work on this that can be accessed at the UNHCR Syria response portal (<http://data.unhcr.org/syrianrefugees/regional.php>).

Method

The collection of data relied mainly on 40 individual interviews and two focus group discussions held over a period of 20 days in February 2014. The interviews of refugees, aid personnel, scholars and others on which this paper is based were planned in advance where possible and based on a schedule of questions covering key thematic areas of interest as developed with input from ENN and the nutrition sub-working group in Jordan. Nevertheless, in the event much depended on the vagaries of chance and access, and who, when it came to an actual meeting, were willing to make themselves available to us, and how far they would go in addressing what turned out to include some highly controversial issues. The research was carried out in various parts of the country. Our interviews involved several visits to non-governmental organisation (NGO) field offices in Amman, Karak and the Jordan Valley, one visit to Zaatari camp and two visits in two informal tented settlements (ITS) - Deir 'Alla and Mafraq respectively. Of course, for a properly social anthropological study (that would be based more on social observation, participant involvement, and generally 'being indeed living there' than reliance on interviewing), a much longer time for fieldwork is needed, besides time to access all the available literature that directly or indirectly could be of help to this type of study. The analytical perspective we designed emerged as our observations proceeded.

Setting the scene

This special edition of Field Exchange contains descriptions of the different situations of Syrian refugees in Jordan. Some live in official camps, others do not; some did, but many have moved out since. Through our research we were told of a number who were in 'informal tented settlements' (ITS) who chose or in instances, were moved¹ to camps whether they originated there or not; most ITS dwellers we heard about, for now anyway, remain in these largely service-less places. Some Syrians fled to Jordan at the very outset of the conflict, others are still coming. In addition, while the total number of Syrian refugees in Jordan (and elsewhere) is very high, those who already resided in Jordan prior to the civil war should also be taken into account. An added complication is that while many refugees have registered with the UNHCR, many others have not, or must manage while their re-registration is still pending. The vast majority of Syrian refugees we met by most accounts are totally or only partly unaware of what relief services there are for refugees, while those that are – and have registered – are not all accessing them². Furthermore, from our inquiries, it appears some Syrians do not register, either as refugees or asylum seekers, as they consider themselves in transit and en route to another country. They believe that having the label 'refugee' would only hinder that. In one informal tented settlement we

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Luigi and Raymond extend sincere thanks extend sincere thanks to UPP, UNHCR, Medair, Save the Children Jordan; many other humanitarian agencies' staff, national and international, who helped us in various ways; the individual scholars and other professionals who shared insights with us and at times accompanied us, and Tara Shoham (ENN volunteer) for setting up most of our meetings and taking part in them.

¹ "On Sunday 5 January, residents of Informal Tented Settlements around Greater Mafraq municipality were evicted and forced to move." See minutes Informal Tented Settlements Taskforce Meeting (meeting date: 9 January 2014). Also, during the researchers field visit in the Jordan valley, a former site was pointed out to us, with the information from the Jordanian Women's Union (JWU) that its former occupants had been relocated.

² It is important to note that UNHCR evidence shows

that 96% of registered refugees have access to MoH services. In a UNHCR supported survey of registered refugees, nearly all households (91.7%) knew refugee children younger than 5 years have free access to vaccination, and 96.3% knew that all UNHCR registered refugees have free access to governmental services at primary health centres and hospitals. Only 65.8% were aware that refugees who can't access governmental health services could seek services at UNHCR-supported health facilities.

were told that no one had registered as a refugee because of fear of their information being made known to Syrian officials or because they saw no benefit to registration since they normally moved in search of work (see Box 1). So, simply what a 'refugee' is exactly – or inexactly – can be a puzzle. Equally important, forced migration may be due to a number of different factors – social, economic, and political. Any overall nutritional profiling must allow for this complex picture.

As two social anthropologists, the ENN asked us to ponder and probe some of the social – and human – aspects of emergency nutrition for the Syrian refugees in Jordan as a contribution to this special issue of Field Exchange. On the basis of a month's 'fieldwork' in Jordan (March 2014 plus a few days reflecting and writing, in April), what we could aim to do was of course limited, but threefold: (a) to model the social side of nutrition arranged and integrated with the bio-medical side and bring it to the fore as 'the social life of nutrition'; (b) to rehearse something of what a 'beneficiaries'-oriented study of the social aspects of nutrition in a refugee population should aim to consider⁴, and why; (c) to interview as many refugee households or household members and 'focus groups' as possible in the circumstances as to their nutritional status and issues, and report briefly our findings.

Nutrition as a social as well as a bio-medical process

Nutrition is integral to and arranged as part of the social life of people. It has social, economic and political pre-conditions, dimensions, and aspects. Refugees' social lives, like other peoples', affect and are affected by their nutrition and malnutrition (see Box 2). That refugees do have social lives of their own, despite being treated by relief agencies for administrative purposes just as displaced demographic categories – such as 'refugee women', 'refugee men', 'refugee infants and children', and such – must itself be a major point to make at the outset of this analysis. Refugees should be studied as people as well as refugees. Besides their refugee needs and concerns, they have everyday agendas of their own about their non-refugee ordinary lives⁵, whether or not these agendas are known to the authorities.

By way of introduction, three points are highlighted to begin with. First, we soon found that for all kinds and categories of refugees in Jordan we met, 'food security' is the overriding issue in their estimation. Second, the overwhelming household priority for those who do not live in refugee camps and settlements – generally said to amount to some 80 per cent of the total – is somehow to meet the high rent that landlords

Box 1 e-voucher and the issue of registration

We visited a Jordanian Women's Union (JWU) centre in the Jordan valley region, opened in 2007 by a former school teacher, followed by two nearby ITSs. The JWU runs social, educational, awareness raising and vocational activities, as well as occasionally providing medical services by visiting doctors in at least one of the ITSs. Many in the medical tents are ill due to exposure to the pesticides they use in the greenhouses where they work³, moreover there are no facilities in the tented settlements to wash, go to the toilet, and no clean water. "The poverty is taking away our children's childhood" someone said. Households pay 25JD per month to have a tent on the land where they work. Syrian refugees work alongside Egyptian refugees but earn less money: Syrians - 1JD per hour, Egyptians - 1 ½ JD per hour.

It is mainly the women who work in the greenhouses, and sometimes the children. The northern Syrian's have brought this culture here. Southern Syrian men do work (especially if they are educated). Their diet is poor in protein. They receive some vegetables, as well as pay, but they sell them for extra income. Their e-cards, which are not exchangeable for cash, are for purchasing food and other items for up to 24JD per month (12 JD every two weeks) per family. It costs however 1JD to go to the mall in Salt to use them. The e-card was introduced to stop refugees selling their vouchers – agency staff considered that, assuming the proceeds would not be spent on food, this would inevitably negatively affect refugees' diet. However, as most people in the tents don't register as refugees, they are not entitled to receive e-vouchers. Interviewees gave two reasons behind this decision: first, they are too afraid, thinking that their information might be given to the secret police who will then send them back to Syria and secondly, many have a very nomadic style of life, moving from one work place to another, so it is not beneficial for them to register.

Box 2 What type of nutrition?

Fatima is a 25 year old woman from Homs. On the 20th July 2013, she left Syria and crossed the border into Jordan with her husband and her two children aged 8 and 10 years. They spent one night in Zaatar Camp for registration purposes; the following day, the whole family moved to Karak, where they are now living.

Fatima works part time for Save the Children Jordan for 10 JOD per day, three days per week. She is the only one to work: her children are too young and her husband is disabled – his right arm was severely injured by a bomb in Syria. The work is regular but the salary too meagre to cope with the daily expenses. To pay the rent of the house, the family sell their monthly food vouchers. The voucher value is 96 JOD, but they sell it only for 60 JOD.

The family would like to have different types of food, but they cannot afford to. They eat potatoes almost every day, only on Friday can they afford to have meat, generally poultry. Fatima laments her incapacity to feed her children and husband with a more varied and balanced diet, especially meat and vegetables. However, she also claims that her first priority would be to give her children sweets. She comments: "you know, if I could buy food, the first food I would buy is chocolate for my children. At the school, (Jordanian) children make fun of them. All the other children have snacks, but they don't have anything but bread. They mock them calling 'Syrian dogs' because they are different. I'm afraid; I don't want my children growing up thieves because of the hardships that they have to endure!"

Box 3 Political economy

Umm Khalil lives in Zaatar Camp. She left Syria with her two children in 2012 to join her husband who was already living in the camp. The husband had left Syria one month earlier after deserting the regular army.

The woman does not work. Her two grown up children and her husband are not in steady employment; they alternated between petty jobs and long periods of economic inactivity. Like many other refugees in and outside Zaatar Camp, the family sells the food vouchers that it receives periodically from the WFP to afford diverse types of food such as dairy products and fresh meat.

Umm Khalil says that they cannot afford healthy complementary foods such as fruit and vegetables as the voucher will not cover this price. She also blames the family's poor diet on the logic of "wasta" that relegates them to the margins of refugees' political economy. The term "wasta" indicates the use of family connections and relationships of patronage that are central in the search of jobs, credit, and favours in the region. Umm Khalil claims that access to regular jobs, and hence to better food, in the camp's informal market is determined by a small community of Syrian refugees originating from a specific part of the Syrian governorate of Dara'a. Being one of the first communities of Syrians to settle down in the camp, they have had the time to consolidate their power over the newcomers. According to Umm Khalili, "there is mafia in the camp! These people are generally related through kinship. This means that they decide who can work and who cannot work. They are also those who can decide who can sell their vouchers and who cannot. Others decide what kind of food can be bought, and they have access to better food because they have money."

³ This is based on reports from the refugees and staff from the JWU

⁴ What are generally termed 'beneficiary' studies tend to focus on selected target groups or supposed representatives of these at a particular point – or points – in time. Loose use of the 'beneficiary' word – such as 'we have served 10s of 1000s of beneficiaries' – is practically meaningless sociologically as well as administratively. Cf. Raymond Apthorpe. 2012. Effective aid: the poetics of some aid workers' angles on how humanitarian aid 'works'. Third World Quarterly. Special Issue, Vol 33, No 8.

⁵ Cf. Achilli, L. Palestinian refugees and identity: nationalism, politics, and the everyday, I.B.Tauris. Forthcoming.

⁶ The researchers felt it important to cite the exact words used and not sanitize others' statements. However in doing so, it is equally important to reinforce the point that the opinion expressed reflects the experience of a single person and, as such, should not be extended to the totality of Syrian refugees' experience.

demand for basement accommodation space.⁷ Third, food has not only nutritional values but it is also politically, socially, and culturally defined.

During our fieldwork we could observe, for example, how refugees' political economy and institutions shape and limit individual and household choice over what to eat and when (see Box 3). Likewise, individual tastes are strictly intertwined with cultural preference; all affect people's nutritional patterns. Virtually everywhere we went we were told no one liked the taste of the World Food Programme (WFP) supplied Super Cereal relief ration food. Apparently, unless you were in a position to afford to find and add sugar, no one would want to eat it (see Box 4). Neither, again according to what we saw or heard practically everywhere we went, would refugees eat frozen meat or fish, even where it was available and affordable. Some said it had a bad taste, others doubted that the use-by dates on frozen food were reliable (given the common practice in some stores of switching off power at night to economise on costs). Yet others said that "though those who travel and are modern eat frozen food, we [ordinary folk] do not" (see Box 5). Regarding dairy products, in Zaatari camp and elsewhere, people told us that while at home in Syria these were available and affordable, they had to do without them in Jordan and use only powdered milk; an inferior substitute, as they saw it, which again they would avoid.

All in all, to what extent, even in extremities of situations, people, refugees included, will or will not change their cultural values and preferences and for example, accept to eat whatever they can get simply to survive, remains to be socially researched as a matter of refugees' knowledge, attitudes, and practices anywhere, let alone in Jordan specifically. Our impressions are that perhaps even in emergencies, cultural preferences may tend to harden. Despite the popular idea that in emergencies and other stressful times there is nothing but social breakdown, our fieldwork and other accounts document the extents to which ordinary social institutions and practices continue to be part of the social scene despite disruptions and other changes. Refugee camp, and non-camp, life is no exception. That in some extremities such avoidances and indeed other social and cultural practices *do* change and perhaps break down is

Box 4 Super Cereal Plus

Shadi and his wife, a young couple in their early twenties, have a 2 year old daughter and another child, only days from birth, when we met them. They came to Jordan partly because they felt unsafe in Syria. They spent 15 days in Zaatari camp and then left because of its poor conditions, to join an aunt who was living nearby.

Shadi farmed sheep in Syria and is now doing the same for a Jordanian employer. They do not pay rent for their accommodation in season, only out of the season, but they have to travel far into the centre of the city to buy the food with the vouchers provided by WFP, which is expensive. They seek to buy the same food that they bought in Syria, but lament the lack of sheep's milk and cheese. They do not like the meat which they could buy with the WFP voucher as it is frozen and so, they claim, unhealthy.

Shadi's wife was identified as moderately malnourished during screening, on account of inadequate calorie intake during her pregnancy. She is, however, suspicious of the WFP's specialised Super Cereal Plus for the treatment and prevention of moderate acute malnutrition among Syrian refugee women and children with which she has been supplied. It tastes wrong, she claims, the procedure to cook it is too complicated, and as we observed, there is not always agreement on how to prepare it (the international aid worker, and the national nutrition staffer, robustly disagreed as to exactly what quantities to mix). Social protection in the sense of household socio-economic-health security may involve a family selling its WFP-supplied Super Cereal Plus at the roadside for a much lower price than its value to supplement a meagre family budget.

Box 5 "Dangerous" food

Abu Omar spent two weeks in Zaatari Camp before moving to Deir Alla in the Jordan Valley. He left the camp because one of his children was very sick, and he knew a Syrian doctor who lived in the Jordan Valley. He rented a house in Deir Alla where he now lives with his wife and children.

Abu Omar used to be a teacher in Syria but is now a plasterer/decorator. He is earning 7JOD per day. Despite living in hardships with a salary that barely covers the rent of his flat, the man claims to be in a far better situation of those Syrian refugees who live in ITSs near his house. These people have established their settlements on the very lands where they work. Households rely primarily on agricultural waged labour - an unsteady source of income that tends to vanish as the winter approaches.

Abu Omar has a fridge and, with that, a far richer diet than his country mates who leave just nearby in the ITS, who rely mostly on tinned/boxed foods. He and his family can afford to eat cheese, olives, olive oil, rice, lentils, beans, vegetable and eggs.

However, despite the "luxury" of owning a fridge, like people living in the ITS, Abu Omar does not eat meat. The WFP voucher allows him to buy only frozen meat. Frozen meat, however, is widely believed among Syrian refugees to be poisonous and toxic. Dishonest sellers are rumored to change the 'use by' date on the packaging of the meat or turn of the fridges at night - to save electricity - and then refreeze the meat. As Abu Omar put it, "people who travel might eat it, but it is not good, it tastes different. We don't even know whether it is halal ['permissible' under Islamic dietary guidelines]".

another scenario - but under what kinds of pressures, against which alternatives, at what thresholds, and with what outcomes?

Nutrition is already an inter-sector

Nutrition is not just one thing, with sharply defined boundaries, but many things, itself an inter-sector. Towards better addressing 'nutrition' amongst Syrian refugees in Jordan, it must be remembered that nutritional status depends on many things at once, not on diet and food intake alone.

To begin with, it is worth noting how 'shelter' and 'health' are part and parcel of refugees' nutrition issues. For example, chronic health conditions can have a big impact on all age categories. At the same time, extremes of climate and weather as in Jordan can mean that poor shelter can be deleterious, especially in the winter, to health and nutrition. Similarly, all of our informants - either development and humanitarian aid agency staff or Syrian refugees - appreciated

the many contributing factors to malnutrition. None pointed to material shortage of food to explain the cases of undernutrition among them.

Another consideration is the new policy in Jordan of cash aid that has gained ground in the form of ordinary vouchers and, more recently, e-vouchers. Indications from our work are that vouchers for food items are actively traded by a range of purchasers. Social protection, in the sense of household socio-economic-health security, may involve a family selling its vouchers for a much lower price than its value (often at a loss to the seller of 12 per cent) in order to supplement a meagre family budget. As to whom such vouchers are sold, it is to other refugees, to the host population, and sometimes even to aid-workers, as for instance in the Zaatari camp (where there are currently an estimated 3,000 aid staff). Needless to say, these transactions are detrimental to refugees' 'proper' nutrition.

⁷ See <http://data.unhcr.org/syrianrefugees/country.php?id=107>.



Dina_EkKassaby/WFP, Jordan, 2014

From our discussions, we cannot judge what overall difference the introduction of vouchers has made to nutrition amongst those we spoke to and certainly not in the refugee population at large. What we can reflect is that much is likely to depend on specifics, such as what food/non-food items, if available, vouchers can be spent on; where, at what time intervals; and as a market in vouchers develops (including in Zaatari camp) precisely who sells and who buys, why and what then is done with the proceeds.

In this context, nutrition's social protection dimension is also evident in several regards. Violent social relations among refugees and between them and/or the host community may be directly or indirectly interconnected with nutrition in various ways. For example, most of the cases of malnutrition reported to us were amongst Syrian refugees living in the ITS. It is likely that sub-standard living conditions and inadequate WASH contributed to the poor nutrition situation that we observed. Yet, ITS have increasingly become a default option for those refugees – mostly coming from the governorates of Aleppo, Hama, and Rural Damascus – who left Zaatari also because of the inter-community tensions within the camp as well as issues like lack of privacy and freedom of movement, feelings of being imprisoned, and humiliation. Another example of refugee host population tensions surfacing occurs in relation to the strong dislike of the taste of WFP-supplied relief food – one refugee interviewed wondered whether it might be poisonous, given that it was not also made available to their poor Jordanian neighbours!

Finally, in this short listing of essential influences, household social-time management needs to be taken into account towards understanding refugees' decision-making about nutrition. For example, on being told by a refugee that she "had not enough time" to take best care of the nutrition of her infants, it turned out this was because of the elderly and infirm she had to care for too. Since she was largely confined to her home space, she was not able to get about much – for example, to the clinic to have her children screened, vaccinated or looked after when ill. She had become socially isolated compared with her life before and as a result, not able to cope and manage well. The nutrition and health of her children suffered as a result.

Nutrition and humanitarian relief

Nutrition is intimately linked with personal matters of health, individual and household income and a whole range of issues important for social policy and administration – such as vulnerability criteria, ease of access, and effective targeting.

For Syrian refugees in Jordan, access needs to be considered in terms of access on the part of the relief agencies to their target populations, and access on the part of these populations to the agencies (see Box 6). This dichotomy has obvious implications. For example, international agencies' views on who are the most vulnerable and in greatest need may differ considerably from those of the refugees themselves. In addition,

Box 6 A special diet

Nadia is a 43 year old woman, from a village near Damascus. In May 2013, she crossed into Jordan with her four children aged between 6 – 15 years. Her husband remained in Syria. She went directly to Karak by-passing Zaatari Camp, choosing that destination because a relative who moved to Jordan before the war would help them settle. Nadia youngest son is very sick, diagnosed with a rare chromosome disorder, "he looks 3 years old but is already 6". An expensive private doctor she consulted prescribed a diet rich in protein, however she said she can only afford to buy potatoes. She does not work. Her two eldest children carry out occasional jobs, but irregularly and without earning enough to cover even food costs.

Nadia is not enrolled in any programme of assistance. She said that she was never contacted by any humanitarian organisation. She had received cash assistance just once, from Save the Children International, she said, but since then nothing, no assistance of any kind from any organisation. It appears that like Nadia, there are numerous other refugees who are unaware of the services available and/or the criteria of access.

NGO and UN vulnerability criteria tend to change over time. In the short time we had for this research and with the resources available to us, we were unable to track such changes and come to any conclusion about overall outcomes and impacts.

A further complication is that straightforward emergency response is rarely unbound from what we consider a developmental agenda or at least a longer term strategy. Nutrition as we have seen is itself inter-sectoral. Like other emergency assistance provision, a nutritional programme may also be, besides one of targeted relief, a project of selective nutritional reform. A case in point is, for example, what came across to us as an "educational war" in Jordan between, on the one side, the advocates of breast-feeding and, on the other, users of infant formula. If such a war is indeed being waged, it is hard to tell which side is losing or winning – and at what costs. Organisations such as Save the Children Jordan (SCJ) strongly advocate breast-feeding support as do international agencies such as Medair who kindly invited us to see some of their work first hand. SCJ's Coordinator for Nutrition - who co-chairs with UNHCR the Nutrition Working Group for the Syrian refugees - showed us in Zaatari camp how SCJ provides education and skilled support on optimal breast-feeding practices⁸. The challenge for SCJ and similar agencies is that most Syrian refugees in Zaatari are from rural areas in Syria where infant formula is commonly used to feed infants. For those we interviewed, this is because, besides the convenience offered through formula feeding, "it is also the modern way to go". For us this raises some questions we found impossible to answer, such as what level of compromise is appropriate between an aid agency's public health interest approach and the individuals own choice, which in turn, is a function of their own values and responses to their circumstances and conditions. And furthermore, to what length should the aid response go to, to achieve behavioural and social change in an emergency context?

As we see it, a relief organisation that embarks on this type of social and nutritional re-education in the context of a relief programme, sometimes using the same programme and staff, has both emergency relief and development objectives in that they are relying on behaviour changes in

an emergency context that may take some time. A question this poses for us (and perhaps research) is whether what may be best for the health of the population at large is difficult for the individual to accept and accommodate and consequently gives the agency a bad name in the eyes of its intended target population. This is a complex matter to resolve.

Conclusion: The complex social relations of nutrition

The social relations of nutrition are to be sought in its sociology, that is who knows and inter-relates with who, as well as its social and cultural institutions at large, such as what and whose knowledge, attitudes and customary, seasonal practices prevail with regard to food, health, nutrition, domestic and political economy and so forth. Hence, as our fieldwork illustrates, there is need for a household and community social context-informed approach to the management of aid programmes and their implementation and evaluation. Refugees are people, not swarms of atoms. Their affairs are not simply 'spontaneous' or automatic 'reflex' reactions to challenges and opportunities. Rather actual health and nutritional outcomes are beyond the bio-medical. They are underpinned by social, political, economic and security variables. They are therefore informed by patterns of communication and choices whether in the circumstances they can be well-informed or not.

Unfortunately, rarely in emergency relief studies do the social relations and social issues in refugees' everyday lives that affect their nutrition and health, and indeed all aspects of their lives, get the attention they deserve.

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⁸ Information note from ENN: The supplementary feeding programme only targeted Syrian refugees given their higher vulnerability. Recognising the population's negative experiences around Super Cereal Plus, considerable work has been done since its introduction to sensitise the population to its value and how it should be prepared. Satisfaction has increased as a result (see articles by Save the Children Jordan and Medair in this 48th edition of Field Exchange).

⁹ Save the Children Jordan and UNHCR also support targeted provision of infant formula to infants who are not breastfed in Zaatari camp. This aspect of the programming was not encountered by the researchers.



UN and INGO experiences of coordination in Jordan

By Alex Tyler and Jack Byrne

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As of July 2014, there are now over 600,000 Syrian refugees in Jordan; with up to 80,000 in camps, and 520,000 in urban and rural areas. The Government of Jordan, civil society and the international community have all stepped up to meet the enormous needs, both of refugees and of the Jordanian communities¹ affected by the crisis. The Jordan Refugee Response is the broad frame for these.

Under the leadership of the Government of Jordan and coordinated by UNHCR, the Jordan Refugee Response is a collaborative effort between the donor community, United Nations (UN) agencies, international and national non-governmental organisations (NGOs), community-based organisations, refugees and Jordanian communities.

All levels of the Government of Jordan are engaged in the response, from the Office of the Prime Minister, the Ministry of Foreign Affairs, the Ministry of Interior and the Ministry of Planning and International Cooperation (MOPIC), to the line ministries working with each of the sectors, and the governorates and municipalities in refugee-affected areas. In 2014, the Ministry of Interior created the Syrian Refugee Assistance Directorate (SRAD), which is the primary government entity for the coordination of refugee issues in the country.

From an inter-agency perspective, the main strategic framework for the response is the

Jordan chapter of the Regional Response Plan (RRP)². In 2014, 64 partners have appealed for a total of USD 1 Billion through the RRP. Delivery is organised through eight sectors—Cash, Education, Food Security, Health, Non-Food Items (NFIs), Protection, Shelter, and Water, Sanitation and Hygiene (WASH). The sectors are linked through an Inter-Sector Working Group (ISWG) – a meeting of sector chairs with the aim to encourage synergies between sectors – which in turn reports up to the heads of UN and NGOs who meet together in the Inter-Agency Task Force (IATF). Nutrition, together with Reproductive Health and Mental Health and Psychosocial Support Services (MHPSS), are sub-sectors of Health.

Complementary yet independent from these structures, the International NGO (INGO) Forum sets common policies and pursues advocacy initiatives, based on consensus among the NGO community. There are currently 53 INGOs signed up to the INGO Forum.

The scale of the refugee response and the myriad of partners and structures involved provide a glimpse into the complexities and challenges faced in achieving effective coordination. This is a massive operation, with staffing numbers well into the thousands. Each organisation has also experienced a significant expansion in staff compared to two years ago. UNHCR alone has grown from around 100 staff in 2012 to now almost 700 staff by mid-2014.

Refugee Coordination pre-dates the Transformative Agenda³ and is distinct from the Cluster system. More recently it has been reaffirmed at the global level through the Refugee Coordination Model⁴. In short, in collaboration with the Government of Jordan and mandated by the UN General Assembly, UNHCR remains the coordinating organisation for the entire response. The time-line for UNHCR's engagement stretches well beyond the emergency phase. It also includes longer term care and maintenance, as well as the pursuit of durable solutions, through voluntary repatriation, local reintegration or resettlement to a third country.

At the same time, there are many parallels with the Cluster system. Key operational UN agencies – especially WFP, UNICEF, WHO and UNFPA – manage sectors in which they have specific expertise. While UNHCR remains overall the 'agency of last resort', other UN agencies are committed to delivery in their sectors, both through their own mandates and through a

¹ The response to vulnerable Jordanian populations is built into every project approved by the Government of Jordan; it is mandated that each project responding to refugees must respond to vulnerable host populations. In recognition of the need to ensure Jordanian communities are effectively assisted, both the RRP strategies in 2013 and 2014 have explicitly targeted host communities. In 2014, over 700,000 Jordanians are benefiting from the RRP.

² Available at <http://www.unhcr.org/syriarrp6>

³ For more information, see www.humanitarianinfo.org

⁴ UNHCR, Refugee Coordination Model, November 2013, available at <http://www.unhcr.org/53679e2c9.pdf>

series of global and national memoranda of understanding with UNHCR. International and national NGOs are crucial at all levels of the response – from strategic leadership down to the daily delivery of protection and assistance to refugees and Jordanian communities.

The Cluster system has also set the tone for what is expected from coordination; in many respects contributing to the professionalisation of coordination as a function within aid work. The efforts of Global Clusters and the Inter-Agency Standing Committee (IASC) have defined standards and guidelines, many of which are applicable in refugee situations. They have also tried and tested coordination structures and appeal mechanisms – developing best practices that have also been adapted by UNHCR and partners across the region affected by the Syria crisis.

For instance, adapting best practices, the process resulting in Jordan's RRP has been robust. Three months of inclusive planning at the strategic and sector levels resulted in a clear strategy, peer-reviewed by sector chairs, and built on over 1,200 projects or activities of the 64 appealing partners.

Professionalising coordination clearly has many benefits – more efficient systems, reducing duplication and better serving partners' information needs. It also brings some risks. While UNHCR and many other organisations now have dedicated coordination staff in Jordan, the danger is that coordination structures become heavy, overbearing on organisations' independence and, at worst, self-serving and dislocated from the realities faced by staff at field level and from the people we are trying to help. The proliferation of coordination structures – the 'task force disease' – can itself be counter-productive. Too many meetings are particularly onerous on the smaller international and national NGOs, who do not have the staffing levels necessary to attend them all. One risk is that some partners opt-out of these meetings, or send junior staff. This can result in actual decision making being further skewed towards the larger organisations.

In Jordan, we have an oft repeated mantra to keep coordination to the "minimum necessary to facilitate collective action", and that each new structure or process proposed needs to demonstrate a clear added value. We have tried various ways to meet this standard. First, regular anonymous surveys are conducted with sector members to canvass opinion on the performance of the sectors in general, and also to elicit feedback from sector members on how coordination structures can be improved or streamlined⁵. Secondly, the INGO forum has a seat on the Inter-Sector Working Group, and is consulted on design of these structures. The recent roll out of coordination fora in three governorates of Mafraq, Irbid and Amman only went ahead after extensive discussions with and within the INGO forum. It has to be said that we are not there yet, and often find ourselves well beyond

the line of 'the minimum necessary', but will go through regular 'retrenchment' of meetings to keep this under control.

Investing in Information Management as a coordination service has been important, both to facilitate planning and implementation by partners, and to shift coordination meetings from long, round-the-table sessions, to being more focused on both strategy development and problem-solving. The Jordan response uses a number of portals and platforms to keep partners updated. An example is ActivityInfo⁶ – an online platform for planning activities and reporting achievements against pre-defined indicators. Originally developed by UNICEF in the Democratic Republic of the Congo (DRC), ActivityInfo allows partners to log their own activities and check what everyone else is doing and where⁷. Used well it is a transparent system designed to empower partners, enabling them to conduct simple gap analysis, generating maps and charts for their activities and for a geographical area or for the sector as a whole. UNHCR is aware that partners need some initial support and training to be able to use its full potential. With high staff turnover this can be a challenge in itself.

From the INGO perspective

The Jordan INGO Forum came together as an informal group of the handful of organisations that had been operating in Jordan before the onset of the Syrian crisis. It has gradually played a much larger role in overall crisis coordination as more and more INGOs established themselves in Amman – with the largest INGOs establishing both a country and regional offices in the capital city. Establishment of the Forum was not at the behest of donors or UN agencies but rather was an organic process to meet the needs of members, at first around safety, security, advocacy and information sharing, and then to be important stakeholders at the table with the UN, the government of Jordan, and with donors. The thirteen largest INGOs operating in Jordan programme well over \$100 million in humanitarian activities to aid refugees and vulnerable Jordanians and are some of the most operational actors in the crisis.

Forum leadership and representation went through a number of iterations, from an informal Chair and Co-Chair that facilitated monthly meetings, to its present structure of a Chair and four Steering Committee members. At the strategic levels, these five people represent INGOs on the Inter-Agency Task Force, the Humanitarian Country Team, the Inter-Sector working Groups, monthly meetings with donors, and with the government of Jordan, mainly through interaction with the MOPIC.

Despite having a legitimate place at the table, achieving meaningful INGO representation within existing and new coordination structures remains a challenge. Some INGOs manage larger budgets and certainly have greater operational capacity than many of the smaller UN agencies.

Conversely, many INGOs are short-term responders with rapid staff turnover, and do not have the resources to dedicate to the Forum or to the multitude of coordination meetings that take place on a daily basis. A particular challenge for INGOs and the UN alike are new coordination mechanisms underway from various stakeholders, which tend to hinder implementation of what has already been agreed to and blur the lines around who is doing what. Additional layers of coordination need strong justification and buy-in from all involved; otherwise there is the risk of alienating donor agencies who fund these mechanisms and of drifting farther from the real purpose of our collective response, which is to assist those affected by the crisis.

It is widely acknowledged among the humanitarian community that in Jordan, coordination and communication between and among INGOs and their counterparts in the UN works well relative to coordination structures in other countries in the region. It is critical that INGOs continue to advocate for issues that affect their ability to operate with neutrality, to choose well-informed representatives to speak for the collective, and to engage actively with the UN and the government of Jordan to protect humanitarian space in the face of concerns over safety and security, which, while unarguable, will have negative effects for Syrians seeking refuge in Jordan and for Syrians already here.

To conclude, there are traditional rivalries between some organisations – both at the UN level and among INGOs. Organisations do compete for funds and for responsibilities over different sectors. While organisations do of course recognise that pursuing common goals collectively is the most effective way to serve refugees' needs, there is an ever present jostling for space between the partners. Coordination cannot be blind to this, or the pursuit of the overall goals may be negatively affected. It is key that structures are balanced, built on mutual respect, consultative and do provide space for visibility and independence of organisations. At the same time, no one organisation can go it alone, and expect to deliver an impact beyond their own project. The strength of the Jordan Refugee Response is that it recognises greater benefits come from collective action of all the organisations involved, each bringing to the table their own skills and expertise in a genuinely inclusive manner.

More information on refugee coordination in Jordan can be found through the Jordan country pages at <http://data.unhcr.org/syrian-refugees/country.php?id=107> and in the draft Coordination Briefing Kit at <http://data.unhcr.org/syrianrefugees/download.php?id=6379>

⁵ See the latest survey results at <http://data.unhcr.org/syrianrefugees/download.php?id=6158>

⁶ For Jordan, Activityinfo is accessed through the URL www.syrianrefugeeresponse.org

⁷ See Claire Barnhoorn (2014). Spreading around the globe: ActivityInfo. Field Exchange 47, April 2014, p51. www.enonline.net/fex/47/spreading

Experiences on Nutrition in Emergencies Training for Syrian refugees response in Jordan

By Caroline Abla



Caroline Abla is the Director of the Nutrition and Food Security Department at International Medical Corps. Caroline has over 22 years of international experience in managing nutrition and public health programmes both in the field and at headquarters. She has implemented programmes in Somalia, Rwanda, Burundi, and Kenya and has responded to humanitarian emergencies including nutrition crises in Ethiopia, Niger, Kenya, Darfur, and Haiti.

International Medical Corps would like to acknowledge UNHCR for funding this NiE training.

With funding from UNHCR, International Medical Corps (IMC) developed and conducted a five days Nutrition in Emergencies (NiE) training course in Arabic, adapted to the Syrian refugee context in Jordan, for 23 health providers from national and international non-governmental organisations (NGOs) and United Nations (UN) agencies assisting Syrian refugees living in Zaatari camp and in host communities. The five days NiE training was conducted from December 16-20, 2012 in Irbid, Jordan. The course focused on infant and young child feeding in emergencies (IYCF-E); maternal nutrition and anaemia; chronic diseases and nutrition in emergency context; as well as coordination and nutrition assessments.

Lessons learnt from previous NiE trainings conducted in Lebanon by the American University in Beirut¹ (AUB) and the International Orthodox Christian Charities (IOCC)², discussions with UNHCR at field and Geneva level, and information gathered from health providers providing services to Syrian refugees in Lebanon, Jordan, and Turkey and to Syrians in Syria, were used to develop the Jordan NiE training. All of the above showed that IYCF; micronutrient deficiencies especially anaemia in women and children; maternal nutrition and chronic disease were critical contextual issues to address in the training. Health care providers and social workers needed the tools and knowledge to counsel Syrians on exclusive breastfeeding and appropriate complementary feeding; nutrition intervention for chronic diseases such as diabetes, heart disease, hypertension, and obesity; prevention and treatment of anaemia and adequate maternal nutrition; and assessment of nutritional status.

The curriculum for the Jordan NiE was based on the IASC Harmonised Training Package (HTP)³ developed under the umbrella of the Global Nutrition Cluster, which was used to develop the two previous NiE Arabic trainings

in Lebanon. However, the HTP and the NiE Arabic curriculum that already existed did not include a module on chronic diseases and their nutrition intervention in emergencies. Additionally, the HTP did not include a specific module on maternal nutrition, but rather had some relevant information scattered in the different modules that needed to be collated. Moreover, the team developed case studies relevant to the Syrian refugee situation in Jordan (camp and non-camp refugees) which differs from the situation in Lebanon (non-camp refugee setting).

For the chronic diseases presentation, education materials that had been developed by IMC and AUB for the Iraqi refugees in Lebanon were used and provided to the Jordan trainees. On one side of the materials there are pictures of what is acceptable and not acceptable to eat according to the chronic disease diet. On the other side, there is written guidance that the health or social worker can provide to the patient. These materials were felt to be adequate to use for the Syrian refugees since the pictures were region appropriate and the Arabic was the official Arabic that is read in all the Middle East.

On day one of the training, the focus was on the causes and types of malnutrition in emergencies and appropriate nutrition interventions in emergencies. On day two, the focus was on assessment in emergencies, assessing nutrition status and needs of at-risk populations, monitoring of nutrition interventions, and micronutrient deficiencies and interventions in emergencies. On day three, the focus was on addressing the needs of pregnant and lactating women in emergencies; common chronic nutrition diseases and their nutritional management, and considerations for chronic disease management in an emergency.

Days four and five, focused on IYCF including an introduction on IYCF-E, guidance on IYCF - getting to know the Code, and optimal IYCF:

recommendations for breastfeeding and complementary feeding guidance and support, breastfeeding mother support, counselling and education, and operational guidance on IYCF for community health workers, assessment and case management.

Coordination between the sectors, as well as between different players providing assistance, was woven into all the presentations. The trainers drove home the concept that the prevention and treatment of malnutrition requires a multi-sectoral approach and close coordination between NGOs, UN agencies, Ministry of Health (MoH), and affected populations. The cluster approach was mentioned but not detailed since this is a refugee crisis and so coordination is within UNHCR's mandate for response.

Daily feedback was solicited from the participants and an end of training evaluation was also conducted. The participants felt that the training was of great value to them. They learnt new skills that will help them improve the quality of their work. They also appreciated the interactive format of the training, that the examples and case studies were reality based from the Syrian context and that they were provided with tools to solve current issues that they face in their day to day work.

The main conclusions from this training was that there is need to develop an HTP module on maternal nutrition and one on chronic diseases in emergencies as these two are currently not fully covered in the HTP modules. In addition, there is need for a critical mass of trained responders to the Syrian crisis on NiE.

For more information, contact: Caroline Abla, email: cabla@internationalmedicalcorps.org

Caroline Abla/IMC, Jordan, 2013

Participants in the NiE training in Jordan in 2012



¹ Source: Dr. Hala Ghattas, American University of Beirut

² Source: Linda Shaker-Berbari, International Orthodox Christian Charities (IOCC)

³ Available at: <http://www.enonline.net/htpversion2/modules>

Agency Profile

Name:	Jordan Health Aid Society (JHAS)
Address:	Um Mutawe Alaslameah Street, Jandweel, building number 69, Amman, Jordan
Phone:	+962 795640906
Email:	president@jordanhealthaid.org
Website:	http://www.jordanhealthaid.org/
Year founded:	2005
CEO/President:	Dr. Yaroup Al-Ajlouni
No. of HQ staff:	70
No. of staff in Jordan (not HQ):	535
No of staff outside Jordan:	290



Interview by Tara Shoham, ENN volunteer



JHAS supported clinic in Amman

In April 2014, the ENN interviewed Ruba Abu Taleb, Nutrition Coordinator with JHAS, about the agency. Ruba joined JHAS in January 2013 as a nutrition coordinator for the JHAS/Medair CMAM/IYCF1 programme. She is a Jordanian national and has a degree in Human Nutrition and Dietetics. You can read about JHAS's nutrition programming in this edition of Field Exchange.

When was JHAS set up, by whom and why?

JHAS is a national non-profit, non-governmental organisation (NGO) serving and supporting the local community in Jordan and the Middle East and North Africa (MENA) region. It was founded July 20th, 2005 by a medical doctor who was experienced in humanitarian work. It was established not due to a specific crisis situation but to provide medical and health services to disadvantaged population groups in Jordan and the MENA region. This includes spreading awareness on healthy living and disease prevention. The main sectors we work in are health, non-food items sector and shelter.

How does JHAS operate?

JHAS provides humanitarian services through partnership agreements with different United Nations (UN) agencies and other international agencies. For example, through UNHCR, JHAS provides primary health care and facilitates secondary life-saving health care and health services to refugees in Jordan. The well-established JHAS/UNHCR system is the only referral system for secondary health care for the Syrian refugees in Jordan. It comprises a central referral hub and an affiliated network of hospitals. In practice, JHAS liaises with around 17 agencies working in primary health care seeking hospital case referrals. As needed, additional funding support is sought from the Emergency Relief Fund (ERF)/OCHA to support the capacity of the existing JHAS/UNHCR system

¹ Community based management of acute malnutrition/Infant and young child feeding

A key partner of JHAS on nutrition in the Syria response is the NGO MEDAIR; JHAS implements the technical plan provided by MEDAIR to provide nutrition services to vulnerable population groups in Jordan. JHAS is the implementing partner for MEDAIR on UNICEF and WFP programmes of work, specifically IYCF and supplementary feeding programming. JHAS is also an implementing partner of both International Medical Corps and Johanniter International, which activities include medical evacuation of refugees and distribution of non-food items.

How is JHAS funded?

JHAS does not receive public donations; international agencies provide JHAS with implementation plans and associated funding, and JHAS provides the space and the staff for the implementation of those programmes. JHAS also directly solicits funding from the ERF in response to calls for proposals.

How many and what is the professional mix of JHAS staff?

JHAS has more than 1,000 employees distributed throughout different JHAS centres. Staff include medical doctors, general practitioners and specialists, pharmacists, nutritionists, nurses, psychotherapists, and other non-medical staff who support management and information exchange, logistics, reporting and patient registration issues. At JHAS, staff are classified as management (logistics, finance, and human resources) or programmes (implementation and direct management).

Does JHAS operate outside Jordan?

Under its emergency response mandate, JHAS is present within Syria providing emergency, primary and secondary medical care. JHAS is also registered and approved in Egypt and Dubai. JHAS had completed emergency deployments in the Gaza strip, Libya and Darfur at the time of those conflicts. Within these countries, JHAS provided medical support through field hospitals and assisted in building the capacity of local health workers to launch health aid response for their countries.

Has JHAS grown in size since the influx of Syrian refugees?

Since 2009, JHAS has had a partnership agreement with UNHCR for the provision of primary and secondary health aid to Iraqi refugees in Jordan. However, in partnership and with continual technical support from UNHCR, JHAS staffing has increased significantly by several hundred in 2011 in order to respond adequately to the Syrian crisis. Even before Zaatar camp opened, Syrians had started to cross over into Jordan. Ever since the JHAS/UNHCR Syrian response programme was launched, JHAS has provided primary healthcare via static and mobile clinics and facilitated referral for advanced medical care for the Syrian refugees in Jordan. Static JHAS clinics have always been (then and now) located at vital points in different governorates, e.g. Irbid, Mafraq and Amman. JHAS also has mobile medical units which 'wander' throughout southern areas of Jordan.

With the opening of Azraq camp (April 2014); there have been calls at health sector level in Jordan for contingency plans to deal with an expected large influx of refugees to the camp. Due to the success of the JHAS/UNHCR system in managing patients' referral for advanced medical care, it is also the designated system for managing Azraq patients' referrals.

Did JHAS' nutrition work only begin with the influx of refugees from Syria?

The JHAS nutrition programme comprising CMAM and IYCF support was launched in January 2013. Before that, health and nutrition education messaging was the extent of our nutrition work with those attending JHAS clinics. Through 2013, the nutrition component of JHAS health services became better defined and gradually other programmes have been developed and integrated into the services, such as management of severe acute malnutrition (SAM) (partnered with UNHCR), management of MAM (MEDAIR-WFP), and management of iron deficiency anaemia in pregnancy. This has been established alongside the ongoing IYCF programme (MEDAIR-UNICEF). Most recently, JHAS participated in the nutrition survey involving UNHCR, UNICEF, WFP, Centres for Disease Control & Prevention (CDC) and implemented by MEDAIR in partnership with JHAS. JHAS participated in supervising teams and the data collection component of the survey. At the Nutrition Working Group level, JHAS has also participated in drafting the operational guidelines for CMAM and for anaemia management.

How did JHAS become the implementing partner on acute malnutrition in the Jordan response?

Through our participation in national health sector meetings and our awareness of all health sector activities, JHAS proposed to implement the CMAM/IYCF programme in 2012. Since then, JHAS and MEDAIR have worked jointly to support different nutrition activities.

How would you describe the culture of the organisation?

As can be seen from the mission statement, the inherent culture of JHAS is to provide medical and health services to vulnerable population groups with non-profit aims. JHAS therefore continuously searches for opportunities for national and international cooperation with different NGO's and UN agencies.

JHAS staff remain in need of further capacity building and technical support, especially in relation to adapting to particular contexts where there is a need to provide health support and adhere to strict humanitarian guidelines. Therefore, training has been regarded as an integral part of the JHAS' recruitment and employee evaluation process.

How would you describe the culture of the international organisations that have 'arrived' in response to the crisis? Are there any challenges to working with the international agencies or knowing what is going on?

Currently in Jordan there are many different agencies working and responding to the Syrian crisis. A challenging feature of the current situation is the rapidly increasing demand of health facilities and health workers themselves. Once JHAS and other agencies agreed on unified working schemes, the challenges remained purely technical and these were always quickly resolved.

International agencies acknowledge the fact that they have access to educated staff to work with in Jordan. In many other countries, they have had to implement programmes themselves but in Jordan they are able just to participate in recruiting key local staff to oversee programmes. There have occasionally been cultural differences. For example, the IYCF programme prompted disagreements regarding how acceptable it is to have a mother on a poster exposing a large area of her breast while breastfeeding. On the whole however, international agencies have worked constructively and productively with JHAS.

Name:	Jordan Hashemite Charity Organisation (JHCO)
Address:	Sa'eed Bino St, Khalda, Amman, Jordan
Phone:	+ 962 6 5523190
Email:	jhco@orange.jo
Website:	www.jhco.org.jo
Year founded:	1990
President:	Ayman Reyadd Alme fleh
No. of HQ staff:	70
No of staff worldwide:	0



Interview by Marie McGrath, Field Exchange Editor



During the ENN's visit to Jordan in March 2014, we had the opportunity to meet with Marwan I. Al-Hennawy, Head of the Division of Coordination, Communication and programmes at Jordan Hashemite Charity Organisation (JHCO), and gain an insight into this national agency that has been at the forefront of humanitarian assistance in Jordan.

When was JHCO founded and how did it come about?

JHCO was founded in 1990. It is a not-for-profit, non-political organisation. It grew out of an initiative by the Government of Jordan and Prince Al Hasan, Crown Prince at that time, to help the Sudanese people during the dry season. When the Iraqi crisis unfolded, the initiative was formulated into JHCO, and became a non-governmental organisation (NGO) registered with the Ministry of Social Affairs. JHCO went on to work as an international NGO, reaching more than 36 countries. JHCO is the biggest 'on the ground' national agency in Jordan, delegated by the Jordanian government as the operational partner for countries wishing to present aid to Jordan or other affected countries. There are about 70 staff, all based in Jordan.

What was JHCO's role in the early Syria response in Jordan?

At the beginning of the Syria crisis response, the government appointed JHCO as the coordinating partner for assistance to Syrian refugees. Many INGOs and United Nations (UN) agencies therefore work with JHCO.

JHCO put in great effort in the early days of the Syria crisis response. "We were almost alone with UNHCR at the very beginning, before Zaatari camp was established. The influx happened so quickly, no one could imagine the large number of arrivals we would see per day". In February 2012, around 50,000 Syrian refugees crossed the border placing a huge burden on the government, UNHCR and JHCO successfully united efforts to establish a decent life in the camp. JHCO was involved in setting up tents, the registration system and a welcome meal. Many organisations coordinated with JHCO for delivery of aid. Later, JHCO coordinated, with the help of donations, to replace more than 5,000 tents with prefabricated units to help refugees cope with the approaching winter.

What are your current areas of operation?

More than three-quarters of Syrian refugees live outside a camp setting. JHCO now focuses on those living outside the camp, given their high proportion and also because the government has appointed a Syrian Refugees Affairs Department, headed by the Public Security Directorate, whose focus is to assist camp refugees.

Could you describe the close working relationship you have with the Jordanian government?

Any NGO in Jordan (whether local or international) must apply to the Ministry of Planning and International Cooperation for approval of any proposed programme of work. Where appropriate, the Ministry will request that the agency coordinate with JHCO on programming. JHCO's operational focus is on in-kind donations and cash assistance. If the proposed work involves another operational sector, then other ministries are involved. For example, if it involves education services, the agency must coordinate with the Ministry of Education. If it involves health, then the Ministry of Health must be consulted.

If an NGO gets the approval of the Ministry of Planning and International Cooperation, then "we work together as a team". One of JHCO's strengths is logistics and distribution capacity throughout Jordan. JHCO has central warehouses in every governorate. If NGOs need to store items until a distribution plan is drawn up, these facilities can be used. JHCO provides help with food and winterisation projects, such as clothes and cash assistance, as well as helping with identification of and access to beneficiaries. JHCO has a database of Syrian refugees in Jordan. The organisation jointly plans with agencies who should be targeted across all governorates and effects distribution through JHCO staff, volunteers and community based organisations (CBOs).

Which agencies have you worked with?

JHCO partners include but are not exclusive to the Lutheran World Federation (LWF), Danish Refugee Council (DRC), International Orthodox Christian Charities (IOCC), World Vision and Islamic Relief. JHCO co-chairs the food sector with WFP and enjoys good relations with UNHCR, regularly attending meetings of the food sector, cash sector and non-food items (NFI) sector.

What other areas of humanitarian assistance are you involved with?

A large component of JHCO's humanitarian assistance is distribution of in-kind donations. Many NGOs operating outside Jordan do not have a national branch. Also, there are often individual efforts to collect materials for refugees in emergencies; JHCO facilitates the collection and distribution of these donations. For example, in February 2014, JHCO received an IFAD¹ donation (Rome) and were asked to distribute on their behalf. The distribution plan was sent by JHCO for approval to IFAD, followed in due course by evidence of the distribution. The donations JHCO receive depend on the season, e.g. in winter, blankets, carpets, clothes and food are common. In summer, food and cash is more typical. Donated food usually takes account of cultural preferences and typically includes rice, sugar, canned foods, tea, tahini, beans, pasta and oil.

JHCO are also involved in supporting cash programming, implemented in an agreement with a local bank. Cash payments

are made on a monthly basis using an ATM card. JHCO help to finalise the beneficiaries list and to contact the beneficiaries. Islamic Relief and DRC are two of the agencies JHCO collaborate with on cash assistance.

Do you provide assistance outside Jordan?

JHCO has been involved in many international responses, such as the Iraqi crisis, Gaza crisis in 2008 and 2010, and now the Syrian crisis. JHCO do not have an operational presence outside Jordan but typically provide in-kind donations that are distributed by contacts in the affected country. "We never reject any kind of request for assistance". Requests may come through JHCO's website or through diplomatic channels. For example, the government of affected countries may contact the Jordanian government via their embassy with a request for assistance. The government of Jordan then contacts JHCO. The Jordanian people are generous and respond to international disasters with monetary or in-kind donations to JHCO. Sometimes JHCO contact local NGOs in Jordan and organise a campaign for urgent assistance for a particular crisis; they usually "come running to help". For international assistance, the government of Jordan may provide transport, e.g. a plane, to deliver the donated supplies.

How are you funded?

JHCO funding mostly comes from the private sector, e.g. private banks, individual business owners, universities and individuals – especially those working in the private sector who may donate any annual benefit/bonus to JHCO.

Do you have any final words on the Syrian crisis from your perspective?

The Syrian crisis is a huge refugee crisis. Unlike many other large scale disasters in the world, e.g. Haiti 2010 or floods in Pakistan, it is not short lived but looks like it will continue. Syrian refugees continue to cross the border into Jordan. Humanitarian assistance is a permanent fixture for the foreseeable future, as politically there is no cause for optimism regarding a solution in the near future.



Gabriele Fänder/Medair, Jordan, 2014

¹ International Fund for Agricultural Development